University of Alberta

Extra-Billing and the History of Health Insurance in Alberta, 1979-1984

by

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ABSTRACT

The question of whether or not to charge patients for access to health care has been a contentious one in Canada. The 1984 federal *Canada Health Act* created the policy infrastructure needed for the federal government to penalize provinces that allowed patient charges. However, in 1984 the Alberta government refused to abolish patient charges. An examination of political, professional, and labour views on extra-billing leading to this situation suggests that the Alberta government's decision not to abolish patient charges favoured physicians, and marginalized nurse and labour groups. As a result, the formal and informal roles of various interested parties in the governance of Alberta's health care system was entrenched.

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LIST OF ABBRVIATIONS

AARN:	Alberta Association of Registered Nurses
AFL:	Alberta Federation of Labour
AMA:	Alberta Medical Association
CPSA:	College of Physicians and Surgeons of Alberta
EPFA:	Established Programs and Financing Act
FOM:	Friends of Medicare
PSNC:	Provincial Staff Nurse Committee
UNA:	United Nurses of Alberta

INTRODUCTION

The question of whether or not patients should pay for medical care from their own pockets has been a contentious one in Canada. The 1984 federal *Canada Health Act* created the legal infrastructure at the national level to sanction provinces that allowed patient charges in the form of financial penalties. However, because health care is considered within the provinces' constitutional purview – and not the federal government's – the decision to abolish patient charges was made by provincial governments. In Alberta, the debate over one particular type of patient charge, extra-billing, illustrates the principles and trade-offs that were inherent in this decision. An examination of political, professional, and labour views on extra-billing policy, as well as their respective roles in shaping the Alberta government's decision not to implement the *Canada Health Act* in 1984, provides insight into the development of health care system governance in Alberta.

The federal government, in making the case for new legislation in 1984, frequently used the province of Alberta, where the practice of extra-billing in particular seemed to be an especially critical issue, as a cautionary tale.[1] The federal government was able to make an example of Alberta in this way, in part, because of the high rate of extra-billing in the province. Political scientist Carolyn Tuohy estimates that 40 percent of Alberta physicians extra-billed in the early 1980s, compared to about 10 percent of

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[1] See Monique Bégin, *Medicare: Canada's Right to Health*, (Ottawa: Optimum Publishing International, 1986).

physicians nationally.[2] The Alberta government's support of patient charges also worked in favour of the federal government's use of the province as an example. Dave Russell, Alberta's Minister of Hospitals and Medical Care, brought forward two pieces of legislation to entrench patient charges in the early 1980s.[3] Later, in 1984, Russell refused to abolish extra-billing after the *Canada Health Act* had been passed, choosing instead for the province to endure the financial penalties created by the act.

The decision of the Alberta government to maintain extra-billing in 1984 was based on the ruling Alberta Progressive Conservative party's priorities and principles. The Alberta government responded to the federal government's concerns about patient charges in the context of defensiveness on most federal-provincial matters. This was especially the case regarding situations in which federal efforts were interpreted by the Alberta government as challenges to the province's constitutional authorities. This was driven by the Progressive Conservative party's ultimate desire to protect Alberta's jurisdiction over its natural resources, but included other areas of constitutional precedent setting, such as health care. The Alberta government was unwilling to appear open to any renegotiation of provincial authority initiated by the federal government. Many of provincial Minister Dave Russell's arguments against the 1984 *Canada Health Act* were therefore based on the constitutional division of powers, which Russell claimed placed health care squarely within the provinces' purview.

Another aspect of the Alberta government's rhetoric was the argument that patient

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[2] Carolyn Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," *Canadian Journal of Political Science*, 21:2 (1988): 293, 280.
[3] Bill 94 was designed to amend the Alberta Health Care Insurance Act (1981) and the

charges contributed to individual responsibility for health. This ideological argument was similar to the political rhetoric of the Alberta Social Credit Party, which argued that individuals should not rely on public social programs for their well-being. Russell proclaimed that patient charges were critical to the financial sustainability of the health care system because they helped to control the costs to the Alberta government. They did this by providing a source of discretionary revenue to physicians and hospital boards above the amount of remuneration that the public system could provide, and therefore relieved the Alberta government of the need to provide increased funding. Russell also argued that patient charges like extra-billing gave patients an incentive to stay as healthy as possible.

Leading up to the Alberta government's decision to refuse the conditions of the *Canada Health Act*, positions on extra-billing were taken by various Alberta-based groups that sought to influence the direction of medicare. These responses included those from top officials in the Department of Hospitals and Medical Care, the Progressive Conservative caucus, physicians, nurses, and labour-based groups, as well as the federal government. However, among the diversity of options available to Russell, many clashed with one another. As a result, when Russell made the decision not to abolish extra-billing he privileged some interested parties and marginalized others. His response on behalf of the Alberta government entrenched the formal health care system governance structure, reinforcing the Alberta government's ultimate decision-making authority relative to the federal government and the public service. It also entrenched the informal health care

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Alberta Hospitalization Benefits Amendment Regulation (1983).

system governance structure, based on the relative degrees of alignment between Russell's decision and the input provided by Alberta-based groups, such as organized medicine, nurses, and labour.

This thesis will add to the existing historical literature on the history of public health insurance in Canada by highlighting the significance of the extra-billing issue, and its attempted resolution, in medicare's development through Alberta-based case studies. To date, historians have only addressed extra-billing as a marginal element of the overall development of public health insurance in Canada. This is partly due to the timing of several significant contributions to the literature on the history of health insurance in Canada. For example, David Naylor's *Private Practice, Public Payment* (1986), and Malcolm G. Taylor's *Health Insurance and Canadian Public Policy* (1987) both emerged in the wake of the extra-billing debate, before conclusions were well-formed.[4] Other scholarship, such as Penny Bryden's *Planners and Politicians*, focused on earlier aspects of the history of health insurance, such as the development of the first federal health policies and the emergence of health insurance in Saskatchewan.[5]

Despite the lack of focus on extra-billing per se, the context in which it became a critical health policy issue has been well documented by these scholars. The federal government did not develop its own health insurance policy until 1958. This was largely

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[4] C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966*, (Montreal: McGill-Queen's University Press, 1986); and Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*, (Montreal: McGill-Queen's University Press, 1987).

[5] Penny Bryden, *Planners and Politicians: Liberal Politics and Social Policy 1957-1968*, (McGill-Queens University Press: Montreal-Kingston, 1997).

due to constitutional barriers, as health insurance was considered to be within the provinces' purview. Several provinces, including Alberta, took measures to implement hospital insurance even prior to federal funding support. Still, at the federal level Liberal Minister of National Health and Welfare, Paul Martin Sr. (1946-1957), did succeed in setting up federal grants to provinces for health capital investment in 1949.[6]

These early developments increased public support for government health insurance and led some provincial governments to reconsider, to an extent, the benefit of defending sole jurisdiction of health policy due to the growing costs of meeting the public's expectations. Saskatchewan and Ontario, in particular, as leaders in provincial health policy development, championed the advancement of a national health insurance program. This ultimately led to the establishment of a federal-provincial cost sharing arrangement for hospital care through the Hospital Insurance and Diagnostic Services Act in 1958.[7] This legislation committed the federal government to finance 50 percent of hospital and diagnostic costs insured under provincial health insurance programs.

The next phase of federal policy development was shaped by the Royal

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[6] See J. L. Granatstein, *Canada's War: The Politics of the Mackenzie King Government, 1939-1945*, (Toronto: Oxford University Press, 1975); Robert Bothwell, "The Health of the Common People" in *Mackenzie King: Widening the Debate*, eds. John English and J. O. Stubbs (Toronto: Macmillan, Toronto, 1977), 191-220; Robert Bothwell, Ian Drummond, and John English, *Canada Since 1945: Power, Politics, and Provincialism* (Toronto: University of Toronto Press, 1989); Paul Martin, *A Very Public Life*, 2 vols., (Ottawa: Deneau, 1983).

[7] See Robin F. Badgley and Samuel Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan*, (Toronto: Macmillan of Canada, 1967); Duane Mombourquette, "'An inalienable right': The CCF and rapid health care reform, 1944-1948" in *Social Welfare Policy in Canada: Historical Readings*, eds. Raymond B. Blake and Jeff Keshen (Toronto: Copp Clark Ltd., 1995), 293-312; and Taylor, *Health Insurance and Canadian Public Policy*.

Commission on Health Services, led by Progressive Conservative Justice Emmett Hall, which released its extensive two-volume report in 1964. In the first tome alone Hall made 200 recommendations pertaining to health services, resources, financing and priorities, most of which were beyond the scope of federal constitutional powers. However, Hall's first recommendation was that a system of federal grants be implemented based on a "Health Charter for Canada," which stated:[8]

> The achievement of the highest possible standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal *Health Services Program* for all Canadians.[9]

Then, in 1968 the Medical Care Act set up federal government funding for provincial medical insurance programs. It drew in spirit from the Health Charter proposed in 1964 by Hall, although it did not include Hall's wording. This legislation enshrined four conditions for federal health insurance funding, including universal coverage of provincial residents, uniform accessibility for all residents, portable coverage between provinces, and public administration.[10] Similar to the funding arrangement under

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[8] Royal Commission on Health Services, *Royal Commission on Health Services*. Vol. 1 (Ottawa, Queens Printer,1964), 11.

[9] Ibid., 11; "'Comprehensive' includes all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide."

[10] See Bothwell et. al, *Canada Since 1945*; Bryden, *Planners and Politicians*; Naylor, *Private Practice, Public Payment*; Taylor, *The Seven Decisions*; J. L. Granatstein, *Canada 1957-1967: The Years of Uncertainty and Innovation* (Toronto: McClelland and Stewart Ltd., 1986). In 1977, the federal government changed the mode of health care funding from 50-50 cost sharing with provinces to block payments supplemented by tax

the 1958 *Hospital Care and Diagnostic Services Act*, the *Medical Care Act* of 1968 committed the federal government to finance 50 percent of medical services under provincial health insurance programs. It added to the existing legislation by expanding coverage of health services to those provided by individual physicians outside the walls of hospitals. Together, the 1958 and 1968 acts became known across Canada as "medicare," a complete system of health insurance to benefit all Canadians. All provinces were participants in this system by 1971.

Following this milestone, the 1970s marked a transition period in which the focus of federal health policy moved beyond the question of whether to have national health insurance to fine-tuning of existing policy. This shift was prompted partly by an increased awareness among policy makers that medical care was only one factor contributing to the health of Canadians. In 1974 Minister of National Health and Welfare Marc Lalonde released *A New Perspective on the Health of Canadians: A Working Document.*[11] This report asserted that four main factors influenced health: human biology, environment, lifestyle, and health care organization.[12] "The health care system," asserted the report,

> ...for all its facilities and for all the numbers, training and dedication of its health professionals, still tends to regard the human body as a biological machine which can be kept in running order by removing or replacing defective parts, or by

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credits with the passage of the 1977 Established Programs and Financing Act.

[11] Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document.* (Ottawa: National Health and Welfare, 1974), 15.

[12] Based in part on Hubert L. Laframboise, "Health Policy, Breaking it Down into More Manageable Segments," in *Canadian Medical Association Journal*, (February, 1973);

> clearing its clogged lines. The medical solution to health problems, while an extremely important aspect of health, is only one of many aspects revealed by an examination of the underlying causes of sickness and death.[13]

In other words, hospital and medical insurance – while valuable – was not the basket into which government should be placing all its eggs.

The transition to fine-tuning during the 1970s was also driven by the federal government's growing sense that it had no way to control, or be recognized publicly for, its large investment in health insurance. This led the federal government to initiate a change in the funding arrangement for medicare. Whereas previously the federal government had committed to provide 50 percent of the funding required by provinces to implement health insurance, the 1977 Established Programs and Financing Act (EPFA) changed this commitment to a combination of block funding and tax credits. Soon afterward, as extra-billing increased in the late 1970s, organized labour and federal politicians made allegations that the 1977 EPFA undercut health funding and led physicians to extra-bill to make up for lost income. Many policy makers and Canadians feared that national health insurance would be rendered meaningless if patients could be made to pay arbitrary bills at a physician's discretion. As a result, the federal government re-appointed Justice Hall, author of the 1964 Royal Commission on Health Services, to lead Health Services Review '79. The review was commissioned by the federal Progressive Conservative Minister of Health and Welfare, David Crombie, in response to the public outcry against patient charges in the late 1970s. Part of Hall's mandate for

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Lalonde, *A New Perspective on the Health of Canadians*, 31.

Health Services Review '79 was to determine whether the connection between the 1977 EPFA and extra-billing was real or imagined.

The report of Health Services Review '79 concluded that the rise in extra-billing was not caused by under-funding, but was partially the result of anti-inflation wage and price controls being lifted in 1978.[14] This event, not the EPFA, freed physicians to seek recompense for income they were denied through most of the 1970s.[15] However, Hall confirmed widespread public opposition to patient charges, especially the practice of extra-billing. He wrote, "I was told from one end of Canada to the other that extra-billing by physicians as practiced in all Provinces but Quebec, was unacceptable." [16] Hall argued that the continuation of extra-billing would destroy medicare and recommended that the federal government's existing health policies be revised to ban the practice.[17] In 1983, the now-Liberal federal government reiterated Hall's points in a white paper entitled *Preserving National Medicare*: *A Government of Canada Position Paper*. Using Hall's assertion that patient fees prevented Canadians from accessing services in times of need as a rationale, the white paper argued in favour of legislation to ensure access without financial barriers for all Canadians.[18] It stated, "the misfortune of illness which at some

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[13] Lalonde, *A New Perspective on the Health of Candians*, 25-6.
[14] Malcolm G. Taylor, *Insuring national health care, the Canadian Experience*, (Chapel Hill: University of North Carolina Press, 1990), 158.
[15] Ibid., 158. See also Eugene Vayda and Raisa Deber, "The Canadian Health Care System, A Developmental Overview," in *Canadian Health Care and the State: A Century of Evolution*, ed. C. David Naylor, (Montreal: McGill-Queen's University Press, 1992), 134.
[16] Emmett Hall, *Canada's National-Provincial Health Program for the 1980s: A Commitment for Renewal*, (Ottawa: Health and Welfare Canada, 1980), 26, 29.
[17]Ibid., 26, 29.
[18] Ibid., 21; Government of Canada, *Preserving Universal Medicare: A Government of*

time touches each one of us is burden enough: the costs of care should be borne by society."[19]

The federal government implemented the *Canada Health Act* in 1984 to discourage patient charges for health care regardless of an individual's ability to pay, based on the arguments expressed in the Health Services Review '79 and its own white paper. Under the 1984 act, the federal government explicitly defined the condition of "accessibility" to health care, and practices such as extra-billing were sanctioned through financial penalties.[20] Specifically, provinces – like Alberta – in which patients were required to pay from their own pockets for insured health services were to be penalized dollar-for-dollar from federal health care funding to provinces. However, in 1984 this disincentive was not enough to persuade the Alberta government to align with the federal government on the matter of extra-billing.

Various groups, in addition to the Alberta and federal governments, took positions on extra-billing leading up to the 1984 decision by provincial Minister of Hospitals and Medical Care Dave Russell to reject the *Canada Health Act*. One such group was the

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Canada Position Paper, (Ottawa, 1983), 18-19.

[19] Government of Canada, *Preserving Universal Medicare*, 7.

[20] According to the Canada Health Act of 1984, accessibility is defined as follows: "In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province (*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons; (*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province; (*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and (*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services."

Department of Hospitals and Medical Care, as represented by its top officials. The advice given to Minister Russell by senior public servants through briefing notes and correspondence suggests their ambivalence regarding the arguments presented in the federal Health Services Review '79. Their advice, based on the Department's papers housed at the Provincial Archives of Alberta, suggests that some Department executives viewed federal arguments as forward-thinking, while others were concerned about the feasibility of Justice Hall's recommendations. Other Department records, including memos, reports, and briefing binders, provide insight into the arguments and information used by Russell to make policy decisions. While exhaustive sources were not readily available due to Freedom of Information and Protection of Privacy Act regulations, the available sources support a comprehensive exploration of the Alberta public service's role in shaping the Alberta government's position on extra-billing.

