

## **Health Reform in Alberta: The Introduction of Health Regions**

**John Church and Neale Smith**

**Paper prepared for the 2007 Conference of  
the Canadian Political Science Association**

**Saskatoon SK**

### **Abstract**

In 1994, the Government of Alberta passed legislation, The Regional Health Authorities Act to abolish nearly 200 existing local hospital and public health boards and replace them with 17 regional health authorities. Consistent with the larger fiscal agenda, the intention of the government was to address the issue of efficiency of the health system through the creation of larger integrated management and governance structures. In this article, we examine why Alberta decided to create Regional Health Authorities through legislation to assume responsibility for the management and delivery of a significant range of health services?

In examining the interaction of ideas, interests and institutions, we conclude that the government was partially successful in altering existing institutional and interest relationships to align with an emerging political consensus related to cost and sustainability of the health system.

### **Introduction**

During the 1990s, provincial and federal governments in Canada engaged in significant public sector reforms. The nature and extent of these reforms was tied directly to general concerns about rising deficits and debts. Because of its share of public resources, the health care sector was one of the more visible and politically contested areas of reform. In 1994, the Government of Alberta passed legislation, The Regional Health Authorities Act, to abolish nearly 200 existing local hospital and public health boards and replace them with 17 regional health authorities. In this article, we examine why Alberta chose to create Regional Health Authorities through legislation to assume

responsibility for the management and delivery of a significant range of health services? To gain insight into this question, the article examines the interaction of ideas, interests and institutions and their influence on policy choices.<sup>1</sup>

The case study is one of six developed in Alberta as part of a cross-provincial study on the determinants of health reform in Canada. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content<sup>2</sup>. Regionalization is an example of the first category, where the policy issue relates to changes in how health care is governed and accountable.

Pertinent documents and public records (e.g., media, Hansard) were reviewed to establish the background for the case study. These information sources were complemented by 17 semi-structured interviews with key informants. Key informants include current and former public servants, politicians and representatives of key stakeholder groups. After providing an historical overview of events, we will then examine the case in greater detail within the context of the conceptual framework.

### **Thinking About Regionalization**

Several decades ago, a wise administrative owl put forward the proposition that sometimes achieving significant policy reform requires governments to work around existing elites to create new structures and processes.<sup>3</sup> A more nuanced interpretation of this idea suggests that when attempting to embed new policy ideas and associated policy actions in the face of significant resistance from powerful policy actors, government must alter existing institutional arrangements to facilitate the development of new patterns of

interaction among the various policy actors (e.g. from a pressure pluralist policy network to a clientele pluralist policy network).

In an historical context, health care regionalization has been characterized as an idea associated with a particular coalition of interests that views the health care system as significantly flawed and in need of better management. According to this coalition, regionalization provides a means of addressing many of the shortcomings of the existing system.<sup>4</sup> In a more general sense, this coalition, referred to as corporate rationalizers, competes with another coalition centred on organized medicine that dominates the health care field.<sup>5</sup> Fundamentally, corporate rationalizers see better management of the health care system as a means of addressing its perceived shortcomings. While a variety of potential barriers to effectively implementing regionalization have been identified, all Canadian jurisdictions have now introduced some form of regional structures in health care.<sup>6</sup> Thus as an idea, regionalization has been sufficiently appealing to governments in recent years to move from being a topic of on-going discussion to a reality. Alberta provides an interesting example of how the interaction of ideas, institutions and interests led to regionalization in health care.

### **Historical Overview**

Alberta's decision to introduce health regions did not come until after several years of consultation with stakeholders, changes to funding arrangements for acute and long term care, a Premier's Commission on health care services in the Province during the late 1980s; a shift in political leadership; the emergence of a right-of-centre, conservative fiscal agenda; a major public relations exercise; and, a provincial election. Each of these is discussed below.

Alberta, like all other Provinces, allowed progressive expansion in its health care delivery system between the 1970s and 1980s, by financing incremental growth. After coming to power as Premier in 1971,<sup>7</sup> Peter Lougheed set about modernizing the province, including developing key infrastructure such as hospitals through capital construction and use of hospitals, expanding the health professional workforce, and paying higher than average wage increases.<sup>8</sup> During this time, political hopefuls and legislature incumbents became very aware that expenditures on local-area health institutions equated with continuing electoral success. Overall, the first half of Lougheed's 15 year tenure as Premier occurred during a time when the province experienced unprecedented economic growth and political stability. The federal Liberal government's National Energy Program (NEP) provided the Lougheed government with a basis to galvanize political support within the province and effectively mute political opposition.

