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The Politics of Hospital Financing in Alberta: 1971-1978

by

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Abstract

This thesis examines the trend of hospital policy in Alberta between 1970 and 1978. It examines the environment of hospital policy in the context of Max Weber's concept of rationalization. Weber is concerned about the direction of modern society; a society in which he argues that the process of seeking particular goals as efficiently as possible leads to a situation in which values and ideals are subordinated to a concern with the means of policy.

In this thesis we find that recent events in Alberta were characterized by the concern of actors about the effectiveness of policy instruments and the impact of such instruments on the power of other actors and on the public. The resulting debate was shaped by two guiding principles. One principle was that government should assume responsibility for providing universally accessible health care: this principle was inspired primarily by the federal Hospital Insurance initiative of 1957. A second basic principle was that government, as the "trustee" of the public's tax money, must ensure the efficient and productive allocation of that money. Hence, the government undertook to stem the growth of expenditures on the hospital care field.

The government's restraint policies generated intense political conflict. For the government's desire to restrain spending conflicted with wage demands of hospital employees and hospital board demands for increased funding. These actors were able to constrain government actions by

affecting the public's accessibility to hospital services through strikes and funding reallocations within hospitals.

Following an examination of these events in chapters three and four, the thesis addresses a number of broader issues about the provision of health care in contemporary Alberta.

Table of Contents

I. Purpose, Focus, and Concepts

Introduction

Any contemporary examination of health care policy in Canada cannot ignore two basic facts: the extensive role of governments in providing health and hospital care services, and governments' recent efforts to control the growth of public expenditures on these services.

The analytical focus in this thesis is public policy. Public policy is the process of making decisions and choosing among alternatives. It is the process of developing initiatives which are derived from values and beliefs articulated in the political arena. In the world of politics, mutually recognized actors seek to realize their value preferences. This process includes the participation of such actors as politicians, bureaucrats, associations, political parties, and the media.

This thesis examines hospital policy issues in Alberta during the 1970s. It focuses on the increasing centralization of power in the hospital funding area, and probes the implications of various provincial government initiatives for the relationship between local and provincial authorities.

This case study of hospital policy in Alberta has been chosen for a number of reasons. First, the provision of hospital services is an important governmental activity both through the regulatory process and administration of initiatives, and through the funding of hospital services.

Such state involvement has expanded considerably over the last half century, and particularly during the last twenty years. A second reason for studying hospital policy is our interest in examining the growing centralization of decision making power in a major area of the social welfare network. This trend effectively removed independent sources of funding for local hospital boards in Alberta. An important point to be remembered, however, is that the various initiatives of the government have not been accompanied by the elimination of the network of hospital boards in the province, even though the boards no longer collect funds. Local hospital boards remain important actors in the policy process, capable of sometimes resisting and thwarting provincial initiatives designed to control and restrain expenditures on hospital services.

Thirdly, the traditional existence of multiple centres of authority in the hospital policy arena leads to often intense conflicts among the provincial government, hospital boards, unions, and municipal governments over jurisdictional priorities. Conflicts over priorities are, of course, the stuff of politics, and therefore an appropriate subject of study. Each of the reasons described serve as considerations for studying hospital policy in Alberta.

The study of public policy should include a consideration of at least the following three dimensions: the goals of government policy makers; the means of achieving these goals; and the relative role and power of

different actors and institutions. There are two very different ways to tackle the subject of hospital policy making in Alberta. One approach would be to examine the structural changes in the administration of policy programs. Such an approach would, for example, focus on the functioning of bureaucratic mechanisms designed to fund and monitor developments in the hospital sector. This approach might also be prescriptive insofar as it would attempt to describe and assess the effectiveness of the structural changes in delivering hospital services.

Another approach would be to examine different actors' conceptions of the role and scope of government involvement in the hospital care area. This approach would, of course, require extensive interviewing and opinion surveys. A common characteristic of both approaches is that they look at the "public face" of politics: that is, the tangible outcomes of decision making and the public expression of the meaning of the actions taken.

In the context of the present study we shall examine various administrative changes, and at the same time examine the way initiatives were interpreted publicly by actors. It is not, however, within the scope of our work to explore the intricacies of political gamesmanship -- the details of bargaining and consultation. The study of these aspects must not be undermined or considered valueless. Given sufficient access to data, an exhaustive study in the spirit of Richard Simeon's *Federal-Provincial Diplomacy* would be a welcome

contribution to our knowledge of "provincial-local diplomacy". The current study concentrates, however, on the publicly expressed principles of policy and their impact on political debate and controversy; the study also analyzes the character of public policy.

Principles of Policy

Principles might be said to define commonly held ideas expressed in terms of symbols, roles, and means of communication. Richard Simeon, for one, has addressed himself to this issue:

> Among these (guiding principles) are the participants own widely shared norms and beliefs, the perceived attitude of the wider publics about what is permissible and what is not, political resources, some dynamic characterstics of the process itself, and the individual personal qualities of the decision-makers.[1]

Accepted principles serve as constraints on the range of action available to government, as well as resources for other actors in their attempts to realize their own goals.

This chapter argues that guiding principles are important elements of the policy making process since they shape the parameters of discussion and choices. In addition, we find that governments invoke the "guiding principles" as a means of rallying support in the form of consensus when structuring the policy agenda. Significantly, however, this attempt at fostering a consensus about the role of government in hospital policy has eluded policy makers.

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[1]Richard Simeon, *Federal-Provincial Diplomacy: The Making of Recent Policy in Canada* (Toronto: University of Toronto Press, 1972), p. 228.

In the field of hospital policy in Alberta, two guiding principles can be inferred from several policy initiatives at both the federal and provincial levels of government. The first principle is a commitment to a role for government in providing health and hospital care services on the basis of universal accessibility. A second guiding principle is government's identified role as the "trustee" of the taxpayer's money. As such, the state is obliged to act to ensure a balanced distribution of the public's finances. Political controversy in Alberta during the 1970s reflected the problem of reconciling the principle of "universality" with the principle of "trusteeship".

In light of this concept, it is not surprising that the government should be less than enthusiastic about spending increasingly large amounts of money for a sector of society which does not yield visible economic dividends. Indeed, this might account for restraint initiatives even during a period of an unprecedented expansion of the provincial economy. Thus, government initiatives and activity in the field of hospital policy reflected an attempt to reduce expectations about the level of support to be received from the government.

Rationalization and Politics

At this juncture we shall discuss some salient aspects of the policy-making environment in greater depth in order to gain a clearer understanding of the context in which the guiding principles have shaped public policy in Alberta.

Weber's perspective is especially relevant because the central characteristic of contemporary health care policy is the expanding role of the state in providing social services generally. At the beginning of this chapter we indicated that the making of public policy is closely bound up with the articulation of political values. Public policy is the means for attaining goals proscribed by those values and is, therefore, concerned with developing techniques in the form of administrative structures.

The relationship between goals and means, so much a part of public policy, was of interest to the political sociologist, Max Weber. Weber argued that the articulation of political values in modern society was becoming increasingly overshadowed by a pre-occupation with instruments and techniques. According to Weber, this was a consequence of the development of what he called "rationalization", a state of affairs of social organization in which "all social activity is regulated according to rationally established laws and regulations, and where a logic of pure instrumentality and calculation increasingly prevails."[2]

Dennis Wrong, a student of Weber's thought, has defined the process of rationalization this way:

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[2] Jeffrey Prager, "Moral Integration and Political Inclusion: A Comparison of Durkheim's and Weber's Theories of Democracy," in *Social Forces* (June 1981):926.

> The process by which explicit, abstract, intellectually calculable rules are increasingly substituted for sentiment, tradition, and rule of thumb in all spheres of activity.[3]

In other words, the realm of social and organizational activity is guided by an array of rules and procedures which enhance the ability to coordinate and calculate activity so that it "runs smoothly."

Social relationships become identified in terms of specified roles and functions based on abstract, impersonal ties. As social activity becomes the instrument for accomplishing specific tasks, it becomes directed to "the methodical attainment of a definitely given and practical end by the use of an increasingly precise calculation of adequate means."[4]

Weber was particularly concerned that the process of rationalization would lead to a situation where concern with values would become subordinate to concern about the instruments which are supposed to serve those values:

> (He felt that) the techniques and social structures created by(...)man's irrationality(...)become self-maintaining procedures, no longer dependent on the rationality that created them, but actually stunting(...)the rational capacity.[5]

The process of rationalization has been an integral part of the modernization process of western society. According to Jurgen Habermas, it arose from the demands for

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[3] Dennis Wrong, "Introduction", in *Max Weber*, ed. Dennis Wrong, (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1970), p. 26.

[4] Jurgen Habermas, *Toward a Rational Society: Student Protest, Science, and Politics*, translated by Jeremy Shapiro (Boston: Beacon Press, 1971), p. 64.

[5] Wrong, p. 27.

legal expertise in overseeing the national economy.[6] In Weber's view, rationalization has also been fostered by the expansion of science and technology which has displaced religion as the source of intellectual authority.[7]

Of special significance to Weber was the growth of bureaucracy as a manifestion of rationalization in an increasingly complex society:

> The more complicated and specialized modern culture becomes, the more its external supporting apparatus demands the personally detached and strictly objective expert.[8]

Bureaucracy requires fixed jurisdictional areas, a heirarchy of expert functionaries, and regular fulfillment of duties, all directed toward the efficient accomplishment of assigned tasks.[9]

The rationalized, bureaucratic state is also essentially promoted by democratic values of "equality before the law."[10]

> The growth of the bureaucratic state proceeds in close connection with the advance of political democratization because the demands made by democrats(...) for equality before the law necessitates complex administrative and juridical

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[6] Habermas, p.64.
[7] Wrong, p. 26.
[8] H. H. Gerth and C. Wright Mills, ed., *From Max Weber: Essays in Sociology*(New York: Oxford University Press, 1967), p.196.
[9] Ibid., p. 216.
[10] "The position of all 'democratic' currents in the sense of currents that would minimize 'authority' is necessarily ambiguous. 'Equality before the law' and the demand for legal guarantees against arbitrariness demand a formal and rational 'objectivity' of administration, as opposed to the personally free discretion flowing from the 'grace' of the old patrimonial domination." See H. H. Gerth and C. Wright Mills, p.220.

provisions to prevent the exercise of privilege.[11]

The creation of these provisions in the context of being "fair" requires mechanisms which seek to minimize privilege and distribute benefits according to some objective criteria:

> ...the abstract regularity of the execution of authority...is a result of the demand for 'equality before the law' in the personal and functional sense -- hence, of the horror of 'privilege' and the principled rejection of doing business 'from case to case'.[12]

Obviously, the mechanism for regularizing the execution of authority, or rationalization, is facilitated by a reliance on such criteria as objective data, comparative statistics, ratios, and other empirical measurements. The regularization of the allocation of resources among various priorities may be most effectively handled at the level of the state; at that level the establishment of regularized procedures enhances the predictive basis for allocating resources throughout society.

Rationalization and Charismatic Authority

Weber argued that the political arena could become increasingly dehumanized without the countervailing influence of values and idealism:

> Weber's intent was to characterize the modern social and political order as one in which belief in transcendent values and their embodiment in individuals and institutions was being driven into a more and more restricted domain, as a result of the

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[11] Anthony Giddens, *Capitalism and Modern Social Theory* (Cambridge: Cambridge University Press, 1971), p. 180.
[12] Gerth and Mills, p. 224.

process of rationalization and bureaucratization.[13]

Another student of Weber's ideas, Richard Bendix, describes the problem of rationalization this way:

> (...)the more bureaucracy depersonalizes itself(...) the more completely it succeeds in achieving the exclusion of love, hatred, and even purely personal, especially rational and incalculable feeling from the execution of official tasks. In the place of the old type ruler who is moved by sympathy, favor, grace, and gratitude, modern culture requires for its sustaining external apparatus the emotionally detached, and hence rigorously "professional expert."[14]

The articulation of charismatic authority, according to Weber, is described this way:

> (...)a certain quality of any induvidual personality by virtue of which he is set apart from ordinary men(...), or at least (possesses) specifically exceptional powers or qualities.[15]

In Weber's view, charismatic authority could be useful as a challenge to the mechanical character of bureaucracy and could help to restore debate and discussion about values and goals in addition to instruments.[16]

Given our interest in understanding the role of rationalization in the political and policy-making spheres, we shall seek to determine the extent to which hospital care issues in Alberta reflected the process of rationalization.

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[13] Edward Shils quoted in Wrong, "Introduction", p. 45.
[14] Richard Bendix, *Max Weber* (Garden City, New York: Doubleday Anchor Books, 1962), p. 427.
[15] Richard Bendix, "Reflections on Charismatic Leadership", in Wrong, p. 169.
[16] Some critics of Weber contend that charismatic authority may indeed be used to *preserve* an existing order. What is valuable in the context of our discussion is the possibility for charismatic leadership to "shake up" the rationalized order. See Wrong, "Introduction", p.43.

Format

The second chapter of this thesis provides an historical perspective to the events of the last decade. We shall examine some major policy initiatives prior to 1970; initiatives which established the basis for recent changes in Alberta. Specifically, we shall examine the initiatives arising from both the federal and provincial governments which really precipitated the drift towards centralization.

The third chapter focuses on the events of the period between 1970 and 1974. In particular, we shall consider the administrative changes which accompanied political concerns about growing expenditures on hospital care, and which provided the foundation for later controversies. Specifically, we shall look at three initiatives designed to foster restraint through changes in administrative structure -- Global Budgeting, the Hospital Services Commission, and Last Dollar Financing.

The fourth chapter examines the 1975 to 1978 period, wh trend toward centralization continued unabated. We shall pay close attention to the impact of hospital policy events as they related to local autonomy for hospital boards and the growing politicization at the provincial level of what had once been "local issues". By the middle of the 1970s, politicization began to concentrate on the consequences of government measures for specific communities and institutions in Alberta.

Our concluding chapter makes some general observations about the implications of bureaucratization for democratic politics: we shall assess the impact of rationalization on the character of hospital policy during thhe 1970s in Alberta. It will be argued that the developments in the hospital policy area reflect how modern politics have become devoid of explicit ideological content and have become very concerned with the *means* of achieving a particular social goal. Thus, we might ask the following sorts of questions. What are budgeting techniques? What does it mean to be concerned with prudent spending? What is important about local autonomy? Clearly, these are means of attaining something else. By basing politics on means of policy, the end, the "something else" becomes obscured.

The concluding chapter also considers the equally important question of government's ability to successfully impose expenditure restraint measures. Does the existence of such groups as hospital boards and unions, and the subsequent conflict over priorities render restraint untenable? Notably, the provincial government has only recently proposed to return to local hospital boards a limited degree of power to requisition funds from municipalities. Does this, therefore, seem to fly in the face of government's insistence on controlling the growth of public expenditure?

A final observation in the concluding chapter will deal with the issue of frames of reference in politics with

regard to hospital and health care in general. For example, does the focus on means make difficult the articulation of innovative approaches for conceiving of health care issues and delivery methods?

The thesis employs a range of resource materials including newspaper and magazine accounts of events in the field of hospital policy. Considerable use is made of the *Alberta Hansard* since its inception in 1972. Other sources of information include reports of the Alberta Hospitals Association and of provincial Departments of Municipal Affairs and Hospitals and Medical Care. Other sources consulted were the Public Accounts of the Province of Alberta, and several theses dealing with various aspects of hospital policy. To supplement such secondary sources, a number of individuals directly involved in the policy process were interviewed.

II. Hospital Policy in Alberta before 1970

This chapter describes the historical development of government involvement in the provision of hospital services in Alberta prior to the 1970s. It also establishes the background for the major events of the 1970s. We shall examine the historical antecedents of hospital policy prior to 1970 as they reflected the commitment to the principle of universal access and the accompanying trend towards centralization of decision making at the provincial level.