Chapter One includes a detailed assessment of the arguments used by Russell in favour of maintaining extra-billing in Alberta, in contrast to the views of his senior advisors. It will contribute to existing literature on the development of health insurance in Alberta in two ways. The first is by suggesting the legacy of the Social Credit predecessors in the ideological underpinnings of health insurance in Alberta. The second is by identifying the strategic aims that guided health policy under the Progressive Conservative government of Peter Lougheed.

Another group that expressed a position on extra-billing in Alberta was organized medicine, as represented politically by the Alberta Medical Association (AMA), which favoured the continuation of extra-billing. Scholars argue that the medical profession in general supported extra-billing to protest their loss of relative income compared with

other professions, and to assert their authority in health care decisions.[21] The AMA's leaders emphasized the latter of these two positions, and lobbied the Alberta government to preserve individual physicians' discretion to extra-bill as they saw fit in an effort to limit the role of the Alberta government in managing the health care system. Their arguments are evident in sources such as the AMA's periodical, *Alberta Doctors' Digest*, submissions to the Alberta Government, and position statements. For the AMA's leaders, extra-billing was a symbolic barrier between the Alberta government and clinical decision making. This point is also evident in the strategies used by organized medicine to control extra-billing. This was done through efforts to define the language surrounding the practice, according to the correspondence and *Digest* articles, and the creation of guidelines for its appropriate use found in College of Physicians and Surgeons of Alberta (CPSA) *Motions of Council.* Unfortunately, the AMA archives are not accessible to non-physician researchers, so I was not able to view any further documentation that may exist. There is also not a CPSA archive per se, and the organization's professional self-governance mandate has led them to abstain from political controversy as much as possible to protect their legislated authorities from being politicized – and questioned.[22] Thus, sources related to the CPSA's contribution to the extra-billing issue are limited almost exclusively to those concerning their regulatory efforts, which can be accessed by contacting the CPSA.

The Alberta Association of Registered Nurses (AARN), an organization concerned with the development and recognition of nurses' professional qualifications,

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[21] See Tuohy, "Medicine and the State;" and Naylor, *Private Practice, Public Payment.*

expressed yet another interest in the outcomes of the extra-billing debate. Its leaders argued for the abolition of extra-billing in the minutes of the AARN Provincial Council, correspondence, which I accessed through the Archives of the College and Association of Registered Nurses of Alberta (CARNA), and the *AARN Newsletter*. The AARN Provincial Council argued that extra-billing was only one small problem compared with the larger issue of health care system organization. It asserted that the Alberta health care system was inefficient and, moreover, it privileged the male-dominated medical profession over other health providers, like nurses, by emphasizing the importance of treatment over that of prevention. The AARN's proposed solution to extra-billing was not merely to abolish the practice, but to restructure health insurance in Alberta to recognize the contribution of nurses to Albertans' health, as both professionals and women.

The interests of organized medicine and those of the AARN in the extra-billing debate clashed. Chapter Two compares the divergent arguments and strategies used by the AMA, CPSA, and the AARN to advance their respective interests through the extra-billing debate. It explores in greater detail the relative roles played by organized physicians and the leaders of the AARN in influencing the direction of the health care system in Alberta, and also the potential reasons for the greater success of organized medicine in advancing their interests. This chapter adds to the historiography regarding the role of health care providers in shaping health insurance in Canada by including, for the first time, nurses in the analysis and focusing on post-medicare developments. Previous historians have focused on the role of the medical profession, and generally only

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[22] Tuohy, "Medicine and the State," 278.

up to the development of the 1968 federal *Medical Care Act*. It also contributes to the history of nursing by emphasizing the role that nurses played in shaping health policy, whereas the existing body of work on nurses' experience of medicare has focused primarily on the impact of policy on nurses' working conditions.[23]

A third interested party that strove to influence the outcome of the extra-billing debate was the labour-based organization the Friends of Medicare (FOM), founded in 1979 by the Alberta Federation of Labour (AFL). The leaders of the FOM stood for a strong health care insurance system without patient charges, based on their belief that health care was a right of Canadian citizenship. The papers of the AFL, including government submissions, brochures, policy positions, and correspondence housed in the Provincial Archives of Alberta, give evidence that the FOM argued that extra-billing discriminated against vulnerable members of society and imposed a tax on the sick. The FOM demanded that the Alberta government abolish extra-billing and implement the 1984 federal *Canada Health Act*. In fact, for their strong support of federal policy proposals against extra-billing in Alberta, the FOM was endorsed financially by the federal Liberal government.

One member organization of the FOM was the United Nurses' of Alberta (UNA), which was the provincial collective bargaining organization for Alberta nurses. The UNA, as is evident from their periodical, the *News Bulletin*, shared the FOM's

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[23] See Janet Ross-Kerr, *Prepared to care: nurses and nursing in Alberta, 1859 to 1996* (Edmonton: University of Alberta Press, 1998); Kathryn McPherson, *Bedside matters: the transformation of Canadian nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003); and Pat Armstrong and Hugh Armstrong, *Wasting away: the undermining of Canadian health care* (Toronto: Oxford University Press, 1996).

perspectives in support of a health care system that recognized health care as a right. As an organization concerned with promoting the interests of nurses, the UNA wanted to ensure a well-funded health care system to employ, and to fairly compensate, its members. As a labour union, the UNA was interested in securing a reliable, publicly-funded health care system to benefit its members, who were health care consumers, as well as providers. This was critical to the well-being of the UNA's members, and helped to ensure the cost of health care would be borne by society, rather than through union dues.

Chapter Three will explore further the role played by the FOM in promoting extra-billing's demise in Alberta, including the organization's efforts to support Alberta's acceptance of federal health policy. It also builds on the discussion of nursing from Chapter Two regarding the AARN's role in shaping health policy by providing an alternate view of Alberta nurses' interests relative to medicare, and the efforts of organized nursing to promote them. This chapter contributes to labour historiography by shedding light on the Alberta labour movement's health policy demands, adding to existing literature on labour's interests that to date has only addressed medicare as one part of a larger social security package.[24] It will also suggest that while nurses were affected by the impact of health insurance on their workplace, they valued and fought for

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[24] See Desmond Morton, *Working People*, (Ottawa: Deneau and Greenberg Publishers Ltd., 1980); Bryan D. Palmer, *Working-class Experience: The Rise and Reconstitution of Canadian Labour, 1800-1980*, (Toronto: Butterworth and Co., 1983); and W.J.C. Cherwinski and Gregory Kealey, *Lectures in Canadian and Working Class-History*, (St. Johns: New Hogtown Press, 1985). The exception is Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*, (Princeton: Princeton University Press, 1998).

health policy that met their needs.

As a whole, this thesis provides three case studies that explore the issue of extra-billing in Alberta, leading to the Alberta government's decision not to implement the *Canada Health Act* in 1984. It contributes to the historiography of medicare's development in Alberta and in Canada by providing an examination of interests related to extra-billing. This thesis suggests that the decision by the Alberta government not to abolish the practice favoured the AMA's leaders' interests over those of the AARN's leaders and organized labour. In 1986 the Alberta government reversed its 1984 decision, and abolished extra-billing, because the economic downturn experienced in the 1980s made it infeasible to reject federal funds for health care. A change in government at the federal level, and a leadership change within the Alberta Progressive Conservative Party, also contributed to a climate that was more amenable to positive federal-Alberta relations. The next three chapters, therefore, focus on a limited time period that was characterized by heightened tension among groups with conflicting interests, some of whom demanded the end of extra-billing while others argued for its preservation. However, these tensions did not disappear in Alberta, even after the *Canada Health Act* was accepted by the Alberta government.

In the pages that follow, there are at least two terms that require qualification: "medicare" and "public health insurance." "Medicare" is a term commonly used to refer to health insurance in Canada. However, unlike the United States and Australia, Canada does not have a policy or program called Medicare – even though this term can at times seem ubiquitous. In fact, it is often used by politicians, public servants, and a wide variety of Canadians. Health Canada's website begins one sentence in the following way:

"Canada's national health insurance program, often referred to as 'Medicare'..."[25] Rather than the existence of an actual program, this reflects a common belief that a program exists, inspired by the political rhetoric surrounding the 1984 *Canada Health Act.* As political scientists Eugene Vayda and Raisa Debber have noted, there is no national program of health insurance in Canada at all – only provincial health insurance systems and federal policy that promotes national standards at the provincial level.[26] Naylor has also purported that as of 1986, "Canadians in all ten provinces and both northern territories were insured against basic medical and hospital expenses through a set of publicly administered programs generally referred to as medicare."[27] There are, as Naylor indicates, multiple programs of health insurance, not one national program.

I use the term "medicare" since many of the sources I reference use it. When the FOM, for example, demanded that medicare be recognized as a right in Alberta, they were building upon the rhetoric of the federal government, which argued that the future of medicare was threatened by patient charges. However, when not citing a direct quotation I will use a lower-case "m" so as to reflect the fact that there is no formal program called "Medicare" in Canada.

The second term, "public health insurance," is used synonymously with "medicare" and other expressions, such as "national" and "provincial" health insurance. It is not intended that this term refer to a program of health insurance covering only "public health" services in the sense of community health care and prevention. It is

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[25] Health Canada, "Canada's Health Care System (Medicare)," http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html (accessed March 1, 2008).
[26] Vayda, "The Canadian Health Care System," 126.

intended to mean "government-funded health insurance" – insurance that is funded publicly through the government.

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[27] Naylor, *Private Practice, Public Payment,* 3.

CHAPTER 1

Politics and Pragmatism: The Alberta Government and the Department of Hospitals and Medical Care

Justice Emmett Hall's 1980 recommendations to abolish patient charges after Health Services Review '79, and subsequent efforts by the federal Liberals to implement his recommendations, were rejected by Alberta's Progressive Conservative Minister of Hospitals and Medical Care, Dave Russell. A former Calgary alderman with a reputation for championing unpopular causes, Russell was appointed by Premier Peter Lougheed to the health portfolio in 1979.[1] Russell argued that patient charges promoted individual responsibility for health by deterring patients from using costly health services as their first line of defense against illness. This view was rooted in Russell's assertion that the provincial government's role in administering health insurance was merely budget management. As well, Russell's rejection of federal health priorities was shaped by the defensive nature of the Alberta government in all federal-provincial interactions during this time. It was a strategy of the Lougheed government to aggressively protect all of Alberta's constitutional decision-making authorities in order to maximize the province's control over its resources. This was particularly the case with respect to natural energy resources, which were coveted by the federal government and other provinces.

In contrast, a great deal of support for Hall's suggestions existed among the staff within the Alberta Department of Hospitals and Medical Care. Several of the

Department's assistant deputy ministers openly viewed the abolishment of patient charges as progressive. They viewed the pre-1980 period as a formative time in which the primary health policy objective of governments was to establish a public health insurance program in keeping with the Health Charter for Canada.

In 1980, the Department produced a brief that clearly positioned Hall's recommendations in a positive light, in the context of an evolving health care system. The brief stated that the 1940s to the 1960s, in particular, marked the maturation of medicare's conceptual underpinnings and the establishment of health insurance as a national publicly-funded system. It described events from the 1960s and 1970s as a period during which the federal government became more conscious of its role as a funder of medicare and more appreciative of the significant cost of the health care. This was demonstrated by the passage of the 1977 Established Programs and Financing Act, which maintained the existing health insurance policies, but also changed the funding mechanism from a set proportion of provincial costs to block payments.[2] This was a significant change in the organization of medicare, indicating the reluctance of the federal government to guarantee funding increases for health insurance at the same rapid pace that the costs of health services were increasing. The problems identified by Health Services Review '79, such as patient charges, were increasingly "hot-button" issues because the primary health policy objective (medicare) had been accomplished, and the remaining policy considerations were related to planning and programming within an

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[1] David Wood, *The Lougheed Legacy*, (Toronto: Key Porter Books, 1985), 94.
[2] The Office of Dr. C. A. Meilicke to Mr. G. R. Beck, Mr. K. G. Moore, Mr. E. H. Wright, and Dr. L. C. Grisdale, November 14, 1980, accession 1994.287, box 12, item

existing system to continuously improve the health of Canadians.[3]

The 1980s, according to the brief, marked Canada's entrance into a new era of health policy development that would be characterized by various priorities, such as securing a national minimum standard of health, addressing disparities created by provincial health programs that exceeded or fell below national health standards, and finding a federal-provincial cost-sharing arrangement that would promote the highest possible level of consistency among provincial health programs across the country. [4] The divergence in views among Russell and officials of the Department of Hospitals and Medical Care officials highlights the rhetorical aspects of the Alberta government's position on patient charges. This is especially the case given that the debate over patient charges occurred during a period of policy capacity development within the Alberta public service. Political scientist Allan Tupper asserts that the maturation of the Alberta bureaucracy to a level on par with the federal civil service was an important legacy of Peter Lougheed's premiership, 1971-1985. This was especially the case in policy matters that strengthened Alberta's ability to set its own priorities without federal interference, including health insurance policy.[5] Thus, the views of the Department of Hospitals and Medical Care officials do not reflect the position of political appointees, but rather the views of professionals in the roles of advisors. Their views, in contrast to those of Russell, an elected politician, demonstrate the significance and contested nature of

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S000 HE, Provincial Archives of Alberta.
[3] Ibid.
[4] Ibid.
[5] Allan Tupper, "Peter Lougheed, 1971-1985," in *Alberta Premiers of the Twentieth Century*, ed. Bradford Rennie, (Regina: Canadian Plains Research Centre, 2004), 221.

political priorities and ideology in shaping Alberta health policy.

Literature that sheds light on the history of health insurance in Alberta suggests that the entrenchment of patient charges in the political culture of Alberta's health care system by the 1970s was largely the result of Social Credit party ideology.[6] Until the dawn of Social Credit health insurance in the 1940s, Albertans had access to only ad hoc community health care resources, although the provincial government provided a number of basic programs to fill major gaps. Historian Paul Collins has demonstrated that, prior to the establishment of provincial health insurance, the United Farmers of Alberta (UFA) government (1921-1935) made a number of precedent-setting forays into state health care. The UFA had a predisposition toward government provision of health care, but ultimately did not believe that government should lead society in improving health. Prior to taking office, the party had successfully pressured its predecessors (the Liberals) to create a Department of Public Health, a municipal hospitals program, and a traveling nurses program.[7] Once in office, the UFA expanded on these initiatives by financially supporting traveling operatives, tuberculosis and mental health clinics, and public health inspections.[8] However, the party thought health care was best provided through existing,

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[6] See Alvin Finkel, *The Social Credit Phenomenon in Alberta*, (Toronto: University of Toronto Press, 1989).

[7] Paul Victor Collins, "The public health policies of the United Farmers of Alberta Government, 1921-2935," (Master's of Arts thesis, University of Western Ontario, 1969), 10-15. See also Dawn Nickel, "Dying in the West: Health Care Policies and Caregiving Practices in Montana and Alberta, 1880-1950," (PhD Dissertation, University of Alberta, 2005).

[8] Collins, "The public health policies of the United Farmers of Alberta Government, 1921-2935," iii.

informal, community support systems, and did not tamper with their organization.[9]

Following several decades of ad hoc provincial government interest in health care, the 1940s saw the birth of health care insurance legislation in Alberta under the Social Credit Party, led by Premier Ernest Manning (1943-1968).[10] The Social Credit government, which had first been elected mid-Depression, in 1935, under the leadership of Premier William Aberhart, took a decisive approach to restoring economic stability to Alberta, and built on free-enterprise values. These values included individual responsibility, self-reliance, and independence from government services. Thus, as historian Alvin Finkel has shown, health insurance developments under Social Credit leadership were significantly shaped by the ideological belief that individual choice and responsibility was essential for the establishment of a strong society, underpinned by a strong economy. The Social Credit government therefore worked to ensure the entrenchment of incentives that reinforced these views, and that promoted desired social behaviours, such as financial self reliance.

Most of the Social Credit government's operating budget was spent on education and social services, but this was not intended to redistribute income or to interfere with the free market. Income variability was desired to preserve entrepreneurial incentives.[11] Instead, social programs were intended to promote a high quality social infrastructure that was accessible to individuals who exhibited desirable behaviours, such as financial solvency, and could therefore afford the nominal user charges. Thus, Alberta's first

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[9] Ibid., 8-10, 136-7.
[10] Cam Traynor, "Manning Against Medicare," *Alberta History*, 45:1, (1995): 9.
[11] Alvin Finkel, *The Social Credit Phenomenon in Alberta*, (Toronto: University of

program of hospital insurance, implemented under 1946 legislation, provided municipally and supported by provincial grants of up to half the operating costs, was neither universal nor cost-free.

