

1990

# The federal government, Ontario and medical care insurance: A study in federal-provincial relations.

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THE FEDERAL GOVERNMENT, ONTARIO AND MEDICAL CARE INSURANCE:  
A STUDY IN FEDERAL - PROVINCIAL RELATIONS

by  
Stephen T. Holloran

A Thesis  
Submitted to the  
Faculty of Graduate Studies and Research  
through the Department of History in Partial Fulfillment  
of the requirements for the Degree  
of Master of Arts at the  
University of Windsor

Windsor, Ontario, Canada

1990

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ISBN 0-315-60997-4

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For Mom, Dad, Lynn and Ananda

ABSTRACT

THE FEDERAL GOVERNMENT, ONTARIO AND MEDICAL CARE INSURANCE:  
A STUDY IN FEDERAL - PROVINCIAL RELATIONS

by

Stephen T. Holloran

This is a history of the medical care insurance system in Ontario. I undertook this study in order to help explain a part of Canadian history that has been severely neglected. The available material relating to the Canadian health care system has been written by an assortment of political scientists, sociologists and medical doctors. There has however been no effort by Canadian historians to examine the evolution of this important area.

In the 1989 - 1990 fiscal year Ontario will spend 33 percent, or \$14 billion, of its budget on health care.<sup>1</sup> Of this, \$ 4.3 billion will be spent on the Ontario Health Insurance Plan (OHIP).<sup>2</sup> Recently, significant changes have been taking place in Ontario's medical care insurance system. In 1986 Bill 94 barred Ontario's doctors from billing their patients above the amount

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<sup>1</sup> Ontario Ministry of Treasury and Economics, Economic Outlook and Fiscal Review, Toronto, November 1989, 62.

<sup>2</sup> Ontario Ministry of Treasury and Economics, 63.

allowed by OHIP. On of January 1, 1990, the Government of Ontario discontinued the monthly premiums that individuals were responsible to pay into OHIP. Considering the enormous amount of money spent and the highly publicized recent changes to health care insurance, it is curious that more has not been written on the history of this vital part of Ontario's social system.

This is an historical account of the events that led to Ontario's acceptance of the national medical care insurance plan, and the consequent introduction of the Ontario Health Services Insurance Plan (OHSIP). After introducing OHSIP (1969) Ontario soon amended the program to the current OHIP (1972). A history of these programs would certainly be a logical extension of this study.

At one time or another medical care treatment is required by everyone. For this reason it is important for society to understand its health care system, so that it can be improved for the present and future generations.



## ACKNOWLEDGEMENTS

First, I would like to thank my thesis advisor Professor Ronald Hoskins for the guidance that he has offered me and his enthusiasm for this project. Thanks also to the other members of my thesis committee, Professors Ian Pemberton and Robert Krause, for their valuable suggestions.

Throughout the course of this project I have had the unique opportunity of interviewing several of the key individuals in the Medicare debates. The Hon. Robert Nixon, Deputy Premier and Treasurer of Ontario, Mr. Charles Black, Vice President of the Canadian Health Insurance Association, and Mr. Arther Bond, President of the Physicians' Services Foundation, all took time from their busy schedules to talk with me about their roles in the development of Ontario's medical care insurance system. Mr. Bond and Mr. Black were kind enough to collect company files and open them for my use.

Both Dr. Robert Colcleugh and Dr. William Butt greatly assisted me in contacting individuals who were involved in the Medicare debates. As former Treasurer of the Ontario Medical Association,

Dr. Butt also offered me invaluable insight into the doctors' attitudes toward the introduction of government medical care insurance and the profession's complicated internal politics.

I received assistance from numerous individuals in the Leddy Library, but the efforts of Ms. Donna Peltier, Supervisor of Inter-Library Loans, and Mrs. V. Agnes Pearson, of the University Archives, were above and beyond the call of duty. I must also acknowledge the assistance of Stephen Cloutier, who took time away from his own studies to read this thesis and offer suggestions. Thanks also to the staff at the Archives of Ontario and especially Associate Archivist Caroline E. Gray.

Finally, I would like to express my thanks to Cathy Buchanan, who patiently assisted me in the final editing and organization of this project.

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## INTRODUCTION

Following a bitter struggle, the Premier of Ontario, John P. Robarts, accepted the federal government's medical care insurance plan.<sup>1</sup> On October 1, 1969, the Ontario Health Insurance Services Plan (OHSIP) came into effect.<sup>2</sup> This plan qualified Ontario for a federal financial subsidy, as outlined in the Medical Care Act (1966). Ontario's acceptance of this plan was a victory for federal social services policy, but was an important factor in the deterioration of federal-provincial relations during the 1960s.

Under OHSIP all of Ontario's citizens received comprehensive medical care benefits. The financing of this program was shared jointly between the federal and Ontario governments. Part of

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<sup>1</sup> Canada's national medical insurance plan is often referred to as Medicare. The term Medicare was taken from the title of the American system of medical care insurance coverage, which, unlike the Canadian system, provides government financed coverage only to recipients of social assistance.

<sup>2</sup> Ontario Department of Health Annual Report, 1969, Introduction.

Ontario's share was financed by low monthly premiums. It would seem that a program such as OHSIP, which provided comprehensive and universal medical coverage, would be well-received; however, feelings were mixed. Certainly, there were those who supported the plan, but there were also many who were much less enthusiastic about its introduction. The latter felt that Ontario already had an existing medical care insurance program that suited the Province's needs. Known as the Ontario Medical Services Insurance Plan (OMSIP) it offered a low cost standard care plan to Ontario's residents.

Brought in by Robarts in 1966, OMSIP offered the people of Ontario an alternative to the plan that Prime Minister Lester Pearson's Government had been proposing throughout the 1960s. Now referred to as Medicare, Pearson's plan was designed to offer quality medical care to all Canadians through a government financed and administered system. Robarts rejected Pearson's plan claiming that Ontario already had OMSIP; which, in conjunction with the private insurance industry and doctor-sponsored plans, covered 95 percent of the Province's medical care needs.<sup>3</sup>

Previous to the introduction of OMSIP Ontario had a flourishing system of medical care coverage. Most of the people were covered by private insurers or doctor-sponsored plans. Those who could

not afford to pay the premiums were insured by the Government of Ontario's Medical Welfare Plan. The introduction of OMSIP helped to increase medical care coverage, while retaining the participation of the private insurers and doctor-sponsored plans. The Medical Welfare Plan was discontinued in 1966 because OMSIP took over the responsibility of insuring the recipients of government assistance.

The two strongest supporters of Robarts in his opposition to the federal plan were the insurance industry, both private and doctor-sponsored and the Ontario Medical Association (OMA). The insurance industry faced losing its medical care market, because the federal plan would render its service obsolete. The OMA feared that the federal plan would decrease doctors' professional autonomy. For instance, they felt that their ability to set fees would be taken away by the government. The insurance firms and the OMA supported Robarts' stance, but they also put certain pressures on the Premier. They had interests which could be protected or threatened by legislation. For this reason, they lobbied the Robarts' Government to pass legislation that would be beneficial to them.

Although Robarts was a nationalist he felt that Canada should consist of a group of strongly united provinces. He was an ardent supporter of provincial rights and often stated that health care was an area of provincial jurisdiction, as set out in section 92

of the BNA Act.<sup>4</sup> Accordingly, Robarts saw the growing federal moves into the health care sector as an infringement on provincial autonomy. The provinces had jurisdiction over health care, but, the federal government had the major financial power. As Section 91 of the BNA Act stated, the federal government was authorized to raise revenue by "any mode or system of taxation."<sup>5</sup> This would ultimately be Robarts' downfall. He established a successful alternative to the federal plan (OMSIP), but, could not resist the tremendous fiscal pressures that were imposed on Ontario.

The history of medical care insurance in Ontario, and across Canada, has been one of endless controversy and compromise between the provincial and federal governments. This history is very much a part of the continuing development of the welfare state in Canada. To appreciate the complexity of the issues involved, the evolution of the medical care system in Canada must be fully understood. By studying the events leading up to the 1960s Medicare struggle, one sees the steady progression of federal initiatives into the health care sector. Robarts' defence against these moves marked a last stance to retain autonomy in one area of provincial jurisdiction.

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<sup>4</sup> Department of Justice Canada A Consolidation of The Constitution Acts 1867 to 1982 (Ottawa, 1986), 32.

<sup>5</sup> Department of Justice. Canada, 29.

CHAPTER 1  
BACKGROUND TO CANADIAN HEALTH INSURANCE POLICY

During and immediately after World War I, Canadian society was changing rapidly. Most importantly, the country was becoming industrialized and with this transition came a demand for social change from the growing urban/industrial class. In addition, Canadian society was influenced by new social policies originating in Britain. The National Insurance Act (1911) passed by the Asquith government in Britain had an important influence on Canadian social policy.<sup>1</sup> This Act introduced a system of compulsory health and unemployment insurance which was partially financed by government. This program sparked similar change in the Canadian government's policy.

Statistics collected on Canadian war recruits indicated that their general health status was lower than would be expected.<sup>2</sup>

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<sup>1</sup> Harry, Eckstein, The English Health Service: Its Origins, Structure, and Achievements (Cambridge, Massachusetts, 1964), 19.

<sup>2</sup> Gordon H. Hatcher, Peter R. Hatcher, Eleanor C.  
(Footnote Continued)



Armed with this knowledge, and with the example set by Britain's National Insurance Act, the new leader of the Federal Liberal Party, MacKenzie King, outlined a plan for national health insurance at the 1919 leadership convention.<sup>3</sup> Although national insurance was not fully achieved until the 1960s, these early proposals brought the issue to the country's attention.

Prior to 1919, the idea of government supported health care insurance had been implemented in Saskatchewan. In Sarnia, Saskatchewan (1914) a form of medical care insurance was introduced, which provided for a retainer to keep physicians in a specific district. This retainer was paid through municipal tax revenues.<sup>4</sup> After Sarnia's successful introduction of this plan, the province passed the Rural Municipality Act. Under this Act rural municipal councils were authorized to levy taxes, based on a property assessment, in order to pay doctors retainer fees.<sup>5</sup> In the same year Saskatchewan passed the Union Hospital Act, which

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(Footnote Continued)

Hatcher " Health Services in Canada " in Marshall W. Raffel Comparative Health Systems (Pennsylvania, 1985), 87.

3

Weller, G. R. "Health Care and Medicare Policy in Ontario," G. Bruce Doern and V. Seymour Wilson Issues in Canadian Public Policy (Toronto, 1974), 93.

4

Susan Watt, "Health Care" in Joanne C. Turner and Francis J. Turner (eds.) Canadian Social Welfare, (Don Mills, Ontario, 1981), 203.

5

Sylva M. Gelber, "The Path to Health Insurance" in Carl A. Meilicke and Janet L. Storch Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends (Ann Arbor, Michigan, 1980), 156.

created hospital districts to be financed jointly by member municipalities and towns.<sup>6</sup> Their combined effort would be utilized to build and maintain hospitals. This was a move toward community co-operation in the provision of health care through government revenue. The Union Act signified a break with the nineteenth-century tradition of the Poor Laws, which placed sole responsibility for the care of the needy on the individual local authority.<sup>7</sup> These early health care programs were part of Saskatchewan's growing co-operative movement. For instance, in 1914 there were 113 registered agricultural co-operative associations in Saskatchewan.<sup>8</sup> Co-operation was the way in which settlers were able to survive in the harsh frontier environment.

Despite the progress in Saskatchewan, and the Liberal proposals in 1919, the federal government avoided moving into the provincial jurisdiction of health care. Many of the new tasks facing Canada after World War I fell under provincial jurisdiction: building highways, harnessing water power, and expanding welfare services.<sup>9</sup> With its great wartime debt, the federal government was hesitant to move into these areas.

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<sup>6</sup> Gelber, 156.

<sup>7</sup> Gelber, 24.

<sup>8</sup> John H. Archer, Saskatchewan: A History (Saskatoon, Saskatchewan, 1980), 156.

<sup>9</sup> A. Milton Moore, J. Harvey Perry, Donald I. Beach The Financing of Canadian Federation (Toronto, 1966), 6.

Nevertheless, federal revenue ultimately found its way to the growing needs of the provinces.

Following World War I the federal government offered to share in the financing of provincial programs. The provinces agreed to participate in these first cost-sharing plans which included: vocational education, highway construction, employment offices, venereal disease prevention, and social assistance.<sup>10</sup> The first major federal move into social welfare assistance was King's Old Age Pension Act of 1927.<sup>11</sup> The Act allowed for old age assistance based on a means test.<sup>12</sup> The program was financed jointly by the the federal and provincial governments on a 50:50 basis.<sup>13</sup> By 1930 the federal government was allocating \$ 10 million per year to this program.<sup>14</sup>

The Old Age Pension Act was an attempt by King to attract support from J.S. Woodsworth and his supporters to his minority

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<sup>10</sup> Donald V. Smiley, Conditional Grants and Canadian Federation: A Study in Constitutional Adaptation (Toronto, 1963), 2.

<sup>11</sup> Smiley, Conditional Grants and Canadian Federalism, 2.

<sup>12</sup> J. H. Perry, "The Historical Background and Development of Federal Provincial Relations", in Canadian Public Administration (Toronto, 1962), 25.

<sup>13</sup> Perry, 25.

<sup>14</sup> Moore, Perry, Beach, 9.

15  
government. The political left was increasingly becoming a factor to consider in government decision-making. For instance, labour was able to pressure the British Columbia government into establishing a Royal Commission to study health care.<sup>16</sup> The findings of this Commission, released in 1922, indicated that health care could in fact be a federal responsibility despite the BNA Act.<sup>17</sup> Leftist politicians were gaining some recognition; but, the post war industrial growth, high employment, and prosperity tended to erode their influence. In addition to these factors, these reformers had not yet united as a coherent force in the 1920s. The urban working class was too weak and fragmented, at that time, to act independently.<sup>18</sup> They were also unable to ally with the growing farmer movements. It was very difficult for the workers in the eastern cities to find unity of purpose with the farmers in the prairie provinces. Into the 1930s, the Depression offered these groups reason to pursue the common goal of social security; therefore, their demands became a very important political consideration.

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15

Christopher Armstrong, The Politics of Federalism: Ontario's Relations With The Federal Government, 1867-1942 (Toronto, 1981), 141.

16

Gelber, 157.

17

Gelber, 158.

18

George M. Torrance, "Socio-Historical Overview: The Development of the Canadian Health System" in David Coburn, Carl D'Arcy, Peter New and George Torrance (eds.), Health and Canadian Society (Canada, 1981) 22.

The onslaught of the Depression in the 1930s drastically altered financial arrangements between the federal and provincial governments. The Depression created severe financial problems for the provinces, because the BNA Act designated welfare matters as a provincial responsibility. The prairie provinces, in particular, suffered greatly as a result of their reliance on single crop economies and because of the severe droughts that hit the region.<sup>19</sup> With the rising unemployment rate, people were increasingly unable to pay their bills, including those for medical and hospital care. In addition to this problem, many municipalities went bankrupt; therefore, local communities were no longer able to help finance health costs. The provincial governments were unable to cope with these rising costs because spending had already been rising rapidly. Between 1921 and 1930 provincial expenditures more than doubled annually, while federal spending rose by only 10 percent.<sup>20</sup> By the 1930s the provinces were unable to assume any additional financial obligations. Thus, the Depression was the first significant political incentive for the federal government to offer social welfare assistance, including health care, to the provinces. Throughout the Depression the federal government was careful to provide only temporary and emergency assistance as outlined by the BNA Act. The amount of relief offered by Ottawa nevertheless was quite

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19  
Torrance, 23.

20  
Armstrong, 133.

substantial. During some years the federal government paid up to  
21  
40 percent of relief costs.

In terms of health care insurance some attempts to establish  
provincially-sponsored plans were initiated. The United Farmers  
of Alberta (UFA) attempted to introduce health care insurance in  
1934.<sup>22</sup> Legislation was passed, but its implementation was  
23  
blocked by the newly elected Social Credit government in 1935.  
In British Columbia the Liberal government, under pressure from  
labour and the Co-operative Commonwealth Federation (CCF),  
24  
pressed for state health insurance. The Liberals' plans were  
attacked by the medical profession and its conservative allies.  
In addition to this, R. B. Bennett's federal Conservative Party  
refused to provide financial support to health care schemes.

Growing pressure from the unemployed masses helped lead to the  
Bennett Government's change in policy. The "On to Ottawa Trek" of  
unemployed relief camp workers in 1935 drew attention to public  
discontent with the federal government's existing social  
assistance system. As part of his "New Deal Legislation" Bennett

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21

G. V. LaForest, The Allocation of Taxing Power Under  
the Canadian Constitution (Toronto, 1981), 25.

22

Torrance, 24.

23

Torrance, 24.

24

Margaret A. Ormsby, "T. Dufferin Pattullo and the  
Little New Deal", in The Canadian Historical Review, Vol. 43  
(no. 4, December, 1962), 282.

passed the Employment and Social Insurance Act in 1935.<sup>25</sup> This Act provided for social security measures including a health insurance program for the unemployed. This program was to be financed by premiums levied on the Canadian people by the federal government.<sup>26</sup> However, Bennett's "New Deal" was never implemented in its entirety, as a result of his loss to the King Liberals in 1935.

King attacked Bennett's employment and social insurance initiatives on constitutional grounds. The legislation went to the Supreme Court of Canada, which declared the Act unconstitutional in 1937.<sup>27</sup> This decision upheld the terms of the BNA Act whereby social welfare, including health care, was a provincial responsibility. To address this constitutional problem the King government appointed a Royal Commission on Dominion-Provincial Relations in 1937. The unconstitutionality of much of Bennett's "New Deal" meant a deferral halting of federal-provincial co-ordinated efforts to implement social legislation. In addition to this, the Depression meant a shortage of provincial revenue. For these reasons social welfare policy did not progress in the late 1930s.

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Spyros Andreopoulos, National Health Insurance: Can We Learn From Canada? (Toronto, 1975), 13.

26

Andreopoulos, 13.

27

Rita Lindenfield, "Hospital Insurance in Canada: An Example in Federal-Provincial Relations" in Meilicke and Storch, 68.

The Royal Commission, appointed by King in 1937, was established to analyze the changing nature of the federal-provincial relationship and the resulting financial repercussions. The Commission was faced with the task of determining solutions to the problems of dealing with the economic stress created by the Depression and the constitutional division of federal-provincial powers.<sup>28</sup> The Rowell-Sirois Report, named after the Royal Commission's chairmen, was presented to the federal government in May of 1940.<sup>29</sup> The Report recommended the transfer of some provincial functions to Ottawa on the understanding that the latter would assume complete control over income and succession duties. The federal government would also assume the provincial debts and make special annual payments to the more needy provinces.<sup>30</sup> These provinces would be provided with subsidies through the Commission's National Adjustment Grant Proposal. The plan recommended the redistribution of tax revenue to poorer provinces. This was to enable them to provide social services equal to the Canadian average standard.<sup>31</sup> The Report's recommendations were unacceptable to the three provinces (Ontario, Alberta, and British Columbia) that were not eligible for the National Adjustment Grants. They were concerned that

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28

Moore, Perry, and Beach, 12.

29

Moore, Perry, and Beach, 14.

30

Paul Martin, "Report From Parliament Hill" delivered in radio series, (Dec 2nd 1950).

31

Moore, Perry, and Beach, 13.



their tax dollars would be redistributed to support other provincial programs, at the expense of their own.

The Report questioned the federal initiatives into shared-cost programs, by explaining that social welfare measures were a provincial responsibility. However, the Report did recommend that unemployment relief, the most crippling social problem, be turned over to the federal government.<sup>32</sup> It also recommended centralization of taxing power to offer greater efficiency. Ontario, Alberta, and British Columbia rejected the Report for reasons previously mentioned; plus, the proposals were an infringement on the provinces' right to administer direct taxation. Premier Mitch Hepburn of Ontario led the attack on the Report. As Premier Oliver Mowat had done before him, Hepburn was determined to protect provincial autonomy. Christopher Armstrong wrote in his book The Politics of Confederation: Ontario's Relations with the Federal Government, 1867-1942:

The government of Ontario preferred to defend its sphere of autonomous authority, and no right was more prized than the right to levy taxes and spend without reference to Ottawa's wishes.

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32  
Moore, Perry, and Beach, 12.

33  
Armstrong, 235.

The provinces rejected the Rowell-Sirois recommendations, but they did consent to the federal government's wartime tax rental agreements. Ottawa proposed an arrangement whereby the provinces would temporarily renounce their rights to collect personal and corporation taxes in return for a federal compensation package. In the spirit of wartime necessity, the provinces accepted the temporary federal offer. Between September 1, 1941, and September 1, 1947, no provinces or municipalities taxed individuals or corporations.<sup>34</sup> Although these were temporary arrangements the tax agreements concentrated a tremendous amount of power in the federal government, making it hesitant to relinquish this power at the end of the War. It was during this period that federal initiatives sparked the real beginning of the Canadian welfare state. During the War the federal government began planning for the future. At this time there was a world-wide move toward ideas of social justice and security. For instance, the Atlantic Charter (August, 1941) of Winston Churchill and Franklin D. Roosevelt proposed "freedom from want" and "social security."<sup>35</sup> In Canada there was also a move toward the political left. Indicative of this trend was the dramatic rise of the CCF Party. In August, 1943 the CCF became the official opposition in Ontario and in June, 1944 the CCF became the governing party in

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Moore, Perry, and Beach, 17.

35

Leonard Marsh, "Report on Social Security for Canada 1943: Introduction to the 1975 Edition", in Meilicke and Storch, 69.

36  
Saskatchewan. The growing power of the CCF and the concurrent growth of labour hostility meant that the federal government had to re-evaluate its social policies.

In order to prepare for the post-war years, the federal government called a Federal-Provincial Conference on Reconstruction in May, 1945.<sup>37</sup> Among the issues discussed at the Conference was an ambitious social security program to be administered jointly between Ottawa and the provinces. These "Green Book" proposals did not contain the hostility towards federal-provincial joint arrangements that characterized the Rowell-Sirois Report.<sup>38</sup> The Green Book proposals reflected the federal government's ambition to have exclusive control of personal and corporate taxes, plus the succession duty fields.<sup>39</sup> In return, the provinces would be offered a subsidy which would vary with the Gross National Product, but this was not to be less than \$12 per capita, based on the 1941 population.<sup>40</sup> Included in

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36  
Malcolm G. Taylor, Health Insurance and Canadian Public Policy ( Montreal, 1978 ), 7.

37  
D.V. Smiley, " Public Administration and Canadian Federalism ", in Canadian Public Administration, Vol. 3, ( September, 1964 ), 374.

38  
Smiley, "Public Administration and Canadian Federalism", 376.

39  
Smiley, " Public Administration and Canadian Federalism", 376.

40  
LaForest, 28.

these proposals was a plan to establish universal health insurance.

The federal health care proposals were a result of projects that took place during the War. The federal Minister of Pensions and National Health, Ian Mackenzie, was heavily influenced by the release of the Beveridge Report (1942) in Britain, which recommended a greater degree of government involvement in social security. Mackenzie was also influenced by the struggle against oppression, which was represented by the War effort:

Few today can regard war as an adventure and there it only becomes tolerable as a crusade with social and economic reform as a banner under which we fight.<sup>41</sup>

Mackenzie petitioned the government vigorously to study the merits of adopting a health care insurance plan. He was given approval from Cabinet to appoint an Inter-Departmental Advisory Committee on Health Insurance. The Committee was chaired by Dr. J. J. Heagerty and functioned between February 1942 and December 1944.<sup>42</sup> The Heagerty Committee determined that the use of the grant-in-aid cost-sharing device was a feasible method to finance health care despite the findings of the Rowell-Sirois Commission.<sup>43</sup> Mackenzie's proposal was presented to Cabinet,

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<sup>41</sup> Taylor, 7.

<sup>42</sup> Taylor, 17.

<sup>43</sup> Taylor, 18

which then referred it to the Economic Advisory Committee. This move irritated Mackenzie, because he felt that it was a stalling tactic to prevent the proposal going to the House of Commons.