With the introduction of the NEP in 1981 and the decline of oil and gas prices throughout the early 1980s, program expenditure increases gradually fell below the rate of inflation. Over the course of the decade, resource revenue flowing into government coffers declined by fifty percent. During the same period, the cost of servicing the debt increased significantly, rising from \$22 million in 1981 to \$880 million (7.3% of provincial expenditures) by 1989/90.

Thus, by the time Don Getty succeeded Lougheed as Premier in 1986, the fiscal and political dynamics had shifted substantially. As a result of a downturn in the oil and gas industry, punctuated by growing deficit spending by the provincial government and mounting debt, Alberta experienced an economic downturn. Provincial expenditures had decreased from **growth of 43 percent** in 1981-82 to 1.9 percent after 1985-86.<sup>9</sup> In addition,

the federal Liberals had been replaced by the Progressive Conservatives who moved almost immediately to end the NEP. The galvanizing effect of the NEP was reduced as a force in Alberta politics.<sup>10</sup>

In the shadow of the province's deteriorating financial position, public sector labour relations became acrimonious. In essence, since 1983, government had been actively seeking to limit wage increases. Although public sector employees in Alberta were legislatively forbidden to strike, Alberta nurses and social workers staged illegal strikes during the late 1980s.

The combination of fiscal and labour issues and a lacklustre performance by Don Getty as Premier resulted in slipping political support in successive elections. Getty, himself, lost his seat in Edmonton and was forced to undergo a by-election in the rural riding of Stettler. Within this larger fiscal and political context, the Government began to consider alternative ways of financing and delivering acute and long-term care services.<sup>11</sup>

In long-term care, the Mirosh Report<sup>12</sup> led to the creation of a standardized assessment system and placement model, including single-point of entry, patient classification system and case-mix funding. A new model for funding acute care hospitals was introduced in 1989:

“The Acute Care Funding Plan...proposed the concepts of efficiency, reallocation of financial resources among hospitals based on performance, and a severity-based funding system. Initially, this plan applied to only thirty-five larger hospitals in Alberta, but in 1993, it was extended to smaller rural hospitals.”<sup>13</sup>

The new acute care funding formula built on the previous work in long-term care.<sup>14</sup>

Community and mental health services were also under review.

While all of this was underway, two major reviews of the overall health system were also taking place. The Advisory Committee on the Utilization of Medical Care

(Watanabe Committee) was established in September 1987 with a mandate to advise the Minister of Hospital and Medical Care on implementing previous recommendations<sup>15</sup> “to reduce or control increases in utilization of medical services.” Three months after the establishment of the committee, the Premier’s Commission on the Future of Health Care for Albertans was announced, chaired by a former prominent Lougheed cabinet minister - Lou Hyndman.<sup>16</sup> The Commission was mandated to conduct an inquiry on future health requirements for Albertans, taking into account such factors as population trends, changing patterns of disease, advances in treatment and prevention, and the delivery and funding of health services and programs. Where the Watanabe Committee relied on expert advice and did not consult the broader public, the Premier’s Commission consulted broadly.<sup>17</sup> Reports from both processes were released in late 1989 (Alberta 1989a, Alberta 1989b). Both reports made recommendations on regionalization in health care. Watanabe recommended regional/local coordination among existing organizations. The Premier’s Commission (Rainbow Report) took a significantly different tack, recommending: the creation of nine autonomous regional health authorities.<sup>18</sup> To paraphrase the Commission, what was being proposed was a “serious redistribution” of “planning and power” away from Alberta Health to local communities, individuals and newly created provincial entities.

The Commission also sounded the warning bell on the implications of increasing expenditures in health care:

“The 1989/90 estimate for Alberta Health is \$2.982 billion. Provincial revenue from personal income tax is estimated to be \$2.326 billion and from corporate income tax, \$0.650 billion, for a total of \$2.976 billion. Thus, if all revenues from personal and corporate tax in Alberta went to health, we would incur a \$6 million deficit. *Every dollar provided by Albertans through taxes, personal and corporate, would not be enough to cover our annual health budget.*”<sup>19</sup>[Commission emphasis]