Local Autonomy and Hospitals

The Social Credit party had governed the province during and after the Great Depression, and was responsible for the initiation of measures to extend health care services, especially following the Second World War. Prior to the Second World War, the power to allocate resources for local hospital services rested almost wholly with municipalities and hospital district boards. The hospital boards had existed since the early 1900s. In the rural areas of the province, district boards normally comprised either popularly elected or municipally appointed members; in urban areas, they were appointed by the municipality. The operations of hospitals were funded through local taxation collected by the boards themselves, and through patient fees. Although rural district boards may have been responsible for more than one facility, the municipal boards

were responsible for only one.[1] Indeed, hospital districts have only recently been designated in Calgary and Edmonton.[2]

Until the late 1930s, hospital boards acted as independent revenue collecting authorities, and were able to requisition funds for hospitals directly from local residents. Provincial legislation subsequently removed this power from district boards in the late 1930s, and transferred all local revenue collection authority to the municipality. Despite this initial reduction of local autonomy, hospital boards were still permitted to requisition the municipal government.[3]

This measure of localized control over hospitals during this early period was largely a function of social and demographic constraints in Alberta. Decentralized control of social welfare services in general had been an integral part of a society characterized by limited transportation, and a sparse population. These characteristics made it virtually

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[1] Interview with Chuck McDougall, Edmonton, Department of Hospitals and Medical Care, 17 August 1979.

[2] There is a general hospital district in Calgary which is responsible for the Rockyview and Holy Cross hospitals. In Edmonton, there is a general hospital district though it has not yet gained responsibility for any facilities. Both cities have auxiliary hospital districts. Interview with Lou Protti, formerly of Department of Hospitals and Medical Care, Edmonton, 7 September 1979.

[3] Other hospitals, such as privately owned or urban hospitals were financed differently and were not eligible for requisitioning. Hospitals managed privately were usually the responsibility of organizations like the Grey Nuns; their financing was for the most part done through fund raising. The city-owned hospitals, of course, were financed through local property taxes. Interview with Murray Ross, former Executive Director of the Alberta Hospitals Association, Edmonton, 4 July 1979.

essential that every community have a hospital facility in close proximity to local residents -- in urban areas as well as the rural communities.[4]

The allocation of power to local district boards was also recognized in legislation. A prime example is the *Alberta Hospitals Act* (c. 174, R.S.A. 1970).[5] According to that legislation hospital boards were granted a wide measure of authority and were permitted to do the following:

1. "Acquire hold, and alienate real property." (sec. 8 (2)(a))
2. Borrow money. (2)(b)
3. "To levy upon the included municipalities for the required portion of its capital and operating costs." (2)(c)
4. "To construct, operate, maintain, manage, and control one or more hospitals in the district."(8)(d)
5. Sections 35 through 46 deal with the boards' authority to oversee hospital operations and the welfare of patients.

The same legislation did, however, provide for considerable provincial involvement in hospital affairs. The Act required that the minister of Health approve the funds requisitioned by the boards.[6] He was also empowered to dismiss board members[7] and to withhold funds from boards which allocated monies not approved by the Minister.[8]

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[4] Interview with Lou Protti, Edmonton, 19 June 1979.
[5] In 1961, an earlier Hospitals Act had consolidated the provisions relating to the powers of the boards until that time.
[6] Sec. 19, sub. 2.
[7] Sec. 26.
[8] Sec. 54.

During the period before World War Two the provincial government did not initiate funding policies designed to ensure the provision of universally accessible hospital services throughout the province. By the 1940s the extent of provincial involvement comprised *per diem* grants to hospitals of forty five cents per patient per day. The provincial government also assumed the costs of services for the treatment of tuberculosis, cancer, and polio, and for maternity care in hospital.[9] The balance of operating expenditures was acquired from patient fees and requisitioning.[10] It was only at the end of the 1940s that the guiding principle of universal access came to exercise much greater influence over the pattern of policy initiatives.

Origins of Universal Access

After World War II government's role in providing health and hospital care services continued to grow, but Ottawa was the dynamic actor in this process. The new initiatives accompanied the advent of complex and increasingly costly health care technologies. Indeed, as one writer has noted in examining the rationale for new government initiatives:

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[9] See Alberta, Department of Public Health, *Annual Reports*, 1946-47 and 1947-48.

[10] The provincial contribution amounted to approximately 15-20 percent of a hospital's needs. Beginning in the late 1940s, the province provided a sum of seventy cents per patient per day for all hospitals. Patients themselves contributed one dollar per day while in hospital.

> It was an attempt on the part of the two levels of government to meet the problems raised by increased utilization of hospitals, significant advances in the treatment of disease with the accompanying complex technology, changing attitudes towards hospital care on the part of physicians and patients, and the cost and availability of hospital resources.[11]

Health care institutions were no longer a preserve of religious organizations, serving merely as a place to die or a centre for the custody of the sick,[12] but increasingly "the focus of community health care, the physician's workshop, and educational centre, and a centre for medical research."[13]

In 1948 the federal government introduced hospital construction grants with the proviso that the provinces agreed to match the federal contribution.[14] As an additional requirement, the federal program stipulated that the provinces must establish universal province-wide insurance plans.[15] Alberta complied and introduced a Blue Cross Plan in 1948.[16] It was thus the introduction of the 1948 program that the post-war expansion of government participation in hospital care began in earnest. It was the first major initiative by a Canadian government which had as its *raison d'etre* the delivery of universally accessible hospital services calling for national standardized provisions.

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[11] Bernard Blishen, *Doctors and Doctrines* (Toronto: University of Toronto Press, 1969), p. 69.
[12] Ibid.
[13] Ibid.
[14] Gordon Ross McLeod, "The Federal Role in Financing Provincial Health Programs," (M.A. Thesis, Hospital Services Administration, University of Alberta, Fall 1976), p. 29.
[15] In Murray Ross, Edmonton, 4 July 1979.
[16] Ibid.

In 1950 the Social Credit government acted on its own to expand universality within the hospital system by establishing the Provincial-Municipal Hospitalization Plan.[17] This scheme permitted patients to use hospitals outside of their own district without incurring additional charges. The Plan provided that patients could receive free hospital services in those districts in Alberta which had mutual agreements with each other. Here we find a further attempt to expand the availability of hospital services for Alberta residents regardless of their place of residence.

A second major federal initiative was the *Hospital Insurance and Diagnostic Services Act* of 1957. This federal legislation required that provincial governments provide a certain predetermined minimum standard of hospital care services and access to those services in order to be eligible for federal shared-cost funding of hospital services.[18]

> Under the provisions of the Act, the federal government may enter into an agreement with any individual province to financially support a portion of the province's costs in operating specified hospital and diagnostic services for patients insured under provincial law.[19]

The Act provided that the federal government must contribute

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[17] See *Statutes of Alberta*, 1950, c. 30 *An Act to Amend the Hospitals Act*

[18] The Act covered the costs of meals, accommodations, nursing and lab services, drugs, x-ray procedures, and surgical supplies. Facilities not covered by the legislation were those deemed to be less costly than general care hospitalization: mental hospitals, nursing homes, and tuberculosis centres. See section 2 of the Act.

[19] McLeod, p. 30.

the sum equivalent to 25 percent of nation-wide per capita costs for hospital care, and 25 percent of a province's individual per capita costs, together multiplied by the number of residents.[20]

In addition to the fact that the legislation tied the federal government to funding increases as costs rose, the intent of the initiative had a direct impact on the way in which hospital services were to be financed by the Alberta government. In order to conform to the principle of universal access, the province instituted a mechanism whereby municipalities turned over to the province the revenue collected from a flat four mill tax levy for hospital services.[21] The immediate implication of this measure was that the province would seek to equalize the standards of services throughout Alberta, regardless of disparities among community tax bases.[22]

The universal approach to health care which began under the 1957 Hospital Insurance plan was reaffirmed ten years later when the federal and provincial governments concluded the agreement which established the Medicare Plan of 1968.[23] The federal legislation which created the Medicare Plan closely resembled the hospital insurance provisions inasmuch as it also required that 90 percent of a province's

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[20] Ibid., p. 34.
[21] Interview with Lou Protti, Edmonton, 7 September 1979.
[22] It should also be noted that daily patient charges were dropped, although an initial admission charge was retained. Ibid.
[23] McLeod, p. 37.

population be covered for services rendered by physicians; services were required to be accessible to all; the program would be funded through a shared-cost arrangement between Ottawa and the provinces.[24] A major characteristic of both health care initiatives was the movement away from local management, funding, and control to a more centralized system shared by the province and Ottawa. This trend seemed likely to continue as government appropriated to itself greater responsibility for health care. In the view of one writer:

> ...the centralization of control is both necessary and inevitable due to the government's responsibility with overall fiscal limits, the levels of service and their distribution throughout the province, standards of care, and equality of treatment between hospitals and citizens.[25]

Public policy was moving towards increasing centralization of decision making, with the consequent reduction in traditional powers of local boards. Significantly, this was true in a number of areas in addition to health care. By 1970 the province had come to assume responsibility for the financing of seventy five percent of the costs of major roads, sixty five percent of public health costs, and eighty percent of local welfare

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[24] Ibid.

[25] T.M. McLeod, cited in H. Brent Skinner, *Mechanisms For the Funding and Monitoring of Hospital Operations in Canada: A Description and Discussion*, (unpublished paper presented for the Division of Hospital Services Administration, University of Alberta, 1977), p. 14.

costs -- as well as ninety six percent of hospital costs.[26]

Origins of Restraint

As the provincial government's role in delivering hospital services expanded,[27] government decision-makers became concerned about rising expenditures. This concern was soon reflected in government measures designed to rationalize spending patterns of hospital boards. As we shall see, this provincial effort became especially difficult because of conflicting jurisdictional priorities between hospitals and the government and administrative structures. The problem has been described in the following way:

> The jurisdictional difficulties which arise whenever any governmental body assumes full fiscal responsibility for some services through the organization and administration of some other agency are indeed of substantial importance and considerable delicacy.[28]

The "delicate" policy environment became increasingly visible in the 1970s when the provincial government sought for the first time to restrain its expenditures on hospital services.

The move in the direction of restraint came at a time when income from a principal revenue source began to decline. This source was in the form of royalties and cash

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[26]Alberta, Department of Municipal Affairs, *Task Force on Provincial -Municipal Fiscal Relations, Portion Dealing with a Plan for Property Tax Relief, 1972.* (Edmonton: Department of Municipal Affairs, 1972) pp. 2-3.

[27] See Figure 1 for the contributions to hospital costs by three levels of government.

[28] McLeod cited in SKinner, p. 16.

Figure 1

The amounts given are in millions of dollars. Apart from the patient contribution, funds come from the provincial treasury, with portions derived from federal funding and the four mill tax levy at the municipal level.

Contributor	*1963*		*1964*	
Patient	11,180	(15%)	11,688	(14%)
Local	8,867	(12%)	10,966	(13%)
Prov.	26,574	(35%)	28,066	(34%)
Fed.	28,628	(38%)	32,747	(39%)
	1965		*1966*	
Patient	11,597	(13%)	12,040	(11%)
Local	11,311	(12%)	11,597	(11%)
Prov.	34,848	(38%)	43,045	(39%)
Fed.	34,278	(37%)	43,166	(39%)
	1967		*1968*	
Patient	14,583	(11%)	16,839	(11%)
Local	14,103	(11%)	12,700	(9%)
Prov.	54,022	(41%)	59,779	(40%)
Fed.	50,624	(38%)	59,075	(40%)
	1969		*1970*	
Patient	19,317	(12%)	15,279	(8%)
Local	16,687	(10%)	4,971	(3%)
Prov.	63,759	(38%)	93,508	(48%)
Fed.	67,947	(41%)	79,374	(41%)

Source: compiled from the *Annual Reports* of the Hospitals Division of the Department of Health, Province of Alberta, 1966, 1968, 1970.

bonuses derived from oil and gas exploration which had begun in 1947. During the two decades between 1947 and 1970, the provincial government had frequently provided grants to

municipalities from the cash bonus component.[29] Until the mid 1960s, the ratio between the two revenue sources was about equal. As time went on, however, fewer oil wells were being discovered and the royalty component did not manage to offset the loss of the cash bonuses. Hence, less revenue was available for sharing with the municipalities.[30] At the same time municipalities were requesting additional funds in response to growing demands for recreational, leisure, and public health services. The imbalance between what was demanded and what the province was willing to allocate resulted in the freezing of municipal grants by the province at existing levels.[31]

These developments were followed by several changes in hospital funding and budgeting arrangements, all of which led to the further concentration of decision-making power in the provincial bureaucracy. As we shall see in the next chapter, the provincial government -- which considered itself to be the proper arbitrator of the policy environment -- assumed responsibility for expenditures restraint.

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[29] *Task Force Report*, p. 2.

[30] In 1960 that part of the revenues contributed to the municipalities was approximately ten percent of the total. By 1970, however, the share had risen to approximately one third. Aside from hospital costs, public school costs represented the largest portion of municipal expenditures. In Calgary, for example, in 1971 sixty percent of the overall mill rate was devoted to the financing of education. Ibid., p. 3.

[31] Ibid.

Conclusion

The impetus provided by the federally-inspired hospital insurance program in 1957 set the foundation for the expanded role of all governments in hospital care financing. The 1957 legislation had as a consequence the assertion of the province's authority in relation to both hospital boards and municipalities. In addition, the province's initiatives after 1957 effectively reduced the once important autonomy of hospital boards. In turn, the expanding authority of the provincial government heightened the visibility and politicization of hospital care-related issues during the 1970s.

The conflict between the commitment to upholding unencumbered access to hospital care services and the commitment to restraining the financial responsibility that accompanied the expanded decision-making role would characterize events after 1970.

III. Trends in Hospital Policy: 1970-1974

This chapter examines in some detail a number of provincial initiatives designed to reorganize the administration and financing of hospitals in the 1970-1974 period. It argues that the policy initiatives were characterized by increasing centralization of policy-making power in the hands of the provincial government. Although there was movement towards centralization beginning in 1970, it was constrained by the ability of local boards to assert their limited power, and thereby embarrass the government.

Both this and the following chapter examine the significance of centralization for the relationships between the provincial government and such actors as hospital boards and hospital employee unions.[1] It will be argued that centralization emphasized the conflict over priorities between the province, as the source of funding and the key policy maker, and the hospital boards. The notion of universality was significant during this period, even as actors stressed the need for restraint. As a consequence, we shall find that decision-makers came to rely heavily on statistical data and "efficiency" in order to justify restraint measures.

The Social Credit Government and Hospital Policy: 1970-1971

In the autumn of 1970, the Social Credit government announced several new initiatives in the hospital policy

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[1]A strike of workers at the Edmonton Royal Alexandra Hospital in 1973 was the first event which accentuated t conflict over centralization.

field, all of which were implemented by early 1971. Among measures to reorganize administrative structures was the amalgamation of the departments of Social Development and of Health.[2] The government also created the Alberta Hospital Services Commission to replace the Division of Hospital Services in the former Deparment of Health. The Minister of Health, James Henderson, argued at that time that the new Commission would "depoliticize" hospital policy by turning responsibility for daily policy judgements over to "specialists",[3] thereby leaving the minister free to concern himself with long-term planning. The minister of the new department would stand at a distance from evaluation of hospital funding requests. The Commission would therefore become a semi-autonomous body responsible to the Minister.

According to the provisions of the *Alberta Hospital Services Commission Act* (c. 45, R.S.A. 1971), the Commission[4] was empowered to advise the minister, to administer the disbursement of funds for hospitals, and to oversee hospital

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[2] James Henderson had been Minister of Health, and became Minister of the newly created Department of the Environment. The provincial government also established a Department of Culture. See Bob Bell, "Social Services To Merge", *Edmonton Journal*, 30 October 1970.