One of the Heagerty Committee members, Dr. Leonard Marsh, was appointed by the federal government to chair an Advisory Committee on Reconstruction.<sup>44</sup> Marsh studied as a graduate student under Sir William Beveridge; therefore, he was heavily influenced by his social welfare thinking.<sup>45</sup> The Advisory Committee on Reconstruction released its findings, the Marsh Report, in 1942.<sup>46</sup> The Marsh Report recommended a comprehensive program of social security and emphasized health and unemployment insurance.

Frustrated with government stalling tactics, Mackenzie wanted the findings of both the Heagerty and Marsh Committees to be studied by a House of Commons Special Committee on Social Security.<sup>47</sup> This Committee was approved by Cabinet and met between 1943 and 1944.<sup>48</sup> The Committee accepted the principle of government health insurance and recommended a draft bill based on the Heagerty

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<sup>44</sup> Rita Lindenfield, 167.

<sup>45</sup> Taylor, 17.

<sup>46</sup> Lindenfield, 21.

<sup>47</sup> Taylor, 20.

<sup>48</sup> Taylor, 20.

49  
Report. Despite these initiatives, health insurance was not given top priority. Rather, the Family Allowance Act (1944) was the next social legislation to be implemented by the federal government.  
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Although the Heagerty and Marsh reports did not produce immediate results, their recommendations were utilized by the federal government at the 1945 Conference on Reconstruction. The Green Book proposals presented by the federal government during the Conference were rejected by the provinces. The latter objected to the federal government's move into provincial jurisdiction. Ontario and Quebec were especially hesitant to allow Ottawa to move into provincial tax domains, and offer uniform social programs.  
51  
Provincial autonomy was at odds with the federal claim that Canadians had the right to defined social welfare standards.

Despite the provincial rejection of the Green Book proposals, the federal government pursued centralist policies, especially in terms of taxation and social welfare. In the immediate post-war period, the federal government did not contribute to provincial welfare programs except in the areas covered by the Old Age

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49  
Gelber, 160.

50  
Lindenfield, 167.

51  
Dennis Gruending, Emmett Hall: Establishment Radical  
( Toronto, 1985 ), 86.

Pensions Act.<sup>52</sup> Nevertheless, Ottawa sought gradual entry, through grants-in-aid to provinces, into particular health functions.<sup>53</sup> Repeated offers were made to the provinces individually, which, accommodated their specific needs. By 1948 all of the provinces, except Ontario and Quebec, had entered into a tax rental agreement with the federal government.<sup>54</sup> The two largest provinces rejected the arrangement because they did not receive the same amount of compensation relative to the other provinces.<sup>55</sup> The federal government put pressure on Ontario and Quebec to join the tax rental agreements. By taxing them in areas occupied by the federal government, while decreasing these taxes for provinces in the program, Ottawa hoped to force Ontario and Quebec to join. Ontario eventually accepted a compromise (1952), whereby the province "rented" personal income tax and received federal compensation, but, it continued to impose its own succession duties and administered a corporate profits tax.<sup>56</sup> Quebec did not reach any agreement with the federal government, due to its concern about losing provincial autonomy. Although the provinces rejected the Green Book Proposals, their acceptance,

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- 52  
9. Smiley, Conditional Grants and Canadian Federalism,  
53  
10. Smiley, Conditional Grants and Canadian Federalism,  
54  
LaForest, 10.  
55  
LaForest, 28.  
56  
LaForest, 30.

excluding Ontario and Quebec, of the tax rental agreements offered the federal government greater ability to move into provincial jurisdiction.



## CHAPTER 2

### GOVERNMENT INITIATIVES INTO HEALTH INSURANCE

Although the Green Book proposals had been rejected, Ottawa still pursued the idea of social programs, including health care, to be administered and financed jointly by the federal and provincial governments. The federal government decided to utilize the grants-in-aid mechanism to help finance provincial health programs. The federal initiatives into health programs were heavily influenced by Paul Martin, the Minister of National Health and Welfare. In 1948, Martin secured approval for the introduction of ten separate, but inter-related, conditional grants: hospital construction, health surveys, professional training, public health research, general public health, mental health, tuberculosis control, cancer control, venereal disease control, and crippled children.<sup>1</sup> These grants added more than \$ 30 million to health spending, which represented \$ 17 million

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<sup>1</sup>  
Spyros Andreopoulos, National Health Insurance: Can We Learn From Canada? (Toronto, 1975), 14.

more than the Green Book Proposals offered.<sup>2</sup> Under the program the country was able to embark on a much needed hospital construction campaign. By 1950 the National Health Grants had provided for the addition of 25,000 additional hospital beds in Canada.<sup>3</sup> Both Paul Martin and Prime Minister King saw these grants as the foundation for a comprehensive national health insurance system.

King declared:

These grants represent the first stages in the development of a comprehensive health insurance plan for all Canadians.<sup>4</sup>

Martin added:

The new services being developed and the new hospitals being built with these federal grants are hastening the moment when in every province it will be possible to consider further action towards hospital and medical care insurance - for which, of course, the federal government stands ready to provide assistance, under satisfactory agreements for dominion-provincial co-operation.<sup>5</sup>

Certainly King and Martin were influenced by the dramatic events taking place in Britain during this time. On July 5, 1948, Britain's Labour Government introduced its publicly-financed

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<sup>2</sup> Paul Martin, Report on National Health Program, in the House of Commons, (Feb 23, 1949), 5.

<sup>3</sup> Paul Martin, Dominion Provincial Relations, in radio series "Report from Parliament Hill", (Dec 2, 1950), 6.

<sup>4</sup> House of Commons, Debates, May 14, 1948, 3933.

<sup>5</sup> Paul Martin, Report on National Health Program, in House of Commons, (Feb 23, 1949), 4.

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National Health Service. This program was a direct result of Sir William Beveridge's 1942 Report that called for social welfare proposals from the "cradle to the grave".<sup>7</sup> Introduced by Mr. Aneurin Bevan, Britain's Minister of Health, the National Health Services Act foreshadowed future proposals in Canada:

1. A compulsory health insurance provision for everyone in the nation, including all medical, hospital and essential health services, without cost at time of service to the recipient.
2. A small weekly individual premium with the major costs being borne by the state.
3. The taking over ownership of all hospitals in the land with the exception of hospitals attached to medical schools.
4. The division of the country into 14 (now 15) hospital regions with councils and committees of laymen and doctors (with the doctors in the minority on the committees of management) in charge of functional operations.
5. The prohibition of buying and selling of medical practices which for decades had been the custom of the British Isles.
6. The setting aside of L 66 million to pay for practices at time of retirement or death. (This price to include a small rate of interest.)
7. The establishment of free choice of doctor and patient (subject to change at quarterly intervals) with each general practitioner who entered the scheme being permitted to enroll up to 35,000 persons on his panel. Each panel patient was entitled to receive free home and office care, for which the attending practitioner would be paid 17 shilling and 6 pence per year. This was known as the "capital fee".

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T. Clarence Routley. "Quality, Quantity and Costs of Medical Care under State Insurance Programs," in The Canadian Life Insurance Officers Association, Proceedings May 24-25, 1962, 54.

7  
Routley, 52.

8. The appointment to households on a full-time or part-time basis, of consultants and specialists who provided free hospital care to panel patients.
9. The control of the moving and locating of doctors to be in the hands of committees of management.
10. The provision of dental, ophthalmic, obstetric and other auxiliary services without cost.
11. The right of General Practitioners to refer to hospital any and all patients who in their judgement required hospital and/or special care.
12. The provision of drug and supplies without cost (later the Ministry put a charge of one shilling per prescription, and now two shillings, because of the astronomical figures that drug prices reached in a very short space of time).
13. That in purely scientific matters doctors be allowed, as indicated by Mr. Bevan, "to run their own show".
14. That the Act would become operative on July 5th, 1948.
15. That doctors had until the above date to declare whether or not they would enter the scheme and those who had not so declared would be considered as remaining outside. Those remaining outside could continue in private practice but their patients would have no rights under the scheme in respect of free medical care, free hospitalization, or free drugs.<sup>8</sup>

While these progressive reforms were being introduced in Britain, similar ideas were being considered in Canada and especially in the Province of Saskatchewan. With the memories of the Depression still in the minds of the people, Saskatchewan was receptive to social welfare policy in the 1940s. After all, in 1937, two

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Routley, 54.

thirds of Saskatchewan's population was on government relief.<sup>9</sup>  
The province already had a municipal doctor system, which covered  
one quarter of the population in 1944, but, there was no  
universal government sponsored system.<sup>10</sup> Under the guidance of  
Tommy Douglas, the newly elected CCF premier, Saskatchewan  
pursued government health care insurance.

Using the example of the 1944 Heagerty Committee Report, the  
Saskatchewan Legislature ordered a select committee to study ,  
among other things, the viability of a government health  
insurance system.<sup>11</sup> Based on the report of this body, the  
provincial government introduced a bill to the Legislature on  
March 21, 1944 recommending the initiation of health insurance.<sup>12</sup>  
The bill passed on April 1, 1944 as the Saskatchewan Health  
Insurance Act.<sup>13</sup> This Act provided for the establishment of a  
commission that would take the initial steps in preparing a plan  
for health insurance in Saskatchewan. Chaired by Henry E.  
Sigerist, Professor of the History of Medicine at Johns Hopkins

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<sup>9</sup>  
Robin F. Badgley and Samuel Wolfe, Doctor's Strike: Medical Care and Conflict in Saskatchewan (New York, 1967), 3.

<sup>10</sup>  
Thomas H. McLeod and Ian McLeod, Tommy Douglas: The Road to Jerusalem (Edmonton, 1987), 146.

<sup>11</sup>  
E.A. Tollefson, Bitter Medicine: The Saskatchewan Medicare Feud (Saskatoon, Saskatchewan, 1963), 27.

<sup>12</sup>  
Tollefson, 29.

<sup>13</sup>  
Tollefson, 29.

University, the Commission recognized the great financial considerations involved in establishing a program; therefore, it recommended a step-by-step approach.<sup>14</sup> The Commission presented its report on October 4, 1944.<sup>15</sup> The report proposed a plan to establish health districts, a research-planning commission, training for the mentally handicapped, and free medical service to pensioners, widows, and orphans.<sup>16</sup>

The doctors of Saskatchewan were disappointed with some of the proposals of the report. For instance, they rejected the Commission's recommendation that physicians receive salaries and that no medical personnel be included in the administration of the program. Despite their objections, Douglas was optimistic that an agreement could be reached; however, negotiation with the doctors was soon terminated.<sup>17</sup> This was because the federal and provincial governments had failed to reach an agreement on a cost-sharing plan at the 1945 Conference on Reconstruction.

Led by Douglas, Saskatchewan decided to pursue health care insurance without federal assistance. Following the recommendations of Sigerist, Saskatchewan began a step-by-step

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<sup>14</sup> Mcleod and Mcleod, 148.

<sup>15</sup> Tollefson, 34.

<sup>16</sup> Mcleod and Mcleod, 148.

<sup>17</sup> Tollefson, 35.

approach to establishing health insurance. The first step taken by Douglas was the introduction of the Hospital Service Act to the Provincial Legislature in the spring of 1946.<sup>18</sup> Douglas referred to this Act as "the first mile stone" on the road to complete socialized health services.<sup>19</sup> The implementation of the plan, on January 1 1947, resulted in approximately 93 percent of Saskatchewan's population having hospital insurance.<sup>20</sup> The only exceptions were some people living in extreme northern communities and those covered under other insurance programs.<sup>21</sup> This plan was financed by a special hospitalization tax. Despite the new tax, Douglas' plan was welcomed by the people of Saskatchewan, giving him an important boost for his successful election campaign of 1948. While the Hospital Services Act was being introduced an experimental move into medical care insurance was being initiated in the Swift Current region of Saskatchewan. Since this region was remote, it had difficulty retaining doctors. For this reason, it was an excellent location to test government-sponsored medical care insurance. On July 1, 1946, the government of Saskatchewan helped to initiate medical care insurance in Swift Current.<sup>22</sup> The plan was financed by a

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<sup>18</sup> Mcleod and Mcleod, 151.

<sup>19</sup> Tollefson, 40.

<sup>20</sup> Mcleod and Mcleod, 152.

<sup>21</sup> Mcleod and Mcleod, 152.

<sup>22</sup> Tollefson, 40.

combination of personal income tax (75 percent of cost) and property tax (25 percent of cost) revenue, with additional provincial medical care grants.<sup>23</sup> The doctors under this plan were paid on a fee-for-service basis, at 75 percent of the 1939 Saskatchewan College of Physicians and Surgeons (SCPS) schedule of fees.<sup>24</sup> This plan provided medical services to all residents of the region irrespective of age or income. The Swift Current experiment was successful, but, government financed medical care insurance was not introduced into any other part of Saskatchewan until 1962. This was because the federal government had not yet entered into agreements to help finance medical care insurance and because of growing resistance from Saskatchewan's doctors.

During the early 1950s there was less popular demand for government involvement in health insurance than there had been previously. This was due to the favourable economic conditions and high employment rate. Employed people were able to afford the health care packages offered by the growing numbers of commercial insurance companies. Nonetheless, only forty percent of Canadians were covered by hospital insurance and much of that was inadequate.<sup>25</sup> This low rate of coverage indicated that there was room for government intervention into the health insurance field.

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23  
Tollefson, 40.

24  
Tollefson, 40.

25  
Andreopoulos, 14.



During this period provincial governments found it increasingly difficult to finance their health care needs. This was because of advances in technology and the unionization of hospital workers, which led to increased provincial costs.<sup>26</sup> These factors made the provinces interested in federal hospital assistance during the mid-1950s.

The federal government also became more interested in the idea of health care insurance during the 1950s. The Saskatchewan hospital plan offered Ottawa a successful working model of a government program. After its introduction to Saskatchewan, hospital insurance systems were adopted by British Columbia (1948) and Alberta (1950) to suit the specific needs of those provinces.<sup>27</sup> These plans indicated to Ottawa that government hospital care insurance could be introduced and accepted in provinces other than Saskatchewan.

There was a major improvement in federal-provincial relations during the 1950s. Much of this had to do with changes in political leadership, both at the federal and provincial levels. Louis St. Laurent replaced King as the leader of the federal Liberal party. George Drew became leader of the federal Conservative party, and Leslie Frost replaced him as Conservative

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26

Andreopoulos, 14

27

Malcolm, Taylor, Health Insurance and Canadian Public Policy (Montreal, 1987), 167.

Premier of Ontario. Frost soon established a more positive relationship with St. Laurent than his predecessor had with King. Federal-provincial co-operation was initiated by Frost in the health care field, when he requested that St. Laurent reopen negotiations regarding cost-sharing of hospital services.<sup>28</sup> At the request of Ontario, British Columbia and Saskatchewan, the federal government agreed to put the subject of health insurance on the agenda for the 1955 Federal-Provincial Conference.<sup>29</sup> St. Laurent suggested a two-step health insurance plan at the Conference: x-ray and laboratory service first with hospital insurance to follow.<sup>30</sup> St. Laurent's strategy was to introduce the most important services that were the least disruptive first.

There were a number of conflicting views at the Federal-Provincial Conference. Some provinces were strongly in favour of the federal plan while others opposed it. In order to appease the majority, St. Laurent proposed a compromise in January 1955.<sup>31</sup> He stated that the federal government would participate

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Susan Watt, "Health Care", in Joanne C. Turner and Francis J. Turner eds., Canadian Social Welfare (Don Mills, Ontario, 1981), 206.

29

Rita Lindenfield, "Hospital Insurance in Canada: An Example in Federal-Provincial Relations," in Carl A. Meillicke and Janet L. Storch, Perspectives on Canadian Health and Social Services Policy (Ann Arbor, Michigan, 1980), 168.

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Lindenfield, 168.

31

Lindenfield, 168.

in a limited plan for the provision of hospital services if "a majority of the provinces representing a majority of the population indicated their desire for such help".<sup>32</sup> Two months later Paul Martin made a further statement to clarify the federal government's intentions. He explained that the federal scheme was not intended to impose a program on the provinces; rather, it would give technical support and financial assistance to them. Martin emphasized that health was primarily a provincial responsibility and that the provinces should take the initiative to start programs.<sup>33</sup> On April 10, 1957 Parliament passed the Hospital Insurance and Diagnostic Services Act (HIDSA).<sup>34</sup> Shortly after, St. Laurent was defeated by John Diefenbaker's Conservative Party in June, 1957.<sup>35</sup> The Conservatives amended the Act to eliminate the six province requirement in June, 1958.<sup>36</sup> This move accelerated the process of bringing hospital care insurance programs to individual provinces. Now the provinces were able to accept the federal offer independent of one another. Manitoba, Saskatchewan, Newfoundland, British Columbia, and Alberta joined on July 1, 1958; Nova Scotia, New Brunswick, and Ontario on

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32

Canadian Welfare Council, Health Insurance: What Are the Issues?, (Ottawa, 1956), 14.

33

Canadian Welfare Council, 46.

34

Lindenfield, 168.

35

A. M. Moore, J. Harvey Perry, and Donald I. Beach, The Financing of Canadian Federation (Toronto, 1966), 61.

36

Moore, Perry, and Beach, 61.

January 1, 1959; Prince Edward Island on October 1, 1959; and  
Quebec entered the program on January 1, 1961.<sup>37</sup>

The primary principle of the HDSA was to make hospital services available to all Canadians on uniform terms and conditions. The federal share of the program's cost was determined by a formula, which allowed for provincial disparities in population size and revenue.<sup>38</sup> The remaining 50 percent of the cost was assumed by the province. The provinces used various methods to raise money to fund their programs: income and property tax, premiums, and allocations from the general revenue.<sup>39</sup> Under the HDSA each provincial government had the right to administer its own separate hospital program so long as it adhered to federal standards. Despite this degree of provincial autonomy, the federal government's involvement in hospital insurance was a direct move into provincial jurisdiction.

As far back as 1944, the provincial government in Saskatchewan had promised medical care insurance, but, it was not implemented until 1962. The Douglas Government continually pushed for federal financial assistance in the 1950s. Saskatchewan insisted that Ottawa ignore the other provinces' hesitations to support health

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37  
Taylor, 233-234.

38  
Moore, Perry, and Beach, 61.

39  
Moore, Perry, and Beach, 63.

care insurance. At the 1955 Dominion-Provincial Conference Douglas stated:

I cannot help but feel that lately there has been a lessening in our sense of national purpose. To some extent the vision which we had in 1945 has been blurred by sectionalism. Too often we have been preoccupied with fragments of the national program when we ought to have been concentrating on an over-all comprehensive plan for the well-being and security of the Canadian people.<sup>40</sup>

When federal assistance did come by way of the HDSA, Saskatchewan was able to free up revenue from its existing hospital insurance plan. By 1955 Saskatchewan was spending \$29 million or 20 percent of its provincial budget on hospital care insurance.<sup>41</sup> The federal financial support allowed Douglas to consider government financed medical care insurance. Saskatchewan was in a much stronger financial position in the late 1950s than it had been ten years previous. This, in large part, was due to the revenue generated by Saskatchewan's growing natural resource sector. In areas such as oil and forestry, the Douglas Government bolstered the economy through direct intervention. Douglas wanted

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T.H. Mcleod, J.H. Perry, and R. Parenteau, "Federal-Provincial Relations - 1958", in Canadian Public Administration, Vol. 1-2, (September, 1958), 9.

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Mcleod and Mcleod, 194.

to "build an economy which would absorb some of the shock of depression", while providing revenue for social services.<sup>42</sup>

In 1959 the Douglas Government unveiled its party platform for the June 30, 1960 provincial election.<sup>43</sup> The most important CCF proposal was government-sponsored medical care insurance. In December, 1959 Douglas released the principles to which this plan would conform: pre-payment of costs, universal coverage, growth in quality and quantity of all health services, administration by a public body that would be responsible to the Legislature, and legislation that was acceptable to both the providers and recipients of health services.<sup>44</sup> While promoting the program, Douglas demonstrated an amazing degree of foresight:

If we can do this - and I feel sure we can - then I would like to hazard the prophecy that before 1970 almost every other province in Canada will have followed the lead of Saskatchewan.<sup>45</sup>

While Douglas and his government were entrenching themselves in their medical care promises the doctors in Saskatchewan became increasingly irritated. The governing body of the province's

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<sup>42</sup> John H. Archer, Saskatchewan: A History (Saskatoon, Saskatchewan, 1980), 274.

<sup>43</sup> Lewis H. Thomas (ed.), The Making of a Socialist: The Recollections of T.C. Douglas (Edmonton, 1982), 369.

<sup>44</sup> Mcleod and Mcleod, 195.

<sup>45</sup> Mcleod and Mcleod, 195.

doctors, the Saskatchewan College of Physicians and Surgeons (SCPS), openly expressed its distaste for the CCF proposals. In April, 1960, Douglas' Health Minister, J. Walter Erb, announced the appointment of a twelve member Medical Care Advisory Committee to study the government's proposals.<sup>46</sup> The SCPS condemned this move, stating that it was simply political maneuvering to attract votes by drawing attention to the medical care issue and by appeasing those who were uncomfortable with it. The SCPS believed that the CCF government had already made up its mind on medical care.<sup>47</sup>

The SCPS supported the already existing medical care plans in Saskatchewan. They emphasized the fact that the Swift Current municipal doctor plans and private insurance plans already covered the medical insurance of two-thirds of Saskatchewan's population.<sup>48</sup> The doctors felt so strongly about the issue that they became deeply involved in the 1960 election campaign. The SCPS collected \$60,000 from its membership, and was given \$35,000 from the Canadian Medical Association (CMA) to use in its attack against the CCF proposals.<sup>49</sup> Under the slogan "Political Medicine

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<sup>46</sup> Archer, 303.

<sup>47</sup> Mcleod and Mcleod, 198.

<sup>48</sup> J.L. Granatstein, Canada 1957-1967: The Years of Uncertainty (Toronto, 1986), 172.

<sup>49</sup> Tollefson, 54.

is Bad Medicine" the doctors waged an emotion-charged campaign. One British born Regina doctor went so far as to state:

What will happen if British doctors pull out of the province en masse? They will have to fill up the profession with the garbage of Europe.<sup>50</sup>

With statements such as these, the SCPS created a negative image of itself. In his book, Bitter Medicine, E.A. Tollefson goes so far as to say that this campaign actually created votes in reaction against the doctors. Whether or not this was so, the Liberal Party, under Ross Thatcher, lost to Douglas' CCF Party. Thatcher had not based his strategy on attacking medical care insurance, but, rather, on offering a plebiscite before it would be introduced.<sup>51</sup>

When Douglas won the election, he declared the victory a public endorsement of the medical care plan. After the election, the CMA released an official statement which declared that "a tax-supported comprehensive program, compulsory for all, is neither necessary nor desirable."<sup>52</sup> The SCPS was totally against any form of government compulsion. This was in large part due to the fact that a very large proportion of Saskatchewan's doctors had settled there after having fled the National Health Service

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50  
Thomas (ed.), 371.

51  
Thomas (ed.), 369.

52  
Tollefson, 55.



in Britain. These doctors had left Britain to escape socialized medicine; therefore, they were prepared to defend against its onslaught in Canada.

Douglas announced his candidacy for the leadership of the newly formed New Democratic Party (NDP) in June, 1961.<sup>53</sup> Before moving into the federal arena, the Premier pushed through the medical care plan in Saskatchewan. Acting on the recommendations of the Medical Advisory Committee interim report, Douglas introduced the medical care insurance plan to the Legislature on October 11, 1961.<sup>54</sup> Among the Advisory Committee's recommendations were: provision of universal coverage, comprehensive coverage, and administration by a public commission that would be responsible to government.<sup>55</sup> The SCPS opposed the proposed legislation and was further aggravated because the government failed to consult it before introducing the plan. After Douglas introduced the Medical Care Insurance Bill, the SCPS voted 295 to 5 against the bill at an emergency meeting on October 13.<sup>56</sup> Douglas felt confident that "the doctors of Saskatchewan would co-operate with the plan once they understood the full implications of it."<sup>57</sup> He

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53  
McLeod and McLeod, 306.