Patient charges were a fundamental element of Social Credit health insurance. Albertan patients were made to pay monthly premiums and hospital user fees to promote individual responsibility for health and to minimize their dependency on publicly financed services.[12] The Social Credit government believed that if health services were provided cost-free at the point of service delivery, individuals would frequently seek medical attention when it was not required, driving up the cost of health insurance. Patient charges also served to ensure that free market dynamics were maintained within the health system because physicians remained independent businessmen. Therefore, health insurance programs endorsed by the Social Credit government were characterized as voluntary and provided through private health insurance companies to minimize the role of government and maximize the potential for "individual choice."[13]

The Social Credit government's approach to social policies pitted Alberta and the federal government against one another in the 1960s as many national programs established universal benefits that contradicted Social Credit ideology. Alberta Premier

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Toronto Press, 1989), 143.

[12] Ibid., 123, 144. The timing of the Social Credit government's rise to power during the Depression, followed by their endorsement of patient charges in the 1940s, and later would seem to suggest a connection between the existence of patient charges and the need to cover the cost of health care in a strained economy. However, based on Finkel's analysis, patient charges were nominal fees that would not have helped to cover costs at all. They were intended to normalize Albertans' behaviours by providing incentives for choices that led to health and self-reliance, and did not promote the financial viability of health policies.

Ernest Manning was even opposed to federal economic development proposals that would have directed funds into Alberta because they would have tampered with free enterprise incentives.[14] In 1964, the Health Charter for Canada, recommended by the Royal Commission on Health Services, clashed with the Social Credit belief that universal programs stifle important economic incentives for individuals to work hard. In response, Premier Manning assumed the role of national anti-medicare advocate, arguing it would reduce individual choice, would be costly and inefficient, and would require higher taxes.[15] His actions in this regard included a televised documentary on the perils of socialized medicine and the distribution of a pamphlet entitled, *National Medicare: Let's Look Before We Leap*. However, when the federal proposals for national health policy succeeded, and the 1968 *Medical Care Act* passed, the financial incentive for the provinces to submit to the federal direction was too great for Alberta to resist. In 1969, under the leadership of new Social Credit Premier Harry Strom, Alberta reluctantly opted into medicare by establishing the Alberta Health Care Insurance Plan. Feelings about the move were mixed, as demonstrated by the bitter resignation of Social Credit Health Minister Dr. Donovan Ross in response to the implementation of policy that clearly contradicted so much of the party's ideology.[16]

The *tête-à-tête* between Premier Manning and the federal government over medicare was illustrative of Manning's protective attitude toward provincial constitutional powers, such as health care, in addition to his ideology. Traynor writes,

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[13] Ibid., 144.
[14] Ibid., 151.
[15] Ibid., 149-50; Traynor, "Manning Against Medicare," 14.

"the medicare plan forced provinces to join even though health care was primarily an area of provincial jurisdiction."[17] This created concern in Alberta, in particular, as the province became increasingly dependent upon its natural energy resources for economic viability. The constitutional authority of the provinces to set their own priorities was a matter that could not be left to arbitrary interpretation of the federal government, which had much to gain by centralizing provincial powers – especially with respect to valuable natural resources.

When the Alberta Progressive Conservatives replaced the Social Credit Party as the provincial government in 1971, protection of provincial resources from the federal government became priority number one. This led to several significant federal-provincial conflicts and shaped provincial health policy decisions regarding patient charges when the 1984 *Canada Health Act* was passed. Policy under Premier Peter Lougheed was largely shaped by the objective of building the province's power position relative to the federal government through economic development and assertion of provincial jurisdiction.[18] These strategies were entrenched through the 1970s as the federal Liberal government, led by Prime Minister Pierre Trudeau, launched an aggressive strategy of nation building in the context of rising Quebec separatism and dwindling Liberal Party popularity at the federal level.[19] Trudeau's federal strategy,

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[16] See Finkel, *The Social Credit Phenomenon*, for more information.
[17] Traynor, "Manning Against Medicare," 14.
[18] Tupper, "Peter Lougheed," 215-216; and Ed Shaffer, "Oil, Class, and Development in Alberta," in *Essays in Honour of Grant Notley: Socialism and Democracy in Alberta*, ed. Larry Pratt, (Edmonton: NeWest Press,1986), 117-9.
[19] Carolyn J. Touhy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," in *Canadian Journal of Political Science*, (June, 1988), 238.

which involved reinterpreting federal powers more broadly to ensure the relevance of the federal government to Canadians, conflicted directly with Lougheed's provincial strategy. This situation resulted in a number of instances in which Ottawa and Alberta locked horns over issues that were highly public and carried heavy precedent-setting implications, including the future of medicare.

Ownership of natural resources was the area in which the Alberta government was most defensive, and it underpinned the intolerance of the Lougheed government for any attempt by the federal government to act unilaterally in interpreting the constitutional division of powers. The federal National Energy Policy (NEP) of 1980 illustrated the reality of federal interest in Alberta's resources. It was developed in the context of national attention to (and envy of) the Alberta Heritage Savings Trust Fund. This was an innovation of the Alberta government in 1976. The fund oversaw the collection of massive royalties from energy companies to support economic diversification and protect Alberta against an economic downturn. It was seen as a symbol of Alberta's wealth and prosperity across Canada, and trigger of the NEP. The NEP was a federal attempt to encourage oil and gas exploration on federal crown lands, instead of provincial lands, so that the federal government could reap the royalty benefits. The policy also included taxes on energy royalties paid to the provinces. As a result, the NEP became a symbol of western discontent and federal spite.[20]

Another significant issue over which the Lougheed Alberta government tried to "limit the federal government's capacity to shape provincial priorities" was the federal

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[20] Tupper, "Peter Lougheed," 216.

attempt to patriate the constitution in 1982.[21] Alberta led opposition to this effort for several reasons. The first reason was the unilateral initiation of the effort by the federal government without first seeking or achieving the endorsement of the provinces for the process and its aims. The second reason was Prime Minister Trudeau's objective for patriation, which was to promote national unity under a strong federal government and to suppress dissenting voices in Confederation, Alberta being a prime case in point.[22] The Alberta government interpreted this, rightly, as an attempt by the federal government to reinterpret the division of powers and institute the federal authority to set provincial priorities.

The defensive mood of the Alberta government in most, if not all, federal-provincial matters at the time the 1984 *Canada Health Act* was proposed led Minister of Hospitals and Medical Care Dave Russell to reject the Act. Russell, elected to provincial office in the well-to-do Calgary Elbow constituency in 1967, in the same year that Lougheed won his first seat in opposition,[23] was one of the original six Progressive Conservatives who led the party's surge to office in 1971 and formed part of the cabinet's core membership throughout the Lougheed years.[24] He was therefore waist-deep in developing and perpetuating the government's overarching strategies, including Lougheed's defensive province-building.

Federal efforts to change the nature of provincial health insurance programs by revising medicare policy through the *Canada Health Act* were viewed by several

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[21] Ibid., 210.
[22] Ibid., 218.
[23] Ibid., 259.

provinces, including Alberta, as unconstitutional.[25] The *Canada Health Act* was based on the recommendations of the federal Health Services Review '79 report, and a federal white paper entitled *Preserving Universal Medicare*, both of which reflected federal agendas. The Health Services Review '79 report, as well, had only made recommendations at the federal level. While provincial governments were free to review and make decisions informed by its contents, the decision to standardize its recommendations was made federally.

The *Canada Health Act* contained new conditions, and new interpretations of old conditions, for federal health care funding based on the Health Services Review '79 report. Regardless of whether individual provincial governments agreed with these changes, provinces would have to submit to them in order to guarantee the continuation of the steady stream of federal funds upon which their respective health insurance programs relied. The act also contained sanctions against patient charges, which would have been especially costly in Alberta which had the highest rate of extra-billing in the country. In fact, by the time the federal Health Services Review '79 was appointed, Alberta was viewed by the federal government as an example of how rampant patient charges could become under the existing medicare legislation, which did nothing to discourage them.[26] In Ontario, where extra-billing occurred less frequently, the Ontario

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[24] Wood, *The Lougheed Legacy*, 61-2, 94.
[25] See Monique Bégin, *Medicare: Canada's Right to* Health, (Ottawa: Optimum Publishing International, 1986), 112.
[26] Health and Welfare Canada, *Preserving Universal Medicare: A Government of Canada Position Paper*, (Ottawa, National Health ad Welfare, 1983), 5-6; Monique Bégin, *Medicare: Canada's Right to* Health, (Ottawa: Optimum Publishing International, 1986), 112.

Medical Association had acquired an agreement with the Progressive Conservative Ontario government to ensure the future of patient charges. Compliance and non-compliance alike would have their inconveniences – and serious trade-offs – for each province.

In keeping with the mood of federal-Alberta relations in the early 1980s, Minister Russell argued that health care was a provincial jurisdiction according to the constitution. The *Canada Health Act* was just another attempt by the federal government to interpret the division of powers unilaterally. Russell stated that the *Canada Health Act* "restricts the ways in which the province can raise funds to meet rising costs of health services, and it appears to intrude into the area of provincial jurisdiction by setting requirements regarding reasonable access, reasonable compensation and adequate funding."[27] He argued that the proposed *Canada Health Act* was yet another federal government attempt to build Ottawa's position of power at the expense of the provinces' – an inappropriate, unconstitutional, and unilateral attempt to impose national priorities on Alberta.[28]

In addition, Russell argued against the abolition of patient charges as a particular policy because they served as an incentive for desired behaviour among Albertans. He asserted that the government's role in administering health insurance was primarily

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[27] David Russell to Phyllis Giovanetti, March 26, 1984, accession 1991.508, box 1, item A0003, Provincial Archives of Alberta.

[28] David Russell, Submission by the Honourable David J. Russell on Behalf of the Alberta Government Re: Hearings on Bill C-3, the Canada Health Act, February 20, 1984, (Canada: House of Commons Standing Committee on Health, Welfare and Social Affairs, 1984). Russell's view that the proposed Act was a unilateral imposition on the provinces was shared by other provinces and is corroborated by the Liberal National Minister of Health and Welfare responsible for the Canada Health Act, Monique Bégin in her memoirs. See Monique Bégin, *Medicare: Canada's Right to Health*, (Ottawa:

administrative and financial.[29] In 1980, he told the members of the Health Service Review '79 that "the universal plan, providing a high level of services 'on demand' for Canadians is creating difficulty in continuing reasonable financial controls."[30] Patient charges helped communicate the cost of health insurance to Albertans, who he claimed had "no idea what health care costs. No idea."[31] Patient charges were also an "additional discretionary source of funding for the providers of the services (i.e. professionals and hospital boards)," and helped to alleviate physician pressure for increased government rates of reimbursement for services.[32] Thus, not only did patient charges reduce costly use of health services, they were also a source of revenue for hospitals and physicians that relieved financial pressure on the government.

In 1983, when the proposed *Canada Health Act* included financial penalties for the existence of patient charges, Russell's primary arguments against the Act were from the perspective of a budget manager. He complained to the House of Commons Standing Committee on Health, Welfare and Social Affairs that the Act punished provinces that "take moves towards trying to institute some kind of personal responsibility, cost awareness or cost control in the system."[33] He described the Act as "removing any

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Optimum Publishing International, 1986).
[29] Ibid., 10:73.
[30] David Russell, "Submission to Honourable Justice E. Hall By: Honourable D. J. Russell, Minister of Hospitals and Medical Care Province of Alberta," 1980, accession 94.287, Box 12, item S000 HE, Provincial Archives of Alberta.
[31] "Balance billing requires M.D.'s to utilize 'common sense': Medical Care Minister," in *Alberta Doctors Digest*, August 1982, 2.
[32] Russell, *Submission by the Honourable David J. Russell on Behalf of the Alberta Government Re: Hearings on Bill C-3*, 10:79; and Russell, *Submission to Honourable Justice E. Hall*, 8.
[33] Russell, *Submission by the Honourable David J. Russell on Behalf of the Alberta*

flexibility whatsoever the provinces have with respect to applying budgetary controls."[34] Russell was concerned about the high costs of funding the Alberta Health Care Insurance Plan and, similar to the Social Credit belief that cost-free health services would be over-used, he argued that patient charges created a disincentive for abuse of public health care programs.

While the political and economic implications of federal efforts to ban patient charges were largely responsible for Russell's opposition to changes to medicare legislation, the Department of Hospitals and Medical Care viewed patient charges and national activities with ambivalence. In fact, at the same time that the high costs of health insurance, and the strategic political implications of the federal government's effort to set provincial health priorities, were of concern to department officials, many high ranking staffers supported a stronger national health system and the abolishment of patient charges. This is particularly evident in the responses by the Ministry's Assistant Deputy Ministers to the September 1980 report of the Health Services Review. Following the report's public release, Russell asked for immediate reactions from all areas of the Department and for a more comprehensive analysis of the report's implications within several months, to be coordinated by Assistant Deputy Minister of Policy Development, Dr. Carl Meilicke.[35] Accordingly, a brief was prepared by each of the Department's four divisions, demonstrating varying levels of support for the report's recommendations, particularly with respect to extra-billing.

Government Re: Hearings on Bill C-3, 10:72.

[34] Ibid., 10:72.

[35] G. R. Beck to Executive Committee Hospitals and Medical Care, September 4, 1980,

One of the four briefs on the Health Services Review report, as well as initial advice from Meilicke in a separate memo, illustrates pragmatic reactions that emphasized economic considerations and strategic political maneuvering within Confederation. Senior medical consultant Dr. A. V. Follet conjectured that the report's estimated costs of medicare, used to demonstrate the affordability of a single-tiered system of health insurance, were too low, suggesting that Hall was painting a prettier picture than the financial reality of already-costly health insurance. Hall had warned that extra-billing would lead to a two-tier system, "which would cast the poor, the aged and the unemployed into a category apart from those who are able financially or considered financially able by individual physicians to absorb an extra charge." Follet believed that the financial limitations of the existing health insurance program would inevitably lead to the rationing of services, since the alternative would be to lower the quality of service by maintaining full bed capacity and by reducing staff.[36] He wrote,

> Ideally, one must support the avoidance of a two tier system. Practically, however, in today's society I question whether this is possible. It is my understanding that even in the highly socialized countries (U.S.S.R., Sweden, etc.) this has been unavoidable.[37]

While patient charges were not ideal, then, Follet believed they were a reality given the budgetary pressures facing the administrators of publicly funded health insurance programs.

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accession 94.287, box 12, item S000 HE, Provincial Archives of Alberta.