[3] Interview with James Henderson, Executive Director of the Alberta Hospitals Association, Edmonton, 23 July 1979.

[4] The Commission was responsible for "active treatment and auxiliary hospitals, nursing homes, and senior citizens' homes now administered by the Department of Social Development. The eight man board will be made up of a Chairman and Commissioners for Finance and for Hospitals, all of whom will be full-time members. The chairman of the medicare commission will be a member with the hospital services commission chairman also sitting on the medicare commission." *Edmonton Journal*, 4 March 1971.

construction and development. The "experts"[5] making up the Commission were charged with the following responsibilities:

> a. to insure the development throughout Alberta of a balanced and integrated system of hospitals and related facilities, and
> b. to conduct a continuing review of the financial needs of the hospitals, nursing homes, and foundations in Alberta and advise the Government with regard to the granting of financial assistance for nursing homes, hospitals, and foundations.[6]

The Commission was also empowered to "determine the amounts of, and pay grants to hospitals for the purposes of the approved capital and operating budgets."[7] In the same legislation, the government also granted the Commission with ministerial authority:

> Every order, decision, direction, instrument, approval, consent, or undertaking made or given before the commencement of this Act by the minister of Health, the minister of Social Development, or the deputy minister of Hospital Service(...)shall be deemed to have been made or given by the Commission.[8]

According to the Commission's first chairman, Dr. Jack Bradley, the new agency was empowered to examine the possibility of establishing regional hospital boards and planning councils.[9] Bradley also argued that the Commission's mandate was to reduce costs and hence limit the

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[5] Among the first Commissioners was an assistant executive director of the Royal Alexandra Hospital in Edmonton, and a provincial government auditor from Calgary. *Edmonton Journal*, 2 April 1971.
[6] Section 12 (a) and (b).
[7] Section 13(K).
[8] Section 29(2). In the same section the Commission was assigned the power of signatory on behalf of the two ministers.
[9] Jim Maybie, "Money Health Service Key", *Lethbridge Herald*, 25 June 1971.

growth of the province's contribution to the financing of hospital care.[10]

This major administrative change was accompanied by changes in the distribution of fiscal powers between the province and hospital boards. These actions were designed to centralize control at the provincial level. According to the minister of Health, James Henderson, these changes were to be part of an effort to rationalize administration in the whole social services sector.[11] The four mill municipal tax levy introduced in the late 1950s was abandoned, and requisitioning was restricted to only ten percent of the overall provincial contribution.[12] Requisitioning levels above ten percent would have to be submitted for local approval through a plebiscite.[13] Finally, the Commission would provide operating and capital funds from general revenue.[14]

The process of developing hospital budgets was also changed by the Social Credit government in 1970-1971.[15] Prior to 1970, that part of the hospital budgets annually

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[10] Ibid.
[11] *Edmonton Journal*, 18 March 1971.
[12] This level was decided by the Cabinet: the legislation authorized the Cabinet to make this decision. *Edmonton Journal*, 4 March 1971.
[13] Ibid.
[14] *Edmonton Journal*, 30 October 1971.
[15] J. R. Newhouse, "An Experiment in Financing Hospitals in Alberta", Paper prepared for Health Services Administration 400, University of Alberta, Edmonton, March 1970, p. 13, cited in Terrence Frizzell, "A Description and Critique of the Funding and Monitoring of Hospital Operations in British Columbia and Alberta", (unpublished paper, prepared for the Division of Health Services Administration, University of Alberta, Edmonton, Spring 1974), p. 8.

funded by the provincial government had been open to revision during the course of a given fiscal year in the form of a retroactive grant to cover hospital deficits.[16] The new system changed the criteria for allotting funds each year. It provided that funding for a particular institution should be based on average requirements and historical spending patterns for various classes of hospitals.[17]

The provincial government, through the Commission, enjoyed ultimate authority in determining the size of hospital budgets. Premier Harry Strom, speaking in support of the initiative, claimed the new provincial controls would manage hospital expenditure "before it was spent."[18] The ten percent requisitioning limit, the budget techniques, and the creation of the Hospital Services Commission all contributed to the centralization of decision-making at the provincial level.

Opposition to Centralization

Centralization was opposed by political actors who worried that it would reduce the autonomy of municipalities and hospital boards. In response, the government maintained that its initiatives would actually enhance local autonomy:

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[16] Frizzell, p. 36.

[17] Interview with James Henderson, 16 August 1979. The system was designated "Global Budgeting": this meant that a given approved lump sum granted to a hospital could be allocated internally by the hospital "within the general constraints of a regular financial audit, general standards of care, and agreed institutional objectives." See H. Brent Skinner, p. 33.

[18] *Edmonton Journal*, 30 October 1970.

> Premier Strom said in announcing the hospital services commission(...)that the government wants to give more autonomy to local boards and decentralize the operation of hospital services. The boards would act as management and decision-making bodies rather than simply act as a channel for funds.[19]

The government's position was not persuasive enough for Lethbridge hospital trustee Charles Virtue, who contended that the Commission and budgeting schemes would result in "the dissipation of the power of the people."[20] He appealed to the government "...not to turn our hospitals into institutions with no human element left."[21] Virtue also argued that the limit on requisitioning would precipitate conflict between board officials and municipal authorities; he feared boards would be portrayed as reckless and irresponsible whenever they requested municipal funds above the province's contribution.[22]

Another opponent of the province's initiatives was Alderman Una Evans of Edmonton. She argued that municipalities were not being given any control over the money they might be required to provide to the hospital boards. Evans described the government's action as:

> "...a further indication of the centralization of power being attempted by the Social Credit government (to) further restrict authority while adding to the municipal tax load.[23]

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[19] Ibid.
[20] Lynn Rach, "Financing Plan Said Threat to Hospitals", *Albertan*, 25 March 1971.
[21] Ibid.
[22] Ibid.
[23] *Edmonton Journal*, 31 March 1971.

The Alberta Hospitals Association,[24] the organization charged with representing the province's hospitals, argued that its ability to communicate local boards' concerns to politicians would be hindered by having to deal with lower level administrators rather than with the deputy minister of Health.[25]

The Conservative Opposition in the Legislative Assembly argued that the reorganization efforts conflicted with ideals of parliamentary oversight of bureaucracy.[26] The health affairs critic of the Opposition, Dr. Hugh Horner, described the government's initiative as "just one more method of constructing walls between the government and the people."[27] Horner attacked the concept of the Hospitals Commission as part of the overall tendency of the Social Credit government to move towards expanding the provincial bureaucracy through government reorganization. The Conservatives pressed the government to accept, and persuaded it to adopt, a legislative amendment to the legislation which permitted appeals to the Commission against decisions of individual Commissioners which might

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[24] According to the "Guide to the Alberta Hospital Association" the organization represents the boards of trustees of some 234 institutions in the province including general hospitals and nursing homes and two government operated psychiatric insitutions. The Association is also responsible for negotiating with employees on behalf of the hospitals and representing the views of hospital boards to the provincial government.
[25] *Edmonton Journal*, 9 March 1971.
[26] Paul Bennett, "Health Boards: Efficiency or Bureaucracy?", *Edmonton Journal*, 18 March 1971.
[27] *Edmonton Journal*, 9 March 1971.

result in the closing of a hospital or the establishment of regional hospital boards.[28]

The major impact of the Social Credit initiatives was to change the environment within which hospital boards, municipalities, hospital employee unions, and the province interacted. The province was really re-writing the rules. The changing frames of reference dictated that board officials would deal with an agency "at arm's length" from politicians. The new financial scheme informed the hospitals that the largest part of the financial burden for providing hospital services would rest with the province. Once institutions were allotted their operating funds, they could distribute them according to their internal priorities; the scope for supplementary support was curtailed. The new environment included an ostensibly more rational and objective method for establishing hospital budgets.

The new environment also affected the relations between the unions in the hospital sector and the provincial government, after the Conservatives came to power. The desire of unions to improve their incomes came into direct conflict with the Conservatives' proposed restraint initiatives. The growth of union activism in the hospital care sector after the election of the Conservatives clearly exemplified the shift in focus which accompanied the centralization of virtually all funding initiatives with the province.

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[28] *Edmonton Journal*, 18 March 1971.

The Conservatives In Power

The provincial election in 1971 marked the first time since 1935 that a party other than the Social Credit came to power. In the 1971 election the Conservative Party won a stunning increase in the number of seats held since the previous election.[29]

Despite their earlier opposition to the creation of new bureaucratic structures, the Conservatives did not radically depart from the Social Credit government's basic approach. Indeed, developments following the change of government continued to focus on the issues of universal access, efficient allocation of resources, and centralization versus local autonomy. Just after the new government took office, the Commission chairman, Dr. Jack Bradley, stated that the Commission would study the high ratio of active care hospital beds per thousand residents; this was of particular concern because data showed that Alberta was "out of step" with other provinces.[30]

> He told the annual convention of the Alberta Hospitals Association that Alberta has between seven and eight acute care beds per thousand population compared to the national average of about four to five acute care beds per thousand population.[31]

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[29] In the 1971 election the Conservatives won 49 seats out of 75; the Social Credit won 25 seats, the NDP a single seat. By contrast, the Conservatives held six seats after the 1967 election, the Social Credit 55, the Liberals 3 and one independent. Between the two elections a reapportionment increased the number of consituencies from 65 to 75.

[30] Terry McDonald, "Study May Result in Hospital Freeze", *Edmonton Journal*, 5 November 1971.

[31] Ibid.

In order to restore the balance with the rest of the country, Neil Crawford, the new minister of Health and Social Development, announced in early 1972 the imposition of a five year freeze on the construction of new hospital beds. Crawford argued that his decision was necessary to allow "demand for beds (to catch) up with available supply."[32] He also stated that "little capital increase will be made available over the next few years except for selected communities which do not have adequate hospital space."[33]

The new government continued on the road toward centralization of funding power, and set the stage for controversy which followed. In the Spring of 1972 the government articulated its position about its responsibility to deal with cost increases. The government introduced legislation to amend the Hospital Services Commission Act; this legislation directed the Commission to:

> recommend for the approval of the government policies that have as their aim, the reduction of the escalation of costs within the system of hospitals and related health facilities.[34]

The change also provided for the addition of one or two legislative members to the Commission. Concern with ratios was not only the preoccupation of the new government. Former Health minister James Henderson proposed that municipalities

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[32] *Alberta Hansard*, 53-15, 18 May 1972.
[33] *Edmonton Journal*, 28 April 1972. The level of overall spending on hospital care was cited to be eleven percent above the previous fiscal year, while the increase in the provincial budget as a whole was only eight percent. See *Edmonton Journal*, 18 March 1972.
[34] *Alberta Hansard*, 19-2, 8 March 1972.

should pay the costs of capital expansion of hospitals in which the bed ratio exceeded six per thousand.[35] Henderson's proposed remedy would have, of course, made the municipalities politically responsible for "inefficient" hospitals.

By contrast, Conservative M.L.A. Roy Farran called for "desperately needed guidelines" for hospital boards in order to relieve the municipalities of requisitioning altogether.[36] Farran was disturbed that "(t)he costs for health care are growing almost as fast as the other money eating monster, education."[37] The minister, Neil Crawford also expressed concern since "current figures would show that with active treatment hospitals the capital cost is about twice one year's operating cost."[38]

The Task Force on Provincial-Municipal Fiscal Relations

Roy Farran's hard-hitting views seemed to have made him a prime candidate to investigate the state of the funding of the "two monsters". For in 1972, Farran was appointed the chairman of the Task Force on Provincial-Municipal Fiscal Relations, which was assigned to examine the fiscal powers of the province and the municipalities, and to suggest ways to rationalize and to streamline the methods of funding education, health care, and social services.

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[35] *Edmonton Journal*, 18 March 1972.
[36] *Alberta Hansard*, 11-31, 16 March 1972.
[37] Ibid.
[38] *Alberta Hansard*, 53-15, 18 May 1972.

The Farran Task Force reported in late 1972. In the area of hospital policy, it rejected the notion of requisitioning because the practice appeared to limit the province's ability to control and monitor spending on hospital services; in addition, the Task Force report noted that funds provided to boards from municipalities were not subject to matching grants from the federal government.

> The previous government had a theory that expanding hospital costs could be held by insisting on 'local accountability' through supplementary requisitioning. In carrying this policy to extremes it is maintained that the Alberta citizen was denied some federal matching grants which would have been available had the total hospitalization cost been paid by the province.[39]

Given this orientation, the Task Force rejected, not surprisingly, the strategy of gentle pursuasion through the incentives implicit in limited requisitioning; it opted instead for more provincial power to impose funding rules for the hospital system. The Task Force recommended among its proposals[40] that:

> "the province should assume the entire costs of hospitalization. Boards would be appointed then by the province....[41]

This innovation was expected to rationalize the delivery of services, to reduce duplication, and to monitor the costs of diagnostic services. Centralization was therefore deemed the only reasonable route for the province to follow. The report went beyond recommending full

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[39] Task Force Report (main text), p. 67.
[40] Ibid. See pp. 70-71.
[41] ibid., p. 71.

financing of hospitals by the province; centralization implied other measures as well. The Task Force report put it this way:

> (The provincial government should) take over all hospitals in the province and hospital districts (should) *be abolished*. Hospitals should be grouped into regions under regional boards to which each hospital board elects members. (emphasis added)[42]

Rationalization and Local Autonomy: 1973

Although government policy had reflected, and would continue to reflect, the general conclusions of the report, it did not go as far as recommended by the Task Force. The recommendation to implement "last dollar financing" was endorsed by the government, and had the sanction of the Alberta Association of Urban Municipalities[43] which had made a similar recommendation in 1971. The government did not, however, take the step of abolishing the boards; thus, although the power to disburse funds rested exclusively with the province, boards would still be able to establish internal priorities. As we shall see, even such apparently limited power enabled boards to resist government restraint measures.

The complete assumption of hospital financing by the province was provided for in section 34 of the *Alberta Property Tax Reduction Act* (c. 46, Revised Statutes of Alberta 1973) enacted in the Spring of 1973. This section

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[42] Ibid., p. 68.
[43] See *Edmonton Journal*, 1 October 1971.

removed all requisitioning powers from hospital boards.[44]

To assuage the fears of local hospital boards, the government argued that its policy of Last Dollar Financing was a considerable "revision" of the Task Force's proposals. Indeed, the minister of Health and Social Development insisted that rationalization of spending powers would not extinguish local autonomy. The new direction was described this way:

> "... the province is assuming 100 per cent of the costs of hospital requisitioning and local health unit requisitioning, Health minister Neil Crawford said he did not envision a need to have government scrutiny on health budgets at the municipal level.[45]

At the same time, the minister noted that municipal authorities should take care not to submit "padded costs" lest Last Dollar Financing be reconsidered.[46]

In February, while arguing that the government was not seeking to "usurp" the autonomy of hospital boards, the minister announced that hospital funding for the next fiscal

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[44] The Act dealt generally with the issue of municipal taxation of which hospital requisitioning was a part. Although local autonomy as a concept had been a subject of considerable political discussion, it has meant considerably more in theory than in reality, even before Last Dollar Financing. For example, according to the Barran report, the province was responsible for financing 75 percent of the cost of major roads in the province; it already paid some *96 percent* of the costs of hospital operations, 65 percent of public health and 80 percent of local welfare costs. *Task Force on Provincial-Municipal Fiscal Relations, Portion Dealing With a Plan for Property Tax Relief*, pp. 2-3.

[45] John Lindblad, "Lougheed Cuts Home Taxes", *Edmonton Journal*, 16 January 1973.

