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The Story Behind the Ontario Health Insurance Plan and Its Impact on the Public Sector

Marvin L. Simner

Abstract

The Ontario Health Insurance Plan is a provincially supported health care program that required fifteen years to develop and emerged through seven distinct and frequently controversial stages. It was said at the time to have generated more heated debate in the House than any other legislation previously approved by the provincial government. The purpose of this report is to provide a review of these seven stages, the arguments that accompanied each stage, and the impact of the stages on the local community. In the final section we discuss how certain elements in these stages, if known at the time, might have offered ways to help avoid the mandatory enrolment requirement that has continued to be one of the main pitfalls of the Affordable Care Act in the United States.

KEYWORDS: OHIP, Canadian Health Care, Obamacare, Patient Protection and Affordable Care Act, mandatory enrolment

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Introduction

...it is in the public interest to establish a plan of hospital care insurance for the people of Ontario (that will be) universally available to all without regard to age, financial circumstances or condition of health...

With these words in the preamble to Bill 165, known as the Hospital Services Commission Act of 1957, the Province of Ontario initiated an undertaking that, in 1972, became the Ontario Health Insurance Plan or OHIP. Although a broad outline of the rationale and the steps needed to accomplish this undertaking have been reported elsewhere,¹ the purpose of this report is to provide for the historical record, the key elements in these stages along with some of the arguments that accompanied each stage, and the impact that many of the stages had on the local community.

The overall process began in 1955 during a series of federal-provincial meetings which, in turn, were followed by a special meeting on health insurance in January 1956. At the end of that meeting the *London Free Press* introduced its readers to some of the issues and solutions that had been explored during the course of the meeting.

The problem of health insurance has been studied and debated for years. The projected scheme (currently under review by the federal government) avoids many of the difficulties of "state medicine" by concentrating on hospital care rather than venturing into the field of private practice and disturbing the relationship between doctors and patients. No doubt a good many problems will have to be worked out if the plan is accepted, but it does seem as though the biggest step toward providing adequate hospital care for all has been taken.

With the announcement by the Federal Government that it will pay half of the cost of a national health insurance program that scheme comes into the realm of probability...According to the Ottawa announcement the plan would provide standard ward treatment without a time limit for all patients receiving active and necessary treatment in any general, chronic or convalescent hospital; diagnostic services and radiology for both in-hospital and out-of-hospital patients.²

While this coverage by the *Free Press* contained an overview of the proposed hospital plan, it was not until the end of January, 1957, that the province unveiled the details associated with the first stage in the plan.

Stage 1: Bill 165 - The Hospital Services Commission Act

The major issue that initially arose in the House was the need to justify a health care plan since, at the time, 3.5 million of the 5.5 million people in the province, which was nearly 65% of the population, were already covered by some form of private health care hospitalization insurance. Premier Leslie Frost, leader of the Conservative Party that introduced the plan,

addressed this issue by pointing to the fact that although employer-based group insurance hospitalization policies were designed to cover all employees independent of health status, for those who were self-employed, insurance companies only offered policies to people they considered to be at low-risk for hospitalization, and even then the policies contained restrictive clauses that eliminated coverage for certain illnesses. In the words of the Premier:

a heart or a lung weakness may appear and a rider is put on the policy stating that ailment is excluded from coverage...I may add that in many cases cancellations take place many years later, and in fact the cancellation takes place at the very time the policy is needed...and in most cases the coverage is not available for individuals after 65 years of age, except in group policies...Then again, present policies are limited as to the length of stay in hospital. The limit varies from a few weeks to a maximum of about 200 days. They do not, therefore, cover the catastrophic expense of hospital stay.³

The Premier then outlined the seven components in the proposed plan.⁴

- 1) Our hospital insurance plan will provide basic coverage limited to public ward care...There will be no cancellation of, or limits placed upon the time required for essential treatment in hospital. There will be no limit on grounds of age or disability.
- 2) The plan we propose will be available to every citizen who will enroll. It will be made mandatory as the commission deems it to be feasible.
- 3) Our objective in Ontario will be to attain as close to universal coverage, total coverage, as possible, premised upon good administration and other factors.
- 4) Our proposal, if adopted, will eliminate hospital deficits.
- 5) It will lighten and in most cases totally remove from all municipalities the present financial burdens incidental to the hospital care of indigents.
- 6) It will cover at provincial expense, without any contribution from the federal government, the care and treatment of mental illness and tuberculosis.
- 7) The plan will come into operation on January 1, 1959.

The Premier also addressed the issues of costs and administration. The overall operation of the program would be controlled by the Ontario Hospital Services Commission either “through the agency of the Blue Cross or by a Crown corporation similar to Blue Cross, and by personnel drawn from the Ontario Hospital Association.” With respect to costs the Premier stated that

the success of the plan depends upon a wide coverage of our people, and not merely of those with a high incidence of sickness. As the cost to the province is very formidable, it is essential to spread the burden. Our advisors, and we ourselves, however, feel that broad coverage can be obtained, and that we can achieve our objective of from 85 to 90 percent coverage, or perhaps more...On the other hand, we can give no guarantee as to when that can be achieved...I would say this--and I think the reasons are very plain—I would say that slow, but not too slow, and sure should be the motto regarding this matter if we are going to avoid the mistakes and the errors of some other places...As an

example of the danger is shown in the information we have already presented to the public, namely, that for an all-embracing plan such as we propose, the costs, based on 1956, for the entire population of the province, would run to about \$160 million. By 1960, however, we are warned that costs could total nearly \$300 million.

The Rebuttal

Although considerable discussion took place, the leader of the Liberal Opposition raised two main concerns. The first, which was solely political in nature, had to do with the rationale behind the selection of January 1, 1959, as the start-up date.

On this side of the House in the opposition group, there is continued adherence to the idea of hospital insurance, that it is a good thing, and we do not want it any further delayed than is really necessary....Regarding the date of January 1, 1959; I am obliged to say I do not like to impute motives, political motives, but I am afraid in this case I will have to do so; the date of January 1, 1959, is of particular significance. The Premier says he cannot see how we can have it before January 1, 1959. Well January 1, 1959, in all probability will be an election year, and he has been advised, as I will point out in a moment or two, by those who have given much thought to this particular question that it would be unwise for a government to bring in a hospital insurance scheme just prior to a provincial election.⁵

Because the leader was certain that the plan would appeal to a large number of voters, he was concerned that this date would provide the Conservative Party with a definite political advantage during the lead-up to the 1959 election. To avoid this problem the leader felt that the commencement date should have been set well before but not "just prior to" the forthcoming election.

His second concern, which was more substantive, had to do with the lack of any reference to mandatory coverage at the onset of the plan.

What position are we placing the federal government in? They are dealing with 10 provinces in Canada, what kind of scheme would they have if other provinces of Canada said, Now, we think we will get to 85 percent, some time, but we do not know when; would the federal government be justified in the expenditure of public money to bring in a hospitalization scheme, in which all of 10 provinces would participate, before they knew what their commitments in respect to this are, what the coverage would be for their people? I suggest to the Hon. Prime Minister that there is a great loophole in the plan that he has offered...⁶

In his reply to both of these concerns the Premier shared with the House a review of all of the relevant meetings held in 1956 that preceded the January 29, 1957, meeting together with all of the correspondence that he had received from the Federal Government that dealt with this matter through March 18, 1957.⁷ With regard to the Opposition Leader's first concern over the

commencement date of January 1, 1959, the Legislative Assembly was told that the Federal Government's proposal that had addressed the issue of health care had not been received until mid-December, 1956. Hence, the earliest date that the Premier was able to table his proposal was January, 1957. The Assembly was further informed that it was the Premier's insurance consultants who had recommended a two year delay that started from the date when the plan was approved by the House to when the plan was to be implemented. The rationale behind this delay was to allow sufficient time to coordinate the provincial component of the plan with the federal component as well as to integrate those who currently had a private health insurance plan into the proposed publicly operated provincially plan. When taken together both factors offered a compelling case against the view that January 1, 1959, was selected largely to favour the Conservative Party during the forthcoming election year.

To address the second issue the Premier provided the House with a letter dated March 18, 1957, received from the Treasurer of Ontario in response to Premier's earlier request for further information regarding the issue of compulsory coverage.

The federal government has never, as you know, insisted on compulsory coverage for all residents from the outset, because it believes that the decision as to whether a plan is to be compulsory or voluntary, or a combination of the two, should properly rest with the province. Our concern has been to make sure that there should, in fact, be substantial coverage under any provincial plan to which federal financial assistance is given; and this seems now to be amply assured by the details you have given as to the manner in which the Commission intends to proceed.