When the Government's official response was released in November of 1991, the vision was consistent with the directions and recommendations of the Premier's Commission, spelling out a health care system focused on shifting responsibility to communities and individuals, and shifting the emphasis from disease to prevention and population health. However, the Government explicitly rejected the creation of nine autonomous health authorities in favour of a much weaker recommendation for "cooperative planning" at the regional level.<sup>20</sup> With an election pending and a strong reaction against regional health authorities, especially in rural constituencies, the Government backed away from the issue. However, Minister of Health, Betkowski, may have foreshadowed what was to come in June 1992:

"We must take steps now to move toward area-wide, multi-sector networks to plan and/or manage health services in Alberta...I have indicated on many occasions that I am committed to a collaborative approach in arriving at fundamental change in our system. I believe we must now work together to define the appropriate area planning networks for this province. This is quite unlike the approach taken in several other provinces, where governments have either not attempted or already given up on a collaborative approach and have imposed new regional structures...If however, the collaborative approach does not result in fundamental change, government may need to consider other more prescriptive options...At the end of three years, I would expect that there would be significantly fewer separate hospital boards, long term care boards and health unit boards...As a health system, we will need to demonstrate some financial results in 1993/94, and have the elements in place for the initial restructuring of our system in fiscal 1994-95 system."<sup>21</sup>

Betkowski was also busy delivering the fiscal message that became a hall mark of the Government after the 1993 election:

"expenditures since 1981 to the present fiscal have increased by 178 per cent [15 per cent/annum] although population and prices during the same 12 year period increased by 17 per cent and 66 per cent respectively...To meet the historical expenditures of the social sector and balance the budget on the current revenue base, virtually all of the remaining government departments would have to be closed."<sup>22</sup>

In 1992, Betkowski,<sup>23</sup> toured the province with Ministry of Health officials to conduct

strategic planning sessions as a precursor to health reform. As part of this process, steps were taken to establish multi-sector health service planning networks. The “Network Steering Committees were viewed by some as being ‘super-boards’, resulting in a significant reduction in the authority of existing boards.”<sup>24</sup> What became apparent through this process was that the idea of health regions was not popular, especially in rural areas.<sup>25</sup>

The response from the Minister re-emphasized the preference for a cooperative, grass roots approach:

“As I have said on many occasions...there will be flexibility with respect to the model chosen. It is up to the local area networks, comprised of existing boards, whether or not a request for a change of governance comes to me as Minister of Health...I have no concern with the possibility of several models of network planning around the province. My only imperative is that models are proposed, that future groupings of services be truly multi-sectoral in focus, and that they match the objectives of our fiscal plan.”<sup>26</sup>

As the Government moved closer to a provincial election in 1993, substantial focus was placed on a mounting provincial debt of \$ 32 billion that had accumulated during the 1980s, as a result of deficit budgeting, in part, directed towards economic diversification. Getty’s term as Premier had been punctuated by the collapse of a number of major government-supported firms, revenue losses from plunging oil prices. Although the government responded by cutting expenditures and raising taxes, it remained unable to overcome the mounting financial problems. The net result was a loss of confidence in the strong state presence in the market place initiated by Lougheed.<sup>27</sup>

In addition to these internal problems, the provincial Progressive Conservatives faced a significant challenge from the federal Reform Party. With a platform of fiscal austerity and smaller government, and its political base in Alberta, the Reform Party was a threat to move into the provincial political arena, if the Progressive Conservatives did not fill the political vacuum. This set the stage for the emergence of a political agenda of radical expenditure



reduction. Not surprisingly, conservative political strategists perceived that failure to address this issue could have serious electoral consequences.

The emerging political agenda was further solidified with the resignation of Premier Don Getty as the leader of the Conservative party and his subsequent replacement by Ralph Klein in late 1992.<sup>28</sup> Coincidentally, Klein beat out Betkowski, who was considered the front runner going into the race.

The win by Klein signalled a shift in power as the more moderate and affluent wing of the party represented by Betkowski was swept aside by the more radical right-wing constituency. As noted about the Lougheed years and equally applicable here:

Lougheed saw himself and the core of his Cabinet as the bastion of the progressive part of the Party and the Caucus as being the truly conservative stronghold. Since there were more of the latter than the former, in a legislature with (typically) a tiny opposition rump party, managing the caucus and keeping their views and frustrations under control were essential to the politics of budgeting. The caucus was more rural and the cabinet more urban in basic representation.<sup>29</sup>