[46] Ibid.

year might be held to existing levels.[47] Crawford argued that the dispersal of fiscal powers beyond the provincial government would inhibit the possibility for restraint:

> As soon as you have any body which has two sources of income, you find that your financial accountability becomes very shakey.[48]

He argued that universally accessible hospital care was not incompatible with fiscal restraint:

> (Cost control is) not out of the desire to provide any less service or to provide services that are in any way inadequate, but out of the desire to have sufficient regard for the cost that the taxpayer has found he has to bear in the way that health and particularly, hospital costs have been rising within the last few years.[49]

Opposition member Bob Clark lamented the total removal of requisitioning, and indicated what he saw as the advantage of local requisitioning:

> ...the option of going to their local people for some additional financial support enables the local board to have the final decision on the level of service to the hospital.[50]

The Socreds also expressed dissatisfaction with the government's initiative to reduce the power of local boards; the Socreds accused the government of "turning hospital boards into administrators".[51] Bob Clark expressed some hesitation about the government's emphasis on rationalization:

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[47] *Edmonton Journal*, 3 February 1973.
[48] *Alberta Hansard*, 2380, 17 April 1973.
[49] Ibid.
[50] *Alberta Hansard*, 54-2903, 7 May 1973.
[51] *Alberta Hansard*, 2907, 7 May 1973.

> It's nice to be concerned about dollars and cents but it seems to me that at the same time you had better put a greater value on the basic principles involved, and that is what we are trying to do.[52]

The government recognized that Last Dollar Financing would have an impact upon local autonomy, but it argued that the benefits outweighed that impact. The Municipal Affairs minister, Dave Russell, put it this way:

> If there is concern about the possible loss of autonomy in there, I recognize that and I can see how certain members could build a debate on that. But notwithstanding it, I still think it is a good move....[53]

Russell went on to emphasize the importance of cost control and the continuity of the policy approach begun during the previous government:

> It's an important move for the province to take over last dollar support of hospitals throughout the province. I would hope -- I know the old government was concerned and the previous minister worked very hard at trying to control this rapidly escalating factor with respect to hospital costs -- and hopefully we will be able to continue that trend to try to maintain reasonable control in the growth rate. But in the meantime, at least, that social service cost is removed from the municipal government.[54]

Centralization and Union Demands: 1973

Centralization would have a lasting effect on the relations among hospitals, unions, and the government. Last Dollar Financing focused the attention of boards and unions on the question of the role of the provincial government. Traditionally, hospital unions bargained with hospitals over wage and salary levels on an individual basis: workers

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[52] *Alberta Hansard*, 2909, 9 May 1973.
[53] *Alberta Hansard*, 2807, 7 May 1973.
[54] *Alberta Hansard*, 2907, 7 May 1973.

belonging to organized unions or staff associations of a hospital bargained with that hospital. By the 1960s a number of hospital unions were bargaining with the Alberta Hospitals Association which represented the hospitals. The existence of municipal requisitioning made these negotiations more meaningful since the hospitals were capable of raising funds autonomously to cover additional requirements posed by union demands.

Following the introduction of Last Dollar Financing, labour relations were changed because the relationship between unions and hospitals was overshadowed by the province's total control over hospital expenditures. This new constellation of relationships heightened the link between provincial decisions and the welfare of the public. The response of hospitals to allegedly insufficient funding from the province took the form of internal funding reallocations which were seen to endanger universal access to hospital services. The consequences of Last Dollar Financing -- changing labour relations and levels of service -- evoked increasing politicization of health care-related issues at the provincial level. As we shall see during the period after 1973, the government's efforts dealt with this increased politicization by attempting to transfer accountability to other actors. This forced some hospitals to choose explicitly between increasing wages and salaries and curtailing certain forms of hospital care.

Labour Relations and the Royal Alexandra Hospital

The conflicts engendered by the role of the provincial government were reflected by the events at the Royal Alexandra Hospital in Edmonton in the Spring of 1973.

In April, six hundred staff nurses threatened to strike at the hospital. The nurses demanded an eleven percent wage increase by January, 1974 and an additional ten percent by 1975.[55] The hospital found itself caught between the nurses' demands and provincial guidelines which restricted any salary increase to six percent.[56]

> ...the provincial government has told the Royal Alex Board of Governors to hold out for six percent salary hikes to the nurses over each year of the two year contract.[57]

A conciliator's report recommended an increase of between eight and nine and one half percent -- significantly above the provincial position.[58]

The hospital maintained that without additional provincial assistance any increase above six percent would create a deficit of at least $286,000 (if other workers also demanded comparable wage increases).[59] According to the hospital, the government would have to alter its guidelines or the hospital would have to refrain from replacing vacant

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[55] John Tompkins, "Hospital Nurses Watch Royal Alexandra Negotiations", *Edmonton Journal* 13 April 1973. From the first proposed increase, the nurses' wages were to increase from $550 to $625 monthly, in order to bring their incomes to a level comparable with their counterparts in British Columbia.
[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Ibid.

nursing positions.[60]

The minister of Health and Social Development, Neil Crawford, responded by pointing to the increase in government expenditures on hospital services since 1972 -- a sum of approximately thirty million dollars.[61] But the minister also indicated that the government would not intervene in the dispute;[62] it was the responsibility of the hospital itself to juggle the allocation received from the province:

> Therefore (the allocation) affects the amount of money that they have for the balance of their operations. It's really something they have to do themselves.[63]

On another occasion Crawford reiterated his position that hospitals should take the initiative in dealing with internal matters; they "would have to make whatever arrangements by way of curtailing, perhaps their services, or cutting their cloth."[64]

The chairman of the Royal Alexandra, Joe Katzin, expressed indignation that the hospital was being forced to deal with the nurses when it had no real power to meet their demands without at the same time adversely affecting services:

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[60] ibid.
[61] Ibid.
[62] Ibid. Crawford argued that the Hospital Services Commission was offering its "good services" to resolve the dispute, thereby forestalling Cabinet intervention.
[63] *Alberta Hansard*, 49-2586, 20 April 1973.
[64] *Calgary Herald*, 2 May 1973.

> They're (the government) just playing games with us. If they're supposedly paying 100 percent of hospital costs they should be negotiating -- not us.[65]

Katzin also warned that the hospital might still resort to a direct appeal to the provincial Cabinet.[66]

Following Katzin's statements, the chairman of the Commission, Dr. Jack Bradley, hinted that the province might yet loosen the purse strings;[67] Bradley warned, however, that spending increases by the province could not escalate interminably.[68] In the meantime, the strike threat at the Royal Alexandra resulted in the closing of the hospital's emergency departments, and a subsequent increase of activity at other city hospitals.[69]

The strike was averted on May 4 when the hospital reached agreement with the nurses, granting them the fourteen percent increase by January 1974 and six percent the following year.[70] In early 1974, the province solved the deficit problem projected by Mr. Katzin, providing the hospital with approximately $1,700,000.[71]

The nurses were not the only hospital employees who faced the government over wage demands in 1973 and 1974. The Canadian Union of Public Employees, representing some 35

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[65] *Edmonton Journal*, 2 May 1973.
[66] Ibid.
[67] *Calgary Herald*, 3 May 1973.
[68] Ibid.
[69] Ibid.
[70] *Edmonton Journal*, 4 May 1973. The contract raised the minimum salary level to $625 per month by January 1, 1974, rather than the $615 proposed by the conciliator.
[71] *Albertan*, 24 February 1974. The Calgary General Hospital, also a municipally owned facility, received over $300,000 to cover its own deficit.

hospital associations of non-medical workers[72] in Alberta, was negotiating wage agreements with hospitals. Although approximately two thirds of the local associations had approved a proposal to increase the lowest monthly wage level by seventy five dollars, the union announced that *all* locals would have to come to agreement before any individual association could sign an agreement.[73]

A CUPE representative in the negotiations, Art Roberts of Calgary, expressed his conviction that the relations between unions and hospitals were not really the problem; rather, it was the funding policies of the provincial government. Roberts stated his view this way:

> CUPE's fight is not with hospital administrators, but with the people who dish out the money(...) the miserly government we have in this province.[74]

Roberts even suggested that employees and hospital administrators should join forces against the policies of the provincial government:

> They should be allies in making demands of the government. They should be joining CUPE in the demand for more money.[75]

Roberts also asserted that low wage levels were affecting working conditions in hospitals and reducing morale -- all of which, he argued, dramatically affected the quality of health care. The government, according to Roberts, was "cutting down on the health care of the public

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[72] *Calgary Herald*, 19 April 1973.
[73] Ibid.
[74] Ibid.
[75] Ibid.

at the expense of the hospital employees."[76]

By the end of 1973 the provincial government had acceded to the demands of the nurses[77] and CUPE.[78] At the same time, the government also approved the requests of a number of hospitals which had requested funding to expand capital construction. The government granted one million dollars for the upgrading of the University of Alberta Hospital;[79] it provided the Foothills Hospital in Calgary with 3.6 million dollars to expand its non-active care services, particularly for outpatient services.[80] The Calgary General Hospital received approval to renovate its psychiatric wing.[81]

Despite new government expenditures on hospital services, especially in the "less costly" areas, a number of proposals were put forward which would further rationalize activities in the hospital sphere. One Calgary alderman --

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[76] Ibid.

[77] All employees of a given category, whether or not they actually participate in collective bargaining, receive the same benefits negotiated in the collective bargaining process. This process is the same for the nurses as for CUPE, for example. See *Edmonton Journal*, 13 April 1973.

[78] In June, CUPE public health nurses went on strike in Calgary, and CUPE non-medical workers struck in Edmonton to obtain parity with benefits received by CUPE employees in Calgary hospitals. See *Albertan*, 1 June 1973, and *Edmonton Journal*, 27 July 1973. The CUPE employees received an average increase in January 1974 of between seven and eight percent. See Helene Donahue, *The Impact of Unionization and Collective Bargaining on Hospital Operating Costs in Alberta, 1971-1977(M.A. Thesis, Division of Health Services Administration, University of Alberta, Edmonton, Spring 1980), p. 60, and Appendix 'A'.*

[79] *Edmonton Journal*, 23 October 1973

[80] *Calgary Herald*, 24 October 1973.

[81] The hospital received fourteen million dollars. *Edmonton Journal*, 16 December 1973.

who had also been a member of the Calgary General Hospital board, John Ayers, hearkened back to the approach of the Farran Task Force report when he argued for a total provincial takeover of all hospitals:

> What we need, I think, is one health care system. Each hospital is an independent body, going its own way, and this isn't right.[82]

One health care analyst proposed both that the province intensify its efforts to encourage the public to use cheaper forms of health care such as home care and that hospitals discharge patients earlier.[83] University of Alberta economics professor, Richard Plain, criticized the patient/bed ratio in Alberta, and recommended the utilization of less costly clinic facilities.[84]

The decision in late 1973 to allocate funds for renovation and for non-active care health facilities was followed in 1974 by the funding of an auxiliary hospital facility in Calgary over a two year period.[85] The province also approved renovations instead of new construction at Manning,[86] Peace River,[87] and Hinton.[88]

The province's approach, between 1971 and 1974, was expected to extend its control over funding and thereby restrain the growth of the expenditures on hospital care.

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[82] Stephen Cook, "Single Hospital System Urged", *Edmonton Journal*, 12 October 1973.
[83] *Edmonton Journal*, 28 October 1973.
[84] *Edmonton Journal*, 26 November 1973.
[85] *Alberta Rapport*, 15 February 1974.
[86] *Edmonton Journal*, 21 March 1974.
[87] *Edmonton Journal*, 20 March 1974.
[88] *Edmonton Journal*, 8 October 1974.

According to data,[89] however, the levels of provincial expenditures (and federal matching grants) grew continuously between 1971 and 1975.[90] The wage levels which rose during fiscal year 1974 were low compared to the levels attained in 1975 -- an event which we shall examine in the next chapter.

The provincial government had advocated a "partnership" with unions and hospital boards in 1974. It is not clear how a partnership could really be considered meaningful among "partners" with vastly contrasting degrees of power. The Health and Social Development Minister, Neil Crawford, nevertheless expressed his view that centralization and local autonomy were not necessarily incompatible:

> ...with growing government involvement in hospital funding and setting of standards and regulations, the responsibility of government in hospital affairs has increased....The government has a responsibility to the citizens of Alberta to ensure that public funds raised from taxes are effectively utilized, but at the same time, it wants to give full weight to the input received from hospital boards and others in determining the type of services offered.[91]

Such a position creates, however, a serious dilemma. As we have seen, there was conflict between the priorities of individual hospitals and those of the government. Government restraint impinged upon universally accessible services, and hospital priorities ran up against government calls for more

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[89] Refer to Figure 2 in the next chapter.
[90] By 1975, according to Helene Donahue, hospital care represented two thirds of all spending on health care in Alberta. Hospital care also "represented twenty percent of the province's total operating budget commitments." See Donahue, p. 3.
[91] *Edmonton Journal* 15 November 1974.

frugality. The tensions implicit between the minister's two goals would shortly sharpen the visibility of hospital policy issues.

Restraint in Other Provinces

The effort to control spending levels, and the resulting politicization of hospital issues was not limited to Alberta. The Ontario government restricted spending increases on hospital services to seven percent of existing levels for the years immediately following 1974;[92] hospital administrators in Ontario were directed to cut their 1974 spending levels by two percent.[93] In Nova Scotia, a provincial Royal Commission recommended that the the province assume all costs for health and welfare services from municipalities.[94] Labour strife was also growing in other provinces. Hospital workers went on strike during 1974 in British Columbia,[95] the city of Toronto,[96] and in Saskatchewan.[97]

Conclusions

During the first half of the 1970s, hospital policy was characterized by growing provincial control over hospital financing. The centralization of decision-making, as reflected in several administrative changes, was expected to

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[92] *Globe and Mail*, 29 October 1974.
[93] Ibid.
[94] The Report of the Commission also proposed more extensive planning in these areas; it also recommended levying a part of the provincial tax for this purpose. *Globe and Mail*, 28 June 1974.
[95] *Edmonton Journal*, 24 June 1974.
[96] *Globe and Mail*, 30 April 1974.
[97] *Edmonton Journal*, 6 May 1974.

rationalize funding procedures and to monitor the growth of provincial expenditures.

The Social Credit government established new funding mechanisms and created the Hospital Services Commission. The first Conservative government adopted the approach initiated by its predecessor and proceeded to further centralize hospital policy with the introduction of Last Dollar Financing in 1973. Such initiatives had the effect of heightening the politicization of hospital care issues at the provincial level, particularly after 1974.

Although the word "restraint" seemed to describe the tenor and approach of the government between 1970 and 1975, it seemed to be more a matter of fostering an image rather to severely cut back expenditures in the hospital sector. Restraint took the form of centralization and of various efforts to monitor the *level of growth* of spending on hospitals rather than measures to cut back existing spending levels. As we have seen, the government did not succeed in developing a consensus among the various actors about the merits of centralization or spending limitations. From 1975 onward, this consensus became even more elusive as restraint came to be perceived increasingly as punitive and inappropriate for a province enjoying significant economic prosperity. In Alberta, the implications of centralization continued to dominate events related to hospital care policy after 1974. It is to those developments that we now turn.

IV. Trends in Hospital Policy: 1975-1978

The last chapter traced the growing centralization of decision making in the hospital policy field between 1970 and 1974. We found that government sought to maintain the goals of universal accessibility to hospital services while also enhancing its ability to control the growth of expenditures. Prior to the 1970s government intervention was undertaken in order to expand the accessibility of hospital care services to the public. More recently, however, government intervention has been undertaken to enhance the province's capacity to monitor developments in the hospital sector and to reduce the expectations of other actors.