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Archer, 307.

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Badgley and Wolfe, 37.

56  
McLeod and McLeod, 201.

57  
Archer, 307.

went ahead with the medical plan, and it received royal assent on  
November 17, 1961.<sup>58</sup>

Douglas stepped down as Premier on November 1, 1961, to assume  
his new role as leader of the federal NDP.<sup>59</sup> Woodrow Lloyd  
replaced Douglas as the Premier of Saskatchewan. Lloyd  
immediately replaced the Minister of Health, J. Walter Erb, due  
to his poor handling of the SCPS/CCF dispute. This move did not  
appease the SCPS because Erb was replaced with William G. Davies,  
a former trade-union official. The SCPS was becoming increasingly  
agitated; therefore, the implementation date of the Medical  
Insurance Act was extended from April 1 to July 1, 1962.<sup>60</sup> As the  
implementation date drew nearer, tension increased between the  
SCPS and the Saskatchewan Government. Problems increased to the  
point where Dr. H. D. Dalgleish, the president of the SCPS,  
refused to speak with the Government. Robin F. Badgley and Samuel  
Wolfe in Doctors' Strike describe the situation between the SCPS  
and the Saskatchewan Government:

The classic characteristics of social  
conflict appeared, there was poor  
communication between the opponents, and they  
were deeply committed to their own positions  
because ideology was involved. There were no  
certain guidelines to follow in order to  
resolve the conflict. The public had split on  
the issue along class lines, and neutrality

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58  
McLeod and McLeod, 201.

59  
McLeod and McLeod, 201.

60  
Badgley and Wolfe, 40.

became increasingly difficult. The profession was led by a tough, militant, and highly disciplined group at a time when the government was in the throes of major changes in its own leadership.<sup>61</sup>

The doctors in Saskatchewan in the 1950s had an entirely different philosophy from those in the Depression period and the 1940s. The younger doctors had never experienced the Depression; therefore, they saw less need for social security than their predecessors. In addition, 200 of Saskatchewan's 1000 doctors were from Britain. As stated earlier, these doctors left Britain because of the installation of socialized medicine - the National Health Service. Being of free-market mentality they opposed the CCF medical initiatives and aligned themselves with the Liberals<sup>62</sup> and the Saskatchewan Chamber of Commerce.

As the implementation date of the Saskatchewan Medical Care Insurance Act loomed nearer, a doctors' strike seemed imminent. On July 1, 1962, no solution had been found; therefore, the<sup>63</sup> doctors closed their offices, offering "emergency only" care. Despite heated emotions the strike was short-lived. By July 10 many doctors had returned to work for ideological or other<sup>64</sup> reasons, and by July 23 the strike was over. The Government of

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<sup>61</sup> Badgley and Wolfe, 41.

<sup>62</sup> Badgley and Wolfe, 30.

<sup>63</sup> Archer, 309.

<sup>64</sup> Badgley and Wolfe, 72.

Saskatchewan had partially undermined the effectiveness of the strike by bringing in 110 doctors from outside the province.<sup>65</sup> In addition, the Saskatchewan doctors received very negative publicity across Canada. When the Saskatchewan Government brought Lord Stephen Taylor, a member of the British House of Lords and practicing doctor, as a mediator, the SCPS was ready to make concessions.<sup>66</sup> The doctors agreed to accept the government system of universal and publicly-administered medical care insurance in return for their right to bill patients if they so chose.<sup>67</sup> With the doctors strike over the path was clear for Saskatchewan to install its medical care plan.

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65  
Badgley and Wolfe, 61.

66  
Archer, 309.

67  
Frederick D. Mott, "Medical Service Insurance: The next Phase in Canada's National Health Program", in Medical Services Journal, October 1967, 309.

CHAPTER 3  
THE ONTARIO GOVERNMENT, THE ONTARIO MEDICAL ASSOCIATION  
AND THE INSURANCE INDUSTRY

On December 21, 1960, Prime Minister John Diefenbaker announced his intentions to establish a Royal Commission on the health care needs of Canadians.<sup>1</sup> This announcement set in motion the debate over the federal medical care insurance issue. Seemingly progressive, this move was attacked by the NDP and Liberal Parties. They accused Diefenbaker of using the Commission as a ploy to stall the implementation of a national medical care insurance program, similar to the one being proposed in Saskatchewan. It should be noted that the CMA requested the establishment of this Royal Commission following Douglas' medical care proposal in Saskatchewan. Critics accused the CMA of recommending this Commission in order to block the expansion of socialized medicine. After all, in 1960, 85 percent of CMA

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<sup>1</sup>  
Dennis Gruending, Emmett Hall: Establishment Radical  
(Toronto, 1985), 81.

members favoured the existing types of medical insurance plans.<sup>2</sup> Paul Martin, who had pushed through the HDSA, was among those who criticized the establishment of the Royal Commission. He claimed that Canada had a successful hospital insurance program and the Conservative Party was purposefully stalling the natural extension of health services to medical care insurance. He stated his views often in the House of Commons:

We believe the time has come when the government of Canada, in co-operation with the provinces, should provide a system of responsible medical care insurance so that no individual in this country shall go without such care on the mere grounds of financial incapacity.<sup>3</sup>

Diefenbaker ignored the critics and pressed forward with the Royal Commission. In March of 1961 he announced that Chief Justice Emmett Hall was to chair the Commission.<sup>4</sup> Hall was a lifelong friend of Diefenbaker's and, like the Prime Minister, was from Saskatchewan. Growing up in that province, Hall was familiar with the ravages of the Depression and the subsequent social welfare measures introduced by the provincial CCF. It has been suggested that these influences affected Hall's judgement in his direction of the Commission and its final recommendations.

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<sup>2</sup> Submission of the Trans-Canada Medical Plans to the Royal Commission on Health Services, April 21, 1962.

<sup>3</sup> House of Commons, Debates, April 11, 1962, 2860-61.

<sup>4</sup> Malcolm G. Taylor, Health Insurance and Canadian Public Policy (Montreal, 1987), 341.

Beginning in June of 1962 the Hall Commission moved through every province, hearing 406 briefs over a two year period.<sup>5</sup> When the Hall Report was presented to the House of Commons in June, 1964, its recommendations were very similar to the Saskatchewan medical care insurance program. Despite the similarities between the two, Hall frequently said that he had no preconceived ideas about Canada's health care needs.<sup>6</sup> In his book Emmett Hall: Establishment Radical, Dennis Gruending went so far as to state that "Hall's proposal was essentially the Saskatchewan model on a national scale."<sup>7</sup> Whatever the case may be, the Hall Report recommended a series of sweeping proposals that would totally restructure the health care system in Canada. The Report suggested that health services could not function under the rules of free-enterprise and that collective public action was necessary. The essence of Hall's arguments are outlined on page 11 of the Report:

- The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal health services program for the Canadian people;
- Implemented in accordance with Canada's evolving constitutional arrangements. Based

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Gruending, 84.

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Gruending, 84.

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Gruending, 94.

upon freedom of choice and self governing institutions;  
- Financed through prepayment arrangements;  
- Accomplished through the full co-operation of the general public, the health professions, voluntary agencies, all political parties, and governments, federal, provincial and municipal;  
- Directed towards the most effective use of the nation's health resources and to attain the highest possible levels of physical and mental well-being.<sup>8</sup>

During the Commission's proceedings, Opposition reaction in the House of Commons had become increasingly vocal. The Liberal Party and the newly created NDP both attacked the Commission and demanded immediate government action. Typical of these comments were those of Liberal Leader Lester Person who maintained that:

After the experience of Saskatchewan no one can under-estimate the importance of the obstacles, but we have surely advanced to the point where these difficulties must be faced and solved. In the next Liberal government that will be done, and the question will not be referred to another royal commission.<sup>9</sup>

Tommy Douglas stated that:

The appointment of the Commission has been merely a stall to avoid the necessity of facing this issue.<sup>10</sup>

During the 1962 and 1963 federal election campaigns, the Liberal Party was more committed to health care policy than it had ever

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The Royal Commission on Health Services, Report, 11.

9

House of Commons Debates, Oct 1, 1962, 72.

10

House of Commons Debates, Feb. 5, 1963, 3460.



been. The Liberal Party was especially supportive of government medical care insurance in 1963. In 1962 the electorate was concerned about the impending doctor's strike in Saskatchewan, coupled with the country's economic difficulties; therefore, the medical care insurance plan was not a firm Liberal commitment.<sup>11</sup> By July, 1962, the doctor's strike was over and by 1963 the Saskatchewan medical care plan seemed to be running smoothly.<sup>12</sup> For these reasons, and to take some wind out of the NDP's sails, Pearson was more vocal in his support of a medical care insurance plan during the 1963 election than he had been in 1962.

After the Liberal's crushing defeat by the Diefenbaker Conservatives in 1958, Pearson and Walter Gordon gradually rebuilt the Liberal Party. Among the new faces in the Liberal ranks was Pearson's personal advisor Tom Kent. Kent was a self-proclaimed advocate of the welfare state and, as such, greatly influenced Pearson's social policy.<sup>13</sup> Well aware of the dramatic changes taking place in society, Kent saw the need to offer changes in the government's role. The Liberal Party now had to offer progressive measures to satisfy society's new expectations, and to halt the growth of NDP support. With the disintegration of

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Tom Kent, A Public Purpose: An Experience of Liberal Opposition and Canadian Government (Montreal, 1988), 185.

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Robin F. Badgley and Samuel Wolfe, Doctor's Strike: Medical Care and Conflict in Saskatchewan (New York, 1967), 72.

13

Kent, 5.

Diefenbaker's Conservative Party, Pearson was confident of victory in 1963, but, saw the NDP as a threat to a majority government. For this reason, the Liberals put a tremendous amount of effort into capturing border-line NDP voters. Among the more noteworthy strategy moves was the assignment of Kent to run against Tommy Douglas in the "safe" NDP riding of Burnaby - Coquitlam. Although the Liberals did not expect to win the seat, this maneuver was staged simply to draw attention to Liberal social policy. As Kent explained:

I more than anyone could show that the NDP was irrelevant because the kind of economic and social improvements looked for by people who might be marginal NDP voters could in truth be ensured by voting for a Liberal government.<sup>14</sup>

As was anticipated by the Liberal Party, the media closely followed the Kent-Douglas race. This was only one factor in the Liberal victory, but it was indicative of their commitment to social welfare policy. The two most important Liberal campaign promises in 1963 were a federally sponsored pension plan and a medical care insurance plan known as Medicare. The NDP included Medicare as their main election promise, while the Conservatives avoided the issue, and the Social Credit Party advocated a

free-market approach to health care policy. <sup>15</sup> On April 8, 1963  
the Liberal Party won a minority government. <sup>16</sup>

The Liberal victory marked a move to the left in terms of Canadian voting behavior. This shift caused concern among free-market advocates. The Liberal ideas concerning medical care were especially threatening to the medical profession and the private insurance industry. These groups feared government-sponsored medical care insurance for different reasons, but their reactions were equally negative. The medical profession believed that Medicare would render them civil servants, paid by salary, and controlled by meddling bureaucrats. The insurance industry feared that the government was going to take over the financing and administration of medical care insurance, depriving them of an enormous market.

The medical profession and the insurance industry had expected the move toward Medicare. There had been various warning signs, such as: the National Health Grants, the Hospital Insurance and Diagnostic Services Act, and the Saskatchewan medical care plan. As stated earlier the CMA tried to stall or prevent Medicare by requesting a royal commission to study the country's health care

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<sup>15</sup>Taylor, 333-334.

<sup>16</sup>Peter C. Newman, The Distemper of Our Times (Ottawa, 1978), 42.

needs. In order to maintain the free-market approach the CMA made moves as early as 1949 to co-ordinate local doctor-sponsored plans into a national co-ordinated body.<sup>17</sup> In 1951 the CMA established Trans-Canada Medical Plans (TCMP):<sup>18</sup>

To promote the establishment and operation and to co-ordinate the activities of voluntary non-profit prepaid medical care plans in Canada.<sup>19</sup>

To protect and promote its own interests the insurance industry set up the Canadian Health Insurance Association (CHIA) in June, 1959.<sup>20</sup> Membership in the CHIA included 118 companies representing 96 percent of all the private health insurance coverage in Canada.<sup>21</sup> When the HIDA was introduced, the insurance industry lost this portion of their market. After suffering this loss, the insurance companies realized that collective action was needed to prevent further disintegration of their market share. During an address to the Canadian Life Insurance Officers Association, W. Douglas Bell, first Managing

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Submission of the Trans-Canada Medical Plans to the Royal Commission on Health Services, April 21, 1962, 18.

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Submission of the Trans-Canada Medical Plans to the Royal Commission on Health Services, April 21, 1962, 18.

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Submission of the Trans-Canada Medical Plans to the Royal Commission on Health Services, April 21, 1962, 20.

20

C. Howard Shillington, The Road to Medicare in Canada (Toronto, 1972), 138.

21

Shillington, 138.

Director of CHIA, stated that "united we stand divided we  
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fall."

Sharing a concern about the impending threat of Medicare the TCMP  
and the CHIA established a coalition in 1960 called the Canadian  
23  
Conference on Health Care. The primary purpose of the  
Conference was to assist member organizations with the goal of  
improving prepaid plans and extending these to all areas of the  
24  
population. At the first meeting of the Conference (1961), the  
threat of government intervention was emphasized:

A strong plea was made that government insurance was imminent, that it represented a giant monolith, and that doctors would be prisoners of such bureaucratic operation which would, therefore, completely control the purse strings and dictate the terms of service. Related to this whole approach, was the theme that the doctors' only protection lay in the retention of multiple insurance organizations in the health field.<sup>25</sup>

The federal government faced the united power of the medical profession and the insurance industry. In addition, they had the support of the various provincial chambers of commerce. These

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22

W. Douglas Bell, "Current Developments in Health Insurance in Canada", in The Canadian Life Insurance Officers Association, Proceedings, May 26-27, 1959, 35.

23

Gruending, 88.

24

R. Leighton Foster, "Report on Association Activities", in the Canadian Life Insurance Officers Association, Proceedings, May 26-27, 1960. 84.

25

Shillington, 139.

factors alone made the possibility of a national plan a much more difficult undertaking than the implementation of the Saskatchewan Medical Insurance Act. Saskatchewan had no major industries nor financial interests; therefore, the CCF's only real opposition<sup>26</sup> was the medical profession. Saskatchewan's population and economy were not large enough to support a powerful insurance industry; therefore, the companies that were affected by Douglas' plan had little power to stop it.

When the federal government attempted to bring Ontario into the national medical care plan, it was opposed by the biggest provincial branch of the CMA, the Ontario Medical Association (OMA). In 1961, the OMA represented one-half, or 6500 members, of the CMA.<sup>27</sup> In addition, the OMA was united in purpose with the province's insurance industry, which controlled vast financial resources. In 1960 the total assets of life insurance companies<sup>28</sup> in Canada were 8.26 billion dollars. Most of these companies were headquartered in Ontario, where almost all of the executive members of the Canadian Life Insurance Officers Association<sup>29</sup> lived. The OMA and the insurance industry were joined by the

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Badgley and Wolfe, 5.

27

J. W. Grove, Organized Medicine in Ontario (Toronto, 1969), 36.

28

Canadian Life & Insurance Facts, (1988), 29.

29

Canadian Life Insurance Officers Association Year Book, 1963-64, 1964-65, 1965-66.

Government of Ontario in the quest to retain free-market medical care insurance. In keeping with its tradition of non-interventionist policy and as a champion of provincial rights, the province of Ontario launched a defence against increased federal intervention in the health care field.

In June of 1961, Premier Leslie Frost announced his intentions of retiring.<sup>30</sup> After a hard fought leadership race, John Parmenter Robarts, Frost's Minister of Education, was chosen to lead the provincial Conservative Party. On November 8, 1961, Robarts was sworn in as the seventeenth premier of Ontario.<sup>31</sup> Robarts was a supporter of provincial rights, yet emphasized the importance of a strong unified federal nation. He was against the growing centralization of power in the federal government, but disapproved of Quebec's rising separatist movement. The new Premier explained:

Our position is different from Quebec's. We're trying to pressure provincial autonomy for reasons of efficiency, not ideology. If you accept the basic principle of a federal system you recognize that certain things such as, defence, postal service, and relationships with foreign countries are federal matters. But in recent years the federal government has crept more and more into the provincial field and I don't think it makes for good government because there

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Allan Kerr McDougall, John P. Robarts: His Life and Government (Toronto, 1986), 59.

31

McDougall, 77.

are things the provinces are better equipped to deal with.<sup>32</sup>

Robarts outlined Ontario's position with regard to federal health policy, during the Hall Commission inquiries. In August, 1962, Ontario presented a brief to the Commission which supported the province's traditional laissez-faire philosophy. Robarts acknowledged the right to proper health care, but stressed the importance of maintaining the individual's freedom to choose the sort of insurance he desired. The continued existence of voluntary medical care insurance was necessary to achieve this goal.<sup>33</sup> A government-sponsored compulsory plan, Robarts explained, was an infringement on the freedoms advocated by a democratic society. In further support of the prevailing approach, he drew attention to the rapid growth of voluntary medical care insurance in Ontario. Between 1950 and 1960 coverage under these private plans rose from 26.1 per cent to 63 per cent of the total population of Ontario.<sup>34</sup> Robarts stated that this was a clear indication of confidence in the voluntary plans.

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<sup>32</sup> Janice Tyrwhitt, "John Roberts: the Most Powerful Unknown in Canadian Politics" in MacLeans, (Dec 14, 1963), 23.

<sup>33</sup> Submission of the Province of Ontario to the Royal Commission on Health Services, Aug, 1962, 6.

<sup>34</sup> Submission of the Province of Ontario to the Royal Commission on Health Services, Aug, 1962, 5.



Although Robarts objected to federal moves into the medical insurance field, he did support its continued involvement in hospital financing. In fact, he called for additional federal grants toward hospital construction.<sup>35</sup> Ontario and the other provinces had been conditioned to federal financing of hospital costs since the 1948 National Health Grants program. The Ontario Hospital Association (OHA) strongly supported federal financing if it did not infringe on their administrative control. In presenting its brief to the Hall Commission the OHA explained that:

The principle that a substantial portion of the capital cost of a hospital continue to be provided by the community is affirmed but with the recommendation that such a contribution be on the basis of one-third, the remaining two-thirds to be shared evenly between the province and the federal government.<sup>36</sup>

Unlike the OHA, the OMA and the insurance industry were unwilling to accept federal involvement in medical care insurance. To attain strong political representation for their cause, the OMA and the insurance industry lobbied the government of Ontario.

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35

Submission of the Province of Ontario to the Royal Commission in Health services, Aug, 1962, Conclusions and Recommendations.

36

Submission by the Ontario Hospital Association to the Royal Commission on Health Services, May, 1962, (i).

For various reasons, the OMA was extremely successful at gaining access to members of the Ontario government. The social status and financial power of its members led to personal connections to high-ranking members of government. Because the Conservative Party had governed for so long, there was a tendency for power to concentrate in the executive and bureaucratic sectors of government.<sup>37</sup> F.F. Schindeler explains in Responsible Government in Ontario, that the bureaucracy began "seeing themselves as servants of the party instead of as servants of the administration."<sup>38</sup> For this reason the OMA and the insurance industry had to consider the bureaucrats as well as the politicians when lobbying the provincial government.

The OMA had the advantage of representing society's health, which was considered above political and monetary consideration.<sup>39</sup> The recommendations of the OMA were considered a true representation of society's health care needs because the doctors had a monopoly of expertise in this area. For this reason the OMA was well-represented in the Department of Health.

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David Hoffman, "Interacting With Government: The General Public and Interest Groups", in Donald C. McDonald, Government and Politics of Ontario (Toronto, 1975), 285.

38

F. F. Schindeler, Responsible Government of Ontario (Toronto, 1969), 265.

39

G. R. Weller, "Health Care and Medicare Policy in Ontario", in G. Bruce Doern and V. Seymour Wilson, Issues in Canadian Public Policy (Toronto, 1974), 87.

When lobbying Queen's Park, the OMA tended to concentrate its efforts on the executive. Since the government executive wielded great power, the OMA saw it as the most promising target toward which to direct their interests. The OMA had been successful in its lobbying tactics previous to the introduction of Medicare. This is proven by the non-interventionist role played by government in the medical field. Medical care was left as a private concern, to be administered by the OMA. In addition, the OMA enjoyed almost total self-regulation of its activities:

In short, the medical system in Ontario, prior to the introduction of medicare approximated what the Castonquay Commission in Quebec labelled the "closed" or "medical" model of health, namely one in which the dominant health professionals controlled the system.<sup>40</sup>

Before Medicare the billing of patients was based on a system where patients were charged a fee-for-service. The amount could be set by the individual doctor, but the CMA and the provincial medical associations suggested appropriate fees. The doctor was also given the freedom of choosing whether or not he would treat individual patients. Similarly, the patient had the freedom to choose the doctor that best suited his needs. The medical care system was based on this doctor-patient relationship. During the 1950s this traditional system of medical care began to break down. The expansion of private health insurance plans dissolved

the doctor-patient relationship in terms of fee collection. The patient now paid a third party, the insurance company, rather than the doctor directly.

The increasing power of hospital administrators also helped to break down the doctor-controlled system. In particular, the government financing of hospitals gave more power to the administrators.<sup>41</sup> Nevertheless, the OMA retained dominance over the health care system, but it was forced to become more protective of its position. The introduction of socialized medical care insurance in Saskatchewan was the decisive point at which the medical community became significantly concerned. Dr. Frank Turnbull, chairman of the CMA committee, stated that:

Above all, the Saskatchewan crisis served to alert Medical Associations all across Canada to the importance of a strong, well-ordered efficient organization to represent the doctor-in-practice.<sup>42</sup>

With growing concern about the future, the OMA established a Committee on Long-Term Planning in January, 1960.<sup>43</sup> The implications of Tommy Douglas' recent proposal to establish a government medical care insurance plan in Saskatchewan was

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Weller, 90.

42

Dr. Frank Turnbull, address to the CMA Centenary Conference, 1967, in Grove, 300.

43

Glenn Sawyer, The First 100 Years: A History of the Ontario Medical Association (Toronto, 1980), 152.

considered by this Committee. The recommendations of the Committee, released in January, 1962, served as an ideological framework through which the OMA would pursue its goals during the 1960s:

- People, the profession and governments must share the responsibility of providing a high standard of medical care for all.
  - Those people who can afford to do so should retain financial responsibility for obtaining medical care.
  - Prepayment seems to be the desirable method of meeting the cost of medical care.
  - Freedom to choose or reject the prepayment should be the right of the individual.
  - Public funds are necessary to help pay the cost of medical care for those in need.
  - Prepayment of premiums into plans underwritten by a diversity of competitive carriers is the method of choice to provide coverage for the remainder of the population.
- The following provisions are important,
- coverage should be reasonably comprehensive and universally available;
  - professional remuneration should closely approximate the fee schedule;
  - there should be no exclusions for health reasons.
- Multiple methods of practicing medicine should be encouraged, e.g. various types of clinics, group practice and solo practice.
  - The individual physician must have the right to determine his method of remuneration.
  - Medical research undergraduate and post-graduate teaching should not be inhibited by any medical services insurance program. 44

Further resolutions were expressed at the OMA Council meeting in January 1963:

- In order to ensure universal availability your committee recommends that the Ontario Medical Association initiate discussions and

closer liaison with the doctor-sponsored service plans and all insurance carriers to study a method whereby: a) each could enroll its share of individuals in the high risk group for basic plan coverage and b) each could implement the recommendations in this report to produce an ideal plan.

- That the Ontario Medical Association should initiate discussions with the Government of Ontario, with a view to implementation of an enlarged Medical Welfare Plan, to include the marginal income group.