Given that not much had occurred to alter the nature of Alberta's electoral system, we surmise that Klein's victory signalled a shift from a moderate, urban-based, conservative agenda to a more radical and rural-based right wing agenda. While Lougheed had prided himself on prosperity through greater provincial development and thus bigger government, Klein re-invigorated the Party in the 1990s by promising to once again make Alberta prosperous, by making government smaller.<sup>30</sup> He accomplished this task by forging an alliance between the "conservative populists", concerned with big government, and business, concerned with taxes, royalties and privatization.<sup>31</sup>

Following the shift in party leadership, Government embarked on an extensive public consultation process, dubbed provincial Round Tables. These Round Tables were well

planned exercises, arguably designed to convince Albertans of the new political agenda prior to calling a provincial election. The process itself was a masterpiece in public relations and a tribute to the tradition of limited democracy in Alberta. The first in the series of Roundtables on the provincial budget was held in the Spring of 1993. The object of the exercise was to convince Albertans that there was simply no alternative but to cut costs quickly, or put the security of future generations of Albertans in jeopardy.<sup>32</sup>

As part of its election strategy in 1993 the Government passed the Deficit Elimination Act in the Spring Session of the Legislature. The Act required Government to eliminate the deficit within the next electoral mandate. Armed with this legislation and public confirmation of its political agenda through the Roundtables, Government called a provincial election and won a majority of seats in the provincial legislature.

Following closely on the heels of the election, Government initiated the second series of Roundtables in August-September of 1993; this time on health care. Again, the Roundtables were well crafted exercises in public relations. When Government released its report on the Roundtables on Health Care, the conclusions were consistent with the larger political agenda.<sup>33</sup>

Following the Roundtables was a Report from the Health Planning Secretariat, a Committee appointed by the Premier to develop an implementation plan for health care reform. The Report recommended, based on the Government's interpretation of the Roundtable discussions, creation of a unified administrative and governance structure and integration of health services and institutions.<sup>34</sup>

Having legitimized the political agenda, with an electoral mandate to cut costs and a more specific mandate for health care reforms, Government announced its Three Year

Business Plan for the Ministry of Health. This disclosed expenditure reductions of \$740 million, from \$4.2 billion in 1992-1993 to \$ 3.4 billion in 1996-1997. The major thrust of this reduction in expenditures was directed at the acute care sector, where hospital beds were targeted for reduction from 4.5 beds/1000 to 2.4 beds/1000. At this time, bed utilization was particularly high. For instance, Edmonton had 1089 bed-days/1000 at a time when some other provinces operated in the range of 550-650 bed-days/1000.

Once fiscal targets were established at the provincial level, Government introduced Bill C-20 for the disestablishment of close to 200 local hospital, and public health boards and the creation of 17 regional health authorities (RHAs) and two provincial health authorities, each with appointed boards of governance and management infrastructures. The resulting legislation, the Regional Health Authorities Act<sup>35</sup>, created RHAs responsible for the planning and delivery of a wide range of health services, within consolidated regional global budgets. This involved both the divestiture of programs and services previously planned or provided directly by the Province, such as home care and communicable disease control, and consolidation of existing acute care, home care, continuing care, and public health services under the new organizational structures. Eventually mental health would be phased into the responsibility of RHAs, while the Provincial Cancer Board would remain separate. Notable for their exclusion from the regional umbrella of service delivery responsibilities were: ambulance services, which continued to be the responsibility of municipalities; physicians' services, which continued to be delivered by physicians, operating as independent fee-for-service contractors negotiating with the Province; and, services provided by non-hospital pharmacists.

The initial members for the regional health authority boards were appointed by the

Minister of Health for a period up to July 1996, at which time a second wave of appointments would proceed. In addition to governance by RHAs at the regional level, the enacting legislation also allowed for the creation of community health councils (CHCs) to act in an advisory capacity to RHAs.

### **The Role of Ideas**

The Government choice to introduce health regions was underpinned by existing and emerging policy paradigms. The first paradigm was a “residual” view of the state.<sup>36</sup> In this view, personal responsibility and self-reliance were desirable human attributes. Individuals were first and foremost responsible for their own well-being, in good times and bad. Where individuals were not able to take care of themselves, responsibility fell to other family members. Failing this, the local community became responsible for the well-being of the individual. Only as a last resort was the state seen as an avenue for relief and then only on a short-term basis. The private market was seen as the preferred means of addressing social policy issues.<sup>37</sup>

Running in tandem with the emphasis on personal responsibility was the New Public Management<sup>38</sup> messaging emphasizing minimal or smaller government focused on “steering” rather than “rowing”.<sup>39</sup> In the case of health care regionalization, the Rainbow Report called for a redistribution of power away from the Department of Health and toward local communities:

“The Commission has promoted and recommended greater personal responsibility and accountability for managing our health and health resources, and those of our families. We believe this concept should be extended to our communities and facilities of care. Our philosophy is that we need to return power to choose and decide closer to Albertans and to communities...There must be coordinated and integrated programs and services, locally planned and directed, reflecting the needs and priorities of individuals and their communities.”<sup>40</sup>

As for the role of government in health care, the Commission recommended that:

The provincial government should concentrate its efforts on setting long-term goals; developing priorities and policies; establishing overall standards; ensuring interregional coordination and communication; and allocating funds on a global basis. Looking at the future isn't easy when you're caught in the day-to-day administration and determination of routine programs; neither is being responsive and relevant to local needs when you're removed and remote from the action."<sup>41</sup>

The view of the Commission on the appropriate role of government in health care reflected a broader concern about enhancing expenditure accountability to avoid slipping into a pattern of simply throwing money back into the system.

Alberta Health had been working on developing an accountability framework and measures during the late 1980s. In 1989, the Department of Health (as it was then called) developed an internal discussion paper "to provide a common basis of understanding to facilitate a discussion of 'accountability' and 'accountability mechanisms' among a variety of players within the Department of Health."<sup>42</sup>

In a similar fashion to the thinking of the Commission, Alberta Health saw accountability as involving "stewardship in which all actors in the service system are charged with husbanding and developing resources that belong to someone else...and includes the documentation of where those resources have gone, and that they have been spent wisely and effectively to enhance the quality of service delivery."<sup>43</sup> Stewardship was also seen as involving making "investment" choices that would be informed by "accountability mechanisms such as program evaluation, audit and monitoring."<sup>44</sup>

Finally, accountability involved being responsive to a changing environment. Some of this preliminary internal thinking was shared with other jurisdictions through the Minister's speech at the F/P/T Conference of Health Ministers in September 1989.<sup>45</sup>

By 1991, the way to achieve accountability included:

“planning for health services based on identified needs, goals and outcomes; enhancing health information that will assist in monitoring and evaluating the health system; increasing provider responsibility and accountability in managing resources; and facilitating consumer choice and responsibility in health resource utilization.”<sup>46</sup>

In 1992, Alberta Health was contemplating defining accountability relationships among health providers, the Department and Government and drew heavily on the earlier concepts of accountability mechanisms and measurement.<sup>47,48</sup> As an idea in good currency, accountability was politically attractive to and aligned with the conservative philosophy that people, if given an amount of money, should be responsible and accountable for what happens to it.

Thus, the arrival of business planning and annual performance indicators (1993-94), as part of the reform process,<sup>49</sup> was a natural progression in the Ministry’s thinking that dovetailed with the political agenda of the day. These two mechanisms would form the basis of the accountability relationship between the Ministry and the RHAs. The passage of the Government Accountability Act and subsequent increasing interest in accountability by the Auditor General confirmed the direction in which the Department had been heading for some time.<sup>50</sup>

The Government Accountability Act mandated the development of standardized accountability structures and processes throughout government. Building on many of the ideas on accountability that had shaped the thinking of Alberta Health, The Act required the Finance Minister to develop an annual consolidated fiscal plan, including a government business plan and to provide quarterly reports. In addition, the Minister was required to prepare a consolidated annual report. In a similar fashion, individual ministries were required to develop business plans, annual reports for approval by the

provincial Treasury Board.<sup>51</sup>

As a policy idea in health care regionalization had a long history.<sup>52</sup> Within the Alberta context, regionalization as an approach to health reform was not the creation of the Klein Government. A general sense of the need for health reform had been a central topic in federal-provincial policy circles for at least a decade. By the late 1980s, there was a concurrence across provinces through the political leadership and a commitment to a nation-wide or pan-Canadian agenda. Regionalization was the first significant coordinated pan-Canadian reform.<sup>53</sup>

## **The Role of Interests**

### Alberta Health

As part of thinking about accountability, Alberta Health developed a mission statement “to promote, maintain and improve the health of Albertans by providing strategic direction in the management of resources, to ensure appropriate, accessible and affordable health services in the province.” Six strategic directions were identified: accountability; access to health services continuum; health promotion and disease/injury prevention; fiscal resource management; human resource management; and health system organization.