Events in the earlier part of the decade were characterized by growing conflicts among unions, hospital boards, and the provincial government. During this period various actors began to rely on concepts such as "efficiency", and universality to rationalize their positions. The widely accepted belief among various actors in universal standards and nation-wide access to services proved to be especially important since it provided the rationale for wage demands, funding levels, and restraint itself. Thus, unions wanted wage levels comparable to those received elsewhere in Canada; hospital boards wanted to maintain certain perceived Canadian standards; and the provincial government wanted to keep Alberta's spending patterns "in line" with those prevailing in other provinces.

In this chapter we shall continue to encounter these sorts of justifications in the context of debate about the consequences of centralization following 1974. During the 1970s centralization and administrative reform were frequently employed by the provincial government with a view to reducing expectations about the levels of government support for hospital services. In this chapter we shall find that centralization of funding power increasingly accentuated differences over policy priorities and focused attention on the effect of restraint on the public. Furthermore, we shall find that the differences between the funding authority and the institutions constrained the government's ability to realize its restraint objectives.

New Administrative Structures: 1975

Soon after the provincial election of 1975,[1] the provincial government moved to extend its control over the hospital sector by reorganizing its health care bureaucracy. The former Department of Health and Social Development was divided into two new departments or ministries, each of which was empowered to administer a special area of health care policy. New legislation[2] provided for the creation of a ministry of Social Services and Community Health, headed by Helen Hunley, and a ministry of Hospitals and Medical Care

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[1] The Tories increased their share of seats in the Legislature from 49 to 69 while the Social Credit Opposition was reduced to four.

[2] See Alberta, *The Hospitals and Medical Care Statutes Amendment Act* (R.S.A. 1975, c. 21), and *The Department of Health and Social Development Act* (R.S.A. 1975, c. 12).

headed by Gordon Miniely, the former provincial Treasurer.[3] One report of the changes described them this way:

> ...the new name (of Mrs. Hunley's department) will indicate the emphasis the government will place on social and health services....and clearly differentiate it from the new Department of Hospitals and Medical Care headed by Gordon Miniely. Mr. Miniely's job is being responsible for the Hospital Services Commission and the Alberta Health Care Insurance Commission.[4]

In the 1975 Speech from the Throne, the government outlined the objectives of such administrative changes. These objectives illustrate clearly the twin concerns of reordering spending priorities and also maintaining universally accessible hospital care services:

> Albertans enjoy the highest standard of hospital care in the nation. But my government is increasingly concerned about the rapidly escalating costs of health care services and their impact in the years ahead on our tax-paying citizens. Accordingly, a new ministry of hospitals and medical care will be proposed. It will seek to ensure quality in health services at a reasonable cost.[5]

The new minister of Hospitals and Medical Care, Gordon Miniely, also proclaimed the importance of universal access while at the same time stressing the need to manage the burgeoning hospital care system:[6] The minister explained his position this way:

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[3] *Edmonton Journal*, 16 April 1975.
[4] Ibid.
[5] *Alberta Hansard*, 15 May 1975, p. 3.
[6] Consider Figure 2. It is evident that the proportion of the provincial budget dedicated to hospital care had declined by 1979. Yet the overall provincial budget had increased substantially; this suggests, of course, that other areas have increased their share of the budget relative to the hospital field.

Figure 2

Year	*Hosp. Segment*	*% Increase*
1970-71	188,560,700	15%
1971-72	220,562,666	17%
1972-73	236,874,723	7%
1973-74	264,726,697	12%
1974-75	332,024,797	26%
1975-76	447,573,919	35%
1976-77	488,680,096	9%
1977-78	541,160,249	11%
1978-79	591,518,566	9%

	% of Prov. Budget	*Increase in Total Prov. Budget*
1970-71	20%	14%
1971-72	21%	12%
1972-73	21%	8%
1973-74	20%	16%
1974-75	19%	34%
1975-76	20%	30%
1976-77	17%	30%
1977-78	16%	16%
1978-79	16%	8%

Based on and compiled from *Public Accounts*, *Budget Estimates*, and Budget Speeches.

> I think...that it will represent a major challenge to all of us in terms of trying to come up with more cost effectiveness in the system yet still maintaining the quality of our hospital, auxiliary hospital, and nursing home delivery system.[7]

Labour Unions and Hospital Policy: 1975

Following the election, the tensions between "cost effectiveness" -- the reallocation of fiscal resources -- and "quality care" became evident. The chief characteristic of events after 1974 was the argument of opponents of provincial policy that the government's policy had adversely affected the quality of health care available to the public. We will recall that two actors who responded to the

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[7] *Alberta Hansard*, 6 June 1975.

perceived punishment had been nurses and general service employees at the Royal Alexandra Hospital in 1973: the former group had threatened to strike, and the latter group did go on strike in that year, in an effort to improve their incomes and professional status. The conflict over priorities, and the accompanying impact on access to hospital services, re-surfaced once again in 1975.

Shortly before the election and departmental reorganization, the province's locally administered hospitals entered into contract negotiations with the Canadian Union of Public Employees (CUPE), the representative of the general service employees. CUPE had been moving in the direction of collective bargaining on a province-wide scale during the previous several years as a means of focussing their negotiations on the government rather than on the individual hospitals.[8] As a result of the negotiations between the union and the hospital's negotiator -- the Alberta Hospitals Association -- workers in some forty affiliated hospital unions obtained wage increases.[9] The agreement was signed in April and provided an average wage increase of thirty eight percent for general service workers; other increases ranged from eleven to fifty three

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[8] Although collective bargaining in 1975 did not cover a majority of hospitals, all general service workers enjoyed the benefits obtained in the agreements reached by CUPE. The union represented some 8,000 workers in Alberta hospitals including cooks, tradesmen, janitors, and office staff. See Helene Donahue, pp. 49-50.

[9] Ibid.

percent.[10]

The agreement had an impact upon general service workers employed at provincially-administered hospitals and represented by the Civil Servants Association(CSA).[11] Because of provincial legislation, however, these workers could not legally strike. Nevertheless, general services workers at the University of Alberta Hospital and W.W. Cross Hospital in Edmonton, and at the Glenrose and the Foothills Hospitals in Calgary, went on strike in June, 1975. Among their demands were wage parity with the CUPE workers and the right to strike. The CSA contended that it was intolerable that the differential of wages between the two groups of workers should range from thirty to one hundred dollars monthly.[12]

The Alberta Court of Appeals upheld a government back-to-work order against the CSA members, but the order was ignored.[13] In the legislature, Gordon Miniely was asked by the Opposition Leader, Bob Clark, whether the government would employ contempt of court charges against the strikers. Miniely responded that such a position was not one the government would take since it was the responsibility of

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[10] Ibid., p. 60.
[11] *Edmonton Journal*, 17 June 1975.
[12] The general services workers, included 700 employees at Foothills Hospital in Calgary, and 1200 at the University of Alberta Hospital. Ibid.
[13] A representative of the Alberta Federation of Labour accused the government of "denying its hospital employees full collective bargaining rights and then frustrating its own system by using injunctions." *Edmonton Journal*, 25 June 1975.

hospital administrators to request such injunctions from the courts.[14]

While the strike continued, services were reduced at the hospitals. For example, emergency admissions at the University of Alberta Hospital were halted, and patients received early discharges.[15] One report of events at that hospital gave the following account:

> ...though no disaster ensued as a result of the walkout, it caused unnecessary dismay and distress to a large number of people, particularly the patients and their families. (The hospital) had been reduced to about 50 percent (capacity) during the strike.[16]

Several days after the strike began, strikers returned to work at the request of the union's president.[17] The conflict, however, was not resolved until the autumn. The outcome of the bargaining process did not grant legal recognition to the right of employees to strike. Wages were raised, however, to levels comparable with those obtained by CUPE.[18] One newspaper, commenting on the strike, questioned the wisdom of the government's approach to negotiations in the hospital sector:

> (There) is an impression that the very large, very rich, and very powerful government of Alberta has once again been doing less than justice to its employees -- whether the people in question are employed directly or by such creatures of the province as local school or hospital administrators. It is very easy for a province to hide behind such "local" authorities when it is in fact controls

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[14] *Edmonton Journal*, 17 June 1975.
[15] Ibid.
[16] *Edmonton Journal*, 25 June 1975.
[17] *Edmonton Journal*, 17 June 1975.
[18] *Edmonton Journal*, 25 September 1975.

> their budgets and their negotiating power, when it comes to bargaining time.[19]

The labour difficulties in 1975, like those in 1973, illustrated the competing priorities of restraint and union demands. Not surprisingly, each side argued that its goals were to the benefit of the public -- either in the form of controlled public expenditures or in the form of improved services. The minister -- not unlike his predecessor -- expressed the hope that competing priorities could in fact be reconciled:

> One of the concepts we will be examining(...)is(...) looking at what they want to do now, beyond that global budgeting figure in trying to move toward a longer term plan that will accomplish both the needs within a hospital and a rate of growth of the existing situation that is tolerable in terms of growth in total hospital expenditure.[20]

Federal Restraint Initiatives

The Alberta government was not alone in seeking ways to restrain the growth of public spending on health and hospital care. In June 1975, the federal government announced its intention to change its own funding system for both medicare and hospital care services.[21]

The government announced its intention to terminate the existing hospital insurance and medicare agreements and to replace them by a new system of block grants and tax transfers. The federal authorities initially proposed reducing the growth of expenditures for medicare services; the percentage would be held to approximately thirteen

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[19] *Edmonton Journal*, 20 June 1975.
[20] *Alberta Hansard*, 30 May 1975, p. 321.
[21] See Figure 3.

Figure 3

This table presents the payments of the federal government to Alberta and to all the provinces combined.

1971-1972 *Recipient*	*Expenditure*	*Percentage Change*
Alberta	$94,836,000	+15%
All Provinces	$844,578,000	+15%
1972-1973		
Alberta	$105,803,000	+12%
All Provinces	$962,009,000	+12%
1973-1974		
Alberta	$119,764,000	+13%
All Provinces	$1,067,201,000	+11%
1974-1975		
Alberta	$142,291,000	+19%
All Provinces	$1,309,232,000	+18%
1975-1976		
Alberta	$194,199,000	+36%
All Provinces	$1,743,503,000	+33%
1976-1977		
Alberta	$219,612,000	+13%
All Provinces	$2,018,069,000	+16%
1977-1978		
Alberta	$144,189,000	-34%
All Provinces	$1,762,639,000	-13%

For the last year listed, the reduction is due to the tax transfer provision of the 1977 agreement.
Source: compiled from the *National Finances* of the Government of Canada, 1971 through 1978.

percent in fiscal year 1976, 10.5 percent in fiscal year 1977, and 8.5 percent thereafter.[22] It is notable that the rationale for federal restraint measures resembled earlier statements by the provincial government about its own initiatives. Finance minister John Turner expressed the

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[22] *Edmonton Journal*, 24 June 1975.

federal approach this way:

> These cost trends are due in part to the basic nature of health care, but the statutory rigidity of the programs, the lack of national standards, and the open-ended nature of the cost sharing arrangements with the provinces has made it almost impossible to achieve effective cost-planning control.[23]

The proposed reduction in federal funds to finance provincial health care schemes once again illustrates the dilemma of maintaining universal access to health care while not raising provincial expenditures to "intolerable levels". From the Alberta government's perspective, an alternative to increased spending to make up the shortfall in federal support was to increase health insurance premiums. In the words of Gordon Miniely:

> If the federal government limits escalation unrealistically, and at a level that is unattainable, then certainly we're going to have to reassess our premiums.[24]

Although action on the premium issue was not taken right away, the province did set in motion new measures to deal with hospital care spending. In the winter of 1975 the Hospitals minister announced that the percent increase for the hospital system for fiscal year 1976 would be held at eleven percent.[25] The premier, apparently anticipating criticism of the government's new decision, sought to allay

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[23] Ibid.
[24] *Edmonton Journal*, 10 July 1975.
[25] The announcement originally came in September; the percentage increase of provincial spending for the hospital system would be reduced from the 15 percent rate of the previous fiscal year. *Alberta Hansard*, 12 December 1975, p. 1021.

fears about the future of health care in Alberta:

> ...any suggestion that this government's support for social programs has, in fact, been weakened, is simply not valid. I think we have a better record in the aggregate than any other province in Canada over the last four years.[26]

Two years later, in 1977, the provinces and the federal government concluded the Established Program Financing Agreement which provided for a block grant and tax transfer system, thus effectively relieving the federal government from having to exactly match growing provincial expenditures.[27]

At the same time that both governments were altering their funding mechanisms, they also undertook another initiative which came to have an impact on hospital policy in Alberta. In the autumn of 1975 the federal government enacted Bill C-73 which put into effect wage and price controls covering the segments of the economy within federal jurisdiction (such as federal Crown Corporations) and the private sector. The same legislation also empowered the federal government to make agreements with provincial governments to extend federal controls to the areas of the economy falling under provincial jurisdiction (such as the provincial public service).

In December 1975 the Alberta government enacted legislation which brought the province into accord with the

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[26] Ibid.

[27] The arrangement would provide block grants on the basis of Gross Provincial Products (G.P.P.). Telephone conversation with Terry Roberts, assistant to the minister of Hospitals and Medical Care, Edmonton, 3 September 1981.

federal provisions.[28] The legislation empowered the Lieutenant Governor-In-Council "...by regulation (to) establish guidelines for the restraint of compensation of public sector employees"[29] which the government decided to keep in force until at least March 1977.[30]

The restraint measures implemented by the Alberta government in 1975 would set the stage for events over the coming few years. More than anything else, perhaps, the atmosphere in which hospital policy issues were dealt with was filled with debate about the implications of government policies on the accessibility of hospital services to the public. As we shall find, this atmosphere had the effect of accentuating the role of the minister. Although this atmosphere began in the early 1970s, it was after 1975 that the consequences of centralization became much more visible.

New Provincial Restraint Measures

From the provincial government's point of view, the sharp increases in hospital funding throughout the system needed to be restrained in 1976 in view of the sharp increases in hospital expenditures in 1975 which had amounted to forty percent for general hospital services.[31]

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[28] See the *Temporary Anti-Inflation Act* (c. 83, R.S.A. 1975); also see *Alberta Hansard*, 5 December 1975, p. 1471.
[29] *Act*, s. 3 and 4.
[30] Ibid.
[31] The total dollar figure had risen from $308 million in 1974 to $432 million in 1975. For general hospital services alone, the figure increased from $238 million in 1974 to $335 million in 1975; funding for auxiliary hospitals rose from $21 million to $31 million in the same period. Statement 'A' of the 1975 *Annual Report* of the Alberta Hospitals Services Commission.

At the end of 1975, Miniely announced that 1976 would be a "tough budget year".[32] He emphasized that the government would commit itself to an eleven percent expenditure increase for the hospital system, and that no exemptions from these guidelines would be approved.[33] At a meeting of the Alberta Hospital Association Miniely further indicated that provincial policy would place greater emphasis on home care programs and day patient services in order to reduce hospital care costs.[34]

Because of the province's approach, two things soon became evident. First, actors held conflicting interpretations about restraint. The government argued restraint was a positive step because it would control the growth of public spending. The hospitals and unions considered it a damaging one which would result in lower levels of service to the public. Second, conflicting interpretations existed about who should be held responsible for the public's inconvenience. The government argued that it was the responsibility of the hospitals to determine their internal priorities and the sorts of services available. The boards and unions, not surprisingly, argued equally as strongly that the government was to blame for not granting "adequate funding"[35] in the first place.

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[32] *Edmonton Journal*, 6 December 1975.
[33] Ibid.
[34] Ibid.
[35] *Albertan*, 17 February 1976.