[36] A.V. Follett to Dr. Carl Meilicke, September 5, 1980, accession 1994.287, box 12, item

This pragmatic perspective is also evident in advice from Meilicke to the Minister in a memo recommending a public response to the Health Services Review. He proposed that Russell speak to the newness of the medicare system, the need to continually aim to achieve policy consensus through consultation and discussion among the provinces, and the importance of maintaining a physician workforce whose clinical decisions were not under the direct influence of government priorities. He also recommended that Russell enlist support from other provinces on the issue of extra-billing in order to leverage their solidarity against the federal government in case of a unilateral federal attempt to implement a new national health policy.[38]In contrast to Follet and Meilicke's initial views, the remaining three briefs on Health Services Review '79 and the Department's final analysis reflect a generally favourable perception. E. H. Wright, Assistant Deputy Minister of Hospital Services Division, gave the most tentative response, with several of his observations tending more toward innuendo than firm opinions. Wright stated that the report's "cornerstone" assumptions were "that physicians are entitled, as a right, to adequate compensation for services rendered;" and "that extra-billing will destroy the program."[39] This was an accurate assessment; the report had considered extra-billing a "dominant issue," particularly with respect to the impact it had on access to needed medical care.[40] Wright pointed out that user fees also received (and had received

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S000 HE, Provincial Archives of Alberta.
[37] Ibid.
[38] C. A. Meiliecke to Dave Russell, September 22, 1980, accession 1994.287, box 12, item S000 HE, Provincial Archives of Alberta.
[39] E.H. Wright to Dr. C. Meilicke, September 8, 1980, accession 94.287, box 12, item S000 HE, Provincial Archives of Alberta.
[40] Emmett Hall, *Canada's National-Provincial Health Program for the 1980s: A*

elsewhere) much criticism, which prompted him to ask: "We might want to ask ourselves what benefits are derived from the practice." He observed further that the merits of the health care premium system had been re-assessed many times without consequence.[41] While Wright alluded to his support for abolishing patient charges, strategic research planner Larry Charach's brief, drafted on Meilicke's behalf, used marginally stronger words:

> One of the most striking statements in the report is on Page 24. Justice Hall, in discussing the increasing amount of extra-billing by physicians and the conflicts between the medical professions and the provinces over the scales of fees, states that 'it is imperative that some solution or mechanism to solve the conflict be found, otherwise medicare as Canada has known it since 1970-71 can fail in time.'[42]

Hall purported that patient charges threatened the effectiveness of national universal health care in achieving its aim of promoting the highest possible standard of health for Canadians. Charach shared these views and had previously worked with Ken G. Moore, Assistant Deputy Minister of the Health Care Insurance Division, to develop an internal brief that supported the abolishment of health insurance premiums.[43] Moore gave the strongest and most forceful endorsement of Hall's recommendations on patient charges, clearly favouring the use of legal means to ban extra-billing and compel physicians to

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Commitment for Renewal, (Ottawa: Health and Welfare Canada, 1980), 24.
[41] Wright to Meilicke, September 8, 1980.
[42] Larry Charach to Dr. C. A. Meilicke, September 5, 1980, accession 1994.287, box 12, item S000 HE, Provincial Archives of Alberta.
[43] Ibid.

work within a re-vamped public health insurance program. He stated, "I generally agree with the concept of binding arbitration and not permitting extra-billing. However, the report does not go far enough on these two issues."[44] Moore further argued that a nation-wide ban on extra-billing was the only way to end the practice and simultaneously discourage physicians from migrating to provinces where extra-billing was allowed, creating major health disparities across the country. Moore noted the significant risk that a national ban could lead to large-scale emigration of medical professionals to the United States. He suggested that this could be avoided by changing the mode of physician payment from fee-for-service to salary and by relying on greater use of community health centres, improving access to health care, while simultaneously ensuring a base level of pay for physicians.[45] A second risk was that of whole specialties opting out of medicare, but Moore believed this could be mitigated by the threat of legal action for collusion.[46]

Later in the fall of 1980, Meilicke's office used the divisional briefs to put together a detailed synthesis of the Health Services Review report, demonstrating support for national health insurance as a means of improving the health of all Canadians by promoting a consistent level of health services across the country. The synthesis stated:

> It was a huge task over the last 30 years to develop a reasonably adequate social security system: it will now be an equally huge task to "fine-tune" the existing system, and expand upon it, in ways which will cause it to serve future Canadians

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[44] K.G. Moore to Dr. C.A. Meilicke, September 8 1980, accession 1994.287, box 12, item S000 HE, Provincial Archives of Alberta.
[45] Ibid.
[46] Ibid.

> in the most efficient and effective way possible.[47]

The brief called for health policy that would set the tone of the health system for the foreseeable future, stating:

> It is important to note that, in the eyes of history, the next few months will probably mark the beginning of a new era for the Canadian health care system: inasmuch as this is the case, the decisions made in these next months will determine the shape of the Canadian health system. – the quality and the cost of the services it will deliver – for some decades.[48]

The future of patient charges, then, would largely influence the future of health insurance, and the future health of Canadians. In sum, the brief suggested that progress had been made already through medicare, but more progress lay ahead through the abolishment of patient charges.

In 1984 the Department of Hospital and Medical Care briefly considered a change to its legislation to meet the *Canada Health Act*'s criteria. A memo from the newly appointed Assistant Deputy Minister of Policy Development, D. J. Junk, to Russell summarized the federal government's interpretation of accessibility, universality, user fees, and premiums. Junk estimated that in the first year the potential cost of not complying with the Act would be $18.2-$21.2 million in penalties.[49] The federal

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[47] The Office of Dr. C.A. Meilicke to Mr. G. R. Beck, Mr. K. G. Moore, Mr. E. H. Wright, and Dr. L. C. Grisdale, November 14, 1980, accession 1994.287, box 12, item S000 HE, Provincial Archives of Alberta.
[48] Ibid.
[49] D.J. Junk to Dave Russell, February 29, 1984, accession 1991.508, box 1, item A0003, Provincial Archives of Alberta.

government's interpretation of this condition had also been explicitly stated in the Health Services Review '79 report, leaving little room for alternate interpretations. A later memo to Russell from Deputy Minister Lloyd Grisdale suggested that, should Alberta reform its health insurance policies to reduce extra-billing and increase compliance with the *Canada Health Act*, there would be several considerations. For example, allowing physicians to opt out of medicare would not necessarily reduce extra-billing; an opting-out system would cost more to administer than an extra-billing one; and the costs of conversion to an opting-out system were high. This last point was especially significant considering the possibility that Alberta would need to convert to an even stricter policy in a few years if federal policy continued to determine the structure of provincial health programs.[50]

The Department also looked for ways to challenge the constitutional validity of the proposed *Canada Health Act*. Grisdale contacted the Deputy Attorney General on January 17, 1984, to look into the legality of a federal act prescribing reasonable compensation and adequate amounts of remuneration for the medical profession. He also enquired as to whether the Act could be challenged for interfering with "a province's legal right to levy taxes to finance health care" by requiring that 100 percent of its residents be covered.[51] However, amendments to the proposed Act ensured its legality while maintaining the federal government's "extra-ordinary power to impose financial

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[50] Lloyd Grisdale to Dave Russell, March 21, 1984, accession 1991.508, box 1 item A0003, Provincial Archives of Alberta.

[51] Lloyd Grisdale to R. W. Paisley, January 17, 1984, accession 91.508, box 1, item A0003; Dave Russell to Les Young, April 9, 1984, Provincial Archives of Alberta, accession 1991.508, box 1, item A0003, Provincial Archives of Alberta.

penalties without recourse by the provincial governments to any type of appeal mechanism."[52]

In 1984, Alberta refused to adopt the *Canada Health Act* due to the direction given by the Alberta Progressive Conservative government. The rhetoric of federal-Alberta conflict over resources pervaded the political extra-billing debate, and the conservative rhetoric of individual responsibility for health and independence from government services was also prevalent. This was continuous with the ideological principles of the Social Credit predecessors of the Alberta Progressive Conservatives. These perspectives are made clearer in comparison with the views of professional senior policy advisors employed by the maturing Department of Hospitals and Medical Care. Briefing notes on the Health Services Review '79 recommendations contradicted the direction of the Progressive Conservative Alberta government, and suggest that several assistant deputy ministers across the Department felt the abolition of patient charges would have been a progressive move. However, Minster Russell's decision to preserve extra-billing for the immediate future was informed by the broader political context in which he had been appointed to govern.

Through the extra-billing debate, Minister Russell exercised his authority to make decisions about the future of Alberta health policy relative to his most senior advisors in the Department of Hospitals and Medical Care, and the federal government. While professional bureaucrats played an important role in informing Russell's decision, Russell, as Department Minister, was authorized to set the policy direction. At the same

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[52] D.J. Junk to Dave Russell, March 12, 1984, accession 1991.508, box 1, item A0003,

time, the Alberta Progressive Conservative party was largely influential in the decision making process by providing the strategic framework within which Russell was elected and appointed to the cabinet. While the mandate for health was Russell's, his arguments against the recommendations of Health Services Review '79 suggest that the Alberta political framework was the lens through which Russell understood and carried out his mandate.

Alberta's physicians and nurses had significant vested interests in the decisions made by Russell about the future of the health care system that employed them. Both groups worked through their respective professional associations to participate in and influence the policy direction in their favour. However, the directions sought by the Alberta Medical Association (AMA) and the Alberta Association of Registered Nurses (AARN) were in opposition. The AMA strove to preserve the discretion to extra-bill for individual physicians, while the Alberta Association of Registered Nurses argued for the abolition of extra-billing through allocation of greater responsibility to nurses. At the heart of both demands was a desire for greater decision making authority within the health care system. The next chapter will contextualize these positions, and explore in greater detail their logic, effectiveness, and implications for health care providers in Alberta.

Provincial Archives of Alberta.

Chapter 2

Autonomy and Authority: The Alberta Medical Association and Alberta Association of Registered Nurses

The positions of the Alberta Medical Association (AMA) and the Alberta Association of Registered Nurses (AARN) on the direction that the Alberta government should take respecting the future of extra-billing clashed during the years leading to the 1984 decision not to implement the *Canada Health Act* in Alberta. Alberta physicians extra-billed more than their peers in any other province, and the AMA's leaders defended physicians' right to use and exercise their own discretion over the appropriateness of the practice.[1] In contrast, the leaders of the AARN called for Alberta Minister of Hospitals and Medical Care, Dave Russell, to address the root causes of extra-billing, such as health care system under-funding, and ultimately abolish the practice.

In 1984, the Alberta government's decision to maintain policy that allowed extra-billing aligned with the AMA's position on the practice, and therefore favoured the interests of physicians. At the same time, this decision marginalized the AARN – and by extension nurses. The leaders of the AMA and AARN were expected to speak and act on behalf of their professions, whether their views and aims reflected those of each individual member or not. Membership in both the AMA and AARN was voluntary, however both organizations were concerned with advancing the political and professional interests of their respective constituents as coherent groups. Each organization was led by

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[1] Carolyn Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in Perspective," *Canadian Journal of Political Science*, 21:2 (1988): 280.

elected members of their respective professions to allow individuals to endorse their professional leaders and their mandates. This chapter will compare the AMA and AARN's respective pursuits of influence and authority within the Alberta health care system, as demonstrated by the extra-billing debate. It will also set the context for further exploration of nurses' efforts to stem extra-billing in Chapter 3, where I will discuss the views and activities of the United Nurses of Alberta.

Physicians' contribution to the history of medicare have been well documented by scholars, including David Naylor, Malcolm G. Taylor, Penny Bryden, and others. The literature on this subject demonstrates that, because physician services were explicitly covered in federal medicare legislation, the medical profession was extensively consulted at virtually all stages of medicare policy development. This was especially the case following the 1961 Saskatchewan doctors' strike, which suggested the risks of not securing physicians' endorsement for health policy decisions.[2] As a result, the interests of the Canadian Medical Association (CMA) were accommodated and reinforced by medicare. The *Medical Care Act* of 1968, in particular, solidly established the modern medical model and the authority of physicians within the health care system by insuring only services provided by medical practitioners, and by preserving fee-for-service remuneration.

Another feature of the *Medical Care Act* that favoured physicians was that it implicitly permitted extra-billing by the omission of comments on the practice in the legislation. This loophole allowed physicians' discretion over the use of extra-billing to

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[2] Ibid., 283.

cause a rapid increase in the practice across Canada during the late 1970s. However, the increase in extra-billing was a complex event that was attributed to many possible causes by politicians and interest groups seeking to blame someone or something for the issue. In fact, the federal Health Services Review '79 was appointed, in part, to investigate charges that provincial governments diverted health funds in other areas, leading to under-funding of health services and contributing to extra-billing.[3] The allegation that provinces had diverted health funds to other expenditures was eventually proven false, and later in the 1980s scholars including David Naylor, Carolyn Tuohy, and Malcolm G. Taylor concurred that extra-billing increased in the late 1970s for two main reasons, both directly linked to physicians.

The first reason for the increase in extra-billing was a decline in the medical profession's income relative to other professions – from 5.4 times the average Canadian income in 1971 to 3.4 times the average income by 1978.[4] In 1978, national anti-inflation wage controls were lifted. This led to a period of aggressive "catch-up," in which labour unions and medical associations alike strove to re-gain purchasing power for their members through significant remuneration increases.[5] In Alberta, where the provincial government controlled remuneration increases for physicians, with input from the AMA, physicians who felt increases were too low were free to extra-bill – and many did. In fact,

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[3] See Emmett Hall, *Canada's National-Provincial Health Program for the 1980s: A Commitment for Renewal*, (Ottawa: Health and Welfare Canada, 1980).
[4] C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966*, (Montreal: McGill-Queen's University Press, 1986), 248.
[5] Malcolm G. Taylor, *Insuring national health care, the Canadian Experience*, (Chapel Hill: University of North Carolina Press, 1990), 158.

far more Alberta physicians extra-billed than did their peers in any other province. By 1984, approximately 10 percent of Canadian physicians extra-billed, although total extra-billings comprised a mere 1.3 percent of physician billings for insured services nationally.[6] In Alberta, the number of physicians who extra-billed peaked at approximately 40 percent in the early 1980s.[7]

The second reason extra-billing increased during the late 1970s was the concern of medical association leaders that government officials would try to micro-manage clinical use of costly treatments to save money.[8] Extra-billing took the pressure to increase fee schedules away from governments and removed the financial incentive for governments to meddle in clinical affairs. This was a key concern of the AMA's leaders, who argued that physicians could become marginalized in clinical settings should the government decide to play a greater role in managing costs. They asserted that extra-billing restored, at least symbolically, the economic autonomy the AMA felt physicians required to maintain their authority.[9]

The AMA's leaders' arguments in favour of extra-billing were based primarily around this second cause for the rise of extra-billing. This is evident in their words, their proposed solutions, and their efforts to exert control over the definition and use of extra-billing in collaboration with the College of Physicians and Surgeons of Alberta (CPSA). The AMA's leaders claimed that the government had already usurped some of the medical profession's decision making authority by assuming a greater role in health care

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[6] Tuhoy, "Medicine and the State," 280.
[7] Ibid., 293.
[8] Ibid., 282, 285.

governance. The AMA called this the primary shortfall of medicare in its statement to the Health Services Review '79 committee in 1980. The statement claimed this had occurred through service rationing, universality, under-funding, and inadequate fee-for-service remuneration.[10] The brief expressed irritation at the increasing tendency of government to view doctors as civil servants rather than independent professionals "providing services in accordance with a code of ethics under strict rules for professional conduct" – a trend which, the AMA claimed, had led to "too few members of the public [taking] any personal responsibility for their health."[11]

The solution proposed by the AMA's leaders to safeguard the "freedom, integrity and welfare of the Medical Profession," was to restore private health insurance dynamics under medicare, including the entrenchment of patient charges.[12] In the proposed scenario, the contract for insurance would be between the "carrier and subscriber" and the contract for service between the provider and the recipient of that service.[13] This would, in theory, serve to set clearer boundaries between the role of the Alberta government, as funder, and that of physicians, as medical experts, by defining both parties' relationships with patients. In addition to this, patient charges would discourage over-use and abuse of public health services, and provide a pressure valve for the provincial government in its role as insurance "carrier." Patient charges would include extra-billing, health care

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[9] Ibid., 283.
[10] Alberta Medical Association, *Committee Reports: 75th Annual General Meeting, AMA and CPSA,* (Edmonton: Alberta Medical Association ,1980), 45.
[11] Ibid., 45.
[12] Ibid., 45.
[13] Ibid., 45.

premiums, and user fees – the latter two offering no financial gain to physicians.[14] This proposed scenario clearly suggests that compensating for the loss of relative income compared to other professions was not at the forefront of physicians' reasons for crafting these strategies. Instead, the AMA's leaders wanted to entrench a health care system in which the physicians' roles were clearly understood – and protected. Extra-billing was only one element of the AMA's overall strategy to achieve this goal.

In 1979, the AMA engaged in a debate with the CPSA to define the concept and acceptable practice of extra-billing, demonstrating both organizations' desire to control its use. The CPSA was the professional licensing and regulatory body for Alberta physicians, and was responsible for ensuring professional educational, clinical, and ethical standards were in place. The law required all practicing Alberta physicians to register with the CPSA, and empowered the CPSA to take punitive measures against any individual who did not uphold its standards. The legal authority of the CPSA as a professional self-governing body was critical to the authority of Alberta physicians in society. Its efforts to define and control extra-billing suggest that the leaders of the CPSA, like the leaders of the AMA, were afraid that the medical profession's authority to make decisions about their own future was at stake.

In a letter to all Alberta physicians in 1979, L. H. le Riche, Registrar of the CPSA, sparked the debate when he sought to clarify the difference between the terms "extra-billing" and "balance-billing," the latter of which was preferred by the AMA's leaders.

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[14] Alberta Medical Association, *Committee Reports: 74th Annual General Meeting, AMA and CPSA*, (Edmonton: Alberta Medical Association, 1979), 38; and Alberta Medical Association, "A.M.A. Presents Brief," *Alberta Doctors Digest* 4:2 (1979), 3.