Despite the fact that the two main issues raised by the Opposition on January 29 had been answered, still a third issue arose when the Premier moved the second reading of Bill 165 on March 28, 1957. This time the Opposition expressed its concern over the future of the private insurance companies in Ontario that now would be forced to compete with the province in order to remain in business. Hence, the Opposition asked if the proposal that had been put forward by the Premier was also an attack on the Ontario free enterprise system because it closely resembled a socialist undertaking. In view of the Cold War anti-communist political climate that existed throughout North America during the 1950s, the Opposition's concern was of sufficient importance to cause the Premier to address this matter at some length during the debate that took place on March 28, 1957.

One of the points of view that I received from some people is the fact that this type of legislation goes too far—that it is involving the government and the public in commitments in what might be termed business which goes beyond the realm of government...In some quarters, I am glad to say few and small, there is always a somewhat hysterical opposition to a project such as I proposed to the House this afternoon in the form of the second reading of this bill. I point out that the social system in Canada, if one wants to use the hon. Member's expression, is socialistic... in the same sense as this applies to our great water power program, which, in terms of

what we know as Hydro (developed by Adam Beck) has been imbedded into the life and development of this province for some 50 years.

There are certain things a government can do which, conducted on a broad basis, stimulates and does not retard free enterprise and private initiative...and may I say in those days of 50 years ago there were those who disapproved of what we were doing in Ontario with regard to Hydro, and yet today what we have done is the very foundation of free enterprise in this province.

At the present time we have between 3.5 million and 4 million people covered by policies of private insurance companies...that give them only partial coverage in regard to hospitalization. It is impossible for these fine insurance companies in any practicable combination I know of, to give all our people, regardless of the condition of health, financial circumstances and other conditions coverage that would be universal to all our people.

This is clearly a case where a government agency can carry on this type of business better than anyone else, and that is why I come here today with this bill. I look forward to an arrangement in which our insurance companies can better the fringe benefits they are able to give.

Public Sector Impact

To gauge the impact of this legislation on the local community we reviewed articles that appeared in the *London Free Press*. We also obtained archival data and other historical information from two of London's major private insurance companies (London Life and Ontario Blue Cross) as well as from London's major public hospitals (St. Joseph's and Victoria).

On January 29, 1957, the *Free Press* provided the full text of the proposed plan along with an extensive frontpage summary of its details along with the many benefits that the residents of Ontario would realize once the plan was fully implemented.⁸ The next day the *Free Press* also described the financial benefits that would accrue to the city in terms of cost savings. To fully appreciate the magnitude of the latter benefits, however, it is important to be aware of the following material which covers the early history of hospital financing in Ontario.

In 1881 only 12 public hospitals existed in Ontario. Their primary focus was care of the indigent or the working poor for whom home care was impossible. Because of the high death rate in these hospitals, those who were able to afford it, typically remained at home and were treated by private physicians. Owing to the mission of these hospitals, most if not all of their operating budgets were provided through charitable donations, municipal grants-in-aid, and modest provincial subsidies.⁹ Unfortunately these sources of income were often inadequate to meet the hospital's bills. By way of illustration, the city of London was responsible for a sizable proportion of the yearly budget associated with the London General Hospital, which was the

forerunner of Victoria Hospital and opened on November 3, 1875. As the only public hospital in Western Ontario it catered principally to the destitute.¹⁰

Each year London City Council received a detailed hospital expense account on a quarterly basis from the Chairman of the Hospital and Relief Committee. As reported in the London City Council minutes for the quarter that ended on September 30, 1876,¹¹ of the 32 patients in the hospital, the city was required to pay for the upkeep of the 24 indigent patients who were registered with the city. (The upkeep of four others was charged to Middlesex County while the additional four were able to cover their own expenses either through private pensions or personal savings.) Along with these costs the city was also responsible for all the other expenses associated with the hospital such as coal, groceries and medicines along with such miscellaneous items as the repair of broken lamps, broken windows, etc. Considered together, the total amount charged to the city during this quarter was \$926.

To offset this amount, the city was able to realise at least some income from the hospital's two private patients who were charged a daily fee and from the two other patients who were on a pension. This total, however, only came to \$112 and so the remaining shortfall of \$814 for the quarter needed to come from the city's budget. Added to this problem, in February 1877, City Council received word that the promised yearly grant to the hospital from the Ontario Government was to be reduced by \$803.97¹² which meant the city would now be expected to cover the amount owed largely through voluntary charitable donations. Because situations that were very similar to these existed throughout the province, there was clearly a need for a dependable yearly supply of funds to ensure that the province's public hospitals remained viable.

To meet this need, in 1887 provincial legislation was enacted that guaranteed a yearly public hospital income to be provided in equal shares by the provincial government and the provincial municipalities.¹³ Thus it could be argued that, in view of this cooperative arrangement between the province and the municipalities, the seeds for the first stage in the emergence a provincial/federal hospital insurance plan were sown as early as 1887. The dollar amount for these equal shares was then tied to the average cost associated with the length of stay for the indigent patients who had been treated during the preceding year.

As a result of the forgoing legislation, in the mid-1950s when the Hospital Services Commission Act was under consideration, London was responsible for over 3,000 indigent cases and was required to pay between 6-7 dollars per day for each public hospital stay by London's indigent community. Based on these figures, the overall cost that needed to be incorporated into the city's budget for 1957 was \$195,000 for Victoria and St. Joseph's Hospital combined plus another \$171,000 for the city's indigent residents who received treatment outside of London.¹⁴ Needless to say, as soon as the proposed hospital insurance plan came into effect, these costs would now be covered by the province and therefore London would no longer need to factor these dollars into the city's yearly budget. In view of this benefit it is not surprising that the

Free Press summarized London's financial gain through the passage of The Hospital Services Commission Act in the following words.

The new Government hospitalization insurance plan scheduled to open in 1959 will have sweeping and profound effects on municipal life, a survey of municipal and hospital officials showed today. The saving to London and Middlesex County on welfare patient costs alone runs upwards of \$618, 000.¹⁵

Despite these appreciative words, however, the *Free Press* remained somewhat guarded, though optimistic, in its overall endorsement of the plan as reflected in the following remarks that also appeared in a 1957 *Free Press* editorial.

(the provincial hospitalization plan) is a scheme which may be open to criticism and there may be flaws, but it is a long step forward. It will cost money, as do all social services, but in this day and age it seems inevitable and vital. It is to be hoped that Ottawa and Ontario can reach an agreement.¹⁶

Although the reason for this cautionary note is not entirely clear, it may have resulted, at least in part, from a lack of information over how much of the hospital's actual expenses for indigent care would be covered by the plan. Parkwood Hospital, for example, though considered a public hospital and therefore eligible for funding, was also privately operated which meant that it received only \$5.00 per day from the city and the province combined for each of its indigent patients, yet its actual daily indigent costs were estimated at \$6.84 per patient and so it was forced to rely on outside funding to remain solvent.¹⁷ Victoria Hospital too required outside funding and expressed fear that "a Government hospital insurance plan might result in fewer bequests from private individuals and organizations."¹⁸ In short, until all the details of the plan became known, it may have been difficult for the *Free Press* to grant its unqualified support for this initiative.

The paper's rather guarded approach to a full-scale endorsement was also apparent in its coverage of the speech from the throne delivered by the Lieutenant-Governor on January 27, 1959. While the plan was clearly mentioned in the speech, and the speech was published in its entirety by the paper on January 27¹⁹ the *Free Press* made no reference to the material on the hospitalization plan. Instead the paper highlighted only matters that were largely of local interest such as the promise of more camping, picnic and conservation sites, more money for education, welfare, and the encouragement of driver education in the schools. In fact, the only substantive reference to the plan that appeared in the paper on January 27 was the following comment on Quebec's rejection of the Federal plan.

Joining Hospital Plan Not Quebec's Intention

The premier noted that hospitalization is a domain the constitution reserves exclusively for the provinces. Federal intervention in this field carries the risk that Ottawa might come to control the medical profession, he added. Mr. Duplessis said it would not be

possible to have hospital insurance without the imposition of a new tax. “Would it be reasonable to impose a tax without having enough hospitals for the good operation of a health insurance program?” The Quebec government has added “in a sensible way” to the number of hospitals in the province and it will continue to work this way.²⁰

Unless the paper’s subscribers had read the entire throne speech they would have been unaware of the plan’s essential features and would have been required to wait until January 29 when all of the details finally appeared.