- That the medical profession exert self-discipline in the strict adherence to the fee schedule of its Association, except in exceptional circumstances and with agreement by the patient.<sup>45</sup>

In its lengthy (298 page) brief to the Hall Commission, the OMA expressed the objectives outlined by the Committee on Long-Term Planning. Throughout the brief, the OMA endorsed the prevailing approach to medical care insurance and expressed a distaste of government intervention:

The socialistic beam being played on the health professions is casting a shadow which is becoming sufficiently large to be noticed by those contemplating the future.<sup>46</sup>

In recognition of growing government involvement in the health care field, the OMA offered proposals designed to inhibit this trend. In its brief, the OMA offered lengthy discussion of the already existing doctor-sponsored insurance programs. The OMA explained that expansion of these non-profit programs would

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Sawyer, 155.

46

Submission of the Ontario Medical Association to the Royal Commission on Health Services, May, 1962, 17.

increase insurance coverage, meaning government intrusion could be avoided.

One example offered by the OMA was the Medical Welfare Plan. The Medical Welfare Plan was a non-profit OMA administered program. Initiated in 1935, the plan was financed by the province in return for the OMA administering medical services to those individuals collecting government relief.<sup>47</sup> This system was mutually acceptable to the OMA and the provincial government because both parties received benefits. It helped the OMA retain control of provincial health care; while doing so, it redirected the administrative responsibilities away from the Government of Ontario, which favored non-intervention. The amount of financing that the OMA received was based on a per capita allowance for those receiving relief. As of 1959 the amount offered was \$ 1.25 per capita per month.<sup>48</sup> In an attempt to expand medical services to the marginal income group (those receiving an income just above the welfare group), the OMA suggested an extension of the Medical Welfare Plan to accommodate their needs.

Another example offered by the OMA was Physicians' Services Incorporated (PSI). Established in 1948, PSI was a doctor-sponsored and administered insurance plan, which helped citizens

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Sawyer, 99.

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Submission of the Ontario Medical Association to the Royal Commission on Health Services, May, 1962, 60.

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pay the cost of medical services. In 1962 PSI offered  
province-wide general practitioner services to individuals making  
\$ 7,000 or less, and couples making \$ 10,000 or less per year.<sup>50</sup>  
The OMA looked to PSI as an alternative to the plans offered by  
the insurance companies. As well as offering lower premiums than  
the private companies, PSI helped to retain the doctors' control  
of the financing of medical services. PSI offered medical  
insurance through a service type plan. Service plans offered the  
subscriber a specified range of medical services as agreed upon  
by an underwriting agency. The agency paid the physician  
according to a fee for service.<sup>51</sup> The other type of medical  
insurance coverage offered (usually by private insurance  
companies) was the indemnity plan. This plan offered the  
subscriber a set amount of money on behalf of each medical  
service received. The amount paid by the insurance agency was not  
necessarily enough to cover the physician's charge; therefore,  
the subscriber could receive extra-billing in addition to the  
amount offered by the insurance agency. Unlike the service

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Submission of the Ontario Medical Association to the  
Royal Commission on Health Services, May, 1962, 60.

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Submission of the Province of Ontario to the Royal  
Commission on Health Services, May, 1962, 63.

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Submission of the Ontario Medical Association to the  
Royal Commission on Health Services, May, 1962, 62.



contract the subscriber paid the physician directly in the  
52  
indemnity plan.

There were certain drawbacks to the PSI plan, which Justice Hall was quick to point out at the Royal Commission hearings. Among the problems with PSI was the fact that only general practitioner  
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and not specialist services were offered. The subscribers to PSI had to purchase insurance for specialist services separately, and because many could not afford to do so, their medical coverage was insufficient. Another drawback of PSI was its failure to provide insurance coverage to those over 65 years of  
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age. Spokesmen for PSI explained that more time was needed in order to afford coverage of that group. Hall attacked PSI, and the private insurance companies, after hearing this excuse:

Are you saying, in effect, private enterprise can not find a way of handling this situation to provide the coverage for the over-64s?55

At the Hall Commission hearings in Toronto, Dr. Glenn Sawyer (OMA Secretary) made it quite clear that the OMA had approached the

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Submission of The Ontario Medical Association to the Royal Commission on Health Services, May, 1962, 66.

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Submission of the Ontario Medical Association to the Royal Commission on Health Services, May, 1962, 63.

54

Submission by Physicians Services Incorporated to the Royal Commission on Health Services, May 8, 1962, 9007.

55

Statement by Justice Emmett Hall to the Royal Commission on Health Services, May 8, 1962, 9011.

provincial government about expanding these plans.<sup>56</sup> In addition, executive members of PSI were willing to cooperate with Queen's Park and had suggested that they would assume administrative control of Ontario's medical care insurance system.<sup>57</sup> Sawyer said that the Ontario government refused to help expand these programs for financial reasons. The government explained that it could not afford expanding these plans without federal assistance.<sup>58</sup> This situation created an interesting paradox. If Ontario accepted federal assistance, provincial financial autonomy in health care would be diluted, but, with the extra income, existing facilities could be expanded. The expansion of existing insurance facilities would allow for wider medical coverage and would reduce the need for a government administered-plan. When governments offer financing to a project, they inevitably seek some degree of control over it. As the OMA president, Dr. Bruce Lockhart, explained to the Royal Commission on Health Services:

If governments provide monies then they feel responsible to control its expenditure.<sup>59</sup>

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Submission by the Ontario Medical Association to the Royal Commission on Health Services, May 7, 1962, 8881.

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Interview with Mr. Arthur Bond, January 24, 1990.

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Submission by the Ontario Medical association to the Royal Commission on Health Services, May 7, 1962, 8881.

59

Submission by the Ontario Medical Association to the Royal Commission on Health Services, May 7, 1962, 8831.

The OMA had to be very careful about the type of recommendations that they made. Unintentionally, their recommendations could lead to greater government intervention into medical insurance. After all, the Hall Commission was first requested by the CMA. What the OMA sought was financial assistance, but, without the government moving into the administrative control of medical care. The OMA sought evolution rather than revolution in medical care services.<sup>60</sup> By gradually bolstering the voluntary medical care insurance program, with the co-operation of the provincial government, the OMA hoped to avoid a similar situation as had taken place in Saskatchewan. Dr. Lockhart addressed Ontario's unique situation to the Royal Commission:

When dealing with the Federal-Provincial relationship we are concerned about any overall plan that might thrust something on Ontario, to average it across the Dominion which would not be exactly suitable to Ontario conditions.<sup>61</sup>

The insurance industry shared the OMA's fear of government intervention. Like the medical community, the private insurers sought retention of the laissez-faire principle of limited government intervention and the individual freedoms associated with it. The industry was most concerned about losing its medical care insurance market to a government agency. Once government

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Submission by the Ontario Medical Association to the Royal Commission on Health Services, May, 1962, 72.

61

Submission by the Ontario Medical Association to the Royal Commission on Health Services, May 7, 1962, 8887.

began paying for and administering medical insurance, there would be no need for private sector involvement. In fact, private sector involvement could be prohibited by law. With the introduction of the HDSA in the 1950s, the industry lost the hospital care insurance market. In an address to the Canadian Life Insurance Officers, the president of the association, J.T. Bryden, expressed the need to confront the new threat of national medical care insurance. He emphasized the importance of learning from past mistakes and the challenge of adjusting to current demands on the industry:

What can we learn from this experience (HDSA)? We learn, I think, that the private sector of the economy must attempt the overall approach too, so far as it is able.<sup>62</sup>

Although medical care insurance was not especially lucrative, it brought customers to the insurance industry. As Mr. Arthur Bond, past treasurer of PSI, explained, the private insurers did not give him the impression that direct profits from medical care coverage were their primary motive.<sup>63</sup> For example, the Continental Casualty Company paid 91 cents on every dollar paid by its subscribers in its "Medicall" plan.<sup>64</sup> Once customers

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J. T. Bryden, "Address of the President", in The Canadian Life Insurance Officers Association, Proceedings, May 24-25, 1962, 15.

63

Interview with Mr. Arthur Bond, January 24, 1989.

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"Accident and Sickness Insurers Facing Internal and Government Pressures," Financial Post, April 17, 1965, 65.

bought medical plans company representatives could then attempt to sell them other types of insurance. This is an important factor to consider because of the tremendous growth in private, voluntary medical insurance during the 1950s. The growth in medical plans meant an overall increase in consumers of insurance. Since these consumers were often convinced to purchase other, more lucrative, plans, the industry's profits rose. Government intervention then, meant a threat to the medical insurance market, but also to its subsidiary sales.

Between 1950 and 1960 the insurance industry increased its medical benefit coverage from 12.2 percent to 48 percent of Canada's population.<sup>65</sup> It should be noted that these percentages do not represent total medical coverage. Most of the individuals included in these plans had only partial medical coverage. This became an important point of debate when medical insurance proposals were considered by government. Voluntary insurance was bought by a large percentage of the population, but, the coverage was often insufficient to offer comprehensive benefits.

The CHIA understood that they had to increase the percentage of the population covered and the total amount of personal medical coverage. At the Hall Commission inquiries, the CHIA argued the

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Submission by the Canadian Conference on Health Care to the Royal Commission on Health Services, December 31, 1960, 4.

need to retain the private enterprise approach. They claimed that their proposal "would not swell already large government budgets and create an extra load for the heavily burdened taxpayer."<sup>66</sup>

The CHIA faced the dilemma of defending the current system while expanding medical care coverage. The most difficult obstacle that the private insurance industry had to overcome was covering high risk individuals (e.g. those over 65 years of age). This was because benefits paid to these groups tended to be greater than a reasonable premium rate could finance. In an attempt to solve this problem, the CHIA proposed a plan whereby the insurance carriers would share the costs of this high risk group. This plan would be supported by provincial legislation which would require that all carriers participate.<sup>67</sup> By pooling their resources, the CHIA claimed that it could guarantee coverage of the high risk group.

The Ontario Chamber of Commerce strongly supported the CHIA's recommendations during the Hall Commission hearings. The Chamber had 40,000 members who represented 240 Boards of Trade and Chambers of Commerce throughout the province.<sup>68</sup> The Chamber argued that Ontario's high standard of living enabled the

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Bryden, 15.

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Submission by the Canadian Health Insurance Association to the Royal Commission on Health Services, Sept, 1962, 9.

68

Submission by the Ontario Chamber of Commerce to the Royal Commission on Health Services, April 16, 1962, 1.

majority of the population to provide for their own medical insurance. It was argued that a government plan would cost the Canadian taxpayer a minimum of \$ 665.5 million.<sup>69</sup> In addition to this tremendous cost, the Chamber argued that the medical system would be seriously strained by an unnecessary increase in public demand.<sup>70</sup> The Chamber therefore recommended the expansion of existing government programs such as the Medical Welfare Plan while retaining the participation of private carriers. Supported by interest groups such as the Chamber, and especially the insurance industry and OMA, Robarts pursued a non-interventionist approach to medical care insurance.

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<sup>69</sup>

Submission by the Ontario Chamber of Commerce to the Royal Commission on Health Services, April 16, 1962, 8.

<sup>70</sup>

Submission by the Ontario Chamber of Commerce to the Royal Commission on Health Services, April 16, 1962, 8.

## CHAPTER 4

### ONTARIO ESTABLISHES ITS OWN MEDICAL CARE INSURANCE PLAN

During the Hall Commission hearings, various interest groups were brought together. The briefs that they submitted to the Commission indicated alliances of philosophy and objectives. The insurance industry had already formed a close association with the medical community. Dr. T. Clarence Routley, former secretary of the OMA, summed up this growing affiliation in an address to the Canadian Life Insurance Officers Association when he said that "your co-operation with Canadian Medicine has been truly magnificent."<sup>1</sup> Although the medical community and insurers had established connections, there was need to win political support to represent their cause. At the Hall Commission hearings, it became quite evident that their interests were similar to those of the Ontario government. It appears also that the provincial government became fully aware of their interests during these

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1  
T. Clarence Routley, "Quality, Quantity and Cost of Medical Care Under State Insurance Programs", in the Canadian Life Insurance Officers Association, Proceedings, May 24-25, 1962, 49.



hearings. Government interest in the OMA and CHIA proposals was acknowledged by Matthew Dymond, Ontario Minister of Health, in the Legislature on April 25, 1963.<sup>2</sup>

The government of Ontario, like the OMA and the CHIA, supported a laissez-faire approach to medical care insurance. The province had a tradition of avoiding government intervention whenever possible. During the early 1960s Ontario's Conservative Government faced a difficult situation. It had to retain its tradition of non-interventionism, while, at the same time, denying the NDP the role of initiator in terms of social reform.<sup>3</sup> In addition to this problem, the Robarts government had to confront impending federal moves into provincial jurisdiction, including medical care.

In order to meet these challenges, Robarts and Dymond gathered together a group of advisors to recommend policy strategy. Based on the advisors chosen by Dymond, it appears that the Ontario Government already had an idea of the policies that it wanted. The committee was composed entirely of representatives of the medical profession and the insurance industry.<sup>4</sup> Despite the

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Ontario Legislature, Debates, April 25, 1963, 2797.

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Norman Penner, "Ontario: The Dominant Province", in Martin Robin, Canadian Provincial Politics (Scarborough, Ontario, 1978), 214.

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Kenneth Bryden, "How Public Medicare Came to Ontario",  
(Footnote Continued)

seemingly biased nature of the committee, Robarts explained to the press that no decision had been made about a provincial medical insurance plan.<sup>5</sup> Robarts had in fact been confronted by the OMA and insurance industry prior to the committee's establishment.<sup>6</sup> Though he said that he was unbiased, Robarts was certainly willing to listen to OMA and insurance company proposals. Certainly, the government had some idea of the type of recommendations it sought. After all, its advisors, the OMA and insurance industry, had clearly defined objectives. The insurance carriers sought retention of their markets and the OMA hoped to avoid a Saskatchewan type crisis. In the Ontario Medical Review, Dr. Glenn Sawyer illustrated the new found vigor of these anti-interventionist organizations:

The old adage that the best defence is a good offence probably holds true here.<sup>7</sup>

While Queen's Park was studying the briefs submitted to the Hall Commission and meeting with the OMA and insurance representatives, Alberta was implementing a medical care insurance plan. Oriented toward private enterprise, Alberta's

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(Footnote Continued)  
in Donald C. MacDonald (ed.), Government and Politics of Ontario (Toronto, 1975), 41.

5

Robarts Papers, "MDs, Insurers Give Dymond Lowdown," Toronto Telegram, November 16, 1962.

6

Interview with Dr. William Butt, December 22, 1989.

7

Dr. Glenn Sawyer, "Secretarial Soliliquies," in Ontario Medical Review, 29:8 (August, 1962), 692.

Social Credit government offered a plan designed to expand medical coverage, but retain the existing health insurance system. After a long series of meetings attended by representatives of government, the medical profession, Medical Service Incorporated (the provincial insurance association), and the CHIA, the Alberta Medical Plan was announced on June 25, 1963.<sup>8</sup> The plan was based on four fundamental principles which indicated acceptance of the medical profession's and insurance industry's ideology:

1. The program must be voluntary and free from any government regimentation or interference with individual rights and responsibilities.
2. It must preserve inviolate the doctor patient relationship. This is, in our opinion, necessary to a high standard of medical care.
3. It should employ the insurance principle as the means of equalizing the cost of medical services.
4. It must maintain the responsibility of the individual in providing for his medical requirements, with the state assuming its responsibility to assist to the extent necessary to bring medical services within the financial reach of all the people.<sup>9</sup>

Similar to Ontario, Alberta was concerned about the expansion of federal power into provincial jurisdiction. In Alberta's brief to the Hall Commission, the provincial Minister of Health, Dr.

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Dr. P. B. Rose, "The Alberta Health Program", in Proceedings - Regional Conference on Health Services, April 9-12, 1967, 47.

9

Rose, 46.

Donovan Ross, described the federal moves as an "intrusion ... into areas in which it has no constitutional right to be involved."<sup>10</sup> The implementation of the Alberta Medical Plan was a mechanism that would preserve the free enterprise system while offering an alternative to a federal Medicare proposal.

Using the Alberta Plan as a model, and considering the recommendations of Dymond's advisory committee, Robarts introduced Bill 163, An Act Respecting Medical Services Insurance, to the legislature on April 23, 1963.<sup>11</sup> Bill 163 illustrated Robarts' strong philosophical commitment that the role of government was to reinforce and regulate, rather than to supplant the insurance industry.<sup>12</sup> The Bill was based on proposals presented by the OMA and insurance carriers with some alteration of details.<sup>13</sup> Like the Alberta Plan, Bill 163 offered both a means of retaining the current system while presenting an alternative to a federal plan. Robarts hoped that this scheme, with public support, would block federal intervention.

Bill 163 proposed the formation of a standard medical insurance contract, which all carriers in the province would be required to

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Submission of the Province of Alberta to the Royal commission on Health Services, February 12, 1962, 4900.

11

Ontario Legislature Debates, April 23, 1963, 2714.

12

Bryden, 40.

13

Interview with Dr. William Butt, December 22, 1989.

make available.<sup>14</sup> In addition, the provincial government would have the authority to set a maximum premium on the standard contract.<sup>15</sup> The government explained that this legislation would allow for an extension of medical care coverage. This would be achieved through the standard contract and by government subsidization of those unable to pay for this plan. In order to help finance the extra cost created by offering the standard contract to high risk groups, the insurance carriers would be required to pool their resources.<sup>16</sup> The government was careful to point out that the plan was not compulsory, so that individuals still had freedom of choice. Health Minister Matthew Dymond summarized the objectives of Bill 163 in the Ontario Legislature:

1. The universal availability of medical services insurance to all regardless of age, state of health.
2. It will be guaranteed renewable at a cost never to exceed an agreed-on maximum premium.
3. It will be non-compulsory in keeping with this government's belief that the provision of health care is an individual responsibility, and that the individual has the right to determine if he will assume that responsibility.
4. Medical services will be available on the open market from the carrier of the individual's own choice.
5. There will be no interference with the doctor-patient relationship; nor will there be any interference - by government - with the quality, quantity, or any other aspect of medical practice.

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Bryden, 41

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Bryden, 41.

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Sawyer, 159.

6. The government will assume responsibility of the cost of such insurance, in whole or in part - and I would make it clear, sir, that the government will assume that responsibility - for those of our people deemed to require such help.<sup>17</sup>

Bill 163 was praised openly by the government's allies. For instance, Dr. Glenn Sawyer in the Ontario Medical Review wrote that as " this philosophy parallels that of our Association, there is reason for satisfaction at this point of time."<sup>18</sup> The Bill did not receive such acclaim from other groups. Despite its seemingly progressive proposals Bill 163 was strongly attacked by both the provincial NDP and Liberal Parties. They claimed the Bill was limited in scope and as the leader of the Liberal Party, J.J. Wintermeyer, stated, it was designed merely as a strategy to affiliate the Conservative Party with the "politically desirable goal of prepaid medical insurance."<sup>19</sup> Wintermeyer said that the Bill left too many "loopholes" through which insurance carriers could escape compulsion to offer coverage. For instance, section 16 of Bill 163, stated that the Minister:

May in his discretion insure those people who are blind and under a blind welfare program or unemployed or for some reason are in no position to buy insurance for themselves.<sup>20</sup>

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Ontario Legislature Debates, April 25, 1963, 2799.

18

Dr. Glenn Sawyer, Editorial in Ontario Medical Review, 30:5 (May, 1963), 263.

19

Ontario Legislature Debates, April 25, 1963, 2771.

20

Ontario Legislature Debates, April 25, 1963, 2770.

Wintermeyer opposed the use of the word "may" in this section. He felt that the word "must" should replace "may" in order to make the legislation mandatory and not discretionary. Another area of dispute was the proposed corporation (Medical Carriers Incorporated) that would administer the proposals set forth by Bill 163. This corporate body would be composed of representatives of the various insuring agencies. Wintermeyer argued that this concentrated more power in the hands of the insurance industry.

A further disagreement Wintermeyer had with Bill 163 was the fact that it retained the existence of private insurance plans which primarily utilized the indemnity type contract.<sup>21</sup> Because the indemnity contract did not insure full coverage of doctor's fees, the subscriber was subject to extra-billing. For this reason, Wintermeyer supported the service type contract, and specifically the one offered by PSI. The provincial Liberal's endorsed a compulsory, universal plan, but it was to be administered by PSI.<sup>22</sup> This partial retention of the free-market approach to medical care insurance could be attributed to the fact that Wintermeyer himself was a businessman.<sup>23</sup> The Liberal Party argued

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21 Ontario Legislature Debates, April 25, 1963, 2770.

22 Ontario Legislature Debates, April 25, 1963, 2784.

23 Interview with The Hon. Robert Nixon, February 15, 1990.

that PSI was already in place and therefore, time and administrative costs would be spared by leaving it intact. This proposal was supported by PSI.<sup>24</sup> The Liberal Party also emphasized the fact that co-operation between government and the medical profession was necessary to avoid a Saskatchewan-type conflict.

The NDP was almost as critical of the Liberal Party proposal as they were of Bill 163. They said that the Liberal Party was not committed to a truly complete medical care insurance plan. The NDP accused the Liberals of "waxing" the OMA, as indicated by their support of PSI which was a doctor-sponsored plan. Although the NDP opposed the Liberal plan, they concentrated their effort against Bill 163. Kenneth Bryden, NDP Member for Woodbine, led the attack on Bill 163:

Let us just face it that this is a straight political maneuver, this bill; it is an attempt to persuade the public that the government is serious about this issue when in fact the government has capitulated 100 percent to the insurance companies and the medical profession.<sup>25</sup>

Although Robarts had introduced Bill 163 to the Legislature, he was not yet committed to pushing it through. As a headline in the Toronto Daily Star read, Robarts claimed that he was "not wedded"

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24 Interview with Mr. Arthur Bond, January 24, 1990.

25 Ontario Legislature Debates, April 25, 1963, 2776.



26  
to Bill 163. He was content to defer the Bill to be studied by an independent committee. This was done on April 25, 1963, only two days after the Bill had been presented to the Legislature.<sup>27</sup> Robarts was satisfied simply to introduce the legislation. This gesture made it appear that he had seriously considered the medical care issue and had taken definite steps to expand insurance coverage. By not pushing the legislation through, Robarts conveyed the message that refinements to Bill 163 would be considered. This was shrewd political strategy because he was able to appear progressive without even passing the legislation. Deferring Bill 163 to an independent committee also meant Robarts was able to avoid a potentially controversial struggle with the NDP and Liberal Parties. This was especially important considering the fact that a provincial election was anticipated in the early fall of 1963.

In the 1963 election campaign, Robarts drew attention to his medical care draft bill and the creation and extension of portable pensions through the Pension Benefits Act.<sup>28</sup> Like Bill 163 the Pension Benefits Act was criticized by the Opposition because it allowed for private sector insurance control.

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26  
Robarts' Papers, "Not wedded to my medicare plans - Robarts," Toronto Daily Star, June 25, 1964.

27  
Ontario Legislature Debates, April 25, 1963, 2771.

28  
Allan Kerr McDougall, John P. Robarts: His Life and Government (Toronto, 1986), 97.

Nevertheless, the introduction of this legislation made it appear that Robarts was making important advances in social welfare policy. By referring these sorts of social programs to the private sector, the Premier was able to concentrate on building the Ontario economy, which had suffered during the 1958-1962 recession. Robarts' concern about the economy also led him to seek ways of cutting government spending. In 1963 the Ontario government spent \$ 1.179 billion while revenues were only \$ 93 million.<sup>29</sup> Robarts' strategy was obviously successful, because he won 48 percent of the popular vote and 77 seats in a 108 seat<sup>30</sup> Legislature.

While securing this victory Robarts had to be well-aware of various external factors, including Ontario's relationship with the federal government and the other provinces. With Diefenbaker's defeat by Pearson on April 8, 1963, the Ontario Conservative Party had lost an allied government in Ottawa. In addition, the disintegration of the national Conservative Party threatened to decrease public confidence in Robarts' Government. For this reason, Robarts made an effort to disassociate his Party

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29

"Ten Strong Men and What they Want", Maclean's, February 8, 1964, 12.