He wrote,

> 'Balance' billing is the routine extra-billing of patients for basic health services above the Schedule of Benefits; 'extra' billing is that billing to a patient for services which are over and above the usual as has been practiced in the past.[15]

The AMA's leaders responded in their periodical, the *Alberta Doctors' Digest*, calling le Riche's definition of "balance-billing" "abhorrent to the A.M.A" and denying there was any difference between extra- and balance-billing except in connotation.[16] The AMA associated "extra-billing" with the public's distaste of the practice, while "balance-billing" had a more positive connotation. Both practices, the AMA article declared, were an effort to reconcile, on the one hand, the Government of Alberta's schedule of benefits, stipulating doctors' reimbursements under the Alberta Health Care Insurance Plan for various medical services, with, on the other hand, the AMA schedule of fees, which was often higher for a given medical service. However, later the same year, the AMA conceded a distinction between the two practices in its Presentation to the Caucus Task Force on Extra Billing. This report stated:

> Balance billing is defined by the Alberta Medical Association as a situation where a physician directly bills a patient the difference, or balance, between his fee for an **insured** medical service and the benefit paid by the Alberta Health Care Insurance Plan. Extra billing occurs when a physician encounters unusual

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[15] L. H. le Riche to Members of the CPSA of Alberta, January 31, 1979, Provincial Archives of Alberta.

[16] "Dr. L. H. leRiche's Letter Answered," *Alberta Doctors' Digest* 4:3 (1979), 7. See also "Balance Billing," *Alberta Doctors' Digest* 4:3 (1979), cover-2.

difficulty or spends a disproportionate amount of time with a patient, and charges more than his usual fee for that service.[17]

In addition to their attempt to define the concept of extra-billing, the CPSA established professional guidelines for the use of extra-billing. The guidelines included informing patients of intended balance-billing prior to the provision of services; not pursuing payment of balance-bills until after services had been delivered; and exempting the poor from balance-bills. The "poor" included senior citizens solely dependent on old age pensions and persons on either income assistance or health care premium subsidy (full or partial).[18] According to the CPSA, if these guidelines were followed, but a patient refused to pay a balance-bill, it was considered ethical for the physician to refuse to provide services.[19] In 1979, le Riche communicated to all Alberta physicians that they were expected to comply with these guidelines to preserve "the image of medicine as a worthy profession."[20] The CPSA Council then passed a number of resolutions to create a mechanism for holding physicians accountable to these guidelines. Violation of these resolutions was considered "conduct unbecoming a physician in the province of Alberta."[21] Asserting authority to define and regulate balance-billing, it was hoped, would help to preserve the practice in the future.

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[17] Alberta Medical Association, *Committee Reports: 74th Annual General Meeting, AMA and CPSA*, (Edmonton, Alberta Medical Association, 1979), 37, emphasis in original.
[18] College of Physicians and Surgeons of Alberta, *Motions of Council, 2nd and 3rd September 1982*, (Edmonton, College of Physicians and Surgeons of Alberta, 1982).
[19] L. H. le Riche to Members of the CPSA of Alberta, January 31, 1979.
[20] Ibid.
[21] College of Physicians and Surgeons of Alberta, *Motions of Council, 19th and 20th March 1981*, (Edmonton, College of Physicians and Surgeons of Alberta, 1982); College of Physicians and Surgeons of Alberta, *Motions of Council, 2nd and 3rd September 1982*,

The leaders of the AMA and CPSA sought to protect the practice of extra-billing, and physicians' discretion over its use, primarily in an effort to entrench their role relative to the Alberta government in clinical decision-making. The AMA in particular argued that extra-billing created a solution to health care cost pressures under medicare, and negated the need for the provincial government to interfere in the allocation of costly treatments. This was the organization's primary argument in support of extra-billing, as opposed to its financial benefits. Its leaders therefore fought to protect the practice. The 1984 decision of Alberta Minister of Hospitals and Medical Care Dave Russell to reject the *Canada Health Act*'s stipulation that extra-billing be banned aligned with the AMA's leaders' goals, and was interpreted by the AMA as a victory. However, the AARN had sought a different objective.

Scholars have not studied in detail the contribution of nurses to the extra-billing issue, and in fact contribute to the marginalization of nurses in historical health policy development processes by their omission from the literature at key decision points. This is especially obvious when compared to the medical profession, which was consulted at every stage and decision. This can be partially attributed to the emphasis on physician services in federal medicare legislation prior to the *Canada Health Act* of 1984. Neither the Hospital Insurance and Diagnostic Services Act of 1957 or the *Medical Care Act* of 1968 dealt directly with insuring nursing services. It can also be partially attributed to the federal focus of much academic literature on the history of medicare, which may have led scholars to overlook the role of nurses in provincial policy decisions.

(Edmonton, College of Physicians and Surgeons of Alberta, 1982).

In contrast to what policy historians have not said about nurses' impact on medicare's development, nursing historians have argued convincingly that medicare's development impacted nurses' workplace environments and conditions.[22] The infusion of public funding into the hospital sector, and increased public demand for health care services under the universal state-funded program, led to a proliferation in the number and diversity of nurses and other specialized health care providers.[23] Increasing financial pressures soon prompted hospital administrators to seek the lowest-cost alternatives to nurses whenever possible. This led associations of registered nurses – established to promote professional training and authority for nurses – to emphasize the differences or "boundaries" between themselves and other less-skilled health care providers, such as nurse assistants.[24]

As Cynthia Toman and Meryn Stuart have pointed out, the term "nurse" is increasingly muddled by unclear and changing boundaries among health care workers, creating the need to view "nurses" historical experiences from more than one angle. Although in the early 1980s scholars sought to portray nursing as a unified, universalized body of practitioners and practice," this was not then and is not now the case.[25] Pat and

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[22] See Janet Ross-Kerr, *Prepared to care: nurses and nursing in Alberta, 1859 to 1996* (Edmonton: University of Alberta Press, 1998); Kathryn McPherson, *Bedside matters: the transformation of Canadian nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003); and Pat Armstrong and Hugh Armstrong, *Wasting away: the undermining of Canadian health care* (Toronto: Oxford University Press, 1996).
[23] Ross-Kerr, *Prepared to Care*, 234; McPherson, *Bedside Matters*, 6.
[24] McPherson, *Bedside Matters*, 260-261; Barbara Melosh, *"The Physician's hand": work culture in American nursing* (Philadelphia: Temple University, 1982), 5; and Armstrong, *Wasting Away,* 106.
[25] Cynthia Toman and Meryn Stuart, "Emerging Scholarship in Nursing History," *Canadian Bulletin of Medical History*, 21:2 (2004): 224.

Hugh Armstrong argue that the pace of fragmentation of the health workforce heightened between the 1940s and 1960s as a result of the impact of medicare on demand for health care. Differentiation between nurses-in-training and graduate nurses increased, leading to a proliferation of working titles by the 1970s that included, alongside nurses, various orderlies, nurse assistants, and therapists.[26] Barbara Melosh and Kathryn McPherson have each documented how divisions based on level of education marginalized practitioners with less scientific training and inadvertently created an environment that mimicked the race, class, and gender power hierarchies – and inequalities – that exist in society as a whole.[27]

At the same time, divisions also existed among those who retained the working title of "nurse." In Alberta, for example, Janet Ross-Kerr has described the fierce conflict between the AARN and the United Nurses of Alberta (UNA) that was triggered when the UNA attempted to bargain for the elimination of a salary differential between registered and non-registered nurses in 1982. Ross-Kerr, taking a position supportive of the AARN viewpoint, states: "because the AARN had a responsibility to the public to ensure safe, competent and ethical practice by nurses, it saw the UNA proposals as potentially very damaging to the public interest."[28] The struggle that ensued resulted in a lawsuit filed by the UNA against the AARN, which had implied that the UNA was not concerned with patient care quality.[29] It also led the AARN to seek legislative action to make registration mandatory by law, which was achieved by an amendment to the Nursing Profession Act

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[26] Armstrong, *Wasting Away*, 106.
[27] Melosh, *Physician's Hand*, 4, 7; McPherson, *Bedside Matters*, 6.
[28] Ross Kerr, *Prepared to Care*, 257.

in 1984.

The leaders of the AARN and the UNA had distinct views on extra-billing, partially as a result of their differing mandates and membership. While the AARN was charged with advancing the professional and educational interests of Alberta nurses, the UNA was a labour union charged with improving nurses' working conditions. As a result, the members of the AARN were registered nurses from across the province, while the UNA was more inclusive of a variety of nurses. At the same time, the AARN's members worked in a variety of settings, and affiliated with the organization based on their credentials, while the UNA's members were primarily hospital-based. However, this is not to suggest that the memberships of the UNA and AARN were mutually exclusive. For example, nurse Karin Olsen, a representative of the Edmonton Voters' Association on the Friends of Medicare's Board of Directors, was also an AARN member, and Barb Surdikowski was both a member of the UNA Board of Directors and an AARN member. It is important to remain mindful of the diversity of nurses that these two organizations represented. While each organization took up unique perspectives and strategies, individual members may not have endorsed the views or tactics of only one or the other group exclusively, and some Alberta nurses may not have subscribed to the views of either. Chapter 3 will address the experience of the UNA in greater detail.

The AARN's leaders' position on extra-billing was shaped by the Ad Hoc Committee to Establish an AARN Position on Extra-Billing, which reported in 1981 that extra-billing, while of major concern, could not be treated as an isolated issue: its causes

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[29] Ibid., 287.

and solutions were systemic.[30] More specifically, extra-billing was alleged by the Ad Hoc Committee to be the result of three failings of medicare. The first alleged failing was state under-funding of publicly insured services, leading to inadequate remuneration of physicians and thus contributing directly to extra-billing. The second was policy that mandated only physicians to perform insured services, leading to inefficient use of costly physicians in cases where less costly nurses were qualified to do the work. Lastly, due to the limitation that only physician services were insured, the public frequently sought insured treatment rather than uninsured prevention or counseling services that nurses were trained to provide. This, claimed the Committee, led to overuse of costly medical services when the need for treatment could have been avoided in the first place.[31] This third aspect was especially pertinent in the wake of the 1974 Lalonde report, which had provided statistical evidence of a rapidly increasing prevalence of preventable chronic conditions and injury as the most common health problems.[32] Based on these conclusions, the Committee considered extra-billing a symptom of an under-funded health system that reinforced physicians' authority and undermined nurses.'

As a result of the Committee's advice, the AARN Provincial Council demanded

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[30] "Provincial Council Minutes, December 2 & 3, 1981," AARN Provincial Minutes Council, vol. 39B, September 1981 – September 1982, College and Association of Registered Nurses of Alberta Museum and Archives.

[31] "Report of the Ad Hoc Committee to Establish an A.A.R.N. Position on Extra-Billing by Physicians to Provincial Council, February 10, 11 and 12, 1982," AARN Provincial Minutes Council, vol. 39B, September 1981 – September 1982, College and Association of Registered Nurses of Alberta Museum and Archives; Alberta Association of Registered Nurses, "A.A.R.N. responds to Hall; Review on Health Services", *AARN Newsletter*, 36:9 (1980), 5.

[32] See Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document*, (Ottawa: National Health and Welfare, 1974).

that the Alberta government reorganize the delivery of health services to be more efficient, and abolish extra-billing. They suggested that by increasing the authority of nurses to deliver a greater range of health services, and to serve as the gate-keepers to costly, and often unnecessary, physicians, the need for many expensive treatments could be prevented altogether. The Provincial Council also proclaimed their intention to tolerate the medical profession's use of extra-billing in the short term, until the Committee's alleged failings could be addressed, but demanded the ultimate abolition of extra-billing.[33]

The response of the AARN Provincial Council to the findings of the Ad Hoc Committee was shaped by an analysis of women's work in the context of increasing acceptance of feminist views among nurses in general. Nursing associations were largely separate from the women's movement through the 1970s and the AARN, in particular, was initially reluctant to align with women's interest groups that could dilute the organization's professional priorities.[34] By the late 1970s, as preventable injury and chronic disease became the most prevalent causes of ill health in Canada, nurses once more argued for recognition of the valuable contribution that they could make to the health care system. Nurses in general had an established legacy of championing public health and of demonstrating their effectiveness in keeping the population well – a legacy

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[33] "Report of the Ad Hoc Committee to Establish an A.A.R.N. Position on Extra-Billing by Physicians to Provincial Council, February 10, 11 and 12, 1982," AARN Provincial Minutes Council, vol. 39B, September 1981 – September 1982, College and Association of Registered Nurses of Alberta Museum and Archives.

[34] McPherson, *Bedside Matters*, 254; Ross-Kerr, *Prepared to Care*, 217.

established throughout the twentieth century.[35]

The AARN's leaders, therefore, argued that the treatment-based orientation of medicare policy, positioning primarily male physicians as the sole providers of insured services, was the result of the undervaluing of women's work in the health care system. The AARN's submission to Health Services Review '79 alluded to this argument, stating: "The Nursing Profession [sic] is the backbone of the Canadian Health Care System, yet it continues to receive paternalistic and token recognition for the service it provides."[36] At the 1981 AARN annual convention, nurse Jenniece Larsen elaborated more explicitly on this sentiment in a presentation entitled "The Effects of Feminism on the Nursing Profession." She explained:

> The organization of the work of nursing is most clearly understood only when nursing is viewed as an industrialized form of traditional women's work. Thus the position of nursing in the structure of health care is much the same as the position of domestic labor in the structure of society in general.[37]

Larsen lamented the fact that nurses were over-qualified for the work they were permitted to do as mere physicians' assistants within an oppressive hospital hierarchy premised on sexist norms.[38] This was especially concerning given the rising importance of preventing

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[35] Dianne Dodd and Deborah Gorham, "Introduction," in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, eds. Dianne Dodd and Deborah Gorham, (Ottawa: University of Ottawa Press, 1994), 12; McPherson, *Bedside Matters*, 255-6; Ross-Kerr, *Prepared to Care*, 218.
[36] "A.A.R.N. calls for changes in health care system," *AARN Newsletter*, 36: 5 (1980) 3.
[37] Jenniece Larsen, "The Effects of Feminism on the Nursing Profession," *AARN Newsletter*, 37:7 (1981), 2.
[38] Ibid., 3.

illness and injury.

In spite of the AARN Provincial Council members' increasing dissatisfaction with the inefficient and gendered hierarchy of health services under medicare policy, they believed that the success of their strategy to effect change relied on the AMA. In fact, the Provincial Council members announced their support for physicians on the issue of extra-billing in an effort to leverage the support of the AMA, and criticized the Alberta government for its faulty policies. In a letter to Alberta Minister of Hospitals and Medical Care, Dave Russell, the Provincial Council wrote:

> It appears to the A.A.R.N. that by allowing physicians to charge their clients an additional amount over and above the current schedule of benefits, the Alberta Government is really saying that physicians deserve to be paid more than the Government is willing to provide. The A.A.R.N. believes that it is the Government's responsibility to provide the total amount owing the physicians of Alberta.[39]

The AARN Provincial Council also launched a letter-writing campaign formally petitioning the Alberta government for health policy that would extend the settings in which health services were provided beyond hospitals and that would recognize nurses as an entry point to the health system.[40] The letters argued that placing a higher value on

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[39] Ibid, emphasis AARN's.

[40] Don Junk to Dave Russell, March 15, 1984; Yvonne Chapman to Dave Russell, February 16, 1984, AARN Provincial Minutes Council, vol. 41B, October 1983 - September 1984, College and Association of Registered Nurses of Alberta; Phyllis Giovannetti to Dave Russell, March 5, 1984, accession 1991.508, box 1, item A0003, Provincial Archives of Alberta.

nurses' services by empowering them as gatekeepers to the health system and funding services provided in non-hospital settings would contribute to efficiency, quality care, and access while preventing the use of patient charges. In contrast, the Provincial Council simultaneously wrote to the AMA to profess its solidarity in the matter of extra-billing, stating:

> The AARN would like to inform you of our support in your recent negotiations and ongoing struggle with the Alberta Government. We believe all health care personnel deserve fair and equitable remuneration for their services. We do not like to see the constant erosion of medicare that is happening because of a government that refuses to see Health Care as a priority; only as a burden to be borne and as little as possible paid into it.[41]

The letter went on to request the AMA's support in promoting a stronger health insurance policy – one that would render medicare more sustainable though reorganization.