In contrast to the *Free Press*’ marginal endorsement of the plan, and in disagreement with the Opposition Leader’s concern over the continued viability of Ontario’s private insurance industry, London’s two main private insurance firms fully endorsed the plan. London Life began to issue group hospital insurance as early as 1935 and in 1938 it extended this coverage to include surgical benefits. From the experience it gained over a ten year period, however, it was forced to conclude that “the results were not always too satisfactory.”²¹ The reason was that hospital costs, surgical fees, and medical fees steadily increased while the cost to the consumer was limited by the daily hospital rate specified in the initial group insurance contract. The firm also found that those who were covered by its plan often used hospital facilities to a greater extent than was initially contemplated. As a result, London Life was only able to realize “very small margins of profit for many years” and was not unhappy when informed that the Ontario hospitalization insurance plan would be taking over a portion of the insurance industry that London Life had previously served.

Despite this action by the province, the company was encouraged to remain in the hospital insurance business by offering supplemental coverage to the provincial plan for those who wished something other than ward accommodations and could afford semi-private or private coverage as well as major medical benefits that would cover all surgical, medical, and diagnostic costs beyond those covered by the basic Ontario Hospital Insurance Plan. Because this topped-up option was considered far less costly for London Life and therefor much more likely to be profitable than the company’s previous approach to hospital coverage, the firm fully endorsed the government’s proposal for this basic hospital plan.

Blue Cross, on the other hand, had a very different but extremely interesting as well as profitable history with regard to the implementation of the provincial plan. Although the initial concept for Blue Cross originated in the United States, when it moved to Ontario in 1941 it was “capitalized with a \$15,000 loan secured by the Ontario Hospital Association.”²² Because of this arrangement, the firm’s name along with its business concept was borrowed for use in Ontario and Blue Cross became an autonomous division of the Ontario Hospital Association. By 1944 more than 500,000 Ontario citizens had enrolled in the Blue Cross plan and by around 1950 approximately one of every three provincial residents belonged. In the mid-1950s when the Ontario hospital insurance plan was in the process of being developed, owing to the linkage between Blue Cross and the Ontario Hospital Association, Premier Frost was able to draw upon the expertise of the two organizations for guidance and assistance in establishing the

groundwork for the Ontario plan. According to the Premier, “The plan will be administered by the Ontario Hospital Services Commission either through the agency of the Blue Cross or by a Crown corporation similar to Blue Cross, and by personnel drawn from the Ontario Hospital Association.”²³

In 1959 the Ontario version of Blue Cross acquired the name Ontario Blue Cross Insurance Company, and in keeping with the Premier’s comment, “all Blue Cross facilities were placed at the government’s disposal.” Ultimately this meant that “more than 600 of the Plans 703 employees, including its director, were hired by the new plan which was named the Ontario Hospital Services Commission.”²⁴ The secretary-treasurer of the Ontario Hospital Association was then asked to coordinate all the features in this new plan.

Even though the Ontario Blue Cross Insurance Company had been absorbed into the government’s plan it was still allowed to maintain its private not-for-profit status which it had acquired in 1941, and sell supplementary hospitalization insurance. For example, like London Life, it was able to offer private firms whose employees wished to receive coverage well beyond that which was available through the Ontario plan, an Ontario Blue Cross group plan which could include, if desired, ambulance service, private duty nursing, special appliances, semi-private or private accommodations, etc.²⁵

It is also worth noting, as had been predicted by the Premier, that with the implementation of the Ontario plan, in 1959 the employee’s cost for the purchase of this new topped-up version of Blue Cross Group Insurance had indeed become lower. For example, whereas a subscriber’s monthly premium in 1958 under the original version of the Blue Cross group plan was \$3.60 per month for a single person semi-private accommodation, in 1959 this same coverage was now available for only \$2.65 per month. Similarly, in 1958 semi-private family coverage under the original Blue Cross Group Insurance Plan cost \$8.50 per month while in 1959 this cost had fallen to \$5.30 per month.²⁶

In line with these positive experiences enjoyed by both of the local insurance companies, London’s hospitals too profited in several ways once the Ontario plan was fully implemented. Victoria and St. Joseph’s Hospital commented very favourably on the highly simplified all-inclusive per diem billing system that came into effect shortly after the plan was introduced.²⁷ Of far greater importance though, was the assessment by the Assistant Superintendent of Victoria Hospital who commented on what the results of this implementation meant for the treatment of the public’s current hospital needs as well as for the hospital’s future operations in relation to these needs.

The year 1959 marked the beginning of a New Era for Ontario Hospitals with the successful launching of the new Hospital Insurance Plan. There is no dispute about the degree to which the Plan has contributed to more use of hospital beds and (as a result) it has become very apparent that there is an urgent need for more chronic and convalescent hospital facilities. These types of lower cost accommodations must be

increased if we are to realize the maximum benefit from our active treatment hospital. This greater utilization of hospital beds has also created further demands for trained nursing and technical personnel without which the value of the best hospital physical plant is limited in providing good patient care.²⁸

As justification for these remarks, the Assistant Superintendent then provided a statistical comparison of Victoria Hospital's usage before and after the implementation of this new plan. For example, the number of patients who received physiotherapy in 1959 (37,956) was now far greater than the number recorded in 1958 (27,797). Similarly, the number who visited the emergency department in 1959 (23,572) also exceeded the number recorded in 1958 (18,692) and the same was true for the number who received electrocardiograms in 1959 (2,625) in comparison to the number in 1958 (1,986).²⁹

While it is possible that these numerical increases may have resulted from a change in the city's population over the years in question, the evidence shows that this was not the case. London's population in 1958 was 102,310 and in 1959 it was 102,542.³⁰ The difference between these two figures represented a change of less than .01% whereas the average growth in hospital usage for the examples given above was 28%. Therefore, it was the case that more people were truly in need of hospital care than previously had been acknowledged and that they were now able to seek this care because they no longer had to worry about the cost.

Although it is unknown if the Assistant Superintendent's added claim was valid regarding the overall impact that this new plan would have on what he saw as the hospital's future need for additional facilities, it is worth mentioning that in 1960 "the (Victoria) Hospital Trust announced the imminent construction of a \$1,000,000 addition to the Nurses' Residence. The addition which would house 100 nurses and students was to constitute the first step in a proposed 10-year, \$16,000,000 master expansion and building programme at the Hospital... (Then) in 1964, the Ontario Hospital Services Commission approved an eight-story addition to the east section of the hospital's Y-wing."³¹

Similarly, St. Joseph's Hospital in 1959 launched a building fund campaign which raised \$2,300,000 that enabled it to begin construction on the hospital's Wellington Wing in 1962. Along with many other facilities, the new wing included the addition of 400-500 new patient beds which brought the hospital's total bed capacity to 605 by 1964. It is also worth mentioning that nearly half of the funds raised during this building fund campaign came from individuals and corporations which challenged the fear that had been expressed over the possible loss of charitable donations owing to the introduction of the Ontario plan.

It is also worth mentioning that despite the voluntary enrolment component in the plan, as early as January 27, 1959, the Lieutenant-Governor of the province, in a speech to the House, was able to make the following announcement.

The Ontario hospital insurance plan, a milepost in the history of health and welfare legislation, not only in this province but in Canada, came into operation on January 1.

So acceptable are its provisions that more than 5.3 million or over 90 percent of our people have become insured beneficiaries under its broad coverage.³²

Thus, the province was able to achieve the goal of nearly universal coverage without the need to impose a compulsory enrolment requirement in the plan.

In essence, with the implementation of the Ontario plan, many residents were now able to seek hospital treatment that they would otherwise have avoided possibly out of fear that they would not have been able to afford such treatment. Aside from the fact that the overall gain from this first stage in the health care proposal meant a generally healthier population, an important economic side effect was fewer sick days for the employed and therefore an overall more productive workforce.

Stage 2: Bill 136 - The Ontario Medical Service Insurance Plan

Although this next stage in the program did not take place until nearly 10 years after the start of the first stage, it addressed an equally important preventative need which was to cover the out-patient costs of physician care. To provide a framework for this stage, on May 11, 1965, the Ontario Minister of Health offered a brief overview of the steps that had been taken already by the province to address the further health care requirements of Ontario's citizens.

