Ontario Health Coalition

FACT SHEET: The History of Public Medicare

November 27, 2024

What is Public Medicare?

Public Medicare is the public health care system in Canada which is funded through our taxes. When you see a doctor or visit the hospital for medically necessary services using your OHIP card, you are using Public Medicare. Under Public Medicare, all Canadian residents can receive medically necessary hospital and physician services based on their medical need without user fees or charges. Health care is provided without cost based on our medical need, paid in our taxes, rather than based on our ability to pay or our wealth. Public Medicare enjoys a high level of support from Canadians. It is a source of pride for many, but years of relentless cuts and governments pushing privatization have contributed to problems in Medicare. The solution is not to privatize but to plan well, reorganize care in the public system, and restore and rebuild services that have been cut and downsized too far.

What is it like to not have Medicare?

- Before Public Medicare, Canadians had no choice but to forego medical treatment because they did not have the money to pay for care, leading to suffering and death. Helen Heeney's book *Life Before Medicare* tells the story of a young woman with cancer who refused pain medication because it would bankrupt her family. For two months, she had her husband lock her in their home when he left for work so that no one could enter to help her when they heard her screaming in pain. She did not want to bankrupt her family as she was dying.
- In the United States where private insurance and for-profit delivery of health care services are widespread, health care costs are almost double per person those in Canada.
- More than 26 million Americans did not have health insurance in 2023 and 38% of residents in the United States delayed getting medical treatment because they could not afford it.

Achieving Public Medicare & the Canada Health Act

1947 — The first public hospital insurance plan in Canada was introduced by the Saskatchewan government led by Tommy Douglas in 1947.

1957 — The federal government, with Paul Martin Sr. as Health & Welfare Minister, introduced the *Hospital Insurance and Diagnostic Services Act (1957)* that brought in public hospital insurance across the country. The funding arrangement was that the federal govt shared half the cost of provincial/territorial hospital insurance plans. It faced strong opposition from pro-privatization forces wanting to bill patients directly (doctors, insurance companies, and large corporations).

1959 — Ontario created a public provincial hospital insurance plan in 1959.

1961 — By 1961, all provinces and territories had implemented a public hospital insurance plan.

In 1961, Saskatchewan passed legislation to expand their Medicare program to cover physician care outside of hospitals (e.g. doctors' offices), prompting a three-week strike by doctors who wanted control and wanted to be able to extra-bill patients. The government held strong and brought in Public Medicare but with amendments allowing doctors to opt out of the plan. By 1965, once it was in operation, the majority of doctors supported the plan.

1964 — In 1964, the federal Diefenbaker government's Royal Commission on Health Services led by Justice Emmett Hall called for national Public Medicare.

1966 — The *Medical Care Act (1966)* was passed so that doctors and medical care would be covered for all Canadians (not just in hospital). The federal govt would share half of the cost with the provinces/territories.

1972 — By 1972, each province and territory had implemented Public Medicare plans for hospital and physician services.

1984 — In response to doctors extra-billing patients (charging patients extra user fees on top of OHIP/the provincial public health plan), the Canada Health Act was passed in 1984, establishing five principles for our health care system and banning extra-billing and user fees.

1995

In 1995, the federal Chrétien government with Paul Martin (Jr.) as Finance Minister, brought in major cuts in the federal budget. The Canada Health and Social Transfer (CHST) combined funding for health, education and social services into one block fund and they cut federal health transfers by 40%. These cuts, combined with provincial cuts, led to the expansion of private clinics.

2001

In 2001, the federal government created a National Commission (known as the Romanow Commission) on the future of Medicare, in part because of the crisis caused by the cuts.

2002

The 2002 Romanow Report called for the creation of the Canada Health Transfer (CHT) that would separate out health funding from other federal transfers and an escalator clause in the CHT to match inflation.

2004

In 2004, Ontario's *Commitment to the Future of Medicare Act* was passed to uphold the Canada Health Act. It bans extra-billing, user fees, queue jumping, and restricting access to insured services through block or annual fees. It sets out fines and jail terms for offenders who accept payment for an OHIP-covered service and requires the Ministry of Health to reimburse patients for unlawful extra-billing and user fees.

5 Principles of the Canada Health Act

- Portability: Health coverage must not end or stop when a person travels or moves between provinces/territories in Canada.
- Accessibility: All insured individuals must have reasonable access to health care without barriers, such as financial or physical limitations.
- Universality: All Canadians must be covered by Public Medicare on equal terms and conditions.
- Comprehensiveness: All medically necessary hospital and physician services must be covered, even when the services are provided by another designed health professional.
- Public Administration: Provinces and territories must operate their health insurance plans on a non-profit basis. They must also be administered and operated by a public authority.

2006

The 2004 Health Accord introduced a 6% escalator for the CHT to offset the huge cuts made in the 1990s – although privatization had already gained a foothold. It also increased the federal share of health funding, not back to the historic 50-50 split with the provinces, but back to the 20% range (varying among provinces).

2011

In 2011, the Harper government announced cuts to the funding formula that governed CHT increases by tying them to changes in GDP with a floor of 3% starting in 2017, eliminating the 6% escalator agreed upon in the 2004 Accord. The impact was estimated by the provinces to be a reduction in federal public health care funding by $36 billion over ten years compared to what provinces would have received under the 6% escalator.

The 2006 election of the Harper government halted progress as they sought to remove themselves from health care policy and refused to attend First Ministers' meetings.

2016

During the 2016-17 Health Accord negotiations, the Trudeau govt only minimally modified Harper's cut to the funding formula. After the provinces and territories rejected their proposal, the Trudeau govt left the negotiating table. They then went province-by-province pushing through 10-year bilateral deals (that means different deals between the federal government and each province) to pressure all the provinces and territories into adopting their proposal.

2022

Legislation to implement a national dental care insurance plan was passed in 2022. However, the federal govt contracted a private insurance corporation (Sun Life) to administer the plan.

2024

The Pharmacare Act was passed in October 2024 to create a national pharmaceutical insurance plan, starting with coverage for contraceptives and diabetes medications.

15 Gervais Drive, Suite 201
Toronto, ON M3C 1Y8
Tel: 416-441-2502
Email: info@ontariohc.ca
www.OntarioHealthCoalition.ca

Ontario Health Coalition
Protecting public healthcare for all.