One possible explanation for the AARN Provincial Council's efforts to align with the AMA to advance its leaders' agenda, instead of the Alberta Government, is the AARN's history of strategic deference to the medical profession. Historians have shown that nurse associations generally supported the authority exercised by the medical profession within the "medical division of labour," based on their desire to gain authority

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[41] "Report of the Ad Hoc Committee to Establish an A.A.R.N. Position on Extra-Billing by Physicians to Provincial Council, February 10, 11 and 12, 1982," AARN Provincial Minutes Council, vol. 39B, September 1981 – September 1982, College and Association of Registered Nurses of Alberta Museum and Archives.

for nurses as an autonomous profession.[42] This is evident in nurse associations' promotion of educational standards for registered nurses, which was a tactic to promote the public's best interests by ensuring adequate training and health care standards, and an accentuation of the scientific skills nurses possess relative to other health care workers.[43] In order to validate nurses' own authority, nursing associations, such as the AARN, accepted and promoted educational standards that drew from and aligned with the medical profession – often by placing medical leaders in positions of regulatory authority.[44] Dianne Dodd and Deborah Gorham argue that obtaining scientific training and qualifications, particularly under the direction of medical professionals, was essential for the professionalization of nurses: "Only by doing so could they achieve recognition within the modern health system."[45] Thus, based on their past relationship with Alberta physicians, the AARN may have been more likely to view the AMA as an ally than the Alberta government, which had marginalized nurses as an interest group by excluding them from past policy decisions. Additionally, the AMA, representative of the Alberta medical profession, presumably had greater authority relative to government policy makers based on the inclusion of physicians in these decisions.

Another possible explanation is the close working relationships of many nurses with physicians, especially those who worked outside the hospital sector. These nurses, employed in clinical settings like physicians' offices, would have relied upon physicians for their livelihoods and working conditions. This may have led the AARN's leaders to

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[42] Melosh, *"Physician's hand,"* 5.
[43] Armstrong, *Wasting Away*, 106.
[44] Dodd, "Introduction," 12; Ross-Kerr, *Prepared to Care*, 212.

sugar-coat their distaste for extra-billing by appearing to support the AMA, and blaming the Alberta government for the short-comings of medicare policy instead of physicians.

As the previous chapter demonstrated, the Alberta Government's refusal to abolish extra-billing until 1986 was based primarily on concerns related to constitutional precedent-setting. However, because this decision aligned with the desire of the AMA's leaders to preserve the right of individual physicians to extra-bill, in contrast to the desire of the AARN's leaders to abolish extra-billing and reorganize the health system, it favoured physicians' interests over those of organized nurses.' This was an inadvertent result of the Progressive Conservative provincial government's strategic policy framework, which placed the protection of Alberta's resources as a top priority.

Similarities between the AMA's arguments and those of the Alberta government contributed to an understanding between the AMA and the Alberta government that physicians and the government shared common concerns. This was especially true regarding their mutual arguments in favour of economic disincentives to discourage inappropriate use of insured health services. In 1986, the symbiosis between the AMA and the Alberta government contributed to the abolition of extra-billing in Alberta in a manner that was considered acceptable to the AMA. Alberta physicians had already reduced their use of the practice from 40 percent in the early 1980s to 23 percent in 1986 due to a downturn in the economy, which made the loss of the practice less painful.[46] Additionally, in return for the loss of the right to extra-bill, Alberta physicians gained a new Extraordinary Medical Services Fund, from which remuneration was provided to

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[45] Dodd, "Introduction," 12.

doctors who demonstrated higher-than-normal effort in a particular case. The Alberta government also agreed to de-insure certain high-priced cosmetic procedures – enabling specialists who delivered such services to set their own fees.[47]

In contrast, neither the 1984 Alberta government decision to maintain extra-billing, nor their 1986 decision to abolish it, addressed the concerns expressed by the AARN regarding the pitfalls of marginalizing nurses within the health care system. The *Canada Health Act*, in large part thanks to the federal-level efforts of the Canadian Nurses' Association's leaders, expanded the scope of insured services under medicare to include those provided by "health care practitioners," a term which could be interpreted to include nurses if the provincial administrators of health insurance programs chose to do so. However, Alberta Minister of Hospitals and Medical Care Dave Russell indicated little interest in this option at the provincial level. In March 1984, Russell responded to a letter from AARN Executive Director, Yvonne Chapman, who had requested broader definition of providers of insured benefits. Russell candidly, and somewhat patronizingly, declared that due to constitutional problems with the *Canada Health Act*, there was no intention to recognize nurses as legitimate providers of insured services at that time.[48]

The outcome of the AMA and AARN's efforts to influence the Alberta government's decision regarding extra-billing had implications for health care system governance. The Alberta government's decisions to maintain and later to abolish extra-billing reiterated the ultimate authority of elected officials to make decisions about the

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[46] Tuohy, "Medicine and the State," 293.
[47] Ibid., 293.
[48] Dave Russell to Yvonne Chapman, March 16, 1984, accession 1991.508, box 1, item

direction of the Alberta health care system, with or without input from physicians and nurses. However, the medical profession, as represented by the AMA, was privileged by the policy development process and its outcomes, while nurses, as represented by the AARN, were marginalized. Although the AMA's leaders were not able to control the policy decisions of the Alberta government, their interests were clearly understood and to some extent protected, even though extra-billing was abolished. The policy influence of the AARN's leaders, by comparison and as a result, was far less than physicians'. This situation, combined with the fact that the organization's key strategy in advancing their aims was to support the AMA in hopes of leveraging physicians' endorsement, revealed nurse leaders' dilemma. Nurses had less experience in provincial politics and some dependency on physicians for authority and validation. It also suggested the vulnerability of Alberta's nurses to any ill will against them on behalf of physicians, as professionals in need of educational credibility and as employees. The AARN's leaders worked to protect its members by clearly blaming the Alberta government for its concerns and promising the AMA its solidarity.

In contrast to the AARN, a second group of Alberta nurses, the United Nurses of Alberta (UNA), took a markedly different approach in their efforts to end extra-billing. The UNA did not depend upon physicians' endorsement to advance its goals because, unlike the AARN, it was not concerned with educational credentials or professional authority. Its mandate was to advocate for improved working conditions on behalf of nurses. It also represented primarily nurses employed in hospitals, where working

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A0003, Provincial Archives of Alberta.

conditions had been impacted by health care system dynamics under medicare and collective demands were more cogent. Based on its experience as a union, the UNA aligned with the Alberta Federation of Labour (AFL) for solidarity in labour relations conflicts, and became a member of the AFL-founded organization Friends of Medicare. The case study in the following chapter provides an alternate approach taken by of Alberta nurse leaders' to abolish extra-billing.

CHAPTER 3

The Labour Perspective: The Alberta Friends of Medicare and United Nurses of Alberta

The Friends of Medicare (FOM), an interest group founded and managed by the Alberta Federation of Labour (AFL), provided a unified voice for labour groups and other Albertans concerned about medicare's future in the early 1980s. One "on again, off again" member of the FOM was the United Nurses of Alberta (UNA), the provincial collective bargaining organization for Alberta nurses.[1] Through the FOM, Alberta nurses found a means to express their views on the extra-billing debate separate from the Alberta Association of Registered Nurses (AARN). In contrast to the disappointing, even disillusioning, results of the AARN's efforts to advance their arguments for a re-organized health system under medicare, the UNA capitalized on the momentum of the FOM to generate public support for the end of extra-billing in Alberta.

This chapter provides an overview of the FOM's early years and analyzes the factors that led the UNA to align with the FOM to further its aims. It will suggest that, in contrast to the AARN, many nurses did not respond to extra-billing as a marginalized group dependent on the permission of physicians to advance their goals. It will also demonstrate that nurses were not only impacted by medicare policy, but worked to shape its development from outside the formal policy making process.

Historian Desmond Morton argues that nurses' "unions had ensured that doctors'

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[1] Between its annual meetings of 1982 and 1983, the UNA withdrew its membership

associations were not the only organizations to give health employees a living wage," especially in the conservative labour climates of Ontario and Alberta.[2] This was especially true in the late 1970s, as organized labour across Canada was demonstrating heightened militancy in the context of rising unemployment and declining consumer purchasing power.[3] As labour historian Gregory Kealey wrote in 1985, from the late 1970s onward "erosion of wage differentials, the lessening of autonomy, the decline of stable employment, and the erosion of advancement chances have resulted in rising dissatisfaction and further unionization."[4] This led groups that had historically eschewed unionism, including nurses, teachers, and university professors to organize aggressive collective bargaining units, one of which was the UNA.[5]

The UNA, formerly the Provincial Staff Nurse Committee (PSNC) of the AARN, was founded with responsibility for labour relations for Alberta nurses' groups "in a majority of health care agencies in the province in 1977."[6] The two organizations decided to separate after the PSNC unveiled a costly long-term plan to the AARN Provincial Council in 1976. It seemed that the debate over funds could potentially compromise the arms-length nature of the PSNC as the AARN Provincial Council delved deep into the

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from the FOM. See "FOM defeated," *News Bulletin*, 6:3 (December 1982): 7.
[2] Desmond Morton, *Working People*, (Ottawa: Deneau and Greenberg Publishers Ltd., 1980), 262.
[3] Bryan D. Palmer, *Working-class Experience: The Rise and Reconstitution of Canadian Labour, 1800-1980*, (Toronto: Butterworth and Co., 1983), 291, 194.
[4] Gregory Kealey, "The structure of Canadian Working-class history," in *Lectures in Canadian and Working Class-History*, eds. W.J.C. Cherwinski and Gregory Kealey (St. Johns: New Hogtown Press, 1985), 34.
[5] Ibid., 34.
[6] Janet Ross-Kerr, *Prepared to care: nurses and nursing in Alberta, 1859 to 1996* (Edmonton: University of Alberta Press, 1998), 276.

details of the PSNC's plan. This was a critical consideration in view of the Supreme Court of Canada ruling that provincial nurses' associations could not serve the function of nurses' union.[7] This ruling had determined that, since in many cases nurse managers sat on governing councils of nurses' associations, it was a conflict of interest for the associations to make employer relations decisions.

The rise of nurses' unions opened the door to the entrenchment of a distinctive "labour" analysis of medicare among nurses, as well as the adoption of labour tactics to shape government health care policy. Eugene Foresy and Antonia Maioni each assert that organized labour traditionally demanded more social security, including protection from the financial burden of illness. This is evident in labour groups' support for social democratic political parties – namely, the Cooperative Commonwealth Federation (CCF) and its successor, the New Democratic Party (NDP).[8] The leaders of the Canadian Congress of Labour (CCL) – the predecessor to the Canadian Labour Congress (CLC) – did their best to meet the need for medical insurance through mutual insurance. However, a national government-funded program of health insurance to protect all Canadian workers against the high cost of illness was welcomed.[9] In 1943, therefore, the CCL

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[7] Ross-Kerr, *Prepared to Care*, 275; Kathryn McPherson, *Bedside matters: the transformation of Canadian nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003), 251.

[8] Eugene Forsey, "The History of the Canadian Labour Movement," in *Lectures in Canadian and Working Class-History*, eds. W.J.C. Cherwinski and Gregory Kealey (St. Johns: New Hogtown Press, 1985), 10.

[9] Forsey, "History of the Canadian Labour Movement," 11; Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*, (Princeton: Princeton University Press, 1998), 99.

formally endorsed the CCF and urged its member unions to support the party.[10] This was somewhat effective in advancing labour's demand for health insurance in Ontario and Saskatchewan, where CCF politicians with labour ties were elected to office and successfully implemented pioneer health insurance programs – programs that served as the template for medicare. In 1955 the new CLC resolved to champion a national health insurance program and in 1961, together with the CCF, co-founded the NDP.[11] The NDP was not primarily responsible for developing and implementing medicare in 1968. However, Morton has reported on the central role played by the NDP in refining medicare policy in Manitoba, Saskatchewan, and British Columbia in the early 1970s. Specifically, Saskatchewan's NDP government abolished deterrent fees for health services, while in Manitoba and British Columbia NDP governments abolished health care premiums.[12] These policies advanced the NDP's – and labour's – views on health insurance by removing financial access barriers to health care.

Alberta stands alone among western Canadian provinces as the only one in which neither the CCF nor the NDP ever governed. This is partly due to the lack of labour movement support for establishing a social democratic voice in government during the post-World War II years, in spite of the prominent role played by Alberta labour and agrarian groups in establishing the CCF. In fact, during the 1930s Alberta labour groups were considered exceptionally radical, organizing an illegal march of over 2,000 individuals on the Alberta legislature in the fall of 1932 to demand, among other things, a

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[10] Forsey, "History of the Canadian Labour Movement," 20.
[11] Maioni, *Parting at the Crossroads*, 99.
[12] Morton, *Working People*, 288.

health insurance program. The so-called "Hunger March" degenerated into a bloody riot when the RCMP used batons and machine guns to break it up.[13] However, in the 1940s organized labour allied with the Social Credit government, whose every-man-for-himself health policies were described in Chapter One.[14]

By the late 1960s, the Alberta Federation of Labour (AFL) was more aligned with the direction of the national labour movement with respect to medicare policy. In the midst of the activities surrounding the development of the 1968 federal Medical Care Act, and Alberta Premier Ernest Manning's opposition to medicare, the AFL founded the Albertans for Medicare Committee. This group organized a postcard campaign, petitions "insisting on Medicare Now," and a public relations campaign in support of the implementation of medicare in Alberta.[15] In 1969, after medicare had been formally adopted in Alberta, the AFL's leaders argued in favour of health policy more closely based on the recommendations of the 1964 federal Royal Commission on Health Services. Specifically, the AFL noted that the Medical Care Act did not make health care funding contingent on the comprehensiveness of coverage offered by provincial health insurance plans. Its leaders also criticized the presence of patient charges in Alberta throughout the 1970s.[16]

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[13] Other demands included unemployment insurance and farm debt cancellation. Warren Caratega, *Alberta Labour: A Heritage Untold*, (Toronto: James Lorimer and Company, 1979), 105.
[14] Ibid., 145.
[15] Alberta Federation of Labour, *13th Annual Convention*, 1969, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[16] Alberta Federation of Labour, *Policy Statement*, 1971, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Federation of Labour, *Policy Statement*, 1973, Alberta Federation of Labour Collection, Provincial Archives of

In 1979 the AFL founded the Friends of Medicare (FOM), a coalition of organizations responding to the perceived erosion of medicare in Alberta, which became, in essence, an unofficial arm of the AFL.[17] The AFL and FOM published near-identical position statements. For example, in 1981 the FOM and the AFL submitted parallel reports to the federal Parliamentary Task Force on Fiscal Arrangements that included a great deal of common wording. The AFL and FOM also co-authored a report titled *Friends of Medicare's Concerns on the Erosion of Medicare in Alberta*, which supported the AFL's document *Labours Concerns'* [sic] *on the Erosion of Medicare in Alberta.* Moreover, the FOM promoted occupational health and safety policy (OHS), which demonstrated its labour-based interests and mandate. In its 1981 paper on federal-provincial fiscal arrangements, the FOM stated that one possible solution to current funding cutbacks would be to raise corporate taxes – a justifiable measure in view of the OHS risks created by corporations in the first place and in order to create accountability

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[17] Alberta Federation of Labour, *Submission to the Federal New Democratic Party on the Federal Budget of November 12, 1981*, 1981, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Federation of Labour, *26th Annual Convention Resolutions*, 1982 , Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Federation of Labour, *Alberta Federation of Labour presentation to Caucus Committee of Government*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta. Other original members of the FOM included the UNA, National Farmers' Union, the Consumer Association of Alberta, the Social Justice Commission Catholic Archdiocese, the Edmonton Voters' Association, the Edmonton Cerebral Palsy Association, the Alberta Teachers' Association, the Federal Superannuates Association, the Alberta Council on Aging, the Calgary Senior Citizen Council, Native Outreach, Save Tomorrow Oppose Pollution, and the Family Services Association. See Alberta Friends of Medicare, *Friends of Medicare's Concerns on the erosion of Medicare in Alberta*, 1979, Alberta Federation of Labour Collection, Provincial Archives of Alberta. By 1983, the FOM claimed almost 200,000 members.

for sound OHS practices.[18]

The AFL and FOM also shared senior management and office space. Inside the cover of the FOM report to the federal Parliamentary Task Force on Fiscal Arrangements was the organization's address: care of Don Aitken at the AFL. Aitken, the general services director for the AFL, served as the FOM Coordinator in 1983.[19] Felice Young of the AFL also served on the FOM Board of Directors.[20] In 1982, to raise the profile of extra-billing, the FOM organized a province-wide boycott of physicians who engaged in this practice. An office was set up at the AFL headquarters, offering an FOM hotline for consumers to call for a list of physicians in their area who did not extra-bill – a list that was kept up-to-date through ongoing physician surveys.[21]

As a result of its close ties with the AFL, the FOM represented a labour-based approach to shaping medicare policy in Alberta, serving as the de facto public relations representative for the AFL on medicare-related matters. Under the guise of a separate

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[18] Alberta Friends of Medicare, *The Alberta Friends of Medicare Submission to Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, June 1, 1981*,198, Alberta Federation of Labour Collection, Provincial Archives of Alberta. See also Brochure, "Save Medicare – Ban Extra Billing", n.d., Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[19] Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Second Annual General Meeting, June 23, 1983*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Brochure, *Who are the Friends of Medicare?* n.d. Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[20] Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Second Annual General Meeting, June 23, 1983*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[21] Alberta Federation of Labour, *26th Annual Convention Reports*, 1982, Alberta Federation of Labour Collection, Provincial Archives of Alberta; see also Minutes, Friends of Medicare Board of Directors, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta for a reference to a survey conducted of Calgary physicians.

organization, the FOM drew on the membership of organizations that would not have otherwise worked as closely with the AFL. The UNA was one of these organizations. As a union, the UNA was courted by the AFL, which was, in essence, a federation of many unions that worked toward greater collective gains through solidarity with one another. The UNA valued close ties with the AFL and aligned their views and activities on several occasions. However, no formal relationship ever solidified between the UNA and AFL because the UNA's leadership felt it essential to reinforce the unique workplace environment and needs of nurses.[22] The FOM provided an opportunity for the UNA and AFL to work together, in closer collaboration than they normally would have, in order to advance their common desire to see extra-billing abolished in Alberta.