Within weeks of the introduction of the hospital care insurance programme (Bill 165), the Department of Health, with other appropriate departments of government began studies in depth to seek ways of assisting to meet other health care needs...Since the first step had been taken...it appeared logical that our next step would be in the area of physician's services and that is the purpose, and will be the effect, of this bill.³³

As was the case with Bill 165, the Minister then itemized the following six provisions in Bill 136.³⁴

- 1) Physician's services will be available to all regardless of age, state of past or present health or financial status.
- 2) These services are guaranteed non-cancellable and are renewable.
- 3) Enrolment in the plan will be voluntary. Although many cry out for compulsion, an equal or even greater number cry out against it. The records in Ontario show that, given the opportunity, our people do not want, do not like, and would rather not have compulsion. (Note: this point was subsequently supported on February 11, 1966, in the *Legislature of Ontario Debates* [see page 454] when the Premier cited the outcome of a Gallup poll which showed that "54 percent of the people wanted a voluntary plan; 40 percent of the people wanted a compulsory plan and six per cent of the people were undecided.")
- 4) The cost of a standard contract will not exceed a maximum which will be approved by the government on recommendation of the advisory council.

- 5) The plan will be available from the insurance carrier of the individual's choice except in the case of low income groups where the province will pay in whole or in part for the standard contract.
- 6) The plan will come into operation on June 1, 1966

Because these six points only provided a synopsis of the major provisions in Bill 136, the ensuing discussion in the House led to a clearer understanding of all the provisions. Although the bill called for the implementation of a comprehensive medical insurance plan that would be fully paid for by the province, the bill, in fact, would be confined only to those with no taxable income and would be subsidized for those whose taxable income was less than \$500 (see item 5 above). In addition, both of these groups needed to apply for membership in the plan and both were required to submit their previous year's income tax returns along with their applications to determine eligibility. In the case of the remaining citizens whose earnings were above the financial guidelines established by the Minister of Health, they too needed to apply for membership but had to purchase their coverage from private insurance companies at a rate that would be set by the province and that would be the same for everyone.

The Rebuttal

Unlike the concerns raised in connection with Bill 165, which were very few, here the concerns were many. Not only did these concerns necessitate 15 meetings of the House, it was also said at the time to have been "the longest and wordiest session" in the history of the Ontario legislature.³⁵ On May 25, 1965, the leader of the Opposition offered the following main points of concern in his address to the House at the start of the second reading of the bill.³⁶

- 1) The Bill does not recommend coverage for everybody at rates based on ability to pay. Apart from the poorest people whose rate will be subsidized by the province, all low-income, middle-income and the high-income families will have to pay the same rate.
- 2) There will have to be a means test to separate the poor from everybody else. Organized labour has always opposed the means test as degrading.
- 3) The recommendations cover only medical care. All other essential services, such as dentists and drugs are ignored.
- 4) The insurance companies are in business for profit. The plan is made to order for insurance companies and thus introduces the profit motive into social welfare legislation.

The leader of the Opposition then summarized his overall concern in the following words: "We are firmly committed to a universality in the Medicare plan for Ontario and we are disturbed, even shocked, at the government's hypocritical consistency in introducing a health services bill into this house which will not reach as many citizens of this province as are covered by our hospital plan. We are opposed to Bill 136 because it is a minimum-effort bill."³⁷

The most scathing attack, however, was delivered near the beginning of the third reading by Kenneth Bryden (NDP member from Toronto/Woodbine) on June 21, 1965.³⁸

- 1) Anyone whose taxable income is just above the financial cut-off and therefore would be ineligible for a subsidy, "will have to pay taxes to provide coverage for other people who are only somewhat worse off than he is. What kind of justice is that?"
- 2) The provision that a private carrier must make a standard contract available to any one who applies for it is unenforceable..."thus there is no guarantee that people not in the subsidized group will be able to get a standard contract even if they are willing to pay for it."
- 3) The government has the power to set the cost of the health care package that will be sold by private insurance companies to individual subscribers. If that cost, however, is set to cover the expenses incurred by companies who now must insure high risk individuals, this cost would discriminate against the low risk purchaser because it would force them to pay more than would be necessary and "will simply be permanent open season for insurance companies..." to make a profit.
- 4) "The payment of 100 percent of the Ontario Medical Association schedule of fees for services rendered under standard contracts will result in a huge subsidy to the medical profession, which is already the highest paid group in the community."
- 5) "To add insult to injury, there is nothing to prevent extra billing by doctors." Under Bill 136 a doctor can get 100 percent of the fee set by Ontario Medical Association fee schedule ...and then still send extra bills to his patients if he chooses to do so.
- 6) Because the Ontario Medical Association will be allowed to set their own fees, "there is no possibility of effectively controlling costs under the bill. If the Association decides to increase fees, the cost to the Treasury of covering subsidized groups and the premiums paid by the non-subsidized groups will have to increase willy-nilly...(this is) not a bill for the benefit of the public, it is a bill for the benefit of insurance companies and of the medical profession."

In view of these concerns along with several others raised throughout the debate, such as the issue of voluntary vs compulsory membership, the leader of the Opposition, both at the beginning as well as near the end of the third reading moved, and seconded by the NDP Member for Downsview, that "Bill 136 be not now read the third time, but be read the third time this date six months hence."³⁹ Despite the fact that the ensuing discussion encompassed seventeen pages in the June 21, 1965 Legislation Record, and that the motion was supported by the members from both the Liberal and the NDP opposition parties, the speaker chose to ignore the motion and recognized instead the Provincial Secretary who spoke in the absence of the Minister of Health, and moved that the third reading of the original Conservative motion now be put to the question. Because the House contained a Conservative majority, the vote was 53 in favor of the original motion while 20 voted against.⁴⁰

Owing to this outcome, immediately following the vote Kenneth Bryden once again presented a motion, which was also seconded by a member of the NDP, to amend the title of the bill to read "An Act respecting temporary and partial medical services insurance," based on the following logic.

I believe, Mr. Speaker, that that is a necessary amendment of the title to indicate properly the content of the bill. It is a bill for temporary and partial services and I think the title should so indicate.⁴¹

The speaker, however, ruled Bryden's motion out of order since the bill already had been approved. To counter this ruling Bryden then cited the following passage from Lewis' *Parliamentary Procedure* which the House had been following.

When the motion for the third reading of a bill has been carried, the procedure is closed by the Speaker putting to the House the resolution, "Resolved that the bill do now pass and be intituled as in the motion." This gives an opportunity for the amendment of the title if necessary.

In spite of the last sentence in this passage, which the Speaker obviously chose to ignore, the motion was still said to be out of order which meant that Bill 136 was granted Royal assent together with 46 other bills the very next day.⁴²

Public Sector Impact

The reaction to the passage of Bill 136 was swift and extremely negative. On the day the bill receive Royal assent the *London Free Press* reported that "a group of United Church ministers began a two-day vigil at Queen's Park to express their dissatisfaction with the new Ontario medical health program."⁴³ The reason for their dissatisfaction was identical to the views that had been expressed in parliament by the two opposition parties. "The general council of the United Church favours a program financed by tax money and covering everyone." It was strongly opposed to leaving "medical protection in the hands of privately-owned insurance companies." Two days later "About 75 ministers from the Baptists, Unitarian, United, Presbyterian and Old Roman Catholic churches assembled in the corridors outside Mr. Roberts's office and sent 15 of their members in to see the premier."⁴⁴

Although it is unknown if this public outburst in reaction to the Conservative Party's provisions in Bill 136 had any effect on these provisions, it is the case that a change in the Conservative Parties thinking did take place. Contrary to the normal legislative procedure after a bill achieves Royal assent, Bill 136 did not become law. Instead, it was returned to the House approximately six months later (January 27, 1966) in the form of Bill 6 and, therefore, marked the start of stage 3 in the program.

Stage 3: Bill 6 - An Act to Amend The Ontario Medical Services Insurance Act, 1965

As the title implies, this new bill contained a number of amendments for additional consideration by the House.

- 1) A standard medical services insurance contract will be supplied only by the medical services insurance division of the Department of Health. Private insurance companies will no longer be involved.
- 2) Enrolment of individuals receiving assistance under the various welfare Acts will be automatic.
- 3) Individuals not on welfare who wish to enrol in the plan must apply and will be charged \$60 per year for a single person, \$120 per year for a family of two, and \$150 per year for a family of three or more.
- 4) Individuals who wish to enrol in the plan and whose taxable income is below a specified cutoff will have these premiums reduced by 50% but must apply for membership.