30

Randall White, Ontario 1610-1985: A Political and Economic History (Toronto, 1985), 291.

from the federal Conservatives. Both publicly and privately he<sup>31</sup> stated a determination to "stay clear" of the federal party.

After winning the provincial election, it was not his federal counterparts who concerned Robarts but rather, Liberal Prime Minister Pearson and his persevering ideas concerning social reform. Among the proposals that concerned Robarts was the national Medicare plan. He saw this as a further infringement on provincial jurisdiction, and also as an impediment to economic growth. Government sponsored medical care meant an additional burden on the provincial treasury. Pearson's proposals indicated a possible federal-provincial tax-sharing arrangement similar to the HDSA. The provincial Conservative Party estimated that a Medicare program financed jointly through the federal and<sup>32</sup> provincial governments would cost Ontario \$ 280 million.

Robarts felt that this cost was too much, especially considering the fact that Ontario was trying to avoid a recession. An article by Janice Tyrwhitt appearing in the December 1963 issue of Maclean's stated that:

Robarts appears more interested in creating jobs than in extending direct forms of welfare. Though he has introduced pension and Medicare plans in the legislature, and enacted a minimum wage that applies to the most prosperous third of the province, he says now, "I think we must take a look and

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31  
McDougall, 94.

32  
Ontario Legislative Debates, February 3, 1966, 207.

see what we're going to pay for this. If we place too heavy a tax burden on people we can make our industry noncompetitive".<sup>33</sup>

Bill 163 helped Robarts defer the Medicare issue while he pressed on with rejuvenating the economy. In the meantime Bill 163 was sent to an examining committee. By an order-in-council the government established the Medical Services Insurance Committee in August, 1963.<sup>34</sup> The chairman of this fourteen member committee was Dr. J. Gerald Hagey, President of the University of Waterloo.<sup>35</sup> Known as the Hagey Committee, this group was comprised of three physicians, three representatives of the province's insurance carriers, two nurses, a businessman, a farmer, a lawyer-businessman, a representative of organized labour and a member of the Ontario Hospital Association.<sup>36</sup> Similar to the Hall Commission, the Hagey Committee listened to briefs from numerous organizations and individuals. The purpose of this committee was to examine and enquire into matters related to Bill 163, and then to make recommendations to the provincial

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33

Janice Tyrwhitt, "John Robarts: The Most Powerful Unknown in Canadian Politics", in MacLean's, December 14, 1963, 23.

34

Sawyer, 159.

35

Robarts' Papers, "Medicare Committee Set Up," Toronto Telegram, August 31, 1963.

36

Medical Services Insurance Committee, Report (Toronto, 1964), (i).

37  
government on their findings. After listening to fifty-nine  
briefs and studying other health care systems, Saskatchewan and  
Alberta's in particular, the Hagey Committee reported its  
findings in December 1964.<sup>38</sup> The Committee agreed with the  
recently-released Hall Report's emphasis on extending medical  
insurance benefits. However, there was an ideological difference  
between the Hall and Hagey Reports. The Hagey Report recommended  
that the best and most readily available method to extend medical  
insurance in Ontario was through the existing agencies as  
outlined in Bill 163:

An important difference lies in the nature of  
the insuring agency proposed. The Royal  
Commission recommended establishment of  
programs operated by governments, whereas the  
Ontario program, as approved by the  
Committee, is based on continued activity of  
private insurance carriers issuing standard  
contracts under regulations adopted by a  
government appointed body, and subject to a  
degree of supervision by that body.<sup>39</sup>

The recommendations of the Hagey Committee had been anticipated  
by Robarts. All of the members of the Committee were committed to  
the private enterprise approach, with the exception of Harry  
Simon, the Ontario Regional Director of Organization for the

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37

Medical Services Insurance Committee, Report  
(Toronto, 1964) preface.

38.

Medical Services Insurance Committee Report (Toronto,  
1964), 1.

39

Medical Services Insurance Committee, Report  
(Toronto, 1964), 3.

40  
Canadian Congress of Labour. Simon's views were included in the  
appendices to the Medical Services Insurance Committee's Report.  
The Hagey Report gave Robarts a mandate to reopen legislation to  
introduce a provincial medical insurance plan. It also gave him  
support against the recommendations of the Hall Report. As  
expected, the OMA and insurance carriers approved of the Hagey  
Report. They regarded the Hagey recommendations as practical  
solutions that would address Ontario's immediate needs, as is  
seen in an editorial in the Ontario Medical Review:

Here it becomes obvious that the Royal  
Commission is dealing with the subject on an  
armchair philosophical basis. While the  
Ontario Committee, because of a different  
composition, deals with it in a practical  
manner.<sup>41</sup>

On May 11, 1965, Robarts' Health Minister, Matthew Dymond, moved  
the first reading of Bill 136, An Act Respecting Medical Services  
Insurance.<sup>42</sup> During the introduction of Bill 163, in 1963,  
Robarts was not ready to push through legislation. During 1963,  
Pearson's proposals were only election promises, but by 1965  
things had changed dramatically. Pearson was now ready to  
implement a national Medicare program. Robarts could hesitate no

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40  
Bryden, 42.

41  
Dr. Glenn Sawyer, Editorial in the Ontario Medical  
Review, 32:3 (March, 1965), 156.

42  
Ontario Legislature Debates, May 11, 1965, 2755.

longer. The time had come to introduce a provincial plan that would retain the existing medical insurance system.

The introduction of the new Bill resulted in a lengthy debate in the Legislature. In principle the new Bill was the same as Bill 163, but with some technical modifications. Once again, labour, farm, church, and welfare groups accused the government of serving the interests of the OMA and the insurance companies. A. E. Thompson, leader of the provincial Liberal Opposition, attacked Bill 136, claiming that it was "a completely inadequate bill to present to the people of Ontario."<sup>43</sup> Thompson used the recommendations of the Hall Report to support his arguments. During the 1963 debates the Liberals and the NDP did not have this weapon. The provincial Liberals also had strong federal support in 1965. Pearson was aggressively pushing for a national Medicare program based on the recommendations of the Hall Report. Statements made by Thompson in the Legislature reflect this alliance with federal ideology:

Mr. Speaker, in my opinion, this bill (136) effectively blocks the possibility that we will one day have universal and comprehensive medical care for Canadians, available from coast to coast... There is no doubt in my mind that the Hall Commission correctly anticipated federal

financial participation in such  
coast-to-coast medicare.<sup>44</sup>

The provincial Liberals did not oppose Bill 136 simply to promote federal policy. This maneuver was an attempt to capture support from borderline NDP voters. Labour was one group that was disappointed with the Conservatives' proposal. David B. Archer, president of the Ontario Federation of Labour (OFL), stated that the plan "still has a long way to go to meet the objectives of our federation."<sup>45</sup> Thompson went so far as to quote an OFL pamphlet on the inadequacies of Bill 136 in the Legislature.<sup>46</sup> The OFL represented 1,500 unions with a total membership of 400,000 members.<sup>47</sup> By drawing attention to their empathy with OFL objectives, Thompson and the Liberal Party hoped to share in this vast pool of voting power.

Labour was only one of a number of groups that opposed Bill 136. For instance, on June 23, 1965, clergy of seven denominations picketed the main entrance of Queens Park in protest of the new bill.<sup>48</sup> The clergy, like labour, supported a government Medicare

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44

Ontario Legislature Debates, May 25, 1965, 3213.

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"OFL Criticizes Gaps in Ontario Medicare Plan," in Canadian Labour, June 1965, 30.

46

Ontario Legislature Debates, May 25, 1965, 3210.

47

Submission by the Ontario Federation of Labour to the Royal Commission on Health Services, June, 1962, 1.

48

Robarts' Papers, "Ready to Change Medical Plan,  
(Footnote Continued)



plan based on the Hall recommendations. These groups argued that the continuation of the existing approach would deny numerous citizens access to coverage. Thompson supported their claims and used the Alberta Medical Plan as an example of problems inherent to the free-market approach. Thompson explained to the Legislature that 15 percent of Alberta's population did not join the plan, and these people were generally in the group that most needed assistance.<sup>49</sup> On the basis of the Alberta plan, Thompson estimated that 900,000 of Ontario's citizens would not be insured.<sup>50</sup>

Not to be outdone by the Liberal Party, the NDP, under the leadership of Donald C. MacDonald, attacked Bill 136. Like the Liberals, the NDP claimed that the Bill only promoted the purchase of private insurance, but did nothing to assist the group that did not qualify for government assistance. The Bill allowed for provincially sponsored medical insurance for those with a taxable income of less than \$ 1,000 per year.<sup>51</sup> The NDP asked what would happen to those making just in excess of a \$1,000 taxable income, but who could not afford private medical

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(Footnote Continued)

Robarts Tells Protesting Clerics," Toronto Globe and Mail, June 24, 1965.

49

Ontario Legislature Debates, May 25, 1965, 3215.

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Ontario Legislature Debates, May 25, 1965, 3215.

51

Ontario Legislature Debates, June 21, 1965, 4479.

insurance.<sup>52</sup> The NDP argued that limitations such as these necessitated a universal, compulsory, government financed and administered plan.

Opposition to Bill 136 was strong but nevertheless it passed<sup>53</sup> third reading in the Legislature by a vote of 53 to 20.

Although Bill 136 passed the Legislature, Robarts claimed that it was not a final solution to Ontario's medical care needs. On June 21, 1965, he stated to the Legislature that Bill 136 was "only<sup>54</sup> part of a total plan." In fact, the government decided to introduce amending legislation, in order to make adjustments to Bill 136. It appears that this was done in order to appease the insurance companies, who objected to the requirement that they had to offer a standard contract. The government, therefore, introduced an amending bill to the Legislature on January 27,<sup>55</sup> 1966. Again, after lengthy debate, the Conservative Party pushed through the legislation. On February 18, 1966, An Act to<sup>56</sup> Amend the Medical Services Act was given third reading. The most important alteration that Bill 6 made to Bill 136 was that the private insurance carriers were no longer required to offer

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52  
Ontario Legislature Debates, June 21, 1965, 4479.  
53  
Ontario Legislature Debates, June 21, 1965, 4492.  
54  
Ontario Legislature Debates, June 21, 1965, 4489.  
55  
Ontario Legislature Debates, January 27, 1966, 43.  
56  
Ontario Legislature Debates, February 18, 1966, 689.

the standard contract. As section 5 (1) of the amending legislation read:

Standard medical services insurance contracts shall be made available to residents and their dependents without regard to age, physical or mental infirmity, financial means or occupation, only by the Medical Services Insurance Division.<sup>57</sup>

Queen's Park would assume the responsibility of providing coverage to both government assistance recipients and non-recipient buyers of the standard contract. The provincial government was now content with the legislation; therefore, the Ontario Medical Services Plan (OMSIP) was implemented on April 1, 1966.<sup>58</sup> The introduction of OMSIP meant that Ontario's Medical Welfare Plan would no longer be needed to administer to the medical care insurance needs of recipients of government assistance. As stated earlier, the Medical Welfare Plan was financed by the province but administered by the OMA. The discontinuation of the Medical Welfare Plan took an important area of administrative control of medical affairs away from the OMA. This was a blow to the OMA's ability to regulate the medical care needs of the people of Ontario. Although OMSIP established a provincial medical care plan that the OMA hoped would block the federal plan, it created a government insuring agency that

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57

Statutes of the Province of Ontario, The Medical Services Insurance Amendment Act, 14-15 Eliz. II, Chap. 86, Toronto, 1966, 385.

58

Ontario Department of Health Annual Report, 1966, 53.

actually reduced the doctors' ability to control the medical care  
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system.

Between 1963 and 1965, the medical insurance issue received a tremendous amount of attention in Ontario. At the federal level the issue received much less attention. Periodically the NDP pressured the federal government to fulfill its 1963 campaign promise of a national Medicare plan. The NDP also reminded the Liberals that they had been referring to a federal medical  
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care plan since 1919. The introduction of Bills 163 and 136 in Ontario gave the NDP further support in demanding federal initiative on Medicare. As William Dean Howe, NDP member from Hamilton South, stated:

In view of the fact that the Ontario Government has come close to putting in a rather inadequate health plan that likely would prevent a proper federal health plan, can the Minister assure the House that this government will take some definite immediate steps toward the institution of a federal medicare plan that would prevent this provincial fiasco?<sup>61</sup>

With pressure from the NDP, and an upcoming election, Pearson reintroduced the Medicare issue in 1965. The year 1965 proved a turning point in federal medical care policy. The Liberal

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Glenn Sawyer, Editorial in the Ontario Medical Review, 33:2 (February, 1966), 97.

60

House of Commons Debates, November 14, 1963, 4752.

61

House of Commons Debates, June 4, 1965, 1987.

government launched an intensive campaign to implement a national Medicare plan. These moves, conflicted with provincial interests. In the forefront of the provincial reaction was the province of Ontario.

## CHAPTER 5

### THE FEDERAL GOVERNMENT MOVES INTO MEDICAL CARE INSURANCE

The latter half of the 1960s was marked by further federal moves into the provincial jurisdiction of social welfare. Concerning medical care policy, the Pearson government waged a strong campaign to implement a national insurance program. Despite provincial reaction, the federal government pushed for more participation in this area. The era of "co-operative federalism" displayed by Leslie Frost and Louis St. Laurent in the 1950s came to a close in the mid-1960s.<sup>1</sup> While the provinces had constitutional jurisdiction over social policies, the federal government controlled the largest share of the country's finances. Through fiscal manipulation Ottawa was able to dictate provincial social policy. This situation was a factor leading up to the Federal-Provincial Constitutional Conferences in the late 1960s. The Medicare issue was an important consideration in federal-provincial relations during this period.

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Randall White, Ontario 1610-1985: A Political and Economic History (Toronto, 1985), 288.

At the July, 1965, Federal-Provincial Conference in Ottawa Pearson announced his Government's intention to initiate a national Medicare program. Numerous factors led to the decision to introduce this plan, which included: the Liberal Party's continuing commitment to health insurance, the influence of the Hospital Insurance and Diagnostic Services Act, Saskatchewan's newly established plan, the recommendations of the Hall Report, and the Liberal Party's decision finally to implement its 1963 election promise. In 1963 the Liberal Party promised to introduce three social programs: extended family allowances, a pension plan, and Medicare. By 1965 the first two were implemented, but nothing had been done about Medicare.<sup>2</sup>

A key figure in the development of Pearson's Medicare plan was Al Johnson, Saskatchewan's former Deputy Provincial Treasurer. When the provincial NDP in Saskatchewan lost to the Liberals in 1964,<sup>3</sup> Johnson moved to Ottawa as Assistant Deputy Minister of Finance. Due to his knowledge of Saskatchewan's medical care insurance system, Johnson was assigned to work on a federal Medicare program by Finance Minister Walter Gordon. During this time, Pearson set up a Privy Council Office Committee to consider potential medical care insurance plans. This committee consisted

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<sup>2</sup> Malcolm G. Taylor, Health Insurance and Canadian Public Policy (Montreal, 1987), 363.

<sup>3</sup> Thomas Kent, A Public Purpose: An Experience of Liberal Opposition and Canadian Government (Montreal, 1988), 366.

of a chairman, Gordon Robertson (Clerk of the Privy Council), Tom Kent (Pearson's chief aide), and Donald Cameron (Deputy Minister of National Health and Welfare).<sup>4</sup> Johnson did the basic work for the committee and sat on it as an alternate. Drawing from his Saskatchewan experience, he pushed for four basic principles to be incorporated into the federal plan: comprehensive coverage, universal coverage, administration by the provincial government, and portability of benefits from province to province. Implementing these principles would be no easy task. Provincial governments were becoming increasingly sensitive to federal initiatives into areas over which they claimed jurisdiction. Tom Kent explained that a "subtle" approach was needed:

The federal government did not need to legislate the details of a shared-cost program. It needed only to define clearly, the principles of what it meant by medicare. Then it would contribute to the costs of any provincial program that satisfied these principles.<sup>5</sup>

It was no coincidence that Pearson introduced the Medicare plan during the summer of 1965, considering the fact that there was an upcoming election. The new plan would give the Liberals a definite stance on the Medicare issue. Pearson felt that Canadian society was becoming increasingly willing to accept government social policies, and was now ready for Medicare. At the July,

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<sup>4</sup> J. L. Granatstein, Canada 1957-1967: The Years of Uncertainty and Innovation (Toronto, 1986), 194.

<sup>5</sup> Kent, 366.



1965, Federal-Provincial Conference Pearson made his announcement:

The federal government, subject of course to parliamentary approval, will support provincial medicare plans by means of a fiscal contribution of a pre-determined size.<sup>6</sup>

Pearson's plan called for the administration of medical insurance plans by the provincial governments but with half the cost financed by Ottawa. By offering financial assistance, and not direct administrative control, Pearson argued that the federal government was not infringing on the provincial jurisdiction of health care. Pearson said that the federal government would provide financing to provincial plans if they adhered to his four basic principles. He described the principles at the Federal-Provincial Conference:

First, the scope of benefits should be, broadly speaking, all the services provided by physicians, both general practitioners and specialists. A complete health plan would include dental treatment, prescribed drugs, and other important services, and there is nothing in the approach we propose to prevent these being included, from the start or later, if this were the general wish. We regard comprehensive physician's service as the initial minimum. Secondly, we would propose that the plan should be universal. That is to say, it should cover all residents of a Province on uniform terms and

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Federal-Provincial Conference, July 19-22, 1965, Proceedings, 16.

conditions. In practice, the idea of universality is subject to some qualification by administrative practicability. But it must, I think, be clearly the objective. Since the basic reason for a federal contribution is to make medicare possible for all Canadians, it would hardly be logical to bring a federal contribution into play not aimed at universal coverage. Thirdly, I think it will be readily agreed that a federal contribution can properly be made available only to a plan which is publicly administered, either directly by the provincial government or by a provincial non-profit agency. Fourthly, and finally, I think it is important to recognize the mobility of Canadians; each provincial plan should therefore provide full transferability of benefits when people are absent from the Province or when they move their homes to another Province.<sup>7</sup>

In addition to outlining these criteria Pearson also explained how his government proposed to finance the plan. In his statement, the Prime Minister explained that the federal government would offer the provincial programs one-half of the national average cost of medical care insurance. For instance, in 1967 the estimated national average cost was \$ 28 per capita.<sup>8</sup> Based on this estimate Pearson explained that Ottawa would pay one-half of this amount, \$ 14 per capita, to provinces meeting the four criteria. This program was to be started on July 1, 1967, Canada's centenary.

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<sup>7</sup>  
Federal-Provincial Conference, July 19-22, 1965, Proceedings, 16-17.

<sup>8</sup>  
Federal-Provincial Conference, July 19-22, 1965, Proceedings, 93.

Medicare exposed the federal government to attack from the provinces, based on the questionable constitutionality of the plan. Pearson was well-prepared to defend the federal position. He emphasized the fact that Medicare would not consist of one federally controlled program, but, rather, would consist of ten provincially administered plans partially financed by Ottawa. He emphasized the tremendous importance of co-operation between the federal and provincial governments to work toward common goals. Pearson stated that the Canadian constitution did not establish "absolute distinctions between the functions and powers of our respective governments." <sup>9</sup> Since jurisdictional boundaries were sometimes vague, he explained that co-operation was crucial. As far as Medicare was concerned, Pearson saw it as an area where jurisdictional boundaries overlapped:

It would be our policy to establish and operate a national medical care plan if the constitutional responsibility to do so were ours, or if all the provinces wish to make it ours. But that is not the situation. The responsibilities of decision and execution in this matter are essentially provincial. At the same time, the scope and nature of the problem is such as to create a necessary national concern. Therefore, there is a measure of federal responsibility that has been expressed over the years in many policies of Canadian governments.<sup>10</sup>

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<sup>9</sup>  
Federal-Provincial Conference, July 19-22, 1965, Proceedings, 5.

<sup>10</sup>  
Federal-Provincial Conference, July 19-22, 1965, Proceedings, 15.

Pearson was quick to point out that medical care was not a new shared-cost program. During this period, the shared-cost programs were under review by the Tax Structure Committee which had been established at the Federal-Provincial Conference of 1964.<sup>11</sup>

Unlike the shared-cost programs, Pearson's Medicare proposal offered federal assistance of a predetermined amount (e.g. \$14 per capita) and, as such, would not be simply a federal-dollar-paid-for-every-provincial-dollar-spent-type program. In this sense, Medicare had a form of cost containment incorporated into it.

In his opening statement to the Conference, Robarts supported Pearson's call for cooperation between the federal and provincial governments. However, Robarts clearly indicated that there were divisions of federal and provincial jurisdictions as well as areas of joint responsibility:

The government of Ontario approaches this conference in that spirit (co-operation and consideration) recognizing the spheres of action that properly belong to the federal government, requesting adequate consideration for those areas that are better served by the provinces, and seeking new areas where extended co-operation will serve the interests of all the people of Canada as well as of Ontario.<sup>12</sup>

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Federal-Provincial Conference, July 19-22, 1965, Proceedings, 16.

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Federal-Provincial Conference, July 19-22, 1965, Proceedings, 24.

In his statement to the Conference Robarts made little mention of government financed medical care insurance. He later explained that this was because he had not been notified of the federal government's intentions to announce the program.<sup>13</sup> He stated his curiosity about the federal government's intentions, with respect to the medical care issue, during the Federal-Provincial Conference:

The government of Ontario urges the federal government to clarify its intentions with respect to the implementation of the broad objectives of the Hall Commission and the extension of medical and health services.<sup>14</sup>

Concerning the allocation of government financial resources, Robarts dealt at length with the question of tax-sharing. He stated that the existence of shared-cost programs forced the provinces to accept federal policy, even in areas of provincial jurisdiction. In order to give the provinces greater financial autonomy, Robarts stated that provincial governments should be given wider tax access. This move would give the provinces more revenue; therefore, they would have a greater ability to fund their own programs. Pearson's Medicare plan was completely at odds with what Robarts sought. While Robarts was calling for greater provincial autonomy, Pearson introduced a centralist

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Robarts Papers, Fraser Kelly, "Compromise Necessary, Says Robarts," Toronto Telegram, July 21, 1965.

14

Federal-Provincial Conference, July 19-22, 1965, Proceedings, 29.

policy. In Robarts, eyes, Medicare was much more than Liberal social policy. It symbolized the growing aspirations of an increasingly powerful federal government.

At the time, medicare was not the only social program recently introduced by the federal government. In 1965, Ottawa had introduced the Canada Pension Plan, which added a wage related pension as a supplement to the universal old age pension.<sup>15</sup> In addition, the federal government was working on a further project, which would offer a variety of welfare benefits, including health care, to the working poor. Included in this plan was the subsidization of medical, surgical, obstetrical, optical, dental, and nursing services to people receiving social security benefits.<sup>16</sup> Introduced in 1966 this Canada Assistance Plan was another shared-cost program where the federal government paid half the cost and the provinces paid the remainder.

These social programs introduced by Pearson were a significant drain on the federal treasury; therefore, in 1965, he was not yet ready to implement Medicare. He addressed the issue at the July 1965 Federal-Provincial Conference. Pearson drew attention to the fact that the Canada Assistance Plan was a definite federal move to initiate the recommendations of the Hall Report. Although this

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15

Dennis Guest, The Emergence of Social Security in Canada (Vancouver, 1985), 150.

16

House of Commons Debates, October 25, 1966, 9106.

plan allowed for services only to social assistance recipients, it was a move by the federal government into the health care field. It would only be a matter of time before the federal government would attempt to venture into medical care insurance. Pearson was careful not to take this step too soon:

I do not think that we can plan to take that [medicare] on, at least in any comprehensive way, in 1965. But we do need to make some plans for dealing with the greatest needs in the area.<sup>17</sup>

After hearing the federal proposal, Robarts surprisingly appeared to give cautious approval. His main concern was about the degree to which the plan would be compulsory. The Toronto Globe and Mail reported on July 22, 1965, that Robarts felt the same procedure<sup>18</sup> used in implementing HIDSAs could be used for the Medicare plan. Specifically, this meant that it would be mandatory for companies having 15 or more employees to collect and remit premiums to the provincial Department of Health.<sup>19</sup> The federal Minister of Health and Welfare, Judy LaMarsh, said that this would be acceptable to Ottawa.<sup>20</sup> Although Robarts initially seemed to

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Dennis Smith, Gentle Patriot: A Political Biography of Walter Gordon (Edmonton, 1975), 216.