Historians have established that the introduction of state funding for hospital care in Canada, combined with rapid technological advances, had a profound impact on nurses' working conditions and contributed to unionization.[23] Kathryn McPherson has demonstrated that 1870-1940 was an era characterized by increasing popularity of institutional health services.[24] However, it was not until the introduction of national health insurance that most Canadians could access hospital care, resulting in an explosion of patient demand – a fact that both spurred the growth of the hospital sector and contributed to a significant increase in the number of nurses employed in hospitals.[25] Before long, funding pressures under medicare led hospital administrators to look for cost

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[22] "AFL president urges UNA to affiliate," *News Bulletin*, 4:4 (December 1980): 1; See also United Nurses of Alberta, "Annual Meeting Highlights," *News Bulletin*, 7:5 (October-November 1983): cover, 5-8.
[23] McPherson, *Bedside Matters*, 6.
[24] Ibid., 4.

saving opportunities.[26] Judith Hibberd, in an unpublished dissertation, argues that because nursing services had grown to over 50 percent of hospital budgets, and because the "precise contribution of nursing to the care of hospitalized patients has hitherto been difficult to demonstrate, much less to quantify objectively," nursing services were an attractive area of cut-backs for hospital administrators.[27] "Efficiency measures," such as standardized times for certain tasks, were introduced even as patient volumes increased. In response to the negative effect this had on working conditions, nurse workforce shortages grew.[28]

These changes, in the context of increased militancy of workers in general, directly contributed to the increased use of collective bargaining by nurses as a strategy for improving work conditions and advancing professional aims. According to Mary Kinnear, the assertion of workplace demands, especially through collective action, was at first hindered by divisions among nurses and "the retarding ethic of self-sacrifice."[29] Nurses' training and the nature of health care work emphasized the importance of putting others' needs first and, thus, many nurses felt it was their duty to care for others regardless of work environment.[30] However, it grew increasingly clear that "the bargaining power of nurses depended on their willingness to withdraw their labour."[31]

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[25] Ross-Kerr, *Prepared to Care*, 234.
[26] McPherson, *Bedside Matters*, 251.
[27] Judith Hibberd, "Labour Disputes of Alberta Nurses, 1977-1982" (PhD dissertation, University of Alberta, 1987), 8.
[28] McPherson, *Bedside Matters*, 252.
[29] Mary Kinnear, *In subordination : Professional Women, 1870-1970*, (Montréal: McGill-Queen's University Press, 1995), 113.
[30] Ibid., 113, 121.
[31] Ibid., 113

Moreover, Barbara Melosh argues that as hospitals were reorganized, efficiency measures introduced, and health care transformed into an impersonal assembly line process, many nurses felt as if they were working in a factory environment.[32] It has been argued that the history of nursing was not a "steady march towards professional stature" at all, but a transformation from an independent model of labour to an industrial one based on a "centralized workplace, rationalization of the work process, the intensification of the pace of work, and the rigid, hierarchical division of labour of 'assembly-line' and factory production."[33]

Upon establishment in 1977, the UNA took immediate action to forge strategic bonds with labour organizations, such as the AFL, to leverage public credibility, solidarity, and financial support in case of a strike.[34] It then proceeded to call the first of three strikes that would occur between 1977 and 1982, the participation levels and frequency of which were unprecedented for a nurses' union in Canada.[35] In 1986 Hibberd undertook a study of the UNA to better understand the implications of these activities. She concluded that the strikes had been precipitated by, firstly, the nursing workforce shortage and, secondly, a failure by hospital administrators to appreciate the changing role of women in the workplace.[36] The strike experience was both enlightening and empowering for the UNA, as "union ideology and militant attitudes of the [union] membership were fostered," and nurses became aware of "the power of unionism for

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[32] Barbara Melosh, *"The Physician's hand": work culture in American nursing* (Philadelphia: Temple University, 1982), 196.
[33] McPherson, *Bedside Matters*, 8.
[34] Ross-Kerr, *Prepared to Care*, 276.
[35] Hibberd, *Labour Disputes of Alberta Nurses*, 1.

achieving collective objectives [contributing] to the beginning of an identification with the labour movement."[37]

The UNA's increasing alignment with the Alberta labour movement included the emergence of views on medicare policy that diverged from those of the AARN's leaders. The *News Bulletin* is a useful source of information about the UNA's position on extra-billing, and demonstrates that the UNA openly promoted the right of citizens to receive health care without financial barriers to access. One letter to the editor of the *News Bulletin* from a local chapter of the UNA claimed that medical care insurance was a fundamental right which was being eroded by extra-billing. The author wrote, "We as nurses are finding it increasingly difficult to stand by and see this happening to society."[38] The elderly, the poor and women were considered the most vulnerable to extra-billing – contrary to medicare's objective of ensuring that no one had to scrounge to pay medical bills.[39] Nurses exposed to extra-billing felt it was "disturbing" that patients should have to pay before receiving services.[40]

The UNA also – in marked contrast to the AARN – blamed physicians for the use of patient charges, complaining about the College of Physicians and Surgeons of Alberta's (CPSA) authority in defining the appropriate use of extra-billing. In 1980, the *News Bulletin* expressed dismay at the Alberta government's establishment of a CPSA board,

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[36] Ibid., 8.
[37] Ibid., 166.
[38] "Extra billing erodes rights," *News Bulletin*, 5:3 (June-July 1981): 2.
[39] "Gov't legalizes extra-billing," *News Bulletin*, 4:4 (December 1980): 2. See also "CNA Brief to the Senate Committee on Social Affairs, Science and Technology in Response to the Amended Bill C-3 (The Canada Health Act)," *News Bulletin*, 8:3 (March 1984).
[40] "Extra billing erodes rights," *News Bulletin*, 5:3 (June-July 1981): 2.

composed entirely of doctors, to address citizens' concerns regarding extra-billing.[41] The objective of medicare was to provide health care "with no questions asked." Yet the onus of arguing the inappropriateness of extra-billing had been left to the consumer, and the "foxes are left to guard the chicken coop," so to speak.[42] In 1982 the *News Bulletin* published an article titled "Medicare troubled on 20th anniversary," suggesting that doctors were the driving force behind the opposition to medicare and that they were under-worked and overpaid.[43]

The UNA's critical stance on the authority of physicians suggests that, as opposed to the AARN, the UNA did not view phsycians as helpers in achieving their goals. It is also reflective of the UNA's focus on hospital-based nurses, rather than privately employed nurses. As noted in Chapter 2, nurses who relied directly on individual physicians for their livelihood and working conditions may have been more reluctant to openly criticize physicians and the AMA. However, nurses employed outside the hospital sector would not have been involved in the strikes organized by the UNA in the late 1970s and early 1980s, and would not have shared the collective demands of hospital-based nurses. The AARN relied upon physicians to advance their mandate, as an organization concerned with the educational qualifications of nurses. The AARN also represented non-hospital nurses who may have wanted to avoid the consequences of alienating their physician employers. Outside the mandate of the AARN, the UNA was free to express frustration

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[41] "Gov't legalizes extra-billing," *News Bulletin*, 4:4 (December 1980): 2.
[42] "Extra billing erodes rights," *News Bulletin*, 5:3 (June-July 1981): 2; "Gov't legalizes extra-billing," *News Bulletin*, 4:4 (December 1980): 2.
[43] Skip Hambling, "Medicare troubled on 20th anniversary," *News Bulletin*, 6:4 (October 1982): 14.

with the role of the medical profession in perpetuating patient charges, demonstrating the tension that existed between nurses and physicians within the health care system.

It was in this context of growing solidarity with the Alberta labour movement and strong views about medicare policy that the UNA allied with the AFL to save medicare in Alberta, nominating UNA representatives to sit on the FOM Board of Directors in 1981.[44] After a brief hiatus from the FOM in 1982-1983, UNA Executive Director Simon Renouf urged UNA members to support re-affiliation with the FOM for a number of reasons. He argued that medicare contributed to higher quality health care and also that strong medicare policy was critical to the UNA's aims as a union. In a *News Bulletin* article, Renouf stated that extra-billing indicated that the health care system that employed nurses was being under funded by the Alberta government, and that patient charges undermined hard-fought collective agreements. The UNA had fought for 75 percent employer contributions to nurses' health insurance premiums, a benefit that was undermined by the out-of-pocket charges nurses could be subject to as patients, mothers of patients, and – increasingly – daughters of patients.[45] The UNA not only opted to re-join the FOM, this time the UNA Board of Directors threw its sponsorship behind a new FOM newsletter.[46]

The FOM shared the UNA's view that medicare was more than just a public program or a means to achieving health care – it was a right of citizenship to which Canadians were entitled, proclaiming in one brochure, "Health care is a right not a

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[44] "Friends of Medicare save health scheme," *News Bulletin*, 5:2 (April-May 1981): 8.
[45] "Executive Director's Report: UNA and Friends of Medicare," *News Bulletin*, 7:3 (June-July 1983): 4.
[46] "Policy Resolutions from 1983 Annual Meeting," *News Bulletin*, 7:6 (December 1983/January 1984): 3.

privilege!"[47] The following year, in 1981, the FOM wrote,

> It is our view that medicare is crucial to the health of Canadians. We appreciate that the advancements in the general level of health of Canadians is due in part to a medicare plan that has improved access to the health care system.[48]

When viewed as an arm of the AFL, the FOM's position that medicare was a right appears even more adamant. The purpose of the "Save Medicare" campaign, launched by the AFL in 1982, was to:

> ...bring pressure to bear on the Alberta Government and Mr. Dave Russell, Minister of Hospitals and Medical Care, to provide the citizens with the level of medicare they are entitled to, free from extra and direct billing and medicare premiums.[49]

In 1983 the AFL resolved to lobby the province for "the level of medical care [Albertans] are entitled to, free from extra and direct billing and medicare premiums."[50] The following year, the AFL annual convention resolutions stated, "health care is a basic right that must be available to all citizens of Canada regardless of their location or financial

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[47] Brochure, n.d., Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[48] Alberta Friends of Medicare, *The Alberta Friends of Medicare Submission to Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, June 1, 1981*,198, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[49] Alberta Federation of Labour, *26th Annual Convention Resolutions*, 1982, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[50] Alberta Federation of Labour, *27th Annual Convention Resolutions*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta. See also Alberta Federation of Labour, *28th Annual Convention Resolutions*, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

status."[51] In a 1983 letter to National Health Minister Monique Begin, AFL President Harry Kostiuk pleaded "not to entrench in legislation anything that would jeopardize or allow double standards in our treasured medicare scheme that all citizens of Canada are entitled to."[52]

These examples highlight the use of rights-based language as a key component of the Alberta labour movement's arguments against extra-billing. This occurred in the context of a changing culture of rights at the federal government level, driven in part by Pierre Trudeau's Charter of Rights and Freedoms in 1982. While health care related rights discourse dates back to the 1940s, scholar Candace Redden-Johnson argues that the 1982 Charter had a profound effect on Canadians' expectations of medicare by changing the form of rights claims to indicate that:

> ...by virtue of consumer power or as a matter of individual legal compensation, citizens are entitled to services because they have purchased them in advance through their taxes, or simply have legitimate and legally enforceable claims against the state.[53]

The FOM opposed extra-billing through arguments that aligned with the evolving rights claims paradigm.

The FOM also capitalized on the concepts of discrimination that surrounded the

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[51] Alberta Federation of Labour, *28th Annual Convention Resolutions*, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[52] Harry Kostiuk to Monique Bégin, February 14, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[53] Candace Redden-Johnson, "Health Care as Citizenship Development: Examining Social Rights and Entitlement," *Canadian Journal of Political Science*, 35:1 (March

1982 Charter. The organization suggested that extra-billing created a barrier between public services and individuals, discriminating against vulnerable members of society – the low-income and the elderly. Extra-billing, it was thought, reduced access to health care by those most in need, and contributed to increased condition acuity for those who were already disadvantaged by virtue of their low income.[54] In 1981, the FOM wrote: "the friends of Medicare [sic] believe that any reduction in the accessibility to health care [...] will only serve to widen the health gap between poor and non-poor Canadians."[55] This, in turn, contributed to the high cost of the health system.

The FOM argued that patient charges also contributed to discrimination by perpetuating an inequitable power relationship between patients and physicians – a position that informed the UNA's decision to rejoin FOM in 1983.[56] The public health care system, suggested the FOM, should provide a level of remuneration to physicians in line with the value tax payers placed on their services.[57] One FOM submission to the Government of Alberta argued for the adoption of the Austrian model of physician remuneration. This model, according to the FOM, paid for medical services from community funds, and did not privilege physicians through a much higher relative

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2002) 104, 118.

[54] *The Alberta Friends of Medicare Submission to Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, June 1, 1981*, 1981, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[55] Friends of Medicare, *Submission to the Federal New Democratic Party on the Federal Budget of November 12, 1981*, 1981, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[56] "Annual Meeting Highlights," *News Bulletin*, 7:5 (October-November 1983): cover, 5-8.