Early in 1976 Miniely sought to dilute opposition to the guidelines by comparing Alberta's restraint measures with Ontario's apparently more drastic policies.[36] where the government of that province had actually closed some hospitals.[37] The Alberta minister observed in the legislature that given the expenditure guidelines, "there could be a need for hospitals to assess their priorities internally(...) but there should be no need to close a hospital."[38] On another occasion the minister argued that criticism of the government's restraint policy was unjustified because other provinces were not increasing spending as much as Alberta, and that Alberta's hospitals "could tighten up and still maintain a high level of service because the hospitals do so much beyond providing essential services."[39] As on earlier occasions, Miniely emphasized that ultimately the hospitals would have to work within the restraint guidelines.[40] In March the minister announced that his government would no longer guarantee loans assumed by hospitals.[41] He explained that this decision was prompted by data which showed that Alberta's hospital system had a

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[36] Ibid. News reports at the time described how the Ontario Health minister was denounced in his province for calling for the closing of Toronto's Doctor's Hospital as part of the restraint program there. See Mary Trueman, "Doctor's Hospital is Ordered Closed," *Globe and Mail*, 11 February 1976. In New Brunswick the government closed a number of hospitals. See *Globe and Mail*, 2 February 1976.
[37] *Albertan*, 17 February 1976.
[38] Ibid.
[39] *Edmonton Journal*, 10 March 1976.
[40] Ibid.
[41] *Albertan*, 25 March 1976.

higher ratio of beds per thousand residents (7.5) than the national average (4.5).[42]

The Hospitals React

A number of hospitals responded quickly to the government's spending decisions by appealing to the Hospital Services Commission, and by issuing warnings about potential dislocations in the hospitals. For example, the Red Deer General Hospital district board warned that its home care program -- an acknowledged form of cheaper health care than hospital care -- might have to be reduced by half if funding were not increased above the eleven percent announced by the government.[43] In March an official of the Misercordia Hospital in Edmonton warned that the hospital's outpatient services would have to be curtailed without additional funding.[44] An official of the Royal Alexandra Hospital in Edmonton stated that that hospital faced a shortfall of $500,000 and would be forced to close beds.[45] The University of Alberta Hospital announced it would have to reduce overall service by five percent in the face of the province's funding decision.[46] The Calgary General Hospital expected to close approximately 150 beds,[47] while the Holy

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[42] Ibid.
[43] *Edmonton Journal*, 23 January 1976.
[44] *Edmonton Journal*, 12 March 1976.
[45] *Albertan*, 2 March 1976.
[46] Ibid.
[47] *Albertan*, 5 April 1976.

Cross Hospital in Calgary planned to close thirty five beds[48], and the Rockyview Hospital in Calgary, a total of fourteen.[49] The government itself estimated that in order for the overall ratio of beds to be reduced to one closer the national average, some 400 beds would need to be closed in Alberta hospitals.[50]

By April the Commission received appeals from some thirty hospitals.[51] The minister came close to reversing his earlier position when he announced that a *limited* amount of funding would be available for hospitals whose appeals were accepted.[52] At the same time, the minister continued to maintain that hospitals were responsible for service levels:

> If they decide to close down active treatment beds it is because an individual hospital has decided that it is the lowest priority(,...) that other services in the hospital have a higher priority than keeping the beds open.[53]

Despite the minister's efforts to hold hospitals responsible for the levels of service provided to the public, the outcry over restraint centered, not on the internal allocation decisions of hospitals, but on the province's funding decisions. Several physicians, who chose to remain anonymous, charged that restraint was inflicting hardships on certain communities and was making difficult

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[48] *Albertan*, 23 April 1976.
[49] Ibid.
[50] *Edmonton Journal*, 3 May 1976.
[51] *Albertan*, 27 March 1976.
[52] Ibid.
[53] *Alberta Hansard*, 3 May 1976, p. 1035.

the treatment of cardiac patients.[54] Although the minister contested these charges,[55] he continued to face criticism from the legislative opposition and from the media. Criticism questioned the value of limiting public spending at a time of economic prosperity. Bob Clark claimed that individuals requiring heart surgery might be forced to wait up to twelve weeks because of service cutbacks,[56] and added this comment:

> At a time when we are stashing the sum of $1.5 billion in a Heritage Savings Trust Fund, it is ludicrous that 400 beds are being closed in the province.[57]

The New Democratic Party Leader, Grant Notley, asserted that "you can't throw a blanket restraint policy over the hospitals and say 'You've got to live with it.'"[58] An editorial in the *Edmonton Journal* also criticized the government, and argued that restraint was damaging to the public:

> It's great for Miniely to say that the hospital boards make their own decisions, but they have only three options: staff, supplies, or beds(....)People's needs should not be met in terms of doing better than any other province. They should be met in terms of Alberta(....)Their interests cannot be sublimated to the arm twisting of politicians and bureaucrats far removed from issues in which life and death are weighed.[59]

Fred Kennedy, writing in the *Albertan*, was equally critical:

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[54] Brian Butters and Gorde Sinclair, "Heart Surgery Not Affected by Spending Curbs: Miniely",*Edmonton Journal*, 5 May 1976

[55] Ibid.

[56] *Edmonton Journal*, 3 May 1976.

[57] Ibid.

[58] Ibid.

[59] Ibid.

> There is absolutely no sense or reason for a policy of this kind being adopted in a province that is so rich it doesn't know what to do with the money.[60]

The Case of Medical Research

If the provincial government was less than enthusiastic about new large-scale spending in 1976 on the hospital system, it evidently felt differently about expanding and supporting the technological base of medical research. The government expressed its choice of priorities by using the Heritage Fund to initiate new capital construction in the field of medical research. In the summer of 1976 the Hospitals minister announced a plan to contribute over $100 million to this effort from the Fund.[61] The total allocation rose to approximately $135 million by October; the government announced that the Royal Alexandra Hospital would receive $46 million for research, and the Calgary Children's Hospital and the Alberta Science Centre would receive a total of $10 million.[62] The bulk of the $135 million grant -- approximately $87 million -- was allocated for the construction of a medical research centre at the University of Alberta.[63]

The magnitude of the grant caused at least one observer in the media to question the timing of the decision because "it has been suggested that the government would be

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[60] Fred Kennedy, 'I Write as I Please,' *Albertan*, 29 June 1976.
[61] *Edmonton Journal*, 20 July 1976.
[62] John Barr, "Still More Funds For Health Research", *Edmonton Journal*, 23 October 1976.
[63] Walter Nagel, "$87 Million To Be Spent on Alberta Health Centre", *Medical Post*, 26 October 1976.

reluctant to 'make a formal announcement to spend $100 million during this period of restraint."[64] Perhaps because the funds did not come from normal sources, the government felt this would not be a problem for the taxpayers. According to Premier Lougheed, the grant was a productive use of provincial funds because it would contribute to enhancing Alberta's visibility:

> (The facility at the University) would give Alberta a lead in health care research in this country at a time when concern has been expressed over the degree of support for health care research.[65]

Controversy Over Hospital Budgets

Despite its initiative on medical research, the government continued its approach with regard to the issue of hospital operating costs. In the autumn and winter of 1976, debate began to centre upon the level of increase for hospital budgets in the following fiscal year. Some hospitals were already cautiously predicting a smaller increase from the government.[66] The Alberta Hospitals Association speculated that the government would grant an increase of between seven and eight percent, figures significantly below the eleven percent received for fiscal year 1976.[67] The Misercordia Hospital warned that this would force the hospital to lay off employees.[68] Other hospitals -- such as the Royal Alexandra and the Calgary General --

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[64] *Edmonton Journal*, 20 July 1976.
[65] *Medical Post*, 26 October 1976.
[66] *Edmonton Journal*, 21 September 1976.
[67] Ibid.
[68] Ibid.

could not make any predictions about the effects of further restraint.[69] According to a representative of the Alberta Medical Association, the rising costs of hospital and health care have been virtually unavoidable; government restraint measures would not be effective in dealing with the problems of costs:

> The naked truth is that good health services, as we cautioned over a decade ago, are expensive. They will undoubtedly cost more in the future -- not only as a result of inflationary factors but because of the rising expectations of a sophisticated and civilized society.[70]

The approach of the provincial government seemed to be directed at reducing expectations, at least as far as its own involvement in financing was concerned. It is not surprising that the Hospitals minister mused about re-instituting some form of local requisitioning to provide hospitals with additional funds.[71]

The spectre of less funding for the hospital system was raised by New Democrat Grant Notley, who presented figures from a government memo which seemed to confirm earlier predictions of a seven to eight percent increase for the hospitals. He also asserted that the government had, in fact, already made up its mind to limit increases in 1977 to 7.5 percent.[72] Miniely responded somewhat evasively by arguing that the figures were tentative and unofficial:

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[69] Ibid.
[70] *Edmonton Journal*, 23 September 1976.
[71] Brian Tucker, "User's Fees For Health Care Under Study", *Edmonton Journal*, 1 October 1976.
[72] *Edmonton Journal*, 9 October 1976.

> Government policy isn't government policy until a cabinet decision is made on the question(....)The memo (cited by Notley) was a preliminary determination, a part of a normal budgetary procedure of any organization. In no way is it related to any final decision on a level of hospital funding.[73]

In other words, the figures had been proposed by the Commission and not yet formally sanctioned by the cabinet.[74]

By November, however, the "preliminary determination" had been adopted: Miniely announced that the base rate for funding increases would range between 6.5 and 8 percent, but not above 10 percent.[75] This maximum figure, according to Miniely, would allow for "a certain percentage to that base rate for special programs and growth needs in special areas."[76]

By the end of the year the minister indicated that restraint had been a positive government initiative; it had increased awareness about the need to control spending and cost levels.[77] Events of 1977 revealed, however, that the new "awareness" was no more supportive of the government's efforts than it had been the year before. The government and the minister of Hospitals and Medical Care soon came under fire for their inability to fulfill the stated goals of restraint especially as it applied to hospital construction. The government was also soon embroiled in a nurse's strike in July: nurses, too, were aware of restraint in the

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[73] *Albertan*, 14 October 1976.
[74] Ibid.
[75] *Albertan*, 18 November 1976.
[76] Ibid.
[77] Ibid.

hospital [redacted] and they expressed their disapproval. In both cases, the government attempted to demonstrate both its ability to manage the environment and to express its interest in minimizing the visible effects of strike action on public access to hospital facilities.

Construction Costs and Confusion

The minister addressed himself to the issue of hospital construction costs when it was revealed that the cost of building new hospitals in a number of communities had increased significantly.[78] The minister responded to the information by suggesting that it was the fault of poor local planning, and that "frills would have to go".[79] He emphasized that Alberta already spent more on hospitals than any other province.[80]

Miniely's attack on "frills" was challenged by the executive director of the Red Deer General Hospital, who insisted that there were no frills in the hospital's construction activities, and that funding reductions would result in reduced service.[81] The oft-expressed warnings about service reductions were seen by the minister as predictable responses from big spenders. When the government

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[78] Hospital construction costs had risen to $92 million from the estimated $54 million in the following communities: Red Deer, Cardston, Edson, Lac La Biche, High River, and Viking. The hospital construction costs at Ft. MacMurray had risen to $40 million from $25 million. Andy Imlach, "Hospital Building Cutbacks Due To High Costs: Miniely", *Edmonton Journal*, 3 March 1977.

[79] Ibid.

[80] Ibid.

[81] Gail Helgason, "Hospital Cost Scrutiny 'Bewilders' Boards", *Edmonton Journal*, 11 March 1977.

announced its 1977-1978 budget in April, Miniely remarked that "this government is obviously in no position to accept on a *carte blanche* basis that simply what the hospital board thinks, is what it requires."[82] To emphasize his position, the minister warned that centralization might go so far as to permit the government to examine hospital budget spending priorities in detail in order to advance the cause of cost control.[83] He presented figures showing that the costs of the Red Deer project had risen from $3.8 million to $6.6 million.[84] The minister stated that the budget would be re-checked, and offered the suggestion that funds were being budgeted by the hospital for other activities.[85]

Controversy and the Construction Freeze

In the light of the controversies surrounding capital costs, the minister announced in May the implementation of a ten-month freeze on all new construction, renovation, and replacement in active treatment facilities.[86] Miniely again expressed reservations about frills and "cadillac design". Although hospitals would be permitted to continue project planning, the minister warned:

> If we allow the continuation of local planning, and if we find the estimated project cost is excessive, we will demand a scaling down and redesign.[87]

He explained that since 1971, construction costs for

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[82] *Edmonton Journal*, 29 April 1977.
[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] *Edmonton Journal*, 14 May 1977.
[87] Ibid.

hospitals had risen by 175 percent while overall construction costs in Alberta had risen only 80 percent.[88] He stated further that the government would scrutinize, though not freeze, the construction of extended care facilities; all future construction of hospital facilities would be subject to new guidelines:

> New hospital renovation and replacement policy and control (will) be developed and set into place to try and get a grip on skyrocketing construction costs.[89]

The debate over construction costs continued, nevertheless, and it focused increasingly on Miniely's ability to handle his portfolio.

The minister's decision to freeze new construction impressed neither the High River hospital board which said it would not accept the freeze,[90] nor his political opponents. Ray Speaker of the Social Credit opposition issued a call for Miniely's replacement by someone "with more administrative ability".[91] The Opposition leader belittled the minister's attempts:

> Here we have a minister presiding over a portfolio that will spend $645 million this year, telling us he wants to freeze things so he can find out what's going on.[92]

Clark raised the issue of construction costs for a new wing

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[88] Ibid.
[89] Ibid.
[90] *Albertan*, 4 June 1977.
[91] *Edmonton Journal*, 5 May 1977.
[92] *Albertan*, 14 May 1977.

of the Calgary General Hospital.[93] Clark argued that Miniely should have set construction spending limits in 1975,[94] and pointed to what he considered the minister's failure to restrain capital costs in the hospital sector.[95] The minister attempted to strengthen his position by placing blame for the difficulties onto the Hospital Services Commission[96]-- which the government would soon dismantle.

The freeze was not air tight, however. In August, the government began to recant on the freeze; the Hospitals minister recommended that the Cabinet exempt the town of Hinton from the "holding pattern".[97] Following a meeting in September between the minister and the hospital board in High River,[98] a decision was reached to exempt that community as well. Hinton and High River were exempted because of the demand for new facilities in areas of "growing population and the increasing needs of the elderly."[99] Yet even these exemptions did not escape the guidelines: the government indicated that it would not permit "elaborate designs".

The Nurses Strike

At the same time that the debate over construction costs was underway, the government found itself faced with a

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[93] *Edmonton Journal*, 3 May 1977.
[94] Ibid.
[95] Ibid.
[96] Andy Imlach, "Management Weakness Blamed in Hospital Cost Escalation", *Edmonton Journal*, 16 May 1977.
[97] *Edmonton Journal*, 22 August 1977.
[98] *Edmonton Journal*, 20 September 1977.
[99] *Alberta Hansard*, 14 October 1977, p. 1473.

nurses' strike in the summer of 1977. Earlier in the year, the Alberta Association of Registered Nurses(AARN) announced that if its wage demands were not met satisfactorily, the affiliated nurses would strike in July.[100] The union demanded wage increases of between 32 and 42 percent, new shift arrangements, and a shorter work week.[101] Such a settlement, the AARN argued, would make working conditions in Alberta comparable to those enjoyed by nurses in Saskatchewan and British Columbia.[102] The major difficulty faced by the Alberta nurses, however, was that wage and price controls restricted their increases to six percent.[103]

At the end of June, the nurses voted to strike,[104] and a walkout began on July 4.[105] The strike began at seven hospitals,[106] but the union warned that it would soon be extended to others.[107] A number of hospitals, including the Royal Alexandra said that they might be forced to close during the strike.