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Robarts Papers, "Not Necessarily Compulsory, Robarts Says of Medical Plan," Toronto Globe and Mail, July 22, 1965.

19

Taylor, 225.

20

Robarts Papers, "Not Necessarily Compulsory, Robarts Says of Medical Plan," Toronto Globe and Mail, July 22, 1965.

approve of the plan, he withheld judgement until he had a more thorough understanding of the proposal.

After returning from the Federal-Provincial Conference Robarts' tone altered dramatically. At a press conference held at Queen's Park on July 27, Robarts denounced the federal government's "do it our way or we won't contribute anything" policy, and described it as a "shotgun approach".<sup>21</sup> It is obvious that Robarts was advised upon his return to Toronto, that Ontario's new medical care plan (Bill 136) would not pass the federal criteria. In order to qualify for federal subsidy, the provisions of Ontario's plan would have had to be dramatically altered. Robarts was placed in a very difficult situation. He could accept the federal proposal and with it an estimated \$ 91 million of federal funding per year.<sup>22</sup> He alternately could reject the federal proposal and continue with Ontario's newly legislated medical care insurance plan. Acting in defence of provincial autonomy Robarts rejected the federal plan; however, he was a realist, and understood that national medical care insurance would eventually come to Canada:

Eventually one way or another we'll achieve  
medicare for the people from coast to coast.  
As a question of social development it is

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21

Robarts Papers, "Ottawa used Shotgun Approach to Medicare," Toronto Globe and Mail, July 28, 1965.

22

Robarts Papers, "Ontario's Share in Medicare: Robarts Plans His Strategy," Toronto Daily Star, July 31, 1965.



inevitable. Really it's a matter of how we get there.<sup>23</sup>

The key issue to Robarts was "how we get there". He saw society's growing demand for social legislation, but also realized that private enterprise had to be protected in order to sustain economic growth. Robarts believed that the logical solution was to allow private insurers to carry part of society's health insurance demand in order to free government funds for other priorities, but the estimated \$91 million was an attraction that even the Ontario Tories found difficult to ignore. If Ontario was going to accept this offer, Robarts would fight for the best deal possible. The Toronto Daily Star stated that the implementation of Ontario's Medical Care Act would offer Robarts a "good lever" while negotiating with the federal government.<sup>24</sup> Speaking to the Ontario Legislature, Robarts indicated that the existence of a functioning, government supported medical insurance program in Ontario would put the province in a strong bargaining position:

We will be in a better position, and I say this unabashedly, to negotiate with the federal government, and we will be in a better position to look after the interests of the people of this province, and we will be in a better position to look after the interests of the people of Canada, as far as

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23

Robarts Papers, "National Medical Scheme Inevitable, Robarts Says," Toronto Globe and Mail, July 17, 1965.

24

Robarts Papers, "Ontario's Share in Medicare: Robarts Plans his Strategy," Toronto Daily Star, July 31, 1965.

we have that responsibility as a provincial government.<sup>25</sup>

It appeared in the summer of 1965 that Robarts was ready to defend provincial autonomy in the medical insurance field. The medical community was confident of Robarts' sincerity, although they were somewhat concerned about the sheer might of the federal government and especially of the burgeoning power of the Department of Health and Welfare.<sup>26</sup> In the 1965-66 fiscal year, Health and Welfare had the third largest budget of all federal departments with total expenditures exceeding \$ 1.35 billion.<sup>27</sup> The OMA recognized the difficult position that the Robarts government was in, and supported his decision to block the federal medicare plan. This was aptly expressed in an editorial of the Ontario Medical Review:

We believe that the provinces should assert their right to design a program to meet the particular needs of their citizens. They should resist the efforts of the federal government to dictate the details of the program, the carriers to be used and the administrative mechanism employed.<sup>28</sup>

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Ontario Legislature Debates, June 1, 1965, 3553.

26

Dr. Glenn Sawyer, Editorial in the Ontario Medical Review, 32:8 (August, 1965), 547.

27

"Need Compromise for Full Medicare," Financial Post, June 5, 1965, 47.

28

Sawyer, Editorial in the Ontario Medical Review, 32:9 (September, 1965), 611.

Like the OMA, the insurance firms in Ontario were very concerned about Pearson's Medicare proposal. The insurance industry considered the federal moves very seriously. Reflecting the fear of the business community, the Financial Post reported, on June 5, 1965, that "it's hard to find a federal politician who isn't now in favour of a government-operated, tax-supported, comprehensive national medical plan."<sup>29</sup> In an attempt to defend against further government moves into their market, the insurance carriers made attempts to offer very competitive medical care insurance packages. For instance, the Continental Casualty Company offered the "Medicall Plan". This plan provided medical-surgical coverage regardless of age or previous medical record on a group rate basis (i.e. sold to all employees of a particular company).<sup>30</sup> Despite attempts such as this, the insurance industry realized that Pearson's proposal was tremendously threatening:

The continuing threat of government intervention is the spur behind the companies' drive to find new sources of income. Although some of the provinces seem favourably disposed to keeping the business in the hands of private insurers the Hall Commission argued for a government-operated plan and some insurance men believe that the

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"Need Compromise for Full Medicare," Financial Post, June 5, 1965, 46.

30

"Accident and Sickness Insurers Facing Internal and Government Pressure," Financial Post, April 17, 1965, 65.

federal government may eventually have its way.31

In order to discuss the federal proposal, and offer the provinces an opportunity to present their opinions, a national Medicare conference was scheduled for September of 1965. As expected, Robarts took a hard stance against the federal proposal. His brief to the conference showed that Ontario would only be willing to accept Ottawa's plan if certain important compromises were made. Among Robarts' demands on the federal government were:

- coverage of mental and tubercular patients - which cost Ontario \$ 70 million per year.
- pay one-half the cost of building new medical, dental and other teaching colleges in the health field
- share equally in the operating costs of these schools after the deduction of fees.
- extend present capital cost supports for hospitals for at least five years.
- split costs more reasonably with provincial and municipal governments in construction grants.32

Though Robarts called for additional federal funding in these areas, he was non-committal to Pearson's Medicare plan. He wanted to see the sort of compromises the federal government would make to attract Ontario into the plan. On various occasions Robarts attacked this plan and the general expansion of federal influence. In particular, he became increasingly critical of the

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31

"Accident and Sickness Insurers Facing Internal and Government Pressure," Financial Post, April 17, 1965, 65.

32

Robarts Papers, "Hardline on Medicare by Robarts to Ottawa," Toronto Telegram, September 21, 1965.

federal-provincial tax-sharing agreements, which, Robarts believed, stunted the provinces' ability to implement their own spending priorities:

I do not intend to go in to the complexities and the various arguments pro and con the existing agreements. I would only say that Ontario, having refrained from signing the tax rental agreement in 1947, has never been fully satisfied with the agreements which it did sign in 1952, 1957 and 1962.<sup>33</sup>

Although Robarts expressed his concern about these tax-sharing agreements, he still emphasized the importance of co-operation and national unity. In his book John P. Robarts, Allan K. McDougall said that the Premier's "instincts leaned toward the maintenance of national institutions and policies wherever possible."<sup>34</sup> When the Lesage government in Quebec was pushing to opt out of federal shared-cost programs in 1965, Robarts attempted to retain a nationalistic outlook. For instance, he did not openly object to the introduction of the Canada Assistance Plan.<sup>35</sup> Robarts' stance on national unity led many to believe that he was preparing for the leadership of the federal Tories. He denied these speculations, and sometimes privately joked that

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Text of Robarts' speech to the Ontario-Quebec Newspaper Editors' Seminar, October 8, 1965, in the Toronto Globe and Mail, October 9, 1965.

34

Allan Kerr McDougall, John P. Robarts: His Life and Government (Toronto, 1986), 166.

35

McDougall, 166.

he did not need to run Canada from Ottawa because he already ran  
it from Queen's Park.<sup>36</sup>

In November of 1965 a federal election was held, in which  
Diefenbaker lost to a minority Liberal Government. Throughout the  
election campaign, the federal Liberals tried to make the Tories  
appear anti-medical care. This was not difficult to do,  
considering the fact that they did oppose Pearson's medical care  
insurance plan. During the campaign, Robarts did not commit  
Ontario either to support or oppose the plan.<sup>37</sup> He also kept<sup>38</sup>  
quiet about his intention to go ahead with Ontario's plan.

With the election behind them, Pearson's Government was ready to  
proceed with its Medicare plan. Simultaneously, the Robarts  
Government pushed to establish its own plan. During this period,  
Robarts became increasingly concerned about the tremendous  
financial burden that the introduction of the federal plan would  
create. The interim report of the federal Tax Structure  
Committee, released in December 1965, further entrenched Robarts'  
fear of financial problems if Medicare was introduced. In this  
report, the Committee predicted long-term surpluses in the

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36  
McDougall, 182.

37  
McDougall, 168.

38  
McDougall, 168.

39  
federal treasury, but increased debts for the provinces.  
Robarts feared that these federal surpluses would give Ottawa additional incentive to enter shared-cost programs. Since the provinces were moving toward greater financial deficits, these programs would be to their detriment. Considering this factor, Robarts moved ahead with Ontario's own medical care insurance plan.

Although Bill 136 had previously passed the Ontario Legislature there were some problems with it that had to be addressed. As stated earlier, the most significant problem was the fact that private insurers objected to their obligation to provide a standard medical care insurance contract. For this reason, Bill 6, An Act to Amend the Medical Services Insurance Act, was introduced to the Ontario Legislature by Matthew Dymond, provincial Minister of Health, on January 27, 1966.<sup>40</sup> The three most significant amendments made by Bill 6 were:

1. that standard medical service insurance contracts would be supplied only by the medical services insurance division of the Department of Health,
2. that benefits under these standard contracts would be 90 percent not 100 percent of the Ontario Medical Association Schedule of fees,

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McDougall, 170.

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Ontario Legislature Debates, January 27, 1966, 43.

3. that special waiting periods under the standard medical services insurance contracts were to be removed.<sup>41</sup>

Lengthy debate resulted from the introduction of Bill 6 in the Ontario Legislature. When Bill 136 was introduced in 1965, the federal government had not yet tabled its Medicare plan. By the time Bill 6 was being debated, the federal plan had long since been introduced. Much discussion about the position of Ontario in the federal plan took place during the debate over Bill 6. In his book Health Insurance and Canadian Public Policy, Malcolm Taylor described these debates as a "dress rehearsal" for the national debates to come later in the year.<sup>42</sup>

In defending Ontario's Medical Services Insurance Act, the Tories emphasized the wide range of services that would be offered. They explained that care would be provided to all the people in Ontario wherever they resided, whatever their state of health, or financial position.<sup>43</sup> Supporting the national medical care insurance plan, the Liberals and NDP opposed this Bill. Dymond argued that these moves by the Liberals and NDP were stalling legitimate legislation.<sup>44</sup> Though the provisions in Bills 136 and 6 did not fulfill the federal requirements, the Government of

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<sup>41</sup> Ontario Legislature Debates, January 27, 1966, 43.

<sup>42</sup> Taylor, 368.

<sup>43</sup> Ontario Legislature Debates, February 9, 1966, 368.

<sup>44</sup> Ontario Legislature Debates, February 10, 1966, 392.



Ontario said that they were a move in the right direction. Robarts stated that the Ontario plan was not necessarily in its final form, but was the beginning of the implementation of the Hall Report's recommendations.<sup>45</sup> While Robarts talked about introducing the Hall recommendations he was very careful to explain that medical care was a provincial responsibility. He criticized the other parties for their emphasis on joining the "federal plan",<sup>46</sup> stating that constitutionally, there could be no such scheme. Instead, there would be ten provincial plans to which the federal government would provide partial funding. The Tories argued that the provisions of Bill 136 and 6 were designed to establish a provincial plan, which in the future might qualify for federal subsidies.<sup>47</sup>

As the federal proposals stood in the winter of 1966, Robarts said that "[a] national plan is out of the question if you read the conditions the federal government has laid down."<sup>48</sup> Two of the more important reservations that Robarts had about Pearson's plan were that it was based on 50 percent of the national average medical insurance cost, and that it would not include

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Ontario Legislature Debates, February 11, 1966, 449.

46

Ontario Legislature Debates, February 11, 1966, 452.

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Ontario Legislature Debates, February 11, 1966, 452.

48

Robarts Papers, "Ottawa Medicare is out of the question Premier Robarts says," Toronto Globe and Mail, January 19, 1966.

participation of the private insurance industry. Ontario's average per capita cost was higher than the national average. If Ontario joined the Medicare plan, it would be subsidizing provinces which had an average medical care insurance cost lower than the national average. The second major point of contention with Pearson's proposal was that it would make the provincial government the sole administering body of medical care insurance. This would dissolve 16,000 existing group plans in Ontario which covered 4.6 million people.<sup>49</sup> Robarts feared that Pearson's plan would dismantle the free enterprise system and create dramatic increases in government spending.

In their attack on Bill 6, both the NDP and Liberals said that Robarts was standing in the way of national Medicare. Donald MacDonald said that Robarts' government was pushing through Bill 6, and not the federal plan, in order to appease the medical community and insurance industry.<sup>50</sup> He also said that Newfoundland, New Brunswick, and Saskatchewan had already accepted the federal proposals, and with minor changes British Columbia's plan would conform to the four criteria.<sup>51</sup> MacDonald as well, questioned Robarts' cost estimates of the federal plan. Robarts was basing his estimates on the \$ 14 federal per capita subsidy

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Ontario Legislature Debates, February 11, 1966, 453.

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Ontario Legislature Debates, February 7, 1966, 258.

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Ontario Legislature Debates, February 7, 1966, 258.

that Pearson mentioned in 1965. The federal government had in fact altered its offer to \$ 17 per capita to compensate for the increase in the national medical insurance cost increase. This meant a significantly larger federal contribution to Ontario, of approximately \$ 119 million instead of Robarts' estimated \$ 98 million.<sup>52</sup> These figures gave Robarts' opposition a significantly stronger argument. Stephen Lewis, NDP member for Scarborough, estimated that Ontario would receive at least \$ 110 million from the federal government.<sup>53</sup> The Tories had predicted the total provincial medical insurance costs of the province to be \$ 260 million. This would leave, according to the NDP, \$ 150 million for Ontario to raise.<sup>54</sup> Lewis said that Ontario was already committed to a \$ 70 million expenditure on its own program (OMSIP). He reasoned that an additional \$ 80 million expenditure would allow the province to join the national universal and comprehensive plan.<sup>55</sup> The NDP argued that Ontario should spend the extra money to prove its place as a leader in Confederation. The leader of the provincial NDP, Donald MacDonald, said that Ontario's stalling was crippling Canada's health interests:

In short, Mr. Speaker, the indecision of Ontario stands to date as the main roadblock to this nation finally being able to achieve

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Robarts Papers, Martin Goodman, "Robarts Medicare figure wrong: Ottawa," Toronto Daily Star, January 19, 1966.

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Ontario Legislature Debates, February 9, 1966, 354.

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Ontario Legislature Debates, February 9, 1966, 354.

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Ontario Legislature Debates, February 9, 1966, 354.

this major piece of social legislation, which has eluded us for generations.<sup>56</sup>

The Liberals, like the NDP, attacked Robarts' unwillingness to commit to the federal plan. The Liberals realized that Bill 6 would increase the insurance coverage provided by Bill 136, but that the amendment did not go far enough to satisfy the federal proposal.<sup>57</sup> Once again the Liberals raised the question of "[w]ho is the government protecting?"<sup>58</sup> Bill 6 gave Robarts' opposition the opportunity to accuse him of protecting the OMA and the insurance industry. Robarts addressed these criticisms by quoting a Gallup poll in the Legislature on February 11, 1966. He stated that the poll indicated 54 per cent of Ontario residents supported voluntary insurance plans, 40 per cent supported the idea of a compulsory government plan and 6 per cent were undecided.<sup>59</sup> This, he believed, was a clear mandate from the public to introduce OMSIP. Ironically, the OMA and the insurance industry were not entirely satisfied with Bill 6. The OMA was concerned that OMSIP would be available to all residents, not just those in financial need. Government was to become significantly more involved in the insurance business, in that it would administer the standard contract. The OMA Board of

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<sup>56</sup> Ontario Legislature Debates, February 7, 1966, 259.  
<sup>57</sup> Ontario Legislature Debates, February 7, 1966, 273.  
<sup>58</sup> Ontario Legislature Debates, February 3, 1966, 208.  
<sup>59</sup> Ontario Legislature Debates, February 11, 1966, 454.

Directors commended the Ontario Government for expanding services for the needy, but were critical of the extension of services to self-supporting citizens. The Board was also critical of the fact that OMSIP would pay only 90 percent of the OMA fee schedule. They made it clear that members of the OMA would bill the extra 10 percent at their own discretion. The attitude of the OMA was summed up well in an Ontario Medical Review editorial:

The Bill (6) moves government further into the insurance business. This, in itself, would not be too disturbing if the government had given any assurance that it would stop there. It has given no such assurance; in fact it has created the impression that participation in a federal plan is merely a question of time and money.<sup>61</sup>

Pearson's Medicare proposal also caused concern among the private insurance companies. The insurers in Ontario began looking to the situation in Saskatchewan when government medical care insurance was introduced. The insurance industry in Saskatchewan had to look to other means of income in the health care field. They concentrated more on such coverage as disability benefits and insurance against loss of income due to sickness or disability. Emulating the Saskatchewan experience, many insurance companies

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Statement by the OMA Board of Directors in the Ontario Medical Review, 33:3 (March, 1966), 253.

61

Dr. Glenn Sawyer, Editorial in the Ontario Medical Review, 33:2 (February, 1966), 97.

62

Robert Catherwood, "Insurance firms talk coexistence with medicare," Financial Post, January 29, 1966, 1.

in Ontario began expanding into areas such as those mentioned, plus coverage for special nurses fees, drugs and prosthetic devices.<sup>63</sup> Despite these moves the insurance industry in Ontario did not panic when OMSIP was introduced. This was because the industry made most of its money on group insurance plans, which would be affected little by OMSIP. The standard fees for OMSIP were \$ 60 for a single person, \$ 120 for a family of two, and \$150 for a family of three or more.<sup>64</sup> The private insurance industry could not compete with these low premiums on an individual basis, but the majority of their customers belonged to group plans. These plans were normally organized by the customer's employers. The employers usually paid 25 - 100 percent<sup>65</sup> of the employees insurance costs. Private insurance cost more than OMSIP, but once the employer paid part of the bill the real cost was usually lower than OMSIP. For this reason, people tended not to drop their current insurance coverage unless their employers were not assisting in paying the premiums.

The introduction of OMSIP did cause reason for some concern within the OMA and the insurance industry, but, at that point, things had changed little for these groups. Doctors were free to

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<sup>63</sup> Robert Catherwood, "Anyone for dental insurance? Insurers are looking around," Financial Post, February 5, 1966, 19.

<sup>64</sup> Canadian Labour, March, 1966, 32.

<sup>65</sup> Ontario Legislature Debates, February 27, 1969, 1637.

deal with the insurers which they wanted and were given the option of extra-billing above OMSIP payments. Although the insurance industry lost part of its market to OMSIP, this was generally the least lucrative sector - the aged and other bad risk groups. Because there was no compulsion to join OMSIP, industry was able to retain its group insurance market. By introducing OMSIP, Robarts was able to boast the establishment of a successfully operating government plan, which allowed the private insurance carriers to participate.

From the summer of 1965 to the spring of 1966, the medical care insurance issue in Ontario had been discussed and debated, until it eventually became law. The provincial plan (OMSIP) was implemented on April 1, 1966.<sup>66</sup> Although OMSIP coverage started on this date, it was only for social assistance recipients. Coverage for self-supporting applicants began on July 1, 1966.<sup>67</sup> By the end of 1966, 1.5 million people had joined OMSIP, 400,000 of whom were recipients of social welfare benefits.<sup>68</sup> This still left a market of approximately 5.5 million people in the province for the private insurance industry, and doctor-sponsored plans.

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<sup>66</sup> Ontario Department of Health Annual Report, 1966, 53.  
<sup>67</sup> Ontario Department of Health Annual Report, 1966, 53.  
<sup>68</sup> Ontario Department of Health Annual Report, 1966, 56.

While OMSIP was being introduced, Dr. Kenneth Charron was appointed Ontario Deputy Minister of Health. Charron became Deputy Minister effective January 1, 1966.<sup>69</sup> Previous to this appointment Charron was the Director General of Health services for the Department of National Health and Welfare. He was initially appointed to the federal Department of Health in 1956<sup>70</sup> by Paul Martin. Charron was sympathetic to the ideas of Martin and the federal government. This factor was shown in a study on health care which he conducted for the federal government in 1963, entitled Health Services, Health Insurance and Their Inter-Relationship - A Study of Selected Countries. In this study, Charron makes certain recommendations that are most definitely in favour of previous federal policy:

It would also seem appropriate that any future development in health service arrangement at a national level should take into account the basic principles applied in the Hospital Insurance and Diagnostic Services Act, and under the Health Grants program.<sup>71</sup>

As stated, Ontario's Department of Health was in the process of introducing OMSIP during this time. Charron was responsible for the restructuring of the Department to facilitate the changes. In

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"New Deputy Minister of Health For Ontario," Ontario Medical Review, 32:11 (November, 1965), 799.

70

Taylor, 216.

71

Kenneth C. Charron, Health Services and Their Inter-Relationship - A Study of Selected Countries (Ottawa, 1963), 237.



the 1966 Department of Health Report, Charron wrote extensively about the future. His predecessor as Deputy Minister, Dr. W. G. Brown, tended to concentrate on explaining past events in his reports rather than future projects. Dr. Charron clearly had a different view of things to come:

The reorganization is intended to reflect the changing emphasis on existing programs and the emergence of new areas of interest. It will be part of the dynamic process to reflect the most modern thinking for health services.<sup>72</sup>

It is interesting to note that Charron was an acquaintance of Dr. Glenn Sawyer (OMA Secretary), who introduced Charron to the OMA Executive.<sup>73</sup> Although a supporter of the OMA's objective of retaining the profession's autonomy, and the freedoms associated with it, Sawyer understood the reality of the impending federal plans. For these reasons he worked to cooperate with government in order to get the best deal he could for the doctors.<sup>74</sup> The more conservative elements in the OMA however, retained the organization's distaste for, and distrust of, the federal initiatives.<sup>75</sup> After meeting with Charron many members of the OMA became convinced that he was planted in the position by the

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Ontario Department of Health Report, 1966, 7.

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Interview with Dr. William Butt, December 22, 1989.

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Interview with Mr. Arthur Bond, January 24, 1990.

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Interview with Dr. William Butt, December 22, 1989.

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federal government. This argument is difficult to prove, but the fact remains that Charron, a most obvious disciple of Martin and the federal initiatives, somehow found his way into the Ontario Department of Health.

It should be noted that from October 1, 1965 to January 1, 1966, Charron acted as Assistant Deputy Minister of Health in Ontario.<sup>77</sup> It was during this period and into the beginning of his term as Deputy Minister that Bill 136 was amended to a) decrease the amount the government would pay from 100 to 90 percent of the OMA fee schedule and b) the province assumed the responsibility of administering the standard medical care insurance contract. In addition, Charron was to sit as the chairman of the newly-created health insurance registration board that would administer the plan.<sup>78</sup> What was the position of the Minister of Health, Matthew Dymond, during this period? Was he, as the Toronto Globe and Mail declared, "paving the way for a federal-provincial scheme?"<sup>79</sup> In his article "Medical Services Insurance: The Next Phase in Canada's National Health Program", Frederick D. Mott stated in 1967 that Dymond:

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76  
Interview with Dr. William Butt, December 22, 1989.