[57] Alberta Federation of Labour, *Policy Statement*, 1973, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

income than other members of society. This was the case "even though their importance to the health of the nation is presumably the same as it is in Canada."[58] The FOM argued that individual physicians should not have the power to ask "patients who are seriously ill to haggle or plead with one or more physicians or surgeons over the reasonableness of their extra charges."[59] Patients' awareness that this scenario could occur discouraged them from attempting to access needed medical services. The FOM suggested that if tax payers believed physicians deserved to be paid a high salary, this should be reflected in the remuneration they were provided by the public insurance system, and paid for through taxes – not from the pockets of patients' whose ability to earn was already reduced due to illness.[60]

To advance its arguments, the FOM initiated a number of provincial efforts. These included a "Phone Dave Russell Campaign" - a hot-line to direct citizens to physicians who did not extra-bill. As well, the FOM facilitated the distribution of brochures educating the public on extra-billing and suggesting ways for individuals to protest, such as by refusing to pay extra bills, complaining to organized physician groups and the Government of Alberta, and electing pro-medicare political candidates.[61]

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[58] Alberta Friends of Medicare, *The Alberta Friends of Medicare Submission to Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, June 1, 1981*, 1981, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[59] Alberta Federation of Labour, *Policy Statement*, 1973, Alberta Federation of Labour Collection, Provincial Archives of Alberta. See also Alberta Federation of Labour, *27th Annual Convention Resolutions*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.
[60] Ibid.
[61] Brochure, "Save Medicare – Ban Extra Billing," 1982, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Second Annual General Meeting*, 1983, Alberta Federation of

In addition to its Alberta-based activities and roots, the FOM was part of the Canadian Health Coalition (CHC) – a national collaborative pro-medicare effort founded by the Canadian Labour Congress. The FOM considered itself the Alberta subsidiary of the CHC, although not every province had its own provincial branch, and engaged in a number of activities to promote federal policy implementation in Alberta. In 1982, the FOM organized a campaign that saw the distribution of postage-paid postcards addressed to Minister of National Health and Welfare, Monique Bégin stating,

> As a concerned Albertan, I support universal Medicare and strongly oppose out of pocket costs such as extra-billing and user fees. I believe Medicare should be funded not on the need to pay but on the ability to pay through taxation."[62]

Over 3000 postcards were mailed.[63] As well, in 1983 the FOM sent Coordinator Nancy Kotani and Board of Directors member and nurse Karin Olsen, to make a presentation to the House of Commons Committee on the *Canada Health Act*.[64]

As a result of the FOM's support of stronger federal policy, implemented at the provincial level, the organization and its actions were endorsed by the federal government. In order to leverage the FOM as a champion for its actions, and gain

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Labour Collection, Provincial Archives of Alberta; Minutes, Friends of Medicare Board of Directors, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Federation of Labour, *Alberta Federation of Labour presentation to Caucus Committee of Government*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[62] Postcard, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[63] "Alberta Society of the Friends of Medicare Second Annual General Meeting," 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[64] Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Third Annual General Meeting*, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

recognition for its efforts to address patient charges through the *Canada Health Act*, the federal government demonstrated its support for the FOM in a number of ways. Federal Minister Monique Bégin attended the FOM's first Annual General Meeting to speak against extra-billing and outline her plans to outlaw it through the *Canada Health Act*.[65] In addition, in 1984 the FOM received federal funding to host community forums, resulting in 11 pro-medicare meetings across Alberta, drawing approximately 500 participants.[66] Justice Emmett Hall, author of the Royal Commission on Health Services, and Health Service Review '79, was the keynote speaker in one forum held in Edmonton, speaking out against extra-billing and user fees, calling them a "tax on the sick."[67] However, in spite of the momentum generated by the FOM's efforts and the support provided to them by the federal government, the Alberta government refused to see health care as a right, and moved to entrench extra-billing rather than abolish it.

The early years of the FOM's existence were defined by the extra-billing debate. Exploration of their actions and positions reveals much about the nature of Alberta labour groups' interests. The FOM promoted the expectation that health care should be provided cost-free as a right, taking a position in support of a broader federal system of health

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[65] Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Second Annual General Meeting*, 1983, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[66] Minutes, Friends of Medicare Board of Directors, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Friends of Medicare, *Friend to Friend*, 1:1, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta; Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Third Annual General Meeting, 1984*, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[67] Alberta Friends of Medicare, *Alberta Society of the Friends of Medicare Third Annual General Meeting*, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

insurance that ensured rights were protected. This may have been in part due to the FOM's desire to align with the national labour movement in support of medicare, in order to reinforce the AFL's ability to tap a wider pool of union resources in case the Alberta health care system collapsed. This situation would have left unions to, once again, fill the void left by the absence of a reliable public health care system in order to promote the well-being of Alberta workers.

The UNA, which was also in its formative years at the time of the extra-billing debate, made a strong statement about its organizational identity through its activities as a member of the FOM. This is especially true when compared with the efforts of the AARN to change the organization of the health care system through the extra-billing debate. The dichotomy between the two organizations' interests and tactics exposes the tension that existed among Alberta nurses. It also gives evidence of the unrest that came about as a result of Alberta nurses' increasing sense of marginalization within the health care system and in its governance. The extra-billing debate highlights Alberta nurses' longing to shape their environments through participation in health policy decisions. It also suggests their difficulties compared with the authoritative position of the Alberta government, and Alberta physicians, in setting the direction of the health care system.

At the same time, the efforts of both the UNA and the AARN to shape health policy through the extra-billing debate adds a new dimension to the history of nurses' experience of medicare. Not only were nurses affected by the workplace changes medicare brought about, many nurses valued increased access to health care and a secure source of funding for the hospital sector that employed them. The AARN and the UNA both worked to shape the health care system based on their interests and values, refusing

to accept their marginalization by the gendered organization of health care or the Alberta government.

CHAPTER 4

Conclusion

Building on the legacy of the Social Credit philosophy that the health care system should promote individual responsibility for health, the Lougheed Progressive Conservatives institutionalized patient charges like extra-billing. The Alberta government achieved this through legislation and iterative policy statements by Minister of Hospitals and Medical Care, Dave Russell, that argued patient charges were a foundational element of the province's health care system. However, the direction of the Alberta's health care system was defined by tensions in federal-provincial relations over the increasing importance of natural energy resources to Alberta's economy.

The Alberta government refused to implement the *Canada Health Act* and ban extra-billing in 1984 in order to protect the Alberta government's ability to set its own priorities. This was driven largely by the desire of the Peter Lougheed Progressive Conservative caucus to maintain maximum control of the provinces' natural resources. To achieve this objective, the provinces' constitutional purview could not be left up to the sole interpretation of the federal government, whether regarding specific resource policies or areas like health care. Therefore, the Alberta Minister of Hospitals and Medical Care, Dave Russell, argued against the *Canada Health Act* because it questioned the division of powers, as did any federal attempt to assume a role in setting health care priorities.

This decision not to ban extra-billing favoured the interests of Alberta physicians,

as interpreted by the leaders of the Alberta Medical Association (AMA). The AMA argued that patient charges encouraged patients to think twice before accessing public services, and promoted individual responsibility for health. Through this rhetoric, the AMA's leaders strove to protect the professional status and authority of individual physicians. Their arguments demonstrated the AMA's urgent concern that the Alberta government, as funder of the health care system, might one day interfere with clinical decisions to lower costs. Extra-billing, reasoned the AMA, would prevent this from happening by providing a potential source of revenue for physicians, and thus an alternative to health care system micro-management for the Alberta government. However, while the rate of physicians that extra-billed in Alberta was high compared with the national average, the low economic impact of extra-billing suggests that few, if any, individual physicians used the practice in more than a symbolic manner.[1] Nevertheless, the Alberta government's decision not to abolish extra-billing supported the AMA's desire to maximize the discretion of individual physicians to make decisions without government interference.

In contrast, the labour-based Friends of Medicare (FOM) was critical of the Alberta government's support for patient charges and defiance of federal government initiatives. The FOM argued that health care was a right of Canadian citizenship, and demanded the abolition of access barriers, including extra-billing, through the implementation of the *Canada Health Act*. The organization's position, drawing from the arguments of the national Canada Health Coalition, was supportive of the federal

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[1] See Carolyn Tuohy, "Medicine and the State in Canada: The Extra-Billing Issue in

government's efforts to influence provincial policy, and was endorsed financially by the federal government for their efforts. The rights-based language used by the FOM reflects a sense of entitlement to public services, which was one result of the broader political context in which the extra-billing debate took place. The 1982 Charter of Rights and Freedoms entrenched consumer-based arguments about the nature of public services, and Candace Redden-Johnson argues the 1984 *Canada Health Act* contributed to the entrenchment of this shift in the health care arena.[2]

The interests of the FOM were denied by the Alberta government's decision to reject the federal *Canada Health Act* and entrench extra-billing in 1984. However, the Alberta Federation of Labour (AFL) reaffirmed its support for the FOM, resolving to "increase our assistance to the Friends of Medicare, by rallying the unions and the general public in a united fight back campaign, with the objective of obtaining a fully comprehensive premium free medical and hospitals care plan."[3] Don Aitken, the AFL's general services director, sent a letter to affiliated local unions, staff representatives and labour councils to gauge support for the continuing work of the AFL to promote the *Canada Health Act*'s implementation in Alberta.[4] Aitken wrote, "we urge you to get more involved in the fight for medicare... . We all have a right to fair and equitable treatment,

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Perspective," *Canadian Journal of Political Science*, 21:2 (1988).

[2] Candace Redden-Johnson, "Health Care as Citizenship Development: Examining Social Rights and Entitlement," *Canadian Journal of Political Science*, 35:1 (March 2002), 118.

[3] Alberta Federation of Labour, *28th Annual Convention Resolutions, Alberta Federation of Labour*, 1984, Alberta Federation of Labour Collection, Provincial Archives of Alberta.

[4] Don Aitken to All Affiliated Local Unions, staff representatives and Labour Councils, August 27, 1984, Alberta Federation of Labour Collection, Provincial Archives of

Alberta.

not only in services, but in the taxes we pay and how they are spent."[5] The AFL would continue its campaign for medicare, both in its own right and through FOM, hiring a full-time staff person in 1985 to manage the FOM's research, media and communication needs.

Nurses' interests were also denied by the Alberta government's 1984 decision. Through the extra-billing debate, the United Nurses of Alberta (UNA) sought to ensure access to a reliable health care system for its members as health care consumers, and a well-funded one for its members as hospital employees. However, the objectives and efforts of the UNA's leaders to abolish extra-billing through alignment with the FOM stood in contrast to those of the Alberta Association of Registered Nurses (AARN) leaders. The AARN, whose mandate was to promote educational standards for Alberta's registered nurses, sought not only the abolition of extra-billing but the recognition of nurses' contribution to Albertans' health as professionals and as women. This view was shaped by the rising awareness by Canadians that illness and injury prevention, traditionally areas of nurses' expertise, were increasingly important for health.[6] It was also shaped by feminism.

Leaders of the AARN adopted a gender-based analysis of the Alberta health care system through the extra-billing debate. They argued that medicare was inefficient and privileged the male-dominated medical profession over other health providers, like nurses, by emphasizing the importance of treatment over that of prevention. The AARN

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[5] Ibid.

[6] See Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document*. (Ottawa: National Health and Welfare, 1974).

argued that extra-billing signified that physicians were underpaid by the health care system as a result of its inefficient organization, underpinned by the sexism inherent in insuring only health services provided by physicians. Extra-billing highlighted the AARN's concerns and frustrations regarding the marginalization of nurses by physicians and existing policy. The Alberta government's decision not to abolish extra-billing, which favoured the AMA, suggested that nurses' interests were secondary to physicians not only within the structure of the health care system, but in its governance as well.

In 1986, under a new Progressive Conservative Minister of Hospitals and Medical Care, Marvin Moore, the Alberta government negotiated the end of patient charges. This occurred for two reasons – neither of which relied on a change in political perspective. The first reason was the significant financial implications of not banning patient charges in the midst of a declining economy. As the federal government's sanctions against Alberta for allowing extra-billing mounted, the price of oil – and the resource-based economy it supported – tanked. The *Canada Health Act* gave the federal government the authority to withhold health care funding from the provinces at the rate of one dollar for each dollar patients were charged for health services. At the same time, however, the Act had been designed to allow provinces that banned patient charges by 1987 to receive a refund of the monies that had been withheld. Maintaining patient charges in Alberta was costing the government millions of dollars annually, especially since extra-bills went into physicians' pockets and not into the provincial treasury. Thus, banning patient charges meant that the Government of Alberta received, in full, a refund of the funds that had been withheld since July 1984 by the federal government.

The second factor that led the Alberta Government to negotiate an end to extra-

billing was the ousting of the federal Liberals and election of a federal Progressive Conservative government, which coincided almost exactly with a change in leadership in Alberta, from Progressive Conservative Premier Peter Lougheed to Progressive Conservative Premier Don Getty. The provincial leadership change was important because Lougheed's retirement marked the end of an era characterized by acute province-building and resistance to federal efforts to set provincial priorities. The federal government change from Liberal to Progressive Conservative was even more significant because it created the opportunity for the Alberta government to relax its defensiveness under the guise of good faith among members of a common political party. While Alberta had been defensive in its response to federal movements in the early 1980s, the federal Liberal government had also been especially aggressive in its efforts to raise its profile across Canada as part of a nation-building strategy. This had led to both sides taking ard lines on more than one occasion to protect their positions.

Feeling the pain of reduced federal funds for health care, it was easier for Alberta to save face by bowing to the conditions of the *Canada Health Act* in 1986 under the leadership of a less defensive Alberta Premier and a less aggressive Progressive Conservative government in power federally, than it would have been under less amenable conditions in 1984. Furthermore, physicians were extra-billing only half as much as they had in the early 1980s, and the AMA was cognizant of the financial and political sacrifice the Alberta Government was making to allow extra-billing. The president-elect of the AMA in 1986, Dr. Richard Kennedy, asked Alberta physicians, "If you were Don Getty, what would you do?" and urged the end of extra-billing without

"getting into a major public fight with the Alberta government."[7] In the midst of vociferous public criticism from the Friends of Medicare, the media, and other concerned Albertans, patient charges were banned and federal funds that had been withheld were released to the Alberta government.[8]

Although scholar Malcolm G. Taylor writes that "it was in Alberta that the strongest last-ditch battle by doctors against any attempt to ban extra-billing was expected," an agreement between the Alberta government and the AMA to end extra-billing was accomplished without incident.[9] However, other provinces did not fare so well in concluding the extra-billing debate – especially Ontario. There, a newly elected Liberal government reliant upon the support of the provincial NDP to implement its policy agenda had promised its supporters the end of extra-billing. In spite of massive opposition from the Ontario Medical Association (OMA), the Liberals moved to follow through on their promise in 1986. The OMA responded by instigating a province-wide physician strike and court challenge. This occurred concurrent with the negotiation between the Alberta Government and the AMA to end extra-billing, adding impetus to a peaceful resolution of the issue.[10] By 1987, the *Canada Health Act* of 1984 had been implemented nationwide.

The Alberta health care system that was entrenched through the extra-billing debate was shaped significantly by the province's political parties and resource-based

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[7] "Fundamental right to contract at stake, (Richard J. Kennedy's speech noted to the District Medical Societies)," *Alberta Doctor's Digest*, 11:3 (May/June 1986), 1.
[8] Malcolm G. Taylor, *Insuring national health care, the Canadian Experience*, (Chapel Hill: University of North Carolina Press, 1990), 182.
[9] Ibid., 181.

economy. The Alberta government's decision not to abolish patient charges in 1984 was based on the desire to protect energy resources in support of a strong economy, not to promote access to health care. In fact, senior public servants in the Department of Hospitals and Medical Care advised their minister, Dave Russell, that the abolition of patient charges in keeping with the federal recommendations of the Health Services Review '79 would be wise. The Alberta government's about-face in 1986 was also based on the desire to support a strong economy, only this time that could not be achieved through the protection of constitutional powers or reliance upon energy resources. The "rainy day" Premier Peter Lougheed foresaw when he established the Alberta Heritage Savings Trust Fund had come, and the Alberta government could no longer afford the financial penalties mounting as a result of the *Canada Health Act.*

One conspicuously absent argument on any side of the debate was that which was presented by federal Minister of National Health and Welfare, Marc Lalonde, in 1974. He wrote in *A New Perspective on the Health of Canadians* that while the organization of health care services through medicare was foundational to national health, social and economic factors played a potentially greater role in determining health outcomes.[11] The extra-billing debate centred around the organizational aspect, and ignored completely the relationship between a strong economy, personal income, and health. The Alberta government's ideological claim that patient charges promoted individual responsibility for health was controversial and rejected by Health Services Review '79. Yet it is interesting that the Health Services Review '79 lauded Lalonde's report, and that the

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[10] Ibid., 182.

Alberta government did not leverage this argument in their favour.

The issues highlighted by the extra-billing debate in Alberta remain largely unanswered even today, as is evident in the recent Third Way paradigm proposed by Alberta Progressive Conservative Premier Ralph Klein in 2005. Under the Third Way, the Alberta government explored the possibility of re-instituting patient charges and throwing off the shackles created by the *Canada Health Act*. This occurred in a new era of economic prosperity in Alberta, again driven by energy resources. The Third Way failed to gain political traction due to its unpopularity among Albertans. However, it serves as evidence of the continued influence of the ideological principles put in place by Social Credit governments, and suggests the continued connection between Alberta's resource-based economy and the direction of the Alberta health care system.

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[11] See Lalonde, *A New Perspective on the Health of Canadians*.

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