Four days after the strike began -- when the union threatened to strike at the additional twenty hospitals -- the government decided to order the nurses back to work

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100 *Edmonton Journal*, 4 February 1977.
101 Ibid.
102 Ibid.
103 Ibid.
104 Doug McConachie, "Alberta Nurses Vote For Strike",*Edmonton Journal*, 24 June 1977.
105 Doug McConachie, "Nurses Begin Strike", *Edmonton Journal*, 15 July 1977.
106 The seven hospitals were the Royal Alexandra, the Edmonton General, Red Deer General, the Holy Cross Hospital, the Grande Prairie General, and St. Michael's Hospital in Lethbridge. Ibid.
107 Ibid.

under a provision of the Alberta Labour Act.[108] The minister of Labour, Neil Crawford, explained that the government took the decision because a lengthy and expanded strike would cause "unreasonable hardship and unacceptable reductions in the level of health care services."[109]

This action did not end the dispute, even after it was turned over to arbitration. Although the nurses had reduced their wage demand to thirteen percent just prior to the strike, the arbitrator, Mr. Justice Donald Bowen, recommended a total increase of nine percent.[110] Justice Bowen explained his decision, noting that the wage controls did not technically cover this strike situation because he considered his arbitration to be an "emergency tribunal".[111] The Alberta Hospitals Association insisted that without added provincial funding the full award could not be met:

> A.H.A. spokesman Vern Rheault said the award could cause some difficulties because government funding of hospitals in 1977 provided for only a six percent increase in budgets.[112]

Because the increase went beyond that provided for in the anti-inflation guidelines, the provincial government referred the arbitrator's decision to the Anti-Inflation

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[108] Section 163. Telephone interview with Simon Renouf, Executive Director, United Nurses of Alberta, Edmonton, 11 April 1981. Also see Amanda Touche, "Nurses Ordered to Work", *Edmonton Journal*, 8 July 1977.
[109] *Edmonton Journal*, 9 July 1977.
[110] *Albertan*, 26 August 1977.
[111] Ibid.
[112] Ibid.

Board (AIB) in Ottawa.[113] At the same time, the nurses union announced that it would take its case to the Alberta Supreme Court if the hospitals did not provide its members with the increase awarded in arbitration.[114]

The conflict over the nurses' contract was resolved only when the government enacted the Temporary Anti-Inflation Amendment Act, which finally awarded the nine percent increase by exempting the nurses from the original legislation.[115] The Hospitals minister announced that a total of $2,709,000 would be provided to 79 hospitals in the Province in order to meet the wage and salary increases.[116]

The Demise of the Commission

It was also during the summer of 1977 that the minister of Hospitals and Medical Care revealed his intention to dismantle both the Hospital Services Commission and the Health Care Insurance Commission, and to integrate them directly into the Department of Hospitals and Medical Care.[117] The initiative was accompanied by the minister's proposal to begin a pilot study "to discover ways for hospital operations to be monitored more closely by boards and the province."[118] Not unlike earlier explanations for administrative changes in the hospital field, Miniely announced the dismantling of the Commissions which he argued

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113 *Albertan*, 23 September 1977.
114 See *Edmonton Journal*, 13 October 1977.
115 See the *Temporary Anti-Inflation Amendment Act* (R.S.A. 1977, c. 96).
116 *Edmonton Journal*, 26 August 1977.
117 *Edmonton Journal*, 17 August 1977.
118 *Edmonton Journal*, 12 August 1977.

was necessary to "...bring accountability and efficiency in to a field responsible for more than a fifth of the provincial budget."[119] Miniely also advocated renewed ministerial oversight of the day-to-day decisions of the civil service in order to improve accountability:

> There is a lack of accountability because the commission is at arm's length. I am not satisfied with some of the administrative management procedures, the structure, and organization.[120]

Although, as we will recall, the original decision to establish the Commission in 1970 was in order to "depoliticize" policy making, the new decision would grant ministers and cabinet greater powers over the hospital system.

What is clear from the decision to reorganize administrative structures is that the government, like its Social Credit predecessor, felt that maximum administrative and social benefit would be attained by altering the "chain of command." The two approaches, however, were quite different. The Social Credit government felt that by removing the Health minister from the arena of the daily concerns of particular hospital projects, he would be able to move forward with general policy programs which the commission would then implement. By contrast, the Conservatives viewed the existence of the hospital commission as an encumbrance on the government's ability to

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[119] Editorial, "The Buck Stops Here", *Edmonton Journal*, 17 August 1977.
[120] Rod Ziegler, "Whistle Finally is Blown on Spiralling Health Costs", *Albertan*, 14 May 1977.

control and be accountable for hospital policy making. The approach suggested that the financing of hospital facilities had become so political that it would be absolutely necessary for the Minister to oversee developments in the field -- even to the extent of scrutinizing particular details of hospital projects.

One editorial comment approved of the direct intervention of the minister and cabinet in the day-to-day decision making of hospital policy:

> (The) extension of the political arm of government into health policy is appropriate, because major decisions about Alberta's health care system -- its size and its cost -- are political choices that can be made only at the highest level. With this reorganization, much of the control over the health system will rest with the cabinet and specifically with Mr. Miniely.[121]

The editorial also indicated what it considered to be a major structural weakness of the existing system:

> All too often a semi-autonomous commission has not so much protected hospitals from government interference, but diffused opposition and insulated the government from the political implications of its own decisions.[122]

Clearly, the insulation was rather thin; although the minister attempted to ascribe blame for difficulties in the hospital sector to the Commission, he was nevertheless deeply embroiled in the political implications of his decisions. Indeed, the issue at hand seems to have been the minister's ability to manage the environment. Changing the administrative structures could only further underscore the

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[121] Ibid.
[122] Ibid.

minister's responsibility for the lack of success of the government's policies. Perhaps it was hoped that the new initiative would provided a temporary reprieve from the barrage of criticism emanating from the opposition. Miniely did not feel "that commissions are justified in modern government".[123] He emphasized that the department's budgeting should be accountable to the minister, and that "important information" should not go through the bureaucracy.[124] Miniely blamed the Commission for its failure to live up to the government's expectations about what needed to be done to control costs and expenditures.[125]

Both Opposition parties criticized Miniely for his general approach to the problems in hospital policy and to his new initiatives. Opposition M.L.A. Ray Speaker took the government to task for what he termed irresponsible oversight.

> A department of government if administered correctly can carry on the health care responsibilities of this province. The Commission, if administered properly, in communication as it should have been, could have functioned with(...)ministerial responsibility. The decision-making rested with the minister(...) and in turn the cabinet(....)The Minister is unable to make decisions with regard to needs at the local hospital level.[126]

N.D.P. leader Grant Notley predicted that expanded centralization would result in "...more delays, with paper

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[123] *Albertan*, 15 October 1977.
[124] Ibid.
[125] *Albertan*, 20 October 1977.
[126] *Alberta Hansard*, 8 November 1977, p. 1958.

piling on the minister's desk."[127] The minister envisioned more provincial control over hospital affairs in the future:

> Policies stipulating how much hospitals can spend on new building and advancing technology will be unveiled soon(....)We are going to have to make choices very carefully.[128]

The changes in administrative mechanisms promised by the government did not bring to an end the debates over spending, efficiency, and accountability. The minister was criticized for cost overruns in construction underway at the Foothills Medical Centre in Calgary.[129] The minister responded by saying that the Commission had not provided him with sufficient information; he added that the new system would improve communications in the hospital sector.[130] Opponents of restraint measures continued to perceive them as punitive. The minister was taken to task for failing to be sufficiently sensitive to the effect of the restraint measures on the public. One journalist's account put it this way:

> Miniely failed to set directions for the delivery of quality health care in Alberta. He has failed to balance his responsibility to keep costs down with his responsibility to provide quality health care.[131]

Restraint and Calgary Hospitals

The government's restraint policies enabled its opponents to charge that restraint was reducing the quality

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[127] *Albertan*, 20 October 1977.
[128] *Edmonton Journal*, 21 October 1977.
[129] Duncan Thorne, "Miniely 'Incompetent' Socred Report Charges", *Albertan*, 10 November 1977.
[130] Ibid.
[131] *Albertan*, 24 January 1978.

of service at Calgary hospitals. Early in 1978, the Leader of the Opposition charged that patients were waiting for up to ninety days to be admitted to that city's hospitals because of a shortage of beds.[132] Several newspaper commentators took up Bob Clark's banner. Fred Kennedy, writing in the *Albertan*, attacked what he argued to be the silence of Calgary's Conservative legislators on the problem, while Clark -- a member from Olds -- was left to defend the Calgary hospitals.[133] Les Buhasz, also writing in the *Albertan*, considered restraint untimely during a period of prosperity.[134] Pat McMahon of the *Calgary Herald* offered these comments:

> If a close relative of a provincial cabinet minister needed care, I wonder if he'd have to wait 90 days to get a bed.[135]

The *Edmonton Journal* reported in February that approximately 5,000 people were waiting to be admitted to three Calgary hospitals -- a three-fold increase since 1975.[136] In apparent response to the effect of hospital decisions on the public, the Department of Hospitals and Medical Care agreed to provide funds for additional beds for Calgary hospitals, even though, according to the minister, "there is no immediate shortage."[137] According to the Department, beds would be phased in according to the city's population

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[132] *Herald*, 23 January 1978.
[133] *Albertan*, 26 January 1978.
[134] *Albertan*, 28 January 1978.
[135] *Herald*, 15 February 1978.
[136] *Edmonton Journal*, 18 February 1978.
[137] Duncan Thorne, "More Hospital Beds Slated for Calgary", *Albertan*, 10 March 1978.

growth.[138] Miniely explained the decision this way:

> As the beds are needed we will look to phase in those beds which had been closed down in past years. But(...)Edmonton and Calgary(...) continue to have the highest number of hospital beds per 1,000 population of any province in Canada other than Saskatchewan.[139]

The minister also resurrected the idea of permitting limited requisitioning powers for hospital boards if they felt provincial funding insufficient.[140] The renewal of requisitioning was seen by the *Edmonton Journal* as a means for the province to escape responsibility for the ramifications of restraint measures:

> All this talk of local autonomy -- that's the lure Mr. Miniely throws out as he discusses shifting a share of hospital costs onto the municipalities -- ignores a basic principle: health care is clearly a provincial responsibility. It requires the setting of province-wide standards.[141]

Although the province did not, in fact, reinstate local requisitioning in 1978, it did hold fast to its desire to limit percentage increases for spending in the hospital sector for fiscal year 1978-[redacted]e government decided to keep the funding increase at the same level as that of the previous year.[142] Within days, hospitals began warning of appeals and service cutbacks. Foothills Hospital,[143] Lethbridge General Hospital,[144] and the Calgary General

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[138] Ibid.
[139] *Alberta Hansard*, 18 April 1978, p. 706.
[140] *Albertan*, 3 April 1978.
[141] *Edmonton Journal*, 7 April 1978.
[142] *Edmonton Journal*, 19 April 1978.
[143] *Edmonton Journal*, 19 April 1978.
[144] *Edmonton Sun*, 28 April 1978.

Hospital[145] all warned of imminent cutbacks in their services. Miniely argued that the province was indeed quite generous; nevertheless, he indicated that appeals might be considered, but that they must reflect legitimate need.[146]

Calgary alderman Brian Lee expressed support for the hospitals, and complained of staff hiring freezes and service declines in the city's hospitals.[147] At the same time, the Alberta Hospitals Association questioned the wisdom of continued restraint, citing a federal government study which suggested Alberta's hospital costs to be low in comparison with those of other provinces.[148]

In June, with some sixty hospitals submitting budget appeals,[149] the government softened its position -- as it had previously done with regard to issue of the supply of beds -- and announced that a total of $19 million would be made avialable to hospitals demonstrating "need".[150] In all, 72 percent of the appeals were approved.[151] The Hospitals minister expressed reservations about the added funding, noting that the total percentage of growth in hospital funding was almost 12 percent above the previous year.[152] Meantime, Alderman Lee saluted the government's change of

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[145] *Herald*, 5 May 1978.
[146] Andy Imlach, "Hospitals Plead for More Cash", *Edmonton Journal*, 6 May 1978.
[147] *Albertan*, 16 May 1978.
[148] *Edmonton Journal*, 18 May 1978.
[149] *Edmonton Journal*, 15 June 1978.
[150] Of that amount, $6.5 million was allocated to Calgary hospitals, and another $640,000 to Edmonton hospitals. Ibid.
[151] Ibid.
[152] *Albertan*, 17 June 1978.

heart:

> Lee says he believes (the fact) that Calgary hospitals are receiving $6.5 million of the $7 million they'd appealed for, showed the provincial government "sensitive" to both public and city council concerns.[153]

A number of hospitals also expressed satisfaction at the additional funding: the University of Alberta Hospital noted that it would not be forced to close beds.[154] Some in the news media were not quite so generous. An editorial in the *Albertan* suggested that the process of reconsidering funding policies indicated either that the government poorly estimated funding needs of hospitals, or that it did not have much "political backbone".[155] This, according to the newspaper, reflected badly on the minister and on the government's handling of hospital policy:

> Mr. Miniely seems to have assumed that if hospitals were squeezed for funds, they would respond by revising their programs and practices so as to make what money they had go further. He was wrong. The hospitals merely squealed with pain, predicting reductions in service and consequent anguish for the public unless they got more money at once.[156]

By the spring of 1978 the provincial government had certainly not succeeded in developing a consensus about its restraint policies or even in reducing expectations. Events were characterized by conflicts about jurisdictional priorities, and debate about the government's ability to meet its own stated goals.

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153 *Albertan*, 19 June 1978.
154 *Edmonton Journal*, 20 June 1978.
155 *Albertan*, 20 June 1978.
156 Ibid.

Conclusion

The advent and implications of Last Dollar Financing and Global Budgeting led, as we have seen, to the development of a political environment in which attention was directed at the effectiveness of administrative structures. Attention was also directed to the extent to which government performance corresponded to the proclaimed intent of rationalizing and monitoring of the costs of hospital services.

The government sought to deal with criticism in two ways. It emphasized that while Alberta was not expanding hospital care services as much as some would like, neither was it imposing a level of restraint as severe as that in other provinces. The government also argued that other actors -- such as unions and hospital boards -- were responsible for service reductions because those groups determined the internal priorities for the hospitals. As we have seen, the continued existence of the boards as centres of political influence which lost their funding powers placed constraints upon the ability of the government to meet the goals required by centralized decision-making.

Another rationale for restraint, as well as for protest against restraint, rested on an appeal by various actors to the public's sense of equity -- either in terms of protecting the taxpayer's pocketbook or the benefits of preserving the existing level of accessible hospital care.

By 1978 we found contradictions in the approach taken by the provincial government. On the one hand, it boasted about the level of health care provided to Alberta residents; on the other hand, the evidence of this "pride" -- the high ratios and expenditures -- was precisely what the government considered to be the problem with the health care system. In addition, the image of toughness softened, and unpopular measures were often followed by a grudging willingness on the part of the provincial government to make concessions in the face of significant opposition. In the final chapter we shall make some observations about the character of hospital policy in Alberta and the operative assumptions which have guided it.

V. Conclusions

This chapter offers some general observations about hospital policy in ALberta. It addresses three themes: the relationship between rational planning and politics; perspectives on current notions of health care; and alternative perspectives government might consider in dealing with the issue of restraint. The focus linking these various themes is the relation between the goals and the means to accomplish these goals in public policy. Such concerns remain particularly relevant as recent events suggest that the problems and issues considered of the 1970s have not yet been resolved.