The Rebuttal

The second reading of Bill 6 took place on February 3, 1966. The main thrust of the Opposition leader's attack this time, which occupied the first three pages out of a 215 page rebuttal that spanned 11 days,⁴⁵ centered mainly on items 3 and 4 above. Because these two items provided individuals with an opportunity to join the plan only if they wished to do so, the leader's attack focused solely on the issue that, thus far, had not been adequately addressed, namely, the need for compulsory as opposed to voluntary membership in the insurance plan. The following summary in the leader's own words, captures the core of his argument regarding the need for compulsory membership.

The first principle which I should talk about is the principle of coercion. Now, if we recall when he (the Minister of Health) brought in his bill before, he was quite dramatic about ...the fact that he hated coercion or compulsion of any form....May I say that you are going to have to accept some form of coercion if you are a civilized member of society...I say this because the hon. Minister, in his great outburst about being against coercion, tried to throw a red herring about the whole of this bill, and I think that he has tried to blur what freedom really means...Health has a particular significance to the people; they see it as a collective responsibility. We hear no great outcry by the hon. Minister when we are asked to contribute to the building of hospitals...It is not sapping free enterprise to be building hospitals to provide health for people. It is not taking away freedom when you arrange for a hospital so people can get their health back again, in order that they can be more free to be creative and do their work.

And so the people of this province have a tradition in giving collectively for hospitals, for medical training, and for medical research. We give through laws; we are compelled to give, and I want to point that out to the hon. Minister of Health. We do not all shudder and cry out and say, "I hate every form of compulsion," I am proud to give my taxes to build medical facilities...I am sure the hon. Minister does now as he thinks it over— recognize that collective responsibility is not coercion.

...the bill before this House demonstrates the government's unwillingness to accept a fundamental principle, a principle which must be accepted in order to achieve the goals which the Hall Royal commission has set for this country. The goal: "To make all the fruits of the health science available to all our residents without any hindrance of any kind."

Elsewhere in the rebuttal the leader of the Opposition, as well as other members of the opposition, pointed out several further shortcomings. For example, individuals slightly above the welfare cut off and who wished to apply for a subsidy, would also be subject to a means test and because of the voluntary nature of the plan, those in the highest-risk category would still be the ones most likely to join which, in turn, would substantially raise the overall operational cost of the plan. To counter these drawbacks, the leader then moved that the bill be further amended to "include and be based on the following principles."⁴⁶

- 1) A comprehensive government operated universal health care programme.
- 2) The patient shall have the right to be treated by a doctor of his choice.
- 3) The doctors shall be paid on a fee for service basis and shall be free to practice within or without the plan.
- 4) There shall be no means test.
- 5) Mental illness shall be treated on the same basis as other illnesses.
- 6) Dental and optical services for children up to 18 years of age shall be included.
- 7) Other ancillary medical and health care services such as home nursing or orthopaedic appliances, chiropractic services, and payment of a part of the cost of prescribed drugs shall be phased into the programme as independent health services in order that the programme shall be fully comprehensive by 1971.

The leader also suggested the need for an additional clause. The reason being that since only two groups (the government and the Ontario Medical Association) had been involved in the consultations that led to Bill 6, a broader more representative body needed to be included. To achieve this goal the leader moved the following amendment.

that the bill be referred to the standing committee on health and welfare at which representatives of farmers, trade unions, the business community, the medical profession and the public be invited with instructions to make recommendations to the government and the House in accordance with the recommendations of the Royal commission on health services chaired by the hon. Mr. Justice Emmett Hall.

After an extremely long and heated debate, on February 11, the Premier responded to the amendment as well as to the need for an additional clause with the following words.

All they are saying is: "Let us hand it to a committee, draw up great terms of reference and let them study it for another couple of years and then we will see what we will do about it, or we will wait for the federal government to make up our minds for us" ...as far

as I am concerned the amendment is completely unacceptable. It will do nothing for the people of this province.⁴⁷

Immediately prior to calling the question, the leader of the Opposition asked if a standing committee will be consulted, to which the Premier further responded: "Mr. Speaker, I would just simply say: support this bill and we will have a plan in effect on the first day of July, 1966." The second reading of Bill 6 was approved by a vote of 55 to 23 and the third reading was held on February 18, 1966. Shortly after the start of the third reading the following information was conveyed to the House.

More than 4,500 of the province's 6,500 practicing doctors have already signed individual declarations saying they will not take part in the province's Medicare plan as it now stands...They endorsed a series of resolutions passed at a special meeting of the OMA council on January 7...One resolution insists that the fee schedule is not "open to negotiations" except when the profession wants to make special deals on its own. Another resolution says: The profession should not enter into any billing or other contractual arrangements with the government." This now means that doctors will insist on billing patients directly and patients will have to collect from the government.⁴⁸

Despite the concern that was expressed in the House over this information, the third reading of Bill 6 passed by a vote of 51 to 24 on February 18, 1966, and received Royal assent that same day. It is also worth mentioning that the day after Bill 6 received Royal assent, the *Free Press* quoted a statement by the Ontario Medical Association to wit that doctors are not bound by the declaration referred to in the above poll.⁴⁹ In other words, according to the OMA, the poll results should not be interpreted as suggesting that the Ontario doctors had relinquished their right to decide for themselves whether or not they wished to participate in the plan. On a personal level, they could still either opt in or out of the plan, as they saw fit.

Parenthetically, it is also worth noting that on July 1, 1966, a somewhat similar program had become available for senior citizens in the United States⁵⁰ and that this program had been achieved despite a very similar longstanding opposition by their doctors.⁵¹ Because this need for medical coverage had surfaced at the same time on both sides of the border, and was greeted in the same way by the medical profession in both countries, the *London Free Press* not only addressed the matter but placed the overall issue in its appropriate context.

Doctors throughout North America are undergoing collective and individual self-examination as an irresistible wave of the future sweeps over their proven profession. Almost by definition, members of that profession are individualists; they shrink instinctively from any form of collectivization beyond their own societies...The Saskatchewan doctors' strike was a disgrace. It may have been with memories of this situation that the new president of the American Medical Association warned his colleagues that it would be unethical and an act of bad citizenship for doctors to boycott

medicare once it becomes law... medicare is as much a part of our civilization as any other plan to help those who cannot care for themselves.⁵²

Public Sector Impact

Because the final version of Bill 6 failed to contain the compulsory membership provision called for by the two opposition parties, an important concern raised by the *Free Press* was whether Ontario would indeed be eligible for enrolment in the nationwide federal government medicare plan which was scheduled to begin on July 1, 1967.⁵³ The reason for their concern was that membership in the government plan had a decided advantage in that the government had offered to pay half the average per capita cost of the medical services offered by each of the provincial plans. To belong to this plan, however, each province needed to satisfy all of the following conditions.

- 1) Portability of benefits from province to province
- 2) Public administration by a provincial department of government agency
- 3) Universal coverage
- 4) Protection spanning a full range of physicians' services

The difficulty for Ontario, according to the *Free Press*, was that by adhering to a voluntary as opposed to a compulsory membership, the stipulation of universal coverage specified in item 3 might not be satisfied. While on the surface this certainly would appear to be the case, the term, universal coverage, was subsequently defined as it had been before when the province put forth its proposal for hospitalization insurance alone, to mean that "90 percent of a province's population needed be covered from the start, rising to 95 percent within three years..."⁵⁴ Because the province had been able to achieve these percentages during the first stage of the program, it seemed likely that the same would hold true during this third stage of the program. However, it is worth keeping in mind, according to the *Free Press*, that the Premier was not entirely certain whether it would even be worthwhile for the province to belong to the Federal medicare plan.

the question of nationwide medicare raises too many imponderables to warrant an immediate decision on Ontario's participation. He told the legislature he doesn't feel it necessary to say just yet whether Ontario will join the network of provincial medical care insurance plans the federal government hopes to establish—on its terms—by July 1, 1967.⁵⁵

In making this statement, the Premier drew attention to an opting-out formula that applied to joint spending programs—which would make it possible for the province to simply refuse to join the Federal plan if it elected to do so. In fact, by May 18 only Saskatchewan had complied with all of the requirements in the Federal plan and only New Brunswick, Quebec and Newfoundland had indicated their intention to do so. Manitoba and Prince Edward Island were undecided and Alberta in harmony with Ontario was opposed to the universality requirement.⁵⁶

Nevertheless, on March 1, 1966, Ontario initiated an open enrolment period that extended through May 1, 1966. To encourage enrolment at the local level as well as to fully inform Londoners about the advantages of the Ontario health care plan, an information session was held from 10 a.m. until 2 p.m. on April 23 at the downtown YM-YWCA which garnered “standing room only.”⁵⁷ The expectation was that 2,000,000 would enrol by the time the plan went into effect⁵⁸ and since it was estimated that 1,500,000 had enrolled by the end of June,⁵⁹ this meant that 75% of the 1967 target date would have already been achieved.