The ministry saw accountability (Strategic Direction I) as “fundamental for the provision of a health system which is appropriate and affordable. Key to achieving this was increasing provider responsibility and accountability in managing resources.”<sup>54</sup> About health system organization (Strategic Direction VI), the ministry saw the need to develop a health system that was responsive to the needs of Albertans through: “greater coordination of health services; increased rationalization of health services; moving towards area wide planning; encouraging partnerships and collaborative networks among providers, clients and

community groups; and supporting innovative pilot projects in delivering health services.”<sup>55</sup>

Central to realizing the Strategic Directions was the development of clear role statements. To this end, Alberta Health undertook a stakeholder consultation process with health provider organizations in 1992. The process expanded on consultations already underway in the acute and long term care sectors resulting from the Acute Care Funding Plan and the Mirosh Report. The timetable for the development of role statements was designed to conclude in June of 1993, with initial restructuring and budgetary adjustments occurring during 1994/95.<sup>56</sup>

The well—ordered policy development process characteristic of the role statement process serves as a stark contrast to the rather frenetic pace of the early days of the Klein Era. When it came to developing the legislative framework for regionalization, the department operated largely on-the-fly through a loosely coordinated departmental process. Over a nine month period, staff took several pieces of legislation and cut and paste the new legislation together while trying to second guess what the final vision would be.

### Politicians

As previously mentioned, the shift in leadership from Don Getty to Ralph Klein precipitated, in a variety of ways, a shift in policy style. Getty had created a capital fund to build hospitals and schools that led to a plethora of funding requests. By 1990, there was \$2.5 billion worth of hospital construction projects underway, without a clear sense of how operating costs could be sustained. Related to this was the development of full services hospitals in areas with lower population density.

Where the Getty Government had relied more heavily on department officials to



lead in policy development, Klein set the tone for a new policy style when addressing the Provincial Legislature in reaction to what he saw as overzealous officials in the Ministry of Health:

“officials in the Health Department do not set the policy for this government. The Cabinet, the Executive Council, of this government sets the policy, and it is not the job, but the responsibility of the department to carry out this policy.”<sup>57</sup>

At the time, there was an overriding sense among Conservative MLAs that “knowledge workers” had become too powerful and needed to be reined in by politicians, who, after all, had been elected to make decisions on behalf of the public.<sup>58</sup>

The new policy style was reinforced through several institutional changes. The business planning model required ministries to identify and respond to annual performance measures, embedded in business plans. Government MLAs, including backbenchers, took on a more pronounced role in the development of policy. A series of 12 MLA-led committees, such as the Health Planning Secretariat, were established to develop various key aspects of the health reform agenda. In essence, policy advice that normally would have flowed through department-led committees now flowed through committees led by government MLAs. Between this and the tendency of the premier to duck questions in the legislature, the net, if not the reality, was a perception that policy was being formulated and approved by Government Caucus and Cabinet outside of the Legislative Assembly. On the issue of health care regionalization, the initially large number of regions was the result of continuing nervousness on the part of government MLAs, especially in rural constituencies.<sup>64</sup>

Finally, the communications apparatus of government was centralized by making all senior department communications staff directly accountable to a central agency, the

Public Affairs Bureau, which itself reports directly to the Premier's Office. Although originally created in 1973 to provide non-partisan information to the public, in recent years it has evolved into a well-honed propaganda machine.<sup>65</sup> Being a former news reporter, the Premier demonstrated a mastery of the medium through this government apparatus.<sup>66</sup> Thus, the ability of ministry officials to control key messaging around major policy initiatives was superseded by the Premier's Office.

Klein's role as an effective communicator cannot be underestimated. Through a series of folksy fireside television chats, he was able to win the trust of Albertans while conveying the fiscal reform agenda in straightforward terms. Underlying this simplistic messaging was a consensus from MLAs and Ministers that sharing the pain through across-the-board cuts and moving fast and hard was more likely to succeed than targeted reductions.<sup>67</sup>

As a strategy for moving the health reform agenda forward within the larger context of fiscal reform, Klein picked up on the messaging that had started with the Rainbow Report and then Betkowski about sustainability and decline of revenues. By moving from a soft sell to a hard sell with a particular emphasis on the larger fiscal agenda, Klein was able to mobilize consensus on the need to do something to address the deficit and debt issues and to address sustainability in health care. The fiscal reform agenda became the "glue" that bound Government Caucus together.<sup>68</sup>

From this agenda and from the earlier discussions within health, consensus around the need for integration, coordination and better management within the health care sector emerged. Cost savings and elimination of duplication were tied by Klein to regionalization as a solution in health care. This idea appealed to a number of consumer

groups who were dissatisfied with the current system. Even hospital boards began to realize that having two hospitals ten miles apart delivering the same services, or having a service running when it wasn't being fully utilized didn't make sense. Also, less utilized services meant that the capacity of health professionals could not be maintained. The College of Physicians became concerned about this quality of care issue.