In summary, this thesis suggests the following conclusions about the trend of hospital policy in Alberta between 1970 and 1978:

1. Hospital policy was structured by two principles. One principle recognized the role of the provincial government to provide universally accessible hospital care. The other principle recognized the role of the government -- as the trustee of the taxpayer's money -- to reduce expectations about the government's involvement in supporting the hospital care sector. We argued that this principle related to the idea that continuing government expenditures on hospital care did not contribute to economic productivity. Hence, the government was interested in attempting to control and monitor the growth of spending on hospital services.

2. These two principles clashed because on the one hand universality implied significant government expenditure, while "trusteeship" implied the restraint of government expenditures on hospital services. The clash between the two notions was seen in the way government responded to resistance to its restraint initiatives: restraint was said to benefit the taxpayer, while at the same time not interfering with high levels of services as expressed in statistical data.
3. The process of rationalization -- as conceived by Max Weber -- shaped events in such a way as to focus attention almost entirely upon the effectiveness of policy instruments and the impact of those instruments upon the power of various actors.
4. The government's capacity to implement restraint was constrained by the unions and by the existence of local hospital boards which were able to allocate funds within their institutions. The boards argued that restraint forced them to take measures which would affect the level of health care available to the public.
5. Given the emphasis on jurisdictional power and priorities, and administrative structures, it is not surprising that debate and controversy focused more on the *means* of hospital policy than on the *ends*.

We will remember that recent hospital policy in Alberta has revolved around around the efforts of government to address the "problem" of growing expenditures on hospital

care services. Secondly, hospital policy has also revolved around the consequences of government initiatives for the distribution of power between the provincial government and local hospital boards. We have found that local control over administrative and funding policy has declined as government has undertaken measures to either standardize services or to control funding levels.

Recent events confirm that the focus of political debate and of policy making have not changed significantly since 1970. The jurisdictional conflict continues to overshadow more fundamental questions about the nature of hospital care, and health care in general. Although the requisitioning powers of local boards was seen to interfere with provincial priorities during the 1970s,[1] more recent government pronouncements suggest that requisitioning is now perceived to be a viable instrument to pressure boards to restrain their spending levels rather than to permit them access to additional funds from municipalities.

Hospital Policy in 1981

Although the provincial government still maintains its traditional concern for hospital care expenditures, a limited degree of local requisitioning is again being

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[1] Recall the comment of the Minister of Health and Social Development, Neil Crawford, in 1973, in which he argued that accountability to the public is reduced when too many sources of funding become available for the financing of hospital services: "As soon as you have any body which has two sources of income you find that your financial accountability becomes very shakey." *Alberta Hansard*, 2380, 17 April 1973.

considered. The current minister of Hospitals and Medical Care, Dave Russell, argues that "philosophically (Last Dollar Financing) was right, but perhaps not economically."[2] According to Russell, the purpose of local requisitioning would be "to bring hospital costs under control."[3] Clearly, local autonomy, as far as the government is concerned, is not a hindrance to fiscal accountability, but rather promotes it. Such an approach appears to be a glaring contradiction given the government's historical determination to control expenditures by removing the power to raise funds from local boards.

Criticism of Russell's recent proposals also display a changed attitude toward "local autonomy." Roy Farran, an early advocate of centralization of hospital policy making, has since repented. The former M.L.A. and currently newspaper commentator, now believes that the centralization of funding control was not enough to restrain hospital funding requests:

> When a board is allowed to spend with no parallel responsibility for collection, the result is predictable. Spending will balloon with restraint.[4]

Farran's view now differs from his previous argument that the power to collect funds was too large a grant of power to hospital boards especially in view of the increasing responsibilities of municipal governments. The mayor of

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[2] Dave Cooper, Lorraine Locherty,"Hospital Tax Warning" *Edmonton Journal*, 16 April 1981.
[3] Ibid.
[4] Roy Farran, "Holding the Purse-Strings is a Politically Risky Task", *Edmonton Journal*, 21 April 1981.

Edmonton, Cec Purves, has reiterated the earlier view, asserting that municipalities could not bear additional financial commitments.[5]

Editorial criticism of the Minister's proposals also saw requisitioning as a burden more than a freedom. Also, and equally significant, is the argument -- so reminiscent of previous years -- that government is unable to fulfill its goals. An *Edmonton Journal* editorial made the following comments:

> Mr. Russell wants to shift the political responsibility for the tough decisions needed to bring expenditures under control off the back of the provincial government and onto local ratepayers. (He) wants us to do a little individual bleeding because **he is unable to introduce the cost control measures to reduce health care expenditures.** Instead of doing it himself, he wants us to say "no" to requests for more money from those hospital boards which either refuse or are unable to live within their budgets.[6]

Olive Elliot, also commenting in the *Edmonton Journal*, seemed to make the same point more bluntly:

> Is he (Russell) suggesting that the all-powerful Alberta government, which now pays virtually all hospital costs, can't control these costs?[7]

Perspectives about Health Care: Clarifying Means and Ends

The two guiding principles of centralized fiscal management and universal access provide the basis for the "power" to which Olive Elliot has referred. These principles, of course, contributed to the expansion of

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[5] *Journal*, 16 April 1981.
[6] "Russell's Boondoggle", *Edmonton Journal*, 18 April 1981. Underscore added.
[7] Olive Elliot, "Russell's Hospital Tax Cheap and Chintzy", *Edmonton Journal*, 18 April 1981.

bureaucratic structures and rationalization.

Earlier in this chapter, we suggested that this approach obscures larger questions: although actors continually speak about the problems related to restraint, cost levels, and so on, jurisdictional disputes emphasize the mechanics of administration rather than the ultimate goals which the mechanisms are designed to implement. Max Weber has argued that the rationalization of decision making is especially important in societies which place a premium on the supremacy of law.[8] Moreover, the desire to exclude subjective values in the process of calculation was a prime characteristic of the modern state. In order for rules and definitions to be predictable and comprehensible, they must be calculable.

In Weber's view, political interaction is founded upon notions of subjective value preferences, of "ethical irrationality."[9]

> These conceptions involve the notion that all human actions which approximate to rationality(...)must necessarily be grounded in irrationality ('ultimate values'), but that there is a fundamental dichotomy between reason and value.[10]

We will recall that the process of rationalization attempts to dispense with political values; it is "the methodological attainment of a definitely given and practical end by the

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[8] Reinhard Bendix, *Max Weber*, (Garden City N.Y.: Anchor Books, Doubleday 1962), p. 488.
[9] Anthony Giddens, *Politics and Sociology in the Thought of Max Weber*, Studies in Sociology (London: MacMillan, 1972), p. 57.
[10] Ibid., p.44.

use of an increasingly precise calculation of adequate means."[11]

In the case of hospital financing policy in Alberta the techniques for promoting restraint -- global budgeting, Last Dollar Financing, and even wage and price controls -- were rationalized mechanisms designed to be self-maintaining structures which ought to meet the expectations of the individuals who created them.

The reorganization of administrative structures indicates that a discussion of ultimate values became subordinate to discovering the best "system". Considering the conception of the "nature of policy" in rationalized terms, it appears that rationalized "policy" [redacted] a mechanism, the composite parts of which are expected to work together in harmony for the sustenance of the whole. The system may malfunction -- as in the case of the Hospital Services Commission -- and the responsibility for that breakdown lies with the system. In a like manner, public policy is expected to work or operate successfully when the system is created. Politics in these terms is the process of manufacturing these self-operating "organisms."

Through the process of defining priorities or reaching agreement about the structure of hospital financing, policy makers search for objective techniques in order to enhance calculability and control over decision-making. The impact of these techniques has been to cast aside questions of

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[11] Ibid.

value and opinion in favour of "objectively" correct procedures for resolving policy problems. Under these circumstances there can be no absolute scale by which to measure the "correctness" of "high costs" or "spending" apart from specific value preferences which orient attitudes and subsequently policy choices. Events in the hospital policy area suggest that rationalization of politics was the environment in which policy-making took place. Despite the fact that there were conflicts among the actors over priorities and power, the subject of conflict related primarily to the instruments of policy rather than to overarching values.

The significance of the jurisdictional conflict for the growth of rationalization in the field of hospital policy cannot be underestimated. The fact that the powers to spend and collect funds are institutionally separated from the detailed allocation of the funds by hospital boards certainly has contributed to the subordination of debate about ultimate values relating to health and hospital care. It is not surprising that the institutional responsibilities of the provincial government could not help but emphasize calculation, rationalization, and manipulation of administrative structures over discussion about larger issues.

In responding to the concerns of labour unions or hospital administrators, government policy have demonstrated the conflict between the priorities of centralized fiscal

management and those of various actors who continued to express their concerns about allegedly punitive measures. It is not clear, however, that even further centralization of collecting and spending powers would necessarily result in a move away from the pre-occupation with means and techniques. Such a change would require a greater commitment on the part of politicians to discuss some of the larger issues realated to health and health care.

Yet we have discovered that during the 1971-78 period actors continued to explain their priorities in terms of the rationalized concepts; unions explained their wage demands in terms of comparative statistics, the government explained its priorities in terms of supply and demand. The public assertion of values was never explained in terms of purely subjective values and interests. Individuals consequently become objects of "procedure" in a rationalized decision making environment and become subordinate to the procedure or program.

The responsibility for the failure of policies such as restraint during the 1970s was placed by political actors at the door of scientific techniques and abstract structures which come to assume the responsibility for "their" actions. Thus we found that the responsibility for hospital spending restraint lay with Alberta's higher ratio of hospital beds or with the need to get back into line with the rest of Canada's spending habits. Likewise, responsibility for inconsistent actions in the hospital field lay with the

inefficiency or mismanagement of the Commission, with lines of communication, or with other techniques. Individuals, therefore, assume the role of instruments of policy rather than the responsible initiators of political action.

The preoccupation with structure and technique -- so characteristic of a modern bureaucratic state -- seems to blur the distinction between *ends* and *means*. Thus for example, is the debate about restraint really an end in itself, or a means to something else? Restraint in the hospital sector -- cutbacks in funding, control over funding levels, wage controls -- are ostensibly means of achieving an ultimate end. Is local autonomy an end or merely one technique of achieving something else? As much as various actors disputed the effectiveness of various *means*, no one seemed to seriously debate the *ultimate goal* of these measures. It is difficult to understand how restraint, or for that matter local autonomy, was expected to produce healthier citizens.

Perhaps part of the problem lies in the traditional perspective of a market economy in relation to health care. Should choices for health care policy be defined in terms of supply and demand? Though policy makers speak in terms of supply and demand, it should be clear that people do not "demand" health care or hospitals the way they "demand" cars or clothing. The use of hospital facilities probably has little to do with the traditional notion of the demand for consumer goods; the use of hospital care facilities is

probably more a function of the consequences (or ravages) of contemporary life-styles.

The fundamental issue as yet unaddressed is what kinds of policies should be promoted, in order to achieve a healthier population and discourage resort to hospitals -- the use of which is hardly attractive by anyone's account. Should we outlaw cigarettes and alcohol? Should we subsidize alfalfa rather than tobacco? If on the other hand, these sorts of policies are considered to interfere with individuals liberty, this is quite another issue that restraint measures are unlikely to solve. But to be solely preoccupied with the levels of money being spent on hospital services obscures more fundamental questions about what we really mean by health care, health, and social well-being. What has come to be called hospital policy tells us more about jurisdictional relationships and funding policies than about their purpose. It is thus not surprising that political events increasingly focus upon the "how's" of policy rather than on the ultimate goals.

If restraint is not divorced from ultimate goals, and is part of a re-thinking about what "health" and "health care" mean, then it would be a more meaningful exercise. If government, for example, were to decide to reallocate spending from hospital care to preventive health care programs, restraint on hospital spending would not necessarily be punitive. But restraint, simply for the sake of reducing public spending on health care -- *especially*

when government acknowledges its support of the health care system to be its legitimate function is unlikely to produce the kind of support and success that has so far eluded the politicians.

Such an approach would make clear the belief that government support of health care system, for example, might be directed toward the erradication of heart disease in Alberta by the year 2000. Given a clearly articulated policy goal, all of the appropriate *means* would be employed to accomplish it: be it the use of commissions, locally funded and controlled programs, and so on. Unfortunately, it appears that this larger perspective is ignored in the way decision makers seem to be intoxicated by statistics and "planning". Yet if we accept that many ultimate goals of health care policy are obscured by rationalization, how might their importance be re-established in relation to means? Should a discussion of health care in society solely be constituted in terms of beds, requisitioning levels, wing renovations, and so on? Perhaps we should begin to concern ourselves with the values to be set for the role of health care in society. How might we begin to concern ourselves once again with values?

We might consider the argument of Max Weber, who proposed a counter balance to the consequences of bureaucracy and rationalization; In the beginning of this thesis, we introduced Weber's belief in the importance of assertive or charismatic authority which would begin to

re-emphasize ultimate ends. Weber also wrote about the "ethics of responsibility" in politics, which is also tied to the concern with ends and means.

> (...)there is an abysmal contrast between conduct that follows the maxim of an ethic of ultimate ends(...) and conduct that follows the maxim of an ethic of responsibility in which case one has to give an account of the foreseeable results of one's own action.[12]

In accordance with this ethic, Weber argued that individuals become cognizant of the consequences of their own actions and take responsibility for them, rather than to attribute the cause or the consequences to a force outside of oneself.

> When good intent leads to bad results, then in the actor's eyes, not he but the world or the stupidity of other men, who made them thus, is responsible for the evil.'[13]

As a part of political life, this ethic would restrain any tendency of charismatic authority to otherwise act utterly irresponsibly. The increasing tendency to rely on the experts and on the promise of proper management for the scientific evaluation of policy alternatives lends itself to confront the democrat and the politician. It would be valuable to consider some implications of the views of critics of recent government policy such as Olive Elliot. One question we might ask is whether concern with restraint is very meaningful in view of the context in which government is funding hospital services in the first place.

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[12] Hans Gerth and C. Wright Mills, ed. *From Max Weber: Essays in Sociology*. (reprinted 1967: New York: Oxford University Press, 1946), p. 120.
[13] Weber cited in *Ibid.*, p.121.

The existing health care system is designed to provide high technologies and expertise to treat complex diseases; how will restraint make people well faster?

The utility of restraining expenditures on hospital care cannot be evaluated in isolation. Policy makers need to clarify whether government's goals today should be to enhance the health of the public (at all costs) or only to restrain the growth of government's support of the services. If restraint is unachievable because of the context in which it is proposed, then why continue to talk about it? Health care focuses primarily on treatment; as long as this is the case, then discussion about restraint will be seen as discussion about punitive measures inflicted on those involved in treating the public, and by consequence, the public itself. All talk of efficiency and even "adequate universal hospital care" are considered of little importance when policy initiatives are perceived to be punitive. Indeed, the policy makers, particularly the minister, will continue to be perceived to advocate measures inimical to the public interest. Andrew Snaddon of the *Edmonton Journal* has described the problem this way:

> A minister of welfare trying to keep costs down is easily depicted as a man so mean he hits kiddies, knocks old ladies down, and the hard-hearted Opposition will call for his resignation.[14]

This thesis has suggested that two guiding principles have constituted the parameters of the policy making process

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[14] Andrew Snaddon, "But Where to Lay the Axe Handle?", *Edmonton Journal*, 1 July 1978.

which have shaped hospital policy initiatives in Alberta since 1970. The implementation of Global Budgeting; the creation of the Hospital Services Commission, and the enactment of Last Dollar Financing, in the early 1970s, were all examples of increasing centralization which led to greater bureaucratic rationalization as discussed by Weber. We have concluded that the preoccupation with techniques, and the devotion to calculability, and predictability does not permit policy makers to address themselves to some of the larger questions to which we have referred in this chapter. In light of recent events, it remains doubtful whether a reassessment of the relationships between ends and means can become a reality. It is hoped that this study of the politics of hospital financing in Alberta has contributed to an understanding of the guiding principles effecting the path of public policy in Alberta.

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