77  
"New Deputy Minister of Health for Ontario," Ontario Medical Review, 32:11 (November 1965), 799.

78  
Ontario Department of Health Annual Report, 1966, 53.

79  
Toronto Globe and Mail, April 29, 1967.

has shepherded through the Ontario Legislature since April 28, three bills (100, 101, 102) that point the way to more effective, better integrated, more centralized health care financing arrangements.<sup>80</sup>

Dymond strongly supported Robarts' rejection of the existing federal proposals and his appointment of Charron was to assist Ontario in implementing OMSIP. Charron's great wealth of knowledge about health insurance would prove an obvious asset to the introduction of a government plan, but his enthusiasm for the federal proposals may have influenced Ontario's move toward accepting them. In any event, Charron helped structure the health care system in Ontario to allow for easier implementation of Medicare.

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Frederick D. Mott, "Medical Services Insurance: The Next Phase in Canada's National Health Program", in the Medical Services Journal, October 1967, 1174.

CHAPTER 6  
INCREASED FEDERAL PRESSURE

While Ontario was introducing OMSIP the federal government worked hard to implement its own plan. As Allan McDougall says in his book John P. Robarts, Ottawa now started showing "a hard face of federalism."<sup>1</sup> In spite of provincial opposition, Pearson exercised federal power in pushing through social programs. Among these initiatives was the Medicare plan. On June 29, 1966, Allan J. MacEachen, Minister of National Health and Welfare, moved in the House of Commons:

That it is expedient to introduce a measure to authorize the payment of contributions by Canada toward the cost of insured services incurred by the provinces pursuant to provincial medical care insurance plans.<sup>2</sup>

This statement initiated a series of debates which would result in the House of Commons passing Bill C-227, the Medical Care

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<sup>1</sup> Allan Kerr McDougall, John P. Robarts: His Life and Government (Toronto, 1986), 171.

<sup>2</sup> House of Commons Debates, June 29, 1966, 7003.

Insurance Act. The debate began on July 12, 1966, with MacEachen explaining the social importance of the Bill. He stated that all Canadians deserved a high standard of medical care insurance and that this was only possible through the introduction of a "universal, prepaid, government sponsored scheme."<sup>3</sup> He further explained that this plan would best be implemented by utilizing the four criteria that were introduced at the July 1965 Federal-Provincial Conference. MacEachen suggested that this plan would allow the provinces to administer their own programs, with federal involvement "limited to encouraging provincial action" through the 50 percent grant formula.<sup>4</sup> This program would cost the federal government \$ 680 million in its first year of operation.<sup>5</sup> This, he explained, would be only \$ 80 million more than the estimated \$ 600 million that Canadians would spend on physicians' services in 1967 without the plan.<sup>6</sup>

The NDP supported Bill C-227 saying that it was not the end of government health care policy, but, rather, an important stage in its development. Tommy Douglas made reference to the Liberal Party's 1919 promise to introduce medical care insurance, the 1945 Federal-Provincial Conference, the 1948 Health Grants, the

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<sup>3</sup> House of Commons Debates, July 12, 1966, 7545.

<sup>4</sup> House of Commons Debates, July 12, 1966, 7545.

<sup>5</sup> House of Commons Debates, July 12, 1966, 7549.

<sup>6</sup> House of Commons Debates, July 12, 1966, 7549.

1958 Hospital Insurance and Diagnostic Services Act, the 1964 Hall Commission Report, and the 1965 Federal-Provincial Conference.<sup>7</sup> Douglas said that the introduction of Medicare would establish a program that was a natural culmination of all of these past events. Although Douglas was supportive of the Liberal moves finally to implement Medicare, his praise was cautious. He was concerned about the details of the plan's introduction. In particular, Douglas feared that Pearson might relax the rules about public administration of the provinces' individual plans. If this were to be the case, Ontario's new program (OMSIP) might qualify for federal subsidy. The NDP rejected the participation of any private carriers in the medical care insurance field which might profit from peoples' medical misfortunes. In addition, the NDP argued that government medical plans were more cost-efficient. Douglas said that in Saskatchewan, six cents from every dollar went to administration, while private plans spent sixteen to thirty cents for every dollar.<sup>8</sup> In support of his concern Douglas quoted an article in the Calgary Albertan, dated October 21, 1965:

Provincial governments are free to delegate administration to private agencies Prime Minister Pearson said yesterday.<sup>9</sup>

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<sup>7</sup> House of Commons Debates, July 12, 1966, 7556.

<sup>8</sup> House of Commons Debates, July 12, 1966, 7559.

<sup>9</sup> House of Commons Debates, July 12, 1966, 7559.

Like the NDP, the federal Conservative Party approved of the introduction of Medicare. After all, it was John Diefenbaker who had initiated the Hall Commission whose recommendations in large part led to Bill C-227. The Conservatives did oppose the way in which the Pearson government was introducing Medicare. They were especially critical of the fact that Pearson's plan would end many provincial programs already in place. E. Davie Fulton, Conservative Member from Kamloops, explained that 80 percent of Canadians were covered by some form of medical care insurance, while in Ontario, Alberta and British Columbia that figure approached 90 percent.<sup>10</sup> Since the existing plans already covered such a large portion of the population, the Conservatives argued that the federal government should support and not supplant already existing programs. Concerning OMSIP, the federal Conservatives were openly complimentary, as expressed by Philip Rynard, Member from Simcoe East, in the House of Commons:

Medical care is available in the province of Ontario and, as I have said, 4 million people are covered in that province. I should like to congratulate the Ontario Minister of Health for introducing OMSIP because it is a step in the right direction.<sup>11</sup>

While the Medicare issue was being discussed at the federal level the premiers were seriously considering their options. At the seventh annual premiers' conference held at Queen's Park in early

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House of Commons Debates, July 12, 1966, 7600.

11

House of Commons Debates, July 12, 1966, 7555.

August 1966, Medicare was an important item on the agenda. Of the ten premiers, or their representatives, seven openly attacked the federal Medicare proposal.<sup>12</sup> Only Saskatchewan's Premier, Ross Thatcher, was prepared to accept the federal offer. British Columbia and Newfoundland did not express their positions.

The issue which the provinces contested most was the federal criteria of universal, compulsory coverage. For instance, OMSIP met or could easily be made to meet the other federal criteria. This plan covered 1.5 million people in Ontario, which was far less than the 90 percent coverage called for by the federal plan.<sup>13</sup> The Ontario plan was not considered to be universal by the federal criteria despite the fact that private carriers and doctor-sponsored plans brought the total coverage to 95 percent.<sup>14</sup>

A strong provincial opposition to the federal plan had formed by the time the premiers met. A particularly strong alliance had developed between Robarts and the newly-elected Premier of Quebec, Daniel Johnson. The Union Nationale Party, under the leadership of Johnson, defeated the Lesage Liberals in June,

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<sup>12</sup> Robarts Papers, "Thatcher Says 7 Premiers Hostile to Medicare," Toronto Daily Star, August 2, 1966.

<sup>13</sup> Ontario Department of Health Annual Report, 1966, 56.

<sup>14</sup> Ontario Department of Health Annual Report, 1967, 119.



1966. Johnson's hard stance against Medicare was welcomed by Ontario because Lesage had begun to show signs that he might accept the federal offer.<sup>15</sup> This alliance posed a tremendous threat to Pearson's plans as was expressed in the Montreal Star:

The federal government proposed medicare legislation lies torn, tattered, and politically rejected in the wake of the 2 day conference of provincial premiers here.<sup>16</sup>

With powerful provincial opposition and a disgruntled medical community and insurance industry, it is no wonder that the federal Minister of Finance, Mitchell Sharp, was able to convince Cabinet to postpone Medicare for a year. Sharp argued that the government must practice fiscal restraint in order to curb inflation. He was not inherently opposed to Medicare, but in light of the current circumstances, Sharp believed in a slower and more cautious approach to introducing the plan.<sup>17</sup> On September 8, 1966, in a statement on finance to the Commons, Sharp announced the government's decision:

We have decided that we must defer the commencement of one major program that is already before the House. Many of the provincial governments have indicated that we are attributing too much urgency to the introduction of full medicare programs right away and they do not feel prepared to proceed

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McDougall, 172.

16

Robarts Papers, Harold Greer "Premiers Scuttle Medicare," Special to the Montreal Star, August 3, 1966.

17

J. L. Granatstein, Canada 1957-1967: The Years of Uncertainty and Innovation (Toronto, 1986), 195.

to put such programs into effect next summer as provided for in the bill before the House. We therefore propose to defer the effective date of the plan for a year until January 1, 1968.<sup>18</sup>

The decision to defer Medicare helped to widen the already growing rift in Liberal Party ranks. As Pearson said in his Memoirs, "[m]edicare became the focal issue" of the left-right dichotomy within the Liberal caucus.<sup>19</sup> Sharp led the "right-wing" forces in an attempt to curb government spending. The "left-wing" forces concentrated on the implementation of social security programs, and not on financial stability.<sup>20</sup> Among these "left-wing" forces was the Minister of Health and Welfare Allan MacEachen. He was so upset about the deferment of Medicare that he considered resigning.<sup>21</sup> MacEachen was convinced to stay in Cabinet, but he was insistent that Medicare would be introduced no later than July 1, 1968.<sup>22</sup>

Now the federal Opposition parties had another point to argue with the Liberals' deferment of Medicare. They attacked the Liberal's explanation that the deferment was a result of

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House of Commons Debates, September 8, 1966, 8217.

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John A. Munro and Alex I. Inglis eds. Mike: the Memoirs of the Right Honourable Lester B. Pearson Volume 3 (Toronto, 1975), 227.

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Munro and Inglis, 227.

21

Granatstein, 196.

22

House of Commons Debates, October 13, 1966, 8612.

inflation. Rynard said that this was a "completely ridiculous reason," especially considering the fact that the Liberals intended to introduce Medicare the following year.<sup>23</sup> Stanley Knowles referred to the deferment as "discrimination against the needs of the people of this country."<sup>24</sup> MacEachen was forced to defend the Liberal position based on the current economic situation. He said that while the country was waiting for Medicare, the health provisions of the Canada Assistance Plan would provide an "interim measure until a universal medical care system is in effect."<sup>25</sup>

As a further attempt to satisfy the demands of the provinces, the federal government announced its intentions to relax the criteria concerning universal compulsory coverage. MacEachen explained that a similar system of implementation to the HIDSAs could be used. He said that Ontario achieved 99 percent hospital care insurance coverage by making premiums compulsory for companies employing 15 or more people.<sup>26</sup> This step would retain the voluntary system while introducing the new compulsory one. Robarts had hoped for this concession since the July 1965

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23  
House of Commons Debates, October 13, 1966, 8613.  
24  
House of Commons Debates, October 13, 1966, 8620.  
25  
House of Commons Debates, October 25, 1966, 9106.  
26  
House of Commons Debates, October 25, 1966, 9103.

Federal-Provincial Conference. MacEachen explained that the private carriers could participate in the Medicare plan:

The bill also makes provision for circumstances in which the province may authorize an agency such as an insurance carrier to carry out certain responsibilities on behalf of the provincial government provided of course that the principles relating to public administration including the non-profit principle are adhered to.<sup>27</sup>

MacEachen's announcement that private carriers could be included in the plan met extremely harsh criticism from the NDP. The latter supported the bill so long as the Medicare plan was to be administered by the provinces or a provincial agency. Knowles said that "now we are given a bill which has in it a loophole a mile wide."<sup>28</sup> He argued that the participation of private carriers would jeopardize "the basis of four cardinal principles."<sup>29</sup> Although MacEachen's announcement caused dissatisfaction among the NDP, it did tend to appease some provincial agitation. At the risk of criticism from the NDP, Pearson attempted to convince the provinces of the Medicare plan's flexibility.

Though Medicare was deferred by a year, and Pearson had drawn attention to the flexibility of the plan, there was still

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House of Commons Debates, October 13, 1966, 8610.

28

House of Commons Debates, October 13, 1966, 8624.

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House of Commons Debates, October 13, 1966, 8624.

provincial opposition to this federal initiative. During the October 1966 Federal-Provincial Conference, there appeared to be a nearly total collapse in federal-provincial relations. At the Conference, Robarts stated his strong dissatisfaction with the existing tax-sharing situation. He called for a total reallocation of the various tax fields in order that the provinces could finance and proceed with their own spending priorities. In a statement during the Conference, Robarts said that there would be an increasing federal budget surplus while provincial deficits were expected to increase. He then recommended that federal-provincial responsibilities such as shared-cost programs be withdrawn in order to allow for greater fiscal autonomy. The provinces in return would expect to receive a greater share in the income tax field:

The fact that the federal government will move into a surplus position while the forecasts of combined provincial municipal figures reveal an increasingly large deficit reinforces the danger that the federal government will introduce programs which the provinces can not afford. Although we have all agreed this week upon the absolute priority of education, the proposals of federal financial assistance for education placed before us still fall far short of meeting our requirements. And yet the introduction of medicare as originally proposed for July 1, 1967, would have made it necessary for Ontario to finance, in addition to the \$ 70 million which we are paying for OMSIP, approximately \$ 88 million to meet the requirements of the federal plan. This is the equivalent of 5 points of the personal income

tax. Whereas we agree with the idea of universal public medicare and are in sympathy with the federal governments proposals, this is a matter of priority, timing, and raising of the money by taxes or premiums.<sup>31</sup>

Pearson pushed Bill C-227 through Parliament despite the tensions in federal-provincial relations. On December 8, 1966 Bill C-227 was passed by the House of Commons by a vote of 177 to 2.<sup>32</sup> The only two members who opposed the bill were from the Social Credit Party, which opposed any government participation in medical care insurance. On December 21, 1966, Bill C-227 received Royal Assent<sup>33</sup> to establish as law the Medical Care Insurance Act.

The Medical Care Insurance Act established the legal basis upon which a national Medicare program could be built. This took place forty-seven years after the issue had first been introduced (1919) by the Liberal Party. Although this Act grew out of earlier legislation, especially the Hospital Insurance and Diagnostic Act, it was distinctly different from the former shared-cost programs. The HIDSAs were shared-cost programs, where the federal government paid 25 percent of the national average per capita cost, plus 25 percent of the individual province's per

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<sup>31</sup>  
Federal-Provincial Conference, October 24-28, 1966, Proceedings, 66.

<sup>32</sup>  
House of Commons Debates, December 8, 1966, 10881-82.

<sup>33</sup>  
House of Commons Debates, December 21, 1966, 11512.

34  
capita cost. In this sense the HDSA took provincial circumstances into consideration. The Medical Care Insurance Act paid 50 percent of the national per capita cost to the provinces. This Act was based on a specific cost ceiling. An example of this was the \$ 14 federal cost per capita that was estimated by Pearson in July, 1965. This cost, multiplied by the country's population, established the program's cost ceiling. Unlike the earlier programs, this Act allowed for federal contributions only if a province met the four criteria. The provinces were not under compulsion to join, but they would be denied funding unless they met the criteria. The Act also differed from the HDSA in that the provinces had most of the administrative responsibilities. The federal and provincial governments shared the administration for the HDSA.  
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These technicalities of the Medical Care Insurance Act marked it as unique in Canadian constitutional history, but it was also a landmark issue in terms of federal-provincial relations:

The opposition to shared-cost programs which had long been spearheaded by Quebec gradually gained strength in the other provinces. The introduction of Medicare was to prove to be a

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A.M. Moore, J. Harvey Perry and Donald A. Beach, The Financing of Canadian Federation (Toronto, 1966), 61.

35

Geoffrey R. Weller and Pranlal Manga, "The Development of Health Policy in Canada", in Michael M. Atkinson and Marsha A. Chandler (eds.) The Politics of Canadian Public Policy (Toronto, 1983), 231.

turning point in federal-provincial relations  
in this area.<sup>36</sup>

This is illustrated by Robarts' opinion concerning the issue of whether or not provinces should be allowed to opt out of shared-cost type programs. Before Medicare was passed by the federal government, Robarts' statements were cautious. Regarding opting out, Robarts said to an Ontario-Quebec Newspaper Editor's Seminar in October, 1965, that Ontario must consider "the impact of our decisions on the whole country."<sup>37</sup> His attitude changed considerably by 1967, because in that year Robarts' provincial Treasurer, Charles MacNaughton, requested that Ontario be allowed to opt out of Medicare.<sup>38</sup>

While the federal government was aggressively moving to implement social programs, Ontario was considering its alternatives. In January of 1965, Robarts established the Advisory Committee on Confederation, in order to explore Ontario's position in

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36

G. V. LaForest, The Allocation of Taxing Power Under The Canadian Constitution (Toronto, 1981), 33.

37

Robarts Papers, "Robarts Outlines Three Main Challenges to Confederation," Partial text of Premier John Robarts' Speech at the Ontario-Quebec Newspaper Editor's Seminar of October 8, 1965, in Toronto Globe and Mail, October 9, 1965.

38

G. R. Weller, "Health Care and Medicare Policy in Ontario", in G. Bruce Doern and V. Seymour Wilson, Issues in Canadian Public Policy (Toronto, 1974), 95.



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federal-provincial relations. Based on the findings of this  
Committee, Robarts announced, in January of 1967, that Ontario  
would host a premier's conference to discuss Confederation.<sup>40</sup>  
This "Confederation of Tomorrow Conference" was held in Toronto  
between November 27 and 30, 1967. It was held, Robarts said,  
because the provinces "are concerned about the future of our  
country."<sup>41</sup> While preparing for the Conference, Robarts won a  
provincial election. With his efforts directed at federal  
provincial relations, he had staged a lackluster election  
campaign. Without a real campaign issue, Robarts still won 42  
percent of the popular vote on October 17, 1967.<sup>42</sup>

The two most important themes discussed at the Conference were:  
the relationship between the provincial and federal governments,  
and the place of French Canada in Canadian society. The  
Conference tended to focus on these wide topics, and Medicare was  
not specifically confronted. Though Medicare was not specifically  
discussed, the premiers did discuss federal-provincial fiscal  
relations at length. The attitudes and opinions of the premiers  
illustrated to Ottawa the problems in federal-provincial

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A.K. Mc Dougall and M.W. Westmacott, "Ontario in  
Canadian Federation", in Donald C. MacDonald Government and  
Politics of Ontario (Toronto, 1975), 206.

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McDougall and Westmacott, 206.

41

Confederation of Tomorrow Conference, November  
27-30, 1967, Proceedings, 1.

42

McDougall, 195.

relations. Medicare was both a federal and provincial concern, and for this reason the Conference was very relevant to its future.

The fact that the Confederation of Tomorrow Conference was held was indicative of provincial agitation toward the federal government. This is why Pearson disapproved of the Conference. He was particularly concerned that the Conference was televised, which meant that an enormous audience would witness the proceedings.<sup>43</sup> Pearson feared that provincial unhappiness, as expressed by the premiers, would reflect badly on his government and Canadian unity. The Conference did in fact draw attention to discontent, and illustrated to Canadians that the provinces were prepared to defend what was left of their fiscal autonomy against federal intervention. Although no solutions nor recommendations were made at the Conference, the important fact was that provincial dissatisfaction was publically aired. Quoting Premier Robarts, the Toronto Globe and Mail said that the Conference "is a beginning."<sup>44</sup> As the initiator and host of the proceedings Ontario was credited for the success of the Conference, and for the renewed provincial vigor that it sparked.

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43

Robarts Papers, "Essentials will be present at Mr. Robarts' conference," Toronto Globe and Mail, May 12, 1967.

44

Robarts Papers, John Dafoe, "The Conference of Tomorrow: In Mr. Robarts' words, it is a beginning," Toronto Globe and Mail, December 1, 1967.

It is ironic that while the premiers were discussing the provinces' place in Confederation Ottawa was preparing to implement new federal taxes. On November 30, 1967, Finance Minister Sharp announced a 3 percent surcharge on its share of the personal income tax.<sup>45</sup> It was obvious to the provinces that this new tax measure was being imposed to help finance the federal medical care insurance plan. This move infuriated Robarts, who was currently in the process of calling for a co-ordinated federal-provincial effort in spending priorities and tax adjustments. Robarts responded to this move by stating on January 24, 1968, that Ontario would not join the federal plan until at least a year after the July 1, 1968, starting date.<sup>46</sup> Although Ottawa had gained some ground by allowing private carriers to participate in Medicare, this latest tax imposition threatened Ontario's co-operation. Robarts harshly announced his rejection of Ontario's participation at an address to the Greater Niagara Chamber of Commerce:

I am reflecting the expression of the people of Ontario when I reject the federal proposals as being excessively expensive, unfair to those provinces unable to afford to participate, not consistent with our priorities, unfairly inflexible, and tampering improperly with matters which are the direct responsibility of the provinces.<sup>47</sup>

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House of Commons Debates, November 30, 1967.

46

McDougall, 212.

47

John P. Robarts, Address to the Greater Niagara Chamber of Commerce, in the Ontario Medical Review, 35:2 (February, 1968), 76.

In spite of the hostile provincial reaction against Medicare, Pearson did not waver from the proposed implementation date of July 1, 1968. On that date however only British Columbia and Saskatchewan joined the federal plan<sup>48</sup>. As mentioned, Ontario attacked the introduction of Medicare. During the Ontario budget debates, on July 23, Provincial Secretary Robert Welsh demanded a "reassessment by the federal government of the inflexible<sup>49</sup> position it has adopted."

By the time Medicare was implemented, Pierre Elliott Trudeau had replaced Lester Pearson as both leader of the Liberal Party and Prime Minister. Being an advocate of a strong central power, Trudeau proved to be unmoving on the Medicare issue. His attitude was expressed in his Income Security and Social Services (1970):

The conclusion of the Government of Canada, then, is that health insurance ought to remain a matter of exclusive provincial jurisdiction, subject to the use of the spending power of Parliament as proposed above, for the purpose of bringing about an adaptation of provincial programs to meet national needs.<sup>50</sup>

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48  
Taylor, 375.

49  
Ontario Legislature Debates, July 23, 1968.

50  
Pierre Elliot Trudeau, Income Security and Social Services (Ottawa, 1970), 102.

As Ontario became more deeply involved in the struggle to resist the federal plan, the insurance industry and the OMA began to recognize the reality of the situation. The insurance companies began to believe that the implementation of Medicare in Ontario was only a matter of time; therefore, they moved to broaden their health insurance coverage to new areas. Like companies in Saskatchewan, they were forced to consider expanding into markets such as disability and loss of income insurance. The insurance carriers tried to retain an optimistic attitude; after all the federal government had promised their inclusion in Medicare so long as they operated on a non-profit basis.

The medical profession was more concerned than the insurers because they believed that their ability to function properly as a profession was threatened by the federal plan. Unlike the insurance companies, the doctors could not diversify to lessen the impact of the impending legislation. The OMA had three main criticisms of Medicare: that government should first concentrate on the shortage of medical personnel, that it would lead to disintegration of the doctor-patient relationship, and that it would threaten the very freedom of the profession. <sup>51</sup> The OMA strongly believed that government should concentrate first on training doctors and attracting them to Canada. They felt that

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Dr. Glenn Sawyer, Address to the Western Conference of Prepaid Medical Service Plans, in the Ontario Medical Review, 35:4 (April, 1968), 199.

Medicare would scare away doctors as the introduction of the National Health Service had done in Britain.

Indicative of the doctors' fear was the fact that the OMA Council considered, in January 1968, testing the constitutionality of Bill C-227 in the Supreme Court of Canada.<sup>52</sup> After consulting legal counsel, the OMA decided not to pursue these actions further. This consideration shows that the OMA had started to lose faith in the Robarts government's ability to block Medicare. This consideration was not surprising, because the OMA - Ontario Government relationship had declined since the introduction of OMSIP. As explained earlier, OMSIP established the provincial government as the carrier of the standard medical insurance contract, of which the OMA strongly disapproved. Also in April of 1967, the Ontario government was forced to pass Bill 68, which was amending legislation to OMSIP. Without contacting the government, the OMA had increased its fee schedule by an average of 15 percent.<sup>53</sup> Bill 68 was a measure that Provincial Health Minister Matthew Dymond had to introduce to accommodate this increase. Dymond was quite open about the fact that his government disapproved of the Bill:

However, the fact does remain, sir, that I am not happy about this amendment. I have made

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Dr. Zbigniew Gorecki, "Compulsory Medicare: Is it Constitutional?", in the Ontario Medical Review, 35:3 (March, 1968), 140.