Stage 4: Bill 94 – The Medical Services Insurance Amendment Act, 1968

Despite the fact that Bill 6 had received Royal assent on February 18, 1966, Ontario’s opposition parties in 1965 had called for an expansion of the Ontario Medical Services Insurance Act (Bill 136) to include in addition to medical care, as stated above, coverage of “all other essential services.” Hence, the aim of Bill 94, Introduced on April 10, 1968, was to provide one additional service, Optometry.⁶⁰ Needless to say, the leader of the Opposition asked the Minister “to comment on the principle of this bill as to how he and his advisors decided how it was now possible to extend the coverage in this direction, and what he sees as future extensions in the legislation...” In response the Minister replied that the estimated cost of this additional service is \$6.5 million in the first year and

we have confirmed that about 65 percent of the people who need eye care in respect of refractions turn to optometrists...For this reason and this reason alone, it was decided to extend into this area. I do not believe that the terms of this bill, or the principle of this bill, sir, will permit me to debate the general topic of extension into other areas of health and parahealth services.

Royal assent was granted on May 30, 1968, and eleven months later the House was asked to consider the next bill which dealt with a longstanding issue that still had not been resolved.

Stage 5: Bill 121 - The Ontario Medical Services Insurance Amendment Act, 1968-1969

Almost from the outset of the debate over provincially sponsored health care there was considerable opposition to the fact that the OMA would be allowed to set its own fees and that physicians would be eligible to receive 100% of these fees for their treatment of patients. Because both of these provisions had previously been accepted by the Conservative Party, the opposition parties were concerned that these two provisions had failed to provide the government with any opportunity to control the cost of its plan. Thus, the main component in Bill 121, which was introduced by the Conservative Party on April 1, 1969, was to undo the impact of at least one of these provisions by reducing the fees that the physicians would receive. According to clause 1 in the bill,

The benefits under a standard contract during the period of two years commencing on the 1st day of April, 1969 shall be based upon 90 percent of the Ontario Medical Association's schedule of fees in effect on that day.

The Rebuttal

To understand the nature of the ensuing debate some additional background information may be helpful. Prior to the implementation of Bill 136 nearly 2 million Ontario residents had acquired their health insurance through Physicians Services Incorporated (PSI) which was formed in 1947 as an independent company with majority control vested in the OMA.⁶¹ During the years that preceded the Government's attempt to develop its own health insurance program, the OMA had made use of a 90% reimbursement fee rather than pay its members an amount equal to 100% of the fee that had initially been set by the OMA as appropriate compensation for doctors in their treatment of patients. The OMA had initiated this 10% reduction to help cover its administration costs. When the OMA became aware of the government's plan to enter the health care insurance industry, however, it raised its overall fee structure to compensate for what it thought the government might pay its members if the government also intended to establish a 10% fee reduction to cover the government's administration costs. In essence, this meant that the government would now be required to reimburse Ontario physicians at a higher rate than was the case when their services were covered by the PSI. Needless to say, this move by the OMA infuriated many of the opposition members especially when the normal wages of physicians were compared against the Ontario average wage structure. In the words of one NDP member,

When I look at the average income of persons in Ontario, I realize that the medical income is pretty high in comparison...The Dominion Bureau of Statistics says that in Ontario only 20 percent of our people get an income of \$6,000 or more, nine percent get an income of over \$8,000, only four per cent get an income of over \$10,000 and the average income of the medical profession is approximately three time this last figure...⁶²

While the new fee structure imposed by the OMA was a major concern to both opposition parties, equally problematic was the actual setting of fees. With this concern in mind, the NDP proposed the following amendment to Bill 121.

The government rejects the principle implicit in the bill that the Ontario Medical Association may unilaterally increase the fees for medical services thereby forcing the government to provide for payment of 90 percent of such fees charged in accordance with the Ontario Medical Association fee schedule.⁶³

The speaker, however, ruled that the amendment was inappropriate because it reflected a negation of the original motion. When challenged by a member of the NDP, the speaker replied that "an amendment which is a mere negation of the original motion is out of order because the way to deal with the matter is to vote against the original motion" rather than

through an amendment.⁶⁴ To counter this ruling the NDP then proposed a further amendment specifically designed to address what it considered to be an inappropriate increase in the fee structure by the OMA.

I want to move that clause 1 of Bill 121, be amended by deleting there from the figure "90" and substituting therefore the figure "80."⁶⁵

If approved, the government now would only be authorized to reimburse physicians at 80% rather than 90% of the OMA fee structure. What followed were a series of comments over whether this lower rate as well as the possibly of an even lower rate had ever been discussed during negotiations with the OMA. In response the Minister of Health stated that this was not part of the more recent negotiations and went on to reveal the OMA's general reaction to this issue: "We'll set our fee schedule and you determine how much you will pay, and then we will do what we think we have to do from then on." The Minister, who was a physician, also provided his own reaction to this response by the OMA.

Again I say that out of my dealings and out of some knowledge of the mentality of my profession, I feel quite certain that if, by law, we were to say we would pay 80 percent of the fee schedule, the great majority of patients would get billed to schedule and (therefore would) get a bill for the 20 percent (difference).

In short, according to the Minister of Health, if 80% were to be used in place of 90%, this would lead to double billing which was precisely what the House had hoped to avoid. It is not surprising, therefore, that when the question to insert the amendment in the motion was called, it was defeated by a vote of 52 to 37.⁶⁶ The motion in its original form was subsequently approved and granted Royal assent on May 13, 1969.

Stage 6: Bill 195 - Health Services Insurance Act, 1968-69

Approximately one month after Bill 121 received Royal assent, the House was presented with still a further bill the purpose of which was to serve as a preliminary but vital step toward the final stage in the emergence of OHIP. This bill, known as Bill 195, contained 35 sections, encompassed 216 pages in the legislative debate record, and included all of the previous provisions that had been discussed and approved along with several new provisions designed to address some of the shortcomings mentioned above. The major function of Bill 195 was stated by the Minister of Health at the start of the first reading.

...this bill is designed to meet the criteria set down by the federal government in the Canada Medicare Act... it therefore qualifies Ontario to claim the financial support provided by the federal government under the federal Medicare Act.⁶⁷

To understand the significance of this statement it should be recalled that nearly three years earlier, during the discussion of Bill 6, the Premier had expressed his reservations over whether Ontario was indeed willing to become part of the federal program. At that time the Premier's

reservations stemmed from an assumption that Ontario, along with each of the other provinces, not only had the right to opt out of the federal program if it chose to do so, but that if it did opt out, it would still be eligible to receive an equivalent level of financial support from the federal government which it could then use as it pleased. Unfortunately, the Premier subsequently learned that his assumption was unwarranted.

At the constitutional conference in February of this year, Ontario demanded that the fiscal equivalent (of the Federal contribution to the plan) be turned over to Ontario. We would have preferred this, of course. We still believe that this would have been an eminently more fair method of dealing with the requirements of the people of this province in a total manner. However, we are satisfied that we are not going to obtain the fiscal equivalent...Proceeding from that point, we have been able to make an arrangement with the federal government which will enable the federal Medicare legislation to be applied to the health service programme operating in this province (which) is intended to begin on October 1, 1969.⁶⁸

With this correct information now in mind, and in order to receive the promised federal funds which amounted to \$176,000,000 toward the cost of the provincial plan,⁶⁹ the Premier elected to join the federal Medicare program. To receive these funds, however, the Ontario Legislature needed to approve all of the provisions in Bill 195 prior to October 1, 1969.

Of the several new provisions in Bill 195 two were quite important. The first was the establishment of a Health Services Insurance Council which would consist of no fewer than nine members appointed by the Lieutenant Governor. Two of the members would represent the OMA, two others would represent the insurance industry, and the remaining five were to be selected from the public at large. Because the Ontario Insurance Industry had recently agreed to establish a new non-profit corporation that would be representative of all the large carriers in Ontario, and therefor would embrace 95 per cent of those covered under the various existing health insurance policies, the two industry representatives would be chosen from this corporation.