### Local Communities

Prior to regionalization, a major element of the governance arrangements in health care involved very strong linkages between local municipalities and local hospital boards. The vast majority of them in the province had representation from their municipal councils. Regionalization threatened to break that linkage because the new boards were being called on to deal with health service delivery for a more regional population-based approach as opposed to a community specific approach. Thus, both the structural linkage and the conceptual linkage was broken. The municipalities were not happy, this was a very significant part of the public sector that they all of a sudden had much less influence over than they had in the past. In rural areas in particular, the economic viability of communities was at risk. By extension, regionalization in health was viewed as the thin edge of the wedge of a broader agenda to amalgamate municipalities. In addition to these concerns over control and the impact on the local economy there was also a fear of municipal regional amalgamation. The government had regionalized social services during the 1980s and was now regionalizing health services. Would municipalities be the next sector to undergo regionalization? What likely stopped the government from doing anything about municipalities was the strong tradition of local autonomy and the

importance of municipalities to provincial political parties.<sup>1</sup>

### **Regionalization as a Policy Idea**

After studying reforms in other provinces (Ontario, Quebec, Nova Scotia and Saskatchewan) and internationally, particularly Australia,

“the idea of dividing Alberta into regions which would function as autonomous administrative areas appealed to the [Rainbow] Commission given the vastness of Alberta, the differing needs, and the number of facilities and programs already in place. This would allow the regions to respond more appropriately to changes at the local level, and to design the mix of services, treatments and providers to suit their particular constituents.”<sup>69</sup>

To this end, The Commission recommended the creation of nine administrative, regional “health authorities.”<sup>70</sup>

Although the Government response in late 1991 to the Commission did not agree with the creation of autonomous health regions, by late 1993 the Health Planning Secretariat was recommending creation of a minimal number of regional health structures for local decision-making, based on the public roundtable consultations.<sup>71</sup>

Regionalization as a concept was endorsed by the Health Planning Secretariat because it:

- “encourages local accountability for providing affordable health service;
- recognizes that health needs vary from region to region, and gives providers and consumers the freedom and flexibility to customize service delivery to meet those needs;
- streamlines the health system by eliminating nearly 200 boards;

---

<sup>1</sup> P54; A good discussion of this issue as it applies to Edmonton and surrounding municipalities see, E. C. LeSage Jr. and L. Stefanick, “New Regionalist Metropolitan Action: The Case of the Alberta Capital Region Alliance,” paper presented at the Canadian Political Science Association meetings, Winnipeg, June 2004.

- provides potential economies of scale;
- encourages institutional and professional cooperation within and between regions; and
- encourages innovation within and between regions.”<sup>72</sup>

For Alberta Health, the evolution of thinking around regionalization had been a gradual process. Prior to the merger of health and community services into a single department in 1988, regionalization had been viewed through the lens of regionalizing the acute care sector. Once, the two departments merged in 1998 and the role statement process unfolded, the new Ministry began to see the logic of regionalization as a means to get away from stove-piping in service delivery and funding both within the department and at the local level.

However, as a policy idea emanating from the public service, regionalization was a political non-starter until it became tied to the larger fiscal reform agenda. Where the political executive and the bureaucracy were in agreement was around ending the culture of numerous individual requests for resources being channeled through individual MLAs, making prioritizing difficult. Fewer stakeholders would make it easier to politically and administratively manage the system, leading to a better continuum of care.

As Mayor of Calgary, Klein had interacted on a regular basis with the hospital and health unit boards. From his perspective, regionalization offered a way to reduce the number of local health empires. In a more general sense, this reflected the view of other members of Caucus. The strategic publication of the salaries of existing CEOs as regionalization was being unveiled served to undermine potential resistance from local hospital boards by reinforcing the message that these local empires were very costly.

As for the political view on the provincial bureaucracy, there was a general sense that there were too many provincial public servants wasting too many resources, and that fewer of them would save money. This cost saving argument fit well with the discussion of devolving authority to communities underpinning regionalization as a solution.