53

Ontario Legislature Debates, April 10, 1967, 1930.

no secret of this. I think in the interests of the people whom we are trying to serve this amendment was essential. We are determined to do everything in our power to see to it that this sort of thing cannot happen again.<sup>54</sup>

Although the OMA and Robarts' Government still had similar interests, a rift in their relationship had formed after these episodes. No longer did he draw up provincial legislation, such as Bills 163 and 136, which the OMA supported as an alternative to federal intervention. Instead, Robarts now combatted the federal policy moves primarily at the Federal-Provincial constitutional conferences, where he attempted to initiate provincial reaction against the federal plan.

When Medicare was implemented on July 1, 1968, only British Columbia and Saskatchewan qualified for the federal subsidy, but, other provinces such as Nova Scotia were close to qualifying for the plan. These moves were a blow to Ontario's reluctance to join. The more provinces that joined, the more federal dollars were spent on the program. The funds distributed to the participating provinces were taken from the general tax revenue; therefore, provinces which did not qualify for federal subsidy found themselves subsidizing those that did. This was an important consideration for Ontario, especially considering the

fact that it contributed almost 50 percent of the federal  
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government's direct taxes.

Another more direct pressure to coerce the provinces to join was  
the federal government's introduction of the Social Development  
Tax. In his budget address on October 22, 1968, the federal  
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Minister of Finance, Edgar J. Benson, announced this new tax.  
There was to be a two percent increase on taxable incomes, with a  
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maximum additional charge of \$ 120 per year. Benson explained  
that this would offer an estimated \$ 55 million extra tax revenue  
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for 1968 and \$ 440 million in 1969. Benson realized that the  
provincial governments would express concern over this move:

I recognize that provincial governments will  
be concerned about Parliament using any form  
of income tax at this time when clearly the  
provinces would like to get a larger share of  
it. I believe however that the total income  
tax including this addition and higher rates  
of provincial tax applicable in Manitoba  
Saskatchewan is within the capacity of  
Canadians to bear.59

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Robarts Papers, "Robarts Outlines Three Main  
Challenges to Confederation", Partial Text of Premier John  
Robarts Speech at the Ontario-Quebec Newspaper Editors'  
Seminar of October 8, 1965, in the Toronto Globe and Mail,  
October 9, 1965.

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House of Commons Debates, October 22, 1968, 1691.

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House of Commons Debates, October 22, 1968, 1691.

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House of Commons Debates, October 22, 1968, 1691.

59

House of Commons Debates, October 22, 1968, 1691.



Benson was quite correct when he predicted that the provinces might be "concerned" about this new tax. Robarts and his government were particularly irritated by this move. Robarts referred to the tax as "medicare by coercion."<sup>60</sup> No matter what the tax was called, he said that it was intended to finance the federal Medicare program. He also said that the tax left Ontario in a very difficult position because the province would have to pay for the program whether or not it joined.

The next major clash in the Medicare dispute took place at the February 1969 Federal-Provincial Conference. At this Conference Robarts waged a more forceful attack on the federal Medicare program than he done previously. He explained that Ontario already had a program that suited its citizens' needs; therefore, the federal plan was not necessary. It was clear to Robarts that Ontario was being forced to join Medicare by federal fiscal pressure. The Premier stated that:

We also object very strenuously to the use of the federal spending power to really alter the constitution because -- and I don't lay this on your [Trudeau] doorstep, I might say, because it was done prior to your assuming office -- but Medicare is a glowing example, a Machiavellian scheme that is in my humble opinion one of the greatest political frauds that has been perpetrated on the people of this country.<sup>61</sup>

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Robarts Papers, "Robarts says 2% tax medicare coercion", Toronto Star, October 26, 1968.

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Federal-Provincial Conference, February, 1969, Proceedings, 161.

Robarts explained to the Conference that the new two percent Social Development Tax would amount to \$ 225 million worth of Ontario taxpayers' money.<sup>62</sup> He complained that this would be used to finance a program of which Ontario was not a part and, hence from which it would not benefit. In order to satisfy Ontario, Robarts demanded that the Federal Government pay back the province's "fiscal equivalent" of its medical care costs. Robarts determined that this amount would be about \$ 175 million. This figure was reached by multiplying the average cost of Medicare (about \$ 50 per capita) by Ontario's population of just over 7 million.<sup>63</sup> Standing firm to the federal government's position, Trudeau refused to yield to Robarts' demands. He explained that no provinces were being forced to join Medicare, and that the plan would not take effect at all if no provinces decided to participate. Trudeau flatly rejected Robarts' call for payment of the fiscal equivalent:

If we were to do this - let us just say we were to give you the fiscal equivalence in the Medicare scheme, shouldn't we on the grounds of equality give fiscal equivalence to every Province who, at one time or another in our history did not get into joint

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Federal-Provincial Conference, February, 1969, Proceedings, 183.

63

Robarts Papers, "Robarts: Medicare a great fraud," Toronto Star, February 11, 1969.

shared-cost programs many of which were designed to fit Ontario's needs?<sup>64</sup>

Following the Federal-Provincial Conference, Robarts explained his stance to the Ontario Legislature. He said that if Ontario were offered the fiscal equivalent of Medicare, the money would go to the province's first priorities of housing and education. He explained that the total cost of Medicare would be approximately \$ 1 billion in 1969; therefore, the federal share would be \$ 500 million.<sup>65</sup> Because Ontario paid 46 percent of the federal taxes, the plan would cost the province \$ 230 million<sup>66</sup> toward the federal share. If Ontario were not to join, this money would be lost. If Ontario were to join, tax money would still leave the province. Robarts said that Ontario's estimated per capita cost would be above that of the national average; therefore, the federal government would end up paying only 44 percent of Ontario's plan.<sup>67</sup> The extra 6 percent would be transferred to provinces with a lower average cost.<sup>68</sup> Robarts strongly disagreed with this form of indirect transfer payment. He explained to the legislature that the idea of equalization was

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<sup>64</sup> Federal-Provincial Conference, February, 1969, Proceedings, 197.

<sup>65</sup> Ontario Legislature Debates, February 27, 1969, 1639.

<sup>66</sup> Ontario Legislature Debates, February 27, 1969, 1639.

<sup>67</sup> Ontario Legislature Debates, February 27, 1969, 1640.

<sup>68</sup> Ontario Legislature Debates, February 27, 1969, 1640.

necessary, but that it should be done in "lump sums" and not  
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through hidden indirect channels.

It appeared that Ontario was now in a position where it could very likely be forced into Medicare. If the province did not join, there would be tremendous financial losses, and, by this time, there could be political ramifications. The people of Ontario now realized that they were going to have to pay the extra taxes; therefore, they were more inclined to accept the federal offer. By February of 1969 the entry of Ontario into Medicare seemed unavoidable. The Liberal Opposition even mentioned in the Legislature that it knew the province would  
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join, stating that there had been a budget leak. In his March 4th budget address, the Provincial Treasurer, Charles S. MacNaughton, explained to the Legislature that "the Social Development Tax was clearly designed to finance the Federal  
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Government's own share of Medicare". However, at that point, MacNaughton gave no evidence of Ontario's commitment to the federal plan.

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69  
Ontario Legislature Debates, February 27, 1969, 1628.  
70  
Ontario Legislature Debates, February 27, 1969, 1638.  
71  
Ontario Legislature Debates, March 4, 1969, 1801.

## CONCLUSION

Between March and June of 1969, there was much discussion concerning the details of Ontario joining Medicare. The federal government held fast to its decision not to change the Medicare legislation, but, emphasized that the Medical Care Act permitted a great deal of flexibility. Most important to Robarts was the federal government's promise to allow the participation of private insurance carriers. Robarts' Minister of Health, Matthew Dymond, had numerous meetings with representatives of the insurance industry to discuss the consequences of joining the federal plan.<sup>1</sup> On March 18, Dymond initiated these meetings by inviting representatives of the Canadian Health Insurance Association (CHIA) to meet with him.<sup>2</sup> Dymond stated at this meeting that:

He had been directed by Prime Minister Robarts to pursue with dispatch the possibility of Ontario meeting Ottawa's

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<sup>1</sup> Robarts' Papers, "MPP says Robarts afraid to stand up to insurance firms," Toronto Daily Star, May 1, 1969.

<sup>2</sup> Canadian Health Insurance Association Papers, "Memorandum for the Executive Committee," April 14, 1969.

requirements for participation under the federal Medical Care Act, while utilizing existing mechanisms in the premium collection and claim payment area.<sup>3</sup>

During this meeting, a document entitled "Arrangements to Apply to Agents of the Provincial Authority for Health Services Insurance" was distributed to CHIA representatives.<sup>4</sup> This document suggested that Ottawa might take a more flexible approach to the administration of the plan by a "provincial authority." However, Dymond pointed out that Ontario would consider allowing the participation of the private carriers only if a consortium approach were taken. This consortium of insurers would be centrally administered and responsible to the provincial government. In addition, the participating companies would be required to function on a non-profit basis. The insurers introduced proposals, known as the "10 points", which they felt were mutually acceptable to themselves and the Government of Ontario. Because Dymond was receptive to these, CHIA was willing to cooperate with his government.<sup>5</sup> At a Special General Meeting of CHIA, on May 21, 25 member companies, representing 95 percent

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<sup>3</sup> Canadian Health Insurance Association Papers, "Memorandum for the Executive Committee," April 14, 1969.

<sup>4</sup> Canadian Health Insurance Association Papers, "Memorandum for the Executive Committee," April 14, 1969.

<sup>5</sup> Canadian Health Insurance Association Papers, "Memorandum, Re: Ontario -- Medical Services Insurance," May 1, 1969.

of the premiums paid into medical care insurance, approved of participating as non-profit agents.<sup>6</sup> The "10 points" which these companies supported were:

1. The principle of non-profit and non-loss to the insurers;
2. Formation of a non-profit corporation to represent the insurers;
3. A representative of the province would be located in this corporation to ensure that it was functioning according to the federal requirements;
4. Participation would be open to all CHIA members;
5. Statistics collected would be on the basis of group requirements and not individual, to allow for better efficiency;
6. There would be a standardization of procedures after a period of adjustment;
7. Auditing statements of the corporation and the insurers would be accepted by the provincial authority;
8. Management fee to be paid to the corporation to cover set-up expenses;
9. The claims payment procedures to be carried out on the basis of a claims manual approved and authorized by the appointee of the provincial authority, providing for uniform assessment and payment;
10. Reimbursement of the service agent would be by the non-profit corporation, from the management fee, payable to the corporation under its agreement with the provincial authority.<sup>7</sup>

Because of Robarts' hesitancy to bring Ontario into Medicare, he was accused of protecting the interests of the insurance industry

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Canadian Health Insurance Association Papers,  
"Memorandum for the Executive Committee," May 23, 1969.

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Canadian Health Insurance Association Papers,  
"Memorandum Re: Ontario -- Medical Services Insurance," May 1, 1969.

at the expense of the people's health. Liberal MPP James Trotter went so far as to say that Robarts did not have "the guts to stand up to the private insurance companies." <sup>8</sup> Robarts was stalling Ontario's entry into Medicare, because he felt that it was imperative that the details concerning private carriers first be resolved. After all, the private carriers and doctor-sponsored <sup>9</sup> plans, such as PSI, covered two-thirds of Ontario's population. These, and the government plan, covered more than 97 percent of Ontario's population with some form of medical insurance coverage: 2 million under OMSIP, 2.4 million under private insurance companies and 1.8 million under PSI and community <sup>10</sup> operated health plans. After much discussion with the Government of Ontario, the insurance industry, as represented by CHIA, agreed to cooperate. The Managing Director of CHIA, Robert Foster, sent a letter to Dymond on June 23 stating:

In response to your letter of today's date I am authorized to say that, the Government of Ontario now being committed to participation under the federal Medical Care Act, this Association wishes to lend assistance to your government by proceeding toward the formation of the proposed non-profit corporation in line with the "ten points" discussed with you

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<sup>8</sup>  
Robarts Papers, "MPP says Robarts afraid to stand up to insurance firms," Toronto Daily Star, May 1, 1969.

<sup>9</sup>  
Interview Mr. Authur Bond, January 24, 1990.

<sup>10</sup>  
Robarts Papers, Norm Ibsen "Why Ontario must join national medicare," London Free Press, May 21, 1969.



at an earlier meeting and as sent to you on  
May 6, 1969.<sup>11</sup>

Robarts had reached an agreement with the federal government in which the private carriers could participate if they acted as provincial agents operating on a non-profit basis. The 30 private companies that were still to carry medical care insurance would be administered by a central agency known as Healthco. Although it was a central organizational body for the health insurance industry, Healthco would function separately from CHIA.<sup>12</sup> The companies operating under Healthco would perform all services, including enrolment, billing and claims processing, but would be subject to government audit, to ensure that they were functioning on a non-profit basis.<sup>13</sup> In passing Bill 195, An Act Respecting Health Services Insurance, Ontario qualified for Medicare while its multiple carrier system was retained. This was very significant, in that Ontario was the first province to join Medicare with its private carriers intact.<sup>14</sup> This plan was accepted by the private insurers, though they were not enthusiastic about its introduction. Most important to the

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<sup>11</sup> Canadian Health Insurance Association Papers, Letter from Mr. Robert Foster to Dr. Matthew Dymond, June 23, 1969.

<sup>12</sup> Canadian Health Insurance Association Papers, "Extract from Managing Directors Report No. 15," December 31, 1970.

<sup>13</sup> Ontario Department of Health Annual Report, 1969, 161.

<sup>14</sup> Robarts Papers, "Vital oversight in Ont. Medicare," Toronto Star, June 23, 1969.

insurers was that they could retain their customers. As explained earlier, the insurers made most of their money from medical care customers by selling them other plans. Under Bill 195 Ontario's insurance industry could do this. In addition, the Bill allowed for a more "gentle" introduction of Medicare than if the private insurers were cut out totally. Participating as non-profit agents offered those insurers moving out of the medical care market the opportunity to diversify before leaving altogether. For this reason companies could leave the market gradually, and hence not suffer tremendous short-term losses. Like the insurance industry, the OMA did not approve of the introduction of Medicare. Despite the OMA's distaste for the federal move into the medical care insurance field, they did not react nearly as strongly as Saskatchewan's doctors had done earlier in the decade. In his book, The First 100 Years, Dr. Glenn Sawyer<sup>15</sup> describes the OMA's reaction as "restrained". This apparent restraint, in large part, was due to the fact that the OMA was preconditioned to using insurance agencies. With the tremendous growth of the private insurers and the doctor-sponsored plans in the 1950s and 1960s, doctors accepted the existence of "third parties" administering their bills. When OMSIP was introduced in 1966, the OMA utilized this government agency to do the same thing. Medicare would be one more extension of the move toward

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Glenn Sawyer, The First 100 Years: A History of the Ontario Medical Association (Toronto, 1980), 171.

government control of medical care financing. Although the OMA disapproved of this trend, they were becoming accustomed to it.

In many ways government plans offered a simpler method of remuneration of doctors bills. Instead of dealing with patients, and the numerous forms required by the different insurance companies, government plans offered a standard system of billing. This system offered less administrative time and problems, and hence, lower costs to the doctors.<sup>16</sup> Most important to the doctors was the fact that they would be able to bill either the patient directly or the government plan. If the doctor billed the government plan, he would still be able to extra-bill the patient, so long as consent was given prior to the service being rendered.<sup>17</sup> In this way Ontario's doctors would still be able to retain a certain amount of their autonomy in setting their fees.

In addition to the factors mentioned, the OMA felt a moral obligation to continue their services and not to strike as the Saskatchewan doctors had done.<sup>18</sup> The Saskatchewan experience also created a very negative image of the doctors, which the OMA hoped to avoid. Recognizing society's growing acceptance of social measures, and with promising financial considerations, the OMA

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<sup>16</sup> Interview with Dr William Butt, December 22, 1989.

<sup>17</sup> Sawyer, 172.

<sup>18</sup> Interview with Mr. Arthur Bond, January 24, 1990.

was much less reactionary when Medicare was introduced than it had been in the early 1960s. When Ontario finally accepted Medicare, the OMA, for the most part, was accepting but not supportive.

Although Robarts would rather have retained Ontario's existing voluntary medical insurance system, he was able to secure compromises that made the entry of Medicare into his province less disruptive than it could have been. In addition to the participation of the private carriers and the doctors' ability to extra-bill, Robarts ensured that part of the provincial share of the program would be paid for by premiums. Monthly premiums were levied on subscribers: \$ 5.90 per month for a single person, \$ 11.80 per month for a family of two, and \$ 14.75 per month for a family of three or more.<sup>19</sup> The plan offered subsidies to those in need. People who received social assistance or who had a zero taxable income did not have to pay premiums. Single individuals with a taxable income up to \$ 500 received a 50 percent subsidy. A married couple with a taxable income up to \$ 1000 also received a 50 percent subsidy. Families of three with up to a \$ 1300 taxable income received a 60 percent subsidy.<sup>20</sup>

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Helen Palmer, The Province of Ontario... Its Social Services (Toronto, 1971), 56.

20

Ontario Legislature Debates, June 17, 1969, 5970.

Despite these measures, there was still opposition to OHSIP. Among the NDP's criticisms of the plan were that it failed to lower the already existing OMSIP premiums, allowed doctors to extra-bill, and maintained the existence of private medical insurance carriers.<sup>21</sup> The Liberals had similar complaints about the plan, but, accepted the participation of the private carriers if they would be phased out by 1970.<sup>22</sup> The Liberals felt that the temporary existence of private carriers was necessary because the government would be unable to handle the sudden influx of Ontario's 7 million subscribers. Although each of the opposition parties had reservations about certain technicalities of OHSIP, their biggest complaint was that Robarts had hesitated for a year after the 1968 introduction of the federal plan. For instance, Liberal leader Robert Nixon charged that Robarts' hesitation had lost Ontario \$ 200 million of federal subsidies.<sup>23</sup> Despite this, Nixon was temporarily satisfied with Robarts' plan, because it ensured the initiation of the Hall Report's recommendations in Ontario.<sup>24</sup> It is interesting to note that Nixon did not see a problem with the federal government moving into health care

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Ontario Legislature Debates, June 23, 1969, 5984.

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Ontario Legislature Debates, June 23, 1969, 6003.

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Ontario Legislature Debates, June 17, 1969, 5974.

24

Interview with The Hon. Robert Nixon, February 15, 1990.

policy, if it meant the establishment of a more universal and  
comprehensive medical care plan for the people of Canada.<sup>25</sup>

Although attacked by the Opposition parties, Robarts' plan did meet Pearson's four criteria; therefore, it qualified for the federal subsidies. After years of avoiding a federal Medicare plan, the Robarts' Government announced its intention to join in June of 1969. On June 17, the Minister of Health, Matthew Dymond, stated to the Legislature that the Ontario Health Services Insurance Plan (OHSIP) would become effective on October 1, 1969; thus, bringing the province into the federal medical care program.<sup>26</sup> Although he had accepted the federal plan, Robarts was still openly critical of Ottawa's handling of Medicare. In the Legislature, he stated that Ontario had an effective medical care system prior to the federal plan:

We had medical services insurance that was universally available to all on an individual or family basis.

We had medical services insurance that was comprehensive in that it provided for practically all physicians services.

We had medical services insurance that was available regardless of existing or pre-existing ill health.

We had medical services insurance that removed the financial barrier by providing insurance and assistance to low income groups.

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<sup>25</sup> Interview with The Hon. Robert Nixon, February 15, 1990.

<sup>26</sup> Ontario Department of Health Annual Report, 1969, Introduction.

We had medical services insurance that provided out-of-province benefits and carriage portability; and medical services insurance that finally was guaranteed to be renewable.<sup>27</sup>

The introduction of any program causes certain problems for government. In addition to putting forth their own beliefs, governments have to attempt to keep opposing forces satisfied. The introduction of Medicare in Ontario was a particularly difficult task for Robarts to complete. He was obliged to introduce a plan based on the federal government's four criteria: universal, comprehensive, portable and government administered coverage. While doing this, he had to offer the insurance industry and OMA as good a deal as possible, so as not to alienate them further. Robarts was riding a fine line, because whatever compromise he won from the federal government, he was instantly attacked for by the provincial Liberals and NDP. The ideas and attitudes of the various interest groups created a very difficult situation for Robarts, but these were the very influences that helped formulate a plan that was, if not supported, at least acceptable to the majority of the population.

Included in this dispute was the issue of whether or not the individual had the right to decide to buy medical insurance. Robarts argued that the voluntary system preserved the

individual's right to choose the amount and type of insurance desired. Robarts' opponents argued that a standard compulsory system was required in order to ensure that individual medical care needs were met. This was the classic argument between the rights of the individual versus the responsibility of government to care for society at large.

Also in these debates was the controversy over provincial rights, as outlined in the BNA Act, and the federal responsibility to ensure quality social services to all Canadians. The federal government is a central body, which in theory represents the nation as a whole, while the provincial governments represent the individual needs of the people living in their respective provinces. Federal responsibilities include the redistribution of the country's financial resources among the provinces. The national interests are not always the same as those of the individual provinces. During the 1960s, Ontario was caught in this federal-provincial fiscal dilemma. Ontario had certain interests that were very different from the national policy set forth by Lester Pearson. Pearson had hoped that a national Medicare plan would help to unite Canada, but in fact, his idea became an issue of heated debate and strong provincial opposition.

Robarts' struggle to retain Ontario's own system of medical care insurance was not simply an attempt to avoid Medicare to satisfy certain pressure groups, but was also a move to block the further



intrusion of federal interference into provincial jurisdiction. Throughout the twentieth-century, the federal government had been entering the health care sector. Following World War Two, the federal government moved aggressively to support provincial health care needs, but while doing so, attempted to direct and administer policy. This initiative assisted various regions and provinces in need, but, the burgeoning power and influence of the federal government continually sought greater control of the country's health care needs. Health care affects the whole population and as such is an important electoral consideration. With its tremendous financial power, the federal government was able to promise certain spending increases. These increases might appeal to the country's electorate as a whole, but are often unnecessary for certain regions. Robarts argued that Medicare was a plan that Ontario did not need.

In the early 1960s, Robarts realized that the federal government was intending to initiate a national medical care insurance plan. The Premier was opposed to the idea of a totally government-run medical care insurance program; therefore, he took certain steps to block the introduction of the federal plan. Through provincial legislation (Bills 163, 136 and 6) Robarts was able to implement the Ontario Medical Service Insurance Plan (OMSIP). Although OMSIP was a government-operated plan, it was designed to retain the existing voluntary, multiple carrier, medical care insurance system in Ontario. Important also was the fact that OMSIP was a provincially, not federally, administered program. The plan was

most definitely a provincial defence against the impending federal offensive that would soon follow. His plan did offer an attractive alternative, but fiscal pressure eventually forced Robarts to accept the federal medical care insurance plan.

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## VITA AUCTORIS

Stephen Holloran was born on May 21, 1963, in Nottingham, England. When he was three months old Stephen, along with his family, moved to Toronto, Ontario.

In 1976 the Holloran family moved to Mount Albert, Ontario, where they still live. Between 1978 and 1982 Stephen attended St. Andrew's College in Aurora. He then went on to Queen's University where he received an Honours B.A.

In 1986-87 Stephen worked, travelled, skied and windsurfed.

Stephen began his M.A. at the University of Windsor in 1987.

During Stephen's time at Windsor he was active in university life, namely, as a Graduate Assistant, Residence Hall Assistant and member of the Graduate Student Society Council.

Currently, Stephen is employed by DRG Glass Engineering as an Operations Analyst.