The Council had several purposes. One purpose was to receive and investigate complaints as well as to advise the minister on the operation of the plan. The second purpose was to address a concern that had been raised by the Opposition, as stated above, over whether the OMA had the right to unilaterally increase the fees that physicians were permitted to charge for services rendered. Needless to say, without some form of safeguard, the OMA rate structure could easily increase to a point where future budgetary requirements would be impossible to satisfy. Hence, the goal of the Council according to provisions in Bill 195, was to make recommendations to the Minister of Health respecting the premium rate and thus, according to the minister, "assure the Opposition that the rate was arrived at following appropriate discussions..."⁷⁰ The minister, however, went on to clarify this point by stating that "Conducting discussions does not mean negotiations...The OMA has, in the past, refused to negotiate tariff changes and there is no indication it intends to change its position...The council,

it appears, will function essentially as an information pipeline in this delicate area.” In essence it was quite clear from these remarks that members of the Opposition would need to accept the fact that the government would have, at best, only a very limited role in determining the fee structure that would be set by the OMA.

The other new provision was the need for “designated agents.” During the opening portion of the second reading for Bill 195, the Minister of Health was called upon to explain this provision, which appeared under Section 5 in the bill. According to the minister, about 50 percent of Ontario’s health insured population had already obtained their insurance from commercial carriers under group contracts that had been arranged at the bargaining table as part of wage and salary negotiations. As a result, it was the commercial insurance carriers who were to be the designated agents because they already had “very large numbers of contracts now in vogue (and they) will be providing our plan to a large number of subscribers. They will enrol, they will look after changes in the status of the subscribers, and they will bill, and collect the premiums...” Technically this meant that the Ontario insurance companies would now be drafted by the government to serve in a dual role both as sales representatives and as collection agencies for the provincial insurance program. With this in mind, Ontario’s physicians would now be required to deal directly with the insurance companies and not with the government to receive reimbursement for their work with patients.

To understand how this arrangement would proceed, as was the case under Bill 165, it is important to recall that the insurance companies would still be allowed to sell supplementary or topped-up versions of health care coverage as part of their group policies. This meant, however, that the premiums the insurance companies would now issue to their group policy holders would consist of two parts. One part would belong to the companies to pay for the supplementary topped-up health care packages that the companies offered to the policy holders, while the second part would belong to the Ontario government. The funds that accumulated in the second part would then be housed in the provincial treasury under the auspices of the Ontario Hospital Services Commission and used to compensate physicians for the treatment of their patients.

In view of this new role that the insurance companies would now be expected to play, physicians were told that they should send their bills directly to the insurance companies and not to the government. When their bills arrived they would be adjudicated by provincial employees housed in the company’s offices and, if approved, would be forwarded to the government. The government in turn would then send checks for the appropriate amounts back to the companies and they in turn would forward the checks to the physicians. To compensate the insurance companies for their role in this endeavour, the Ontario government would provide the companies with a fee to cover their administration costs. Under consideration at the time were fees that ranged from 6% to 17% of the actual amount of government health insurance that had been sold by the companies.

The Rebuttal

The major focus of the debate over Bill 195, which lasted 4 days, began during the second reading and continued while the bill was in committee. Although the debate dealt largely with procedural matters it also entailed the need to discuss and then approve each of the bill's 35 sections. The most insightful and important segment of the discussion took place in June 23 when Dr. Morton Shulman, a practicing physician and NDP representative from High Park, elaborated on the possible harmful effects that these designated agents would have on the physician's willingness to comply with the act.

A point that has been very completely overlooked, I think, by all three parties, has been the tremendous problem that his bill is going to produce for the doctors and the medical profession, because of the way it has been drawn. Specifically, I am referring to the fact that there are 200 carriers which are being allowed to bring in this form of medicare.

As it stands today, and as it will continue to be, a busy doctor seeing 30 patients in a day, may see patients who are covered by a dozen different carriers, each of whom will have a different form that will need to be completed and mailed back to the carrier. This will entail extra expenses for the doctor because of the need for extra secretarial help. It could also cut into the number of patients that the doctor will in fact be able to treat each day. I believe this is something the Minister has ignored in this efforts to bring the private carriers into the plan.

If there was one coordinated plan, which means a central clearing house instead of a range of carriers, we would have a scheme whereby a doctor would spend, perhaps, two hours a week with his secretary to fill out the necessary forms and then send them in at the end of the month. Indeed, this was the scheme implemented by the PSI which was developed by the OMA in coordination with its member's needs.⁷¹

Despite the importance of these comments coupled with the fact that two attempts were made to insert amendments into the bill, both of which were defeated, the bill was approved. Before leaving this topic, however, one further issue was raised by the opposition. While the Conservative Party was very clear throughout each of the previous stages in its commitment to a voluntary, as opposed to a compulsory membership in the plan, it now appeared to deviate from this commitment since Bill 195 stated that "coverage shall be mandatory for a firm with 15 employees or more—including the employer." This statement was immediately challenged by the opposition when

the NDP claimed in a complex legal argument that the premiums, because of their mandatory nature, were in fact a tax. And any tax requires a statement by the lieutenant-governor authorizing its appropriation...if the government pushed ahead with the bill without a statement by the lieutenant-governor, it would nullify the entire bill.⁷²

To counter this argument the leader of the Conservatives “pointed out that the legislation is made totally legal by royal assent from the lieutenant-governor after the third reading” which was granted on June 26, 1969.⁷³

It should be noted that, although there was a mandatory provision in the bill, this provision only applied to those who were covered by a group policy. Take for example the University of Western Ontario where all full-time faculty were covered by a group insurance policy administered by the London Life Insurance Company. At the end of July, 1969, which was one month after Bill 195 received Royal assent, “a monthly pay role tax deduction” was initiated to cover the cost of the premium and automatically forwarded to the Ontario Health Services Commission in compliance with the provisions in the bill. Faculty members also received a wallet card that described the nature of their coverage and were told to submit this card to their physicians when they received medical care. The physicians in turn would then send their bills directly to London Life for reimbursement. Those in the community who were not part of a group could voluntarily enrol in the government plan if they chose to do so. For these individuals, the premiums under discussion in 1969 were \$70.80 a year for a single individual and \$177 a year for a family independent of size.⁷⁴ When hospital care was required, all residents in Ontario, regardless of group coverage, received a similar wallet card that provided ward coverage and that needed to be shown to the hospital upon arrival.

Public Sector Impact

On June 18, 1969, the *London Free Press*, under a frontpage headline “Medicare move not surprising, reactions mild,” summarized London’s feelings to this stage 6 endeavour in the following words.

Acceptance with no great stir marked London’s reaction to Ontario’s medicare announcement. Doctors and hospitals expected little effect, insurance people felt no surprise, and labor expressed a wait-and-see optimism... Dr. Glenn Pratt, president of the London Academy of Medicine, said federal medicare “is not an issue any more among doctors”... Albert Anderson, executive vice-president of London Life said “This simply means this part of our business no longer will be available to the public” ...Ernie Parker, area representative of the Canadian Union of Public Employees said “Generally it should be one of acceptance.”⁷⁵

Stage 7: Bill 5 - The Ontario Health Insurance Organization Act, 1971

Up to this point the House had approved two separate plans that governed the delivery of health care to the residents of Ontario: the Ontario Health Services Insurance Plan, which was responsible solely for hospitalization expenses, and the Ontario Medical Services Insurance Plan, which was responsible for non-hospitalization expenses provided by physicians. Because each plan operated under a different administrative umbrella and had its own premium structure, the purpose of Bill 5 was to combine the two into a single plan, with a single set of

premiums that would subsequently be known as the Ontario Health Insurance Plan or OHIP. Despite its overall importance, however, Bill 5 was not introduced to the House in a form that was common to each of the earlier bills in the sequence. That is to say, it was not subjected to a first, second or third reading and even though it was sponsored by the Minister of Health, it was not the minister who introduced the bill to the House. Instead, Bill 5 merely appeared in the Legislative Record on October 13, 1970, where it was briefly introduced by Premier Robarts.

Mr. Speaker, in recognition of the government's continuing responsibilities in the field of health services, I am pleased to announce today a new policy in the administration of health insurance. It has become clear that in order to provide the most effective and convenient health insurance plan, we must combine our hospital and personal health care insurance plans and programmes into a single integrated plan.