### **Regionalization as a Policy Choice**

The choice to develop health regions through the creation of a new legislative framework was necessary to facilitate the implementation of change, especially once the political momentum for change began to build. Based on the experience in New Brunswick, where only hospital services were regionalized, the Alberta Government opted to draft comprehensive legislation to allow for an integrated and coordinated continuum of care. The RHA Act included describing the responsibilities and powers of the authorities, establishment of community health councils, creation of regional health plans, and the powers of the Minister of Health, including the authority to “dismiss the authority and the council.”

Once the decision had been made to proceed with health care regionalization, the Health Planning Secretariat in conjunction with the Ministry of Health established criteria to determine where regional boundaries would be drawn. These criteria included: a limited number of regions (although not specified); a minimum population base of 35,000; boundaries based on trade and travel patterns; and capacity to provide a continuum of care.<sup>73</sup>

The Ministry wanted fewer regions to meet the objective of better integration, coordination and management. However, once the politics took over, the notion of nine regions put forward in the Rainbow Report became initially 15 and ultimately 17.<sup>74</sup> The

strategy was to get regional structures in place as quickly as possible, allow communities to grieve the loss of hospital boards and to revisit the number of health regions as the system evolved.

On the issue of governance, significant discussion occurred about whether or not RHA boards should be elected or appointed. Discussion at the Health Roundtables about elected boards, including health providers, was reflected in the recommendation of the Health Plan Coordination Project for RHA boards with some members to be locally elected during the 1995 municipal elections.<sup>75</sup> In addition, appointed Community Health Councils were suggested as a mechanism for local input.<sup>76</sup> For the same conflict of interest rationale that barred teachers from being school board members, physicians and other health providers were not considered for RHA board membership.

Initially boards were completely appointed by the Minister of Health for a two year period. The rationale for delaying the election of board members was three-fold. First, the Government needed individuals on the boards who could be trusted to move forward without question on implementing the new structures. After being appointed, RHA boards had about six months to develop business plans to get the regions up and running. Second, anyone elected during the initial implementation phase would not likely be re-elected because of the level of turmoil caused by the combination of funding cutbacks and the creation of regions. Third, elections did not necessarily produce the most qualified individuals to do the job. Some highly qualified individuals would not even consider being a board member, if they had to endure a local electoral process.

Subsequent to the initial recommendation of the Health Plan Coordination Project, a task force recommended that direct election of RHA members not be pursued.

Instead, appointments were to be made by the Minister from lists developed through community health councils and municipalities.<sup>77</sup>

The other major governance issue related to how local physicians would be have input into RHA decision making. Regionalization of the health system had eliminated the existing local physician governance structures involving decisions about hospital privileges. Without these structures in place, local physicians felt left out of the decision-making loop. During the transition period and for some time afterwards, many GPs were left without any hospital privileges, the major means at that time of connecting physicians into local health systems. Thus, new regional medical structures needed to be created to connect individual physicians to the new regional systems.

The range of services for which the new health regions were given responsibility was also bounded by a number of political considerations. Although from the point of view of effectively managing the system, having physician services included in regional budgets made sense, organized medicine expressed a preference in retaining a direct relationship with the provincial government on matters relating to remuneration.

Alberta Health recommended that mental health services be excluded initially from RHA budgets because at the time resources were so unevenly distributed across the province that there was no easy short-term solution to including them in health regions. At the time, the mental health community feared that they would take a back seat to other services provided through regional structures.<sup>78</sup>

Ambulance services were funded through municipal budgets and in most cases contracted out to local private or public providers (sometimes fire fighters). Moving ambulance services into regional health authorities would have been met by strong local



opposition and would have resulted in shifting costs from municipalities to health regions.<sup>79</sup>

Again, Alberta Health recommended that cancer services be excluded from RHA responsibilities because they were viewed as a truly province-wide service. Economies of scale could best be realized through the maintenance of existing infrastructure concentrated in Calgary, Pinoka and Edmonton .

### **Conclusion/Discussion**

During the mid to late 1980s, The Government of Alberta had been grappling with the issues of cost control and sustainability within the larger context of declining government revenues and increasing deficits and debts. While regionalization as an option was identified in health care, significant political resistance to change, especially from rural constituencies and organized medicine made proceeding with plans to create comprehensive regional governance and delivery structures politically risky. The political decision was to move forward gradually through a process of consensus-building and locally-driven change. With the change in political leadership in late 1992, the policy style shifted significantly. The political executive under the leadership of Ralph Klein chose to move forcefully on the government-wide issues of deficit and debt reduction. Thus, the pace of policy change moved from incremental to rapid. To overcome the