It is therefore our intention to establish a new health insurance commission...to be known as the Ontario Health Insurance Commission which will be responsible to the Minister of Health for the administration of an integrated health insurance programme. In addition, this commission will have delegated to it the responsibility for the development and maintenance of the public general hospital system in Ontario.

The target date for the complete implementation of the new programme is July 1, 1972. Between now and then, this massive reorganization will take place...The phasing-out of agents and the assumption of their functions by the new commission will be accomplished with minimal disturbance to the employees of these agents.

A single premium for health insurance will be an important feature in the new programme. The social insurance number will be adopted to provide a single numbering system...Another technique will be the distribution to subscribers of plastic cards similar to the now familiar credit cards. These will simplify recording and claims procedures and will reduce errors.⁷⁶

The Rebuttal

While no objections were raised to the premier's remarks, the opposition did voice two interrelated concerns, both of which were noted and answered in an interview that appeared in the *Free Press*. Although Bill 5 had been introduced on October 13, 1970, and would not be fully implemented until July 1, 1972, the first concern had to do with why there needed to be a nearly a two year delay in the implementation of this bill. The second concern had to do with why in the previous bill (Bill 195) there had been a need for "designated agents."

In response to the first concern Premier Robarts said that a "20 month delay in the changeover is due to the massive reorganization involved (and) the announcement was made now so a start can be made on the preliminary work." In response to the second concern, he said

it was obvious that “sufficiently trained administrative staff and facilities were not available to permit the establishment of the type of plan which would meet the criteria established by the federal government... Rather than delay introduction we sought the assistance of the insurance industry which had the facilities to put the plan into effect quickly and efficiently.”⁷⁷

Summing Up

At this point It may be worth asking how the two-part hospital care/ physician’s care program developed in Ontario between 1957 and 1966 compared with similar programs offered by the other provinces. To answer this question we drew upon material in a 1967 publication, *Canadian Opportunities: Social Benefits*, issued by the Federal Government to all Canadian newcomers. The purpose of the publication was to acquaint prospective citizens with the range of benefits that Canadian residents were entitled to enjoy. The following information provides a brief overview of the material devoted to health care benefits.

Hospital Care

Each province, along with the territories, offered its residents hospital care at the ward level that included most if not all of the benefits mentioned above. The need to enrol in a province’s program, however, varied from province to province as did the resident’s yearly premium costs. In Saskatchewan and Manitoba enrolment was compulsory. In Saskatchewan the yearly premium for a single person was \$20 while families paid \$40 per year and in Manitoba the rates were \$24 for single persons and \$48 per year for families. For British Columbia and Alberta, there was neither a compulsory enrolment requirement nor a yearly premium fee. Instead, “a nominal amount was charged on a daily basis when hospital care was provided.”

Physician’s Care

Physician’s care was also available to all residents though the nature of the care as well as the premium costs were set by the provinces and varied from province to province. The following examples illustrate something of the range as well as their costs. In most cases financial subsidies were available to help those with little or no taxable income.

The Saskatchewan plan called for compulsory enrolment of all eligible residents. Benefits included private physician care in a person’s home, office or in a hospital as established by medical necessity; there were no restrictions related to age or pre-existing conditions. The annual premium was \$12 per adult and \$24 per family. In Alberta, only approved commercial and non-profit carriers were permitted to offer this form of insurance and the annual premiums, which were controlled by the province, were not allowed to exceed \$63 for a single person, \$126 for a family of two, or \$159 for families of three or more. The British Columbia plan was similar to the Alberta plan except that only non-profit carriers were authorized to participate and here the

premiums were set at \$60 for a single person, \$120 for a family of two, and \$150 for a family of three or more.

One further point worth mentioning is how the last two stages in the emergence of OHIP translated into the version of OHIP that exists today. As stated above, in the case of the University of Western Ontario, faculty members in 1969 received a wallet card that described the nature of their coverage and were told to submit this card to their physicians when they received medical care. The physicians in turn would send their bills to London Life for reimbursement. In 1972, when OHIP was fully implemented, the faculty received a plastic OHIP card and it is this card that now is given to the health care provider, which means either the member's personal physician or the hospital, both of which at present receive direct reimbursement for their services from the government.

It is also the case that all Ontario residents now are required to pay an Ontario Health Premium tax in amounts based on their total yearly earnings. In 2019, for instance, if their taxable income was more than \$25,000 but not more than \$36,000, their premium was \$300, if their taxable income was more than \$72,000 but not more than \$200,000, their premium was \$750, and for the highest income earners, their premium was \$900.

Epilogue

Are there lessons from the forgoing account that could have influenced the emergence of The Affordable Care Act (P.L. 111-148) in the United States that was approved by congress on March 23, 2010? While the provisions in the Affordable Care Act are extremely detailed and appear in a 906 page document, the Act had three major goals: (a) make affordable health insurance available to more people, (b) expand the Medicare program to cover all adults with income below 138% of the federal poverty level, and (c) support innovate medical care delivery methods designed to lower the costs of health care. (www.healthcare.gov/glossary/affordable-care-act/)

Although widely approved by the public, one of the major complaints levied from the outset was the need for mandatory enrolment in a health insurance plan offered by a private insurance company. This need was implemented because, according to the Act, the insurance companies were required by law to cover the hospital expenses incurred by subscribers who have pre-existing conditions. Prior to its passage companies could deny such coverage to subscribers with these conditions. Needless to say, the implementation of this clause imposed a serious financial burden on the insurance industry because of the high costs involved. To offset these costs, with few exceptions, everyone in the United States above 18 years of age, whether or not they wanted health insurance, was required to purchase, at a minimum, some form of health insurance from a private insurance company or suffer a penalty.

In the early years of its development several attempts were made to compare a preliminary version of the Affordable Care Act with the final version of the Ontario Hospital Insurance Plan

in an effort to seek guidance on the best ways to develop the Act. This comparison may not have been entirely appropriate, however, because the Ontario plan in its final form covered both hospitalization and physicians' care independent of age, income, and health condition, which is far broader in scope than what the American public was willing to endorse. On the other hand, because the Ontario Plan was voluntary throughout its development, the methods used during several of its preliminary stages, had they been known at the time, could have offered ways in which the Act might have been developed to avoid the pitfalls of mandatory enrolment.

As stated above, beginning with the first stage the Ontario government encouraged a cooperative arrangement between itself and Ontario's private insurance sector by allowing companies to sell hospitalization insurance that supplemented the plan that was to be offered by the province. The companies enjoyed this arrangement because it freed them from the responsibility of covering their clients' basic hospital needs while, at the same time, enabling them to increase their earnings through the sale of less frequently required components of hospital care. Moreover, this arrangement was especially helpful to the companies in their sales of group insurance packages because they were also able to lower the cost of these packages which made them more attractive to employers during union/management negotiations. Then in the sixth stage the province made even further use of the companies by enlisting their aid in the sale and distribution of its plan. Here the companies profited because they received a commission for their work without the need to incur any additional expenses.

How might knowledge of these two procedures on the part of the Ontario government have contributed to the development of the Affordable Care Act? As a first step, since the Act called for the use of an expanded version of Medicare, one way could have been to incorporate into the Act an altered version of Medicare Part A. Since the original version of Medicare Part A had already been approved by congress in 1966 and was paid for through tax revenue but was available largely to persons 65 years of age and older, if many of the provisions in this original version could have been altered to serve a broader and healthier population, it might have been possible for the federal government to develop a hospitalization plan that resembled what was available in the first stage of OHIP. In other words, the hospital expenses incurred by the Affordable Care Act would have been fully covered by the government through tax revenue without the need to rely on the insurance companies, and this revised version of Medicare Part A would have served the basic hospital needs of the general population along with those having high-risk conditions.

If it had also been possible for the federal government to convince the states to join the government in a expense sharing venture, this in turn would have greatly reduced the overall cost of the plan, and with the lowered cost, many Americans could have been encouraged to voluntarily join the plan as was true in Canada. Finally, if the federal government also could have enlisted the aid of the American private insurance companies to serve as distribution agents for a fee, the companies may have found this arrangement as profitable to them as it

was to the private insurance companies in Ontario thereby dispelling the view that the federal government was interfering with private enterprise. In summary, it would seem that if these several features from the preliminary stages of OHIP had been known and incorporated into the Affordable Care Act through a revision of Medicare Part A, it may have been possible to eliminate the mandatory enrolment component of the Act, and at the same time satisfy one of the other chief mandates of the Act which was to make “affordable health care available to more people.”

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