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Moving Beyond the Status Quo: Alberta’s “Working” Prescription for Health Care Reform

Evidence from the Alberta Advantage Surveys: 1995-2000

by *Shainoor Virani, Mebs Kanji, and Barry Cooper*

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Executive Summary

Many experts have diagnosed medicare in Canada as an ailing system in need of treatment. Commission after commission has agreed that the health care system, under pressures of an expanding and aging population, and of growing demands for new technologies and prescription drugs, cannot be sustained by endless additions of public funds. Notwithstanding the economically compelling arguments in favour of market solutions, no consensus has been reached on the most effective treatment for medicare. Because monopolistic, state-funded, and state-delivered health care is said to be symbolically important to the Canadian electorate, governments have been hesitant to act at all for fear of political repercussions. Indeed, discussions of reform have been derailed by the twin fears that privatization is downright un-Canadian, and that the unrestrained pursuit of more public funding—rather than being the harbinger of a coming disaster—can somehow stave it off. Given the degree of resistance to changes in attitudes among the Canadian public on this issue, politicians are faced with a major problem: how is it possible to move beyond the status quo in order to save Canada’s ailing health care system? Must the breakdown in the publicly-funded system be complete before anything realistic is done?

To answer this question, it is useful to examine the situation in Alberta, where modest but still unprecedented reforms have taken place under the leadership of Premier Ralph Klein. Despite threats that any such restructuring attempts would be political suicide, Premier Klein and his Tories emerged from their third straight election stronger than they went into it. Of course the pre-

mier’s strong personal appeal and the province’s prosperous economy had a lot to do with the Conservatives’ victory, but our data also indicate that Alberta’s “working prescription” has succeeded in moving health care a few steps beyond the status quo and has improved the popular perception of the overall system. Even though the same remedy may have different effects on different people suffering from the same condition, an examination of the effects of this prescription on Albertans can provide insights for other governments contemplating similar changes.

Understanding public perceptions is essential to creating effective policy reform in a democracy. This is especially true for such an emotional issue as health policy. Our analysis uses data from a series of public opinion surveys—the Alberta Advantage Surveys of 1995, 1996, 1999 and 2000—to trace the impact of the policies of the Klein government during a period of restructuring in health care. In doing so, this *Public Policy Source* aims to describe how changes to Alberta’s health care system have been achieved without severe and adverse political repercussions, and indeed with improvements in overall perceptions among Albertans regarding health care. It also shows that many citizens recognize that an underperforming health care system is a result of factors other than allegedly insufficient expenditures from the public purse. These findings suggest that perhaps Canadian citizens more generally are capable of thinking outside the highly constraining box of health care orthodoxy. Accordingly, there are reasons to expect that with the appropriate prescription, it is possible to treat our ailing system and move beyond the status quo elsewhere in Canada as well.

Introduction

Health care reform poses a major challenge for policy makers worldwide as demands on health care increase and the population changes (GOC, 2000b). The problem is especially acute in Canada, where per capita health care expenditures are the third highest among G-7 countries (CIHI, 2001) and health care spending consumes one-third of provincial program expenditures (GOC, 1999). The experts warn that without reform, the current publicly-funded system cannot be sustained over the long-term without either significantly compromising other program areas or raising taxes (CBOC, 2000b; GOS, 2001).¹ Not surprisingly, therefore, many governments are in the midst of re-examining their policy priorities and placing health care reform at the top of their political agendas. In a recent Speech from the Throne, the Harris government in Ontario announced: “responsible choices and tough decisions are needed not merely to sustain, but quite literally to save Canada’s health care system,” and Premier Harris added that his government would “look to the private sector” to run the province’s hospitals (*National Post*, April 28, 2001, p. A4). Several other provincial leaders have also called for serious discussion with Ottawa over health care reform.

As imaginative as the proposals of the Harris government are, nowhere in Canada has health care restructuring been more evident than in Alberta under the leadership of Premier Ralph Klein. In 1993, the premier stated: “we can no longer afford to solve problems by spending money,” and followed his words with actions

leading to major changes in health care delivery, starting with a reduction of some \$500 million in public funds. Budget cuts were followed by large-scale changes that involved hospital closures and consolidation, regionalization, and the introduction of the controversial Bill 11—officially the “Health Care Protection Act”—which permitted selected surgical services to be contracted out to private facilities (Cooper and Kanji, 2000, pp. 113-19). After they were introduced, these changes were widely seen to be the Achilles heel of the Klein government’s popularity.

The difficulty of health care reform, even for a government as popular as Ralph Klein’s, arises from the notion that health care in Canada is something of a sacred cow. That is, the symbolic importance of health care in the endless discussion of Canada’s distinctiveness from the United States has added to the difficulty of engaging in a moderate and sensible consideration of reform of the system. This is why demands for more public funding have so prominent a role in political discussions of the future of health care in this country. Indeed, widespread public concern about the health care system apparently still forces the hand of governments to increase public funding, even though it is clear that alone more money can neither improve health nor result in the most visible improvement in the system—a decline in waiting times for treatment (Evans, Barer and Marmor, 1994; Zelder, 2000b).²

The importance of health care reform is apparent from recent newspaper headlines, and from fed-

1 For a dissenting voice, see Lewis (2000).

2 At the federal level, a new health accord was signed by the First Ministers on September 11, 2000, that will include the allocation of over \$23 billion over the next five years for health and other social programs to the provinces and territories. Provincial governments have been allocating most new program funding for health care (62%) (CBOC, 2000a).

eral and provincial election campaigns. However, the volatility of public perceptions on health care reform and the perceived threat of adverse political repercussions has led many politicians to avoid discussing how to change the system, let alone actually trying to do so. Instead, governments happily fund one costly study after another on the future of medicare—from the National Forum on Health launched in 1994, to the most recent \$15 million “Commission on the Future of Health Care in Canada” led by Roy Romanow. In practice, however, the dedication of governments to follow through on even the modest recommendations of these studies is much weaker than their enthusiasm to appoint commissions and commissioners (Boessenkool and Harper, 2001). It would be surprising indeed to expect Roy Romanow, a former NDP premier of a province that understands itself as the seed-bed of medicare, to engage in a serious re-examination of the principles of the Canada Health Act.

This *Public Policy Source* provides empirical insight into what is widely held to be one of the main sources of resistance to changes in health care: the unwillingness of the public seriously to entertain the possibility of moving beyond the status quo. A sound understanding of public views and attitudes is vital for the development of policy in health care, and past experience has taught political leaders that almost any attempt to change the status quo is likely to arouse intense public concern. Moreover, advocates of the status quo, or those who want to reinforce it by providing more public funds but no structural changes, typically add to such fears. Accordingly, the entirely predictable response to Premier Harris’ remarks was that his proposals would invariably lead to “American-style, two-tier health care,” as the Ontario NDP leader, Howard Hampton, immediately charged (*National Post*, Apr. 28, 2001, p. A4).

Debate about health care reform has been effectively derailed by denouncing, rather than discussing, market alternatives and private funding. The small changes made by the Klein government in an effort to integrate private health clinics into the existing system sparked negative and critical advertising campaigns, petitions, and efforts by lobby groups against the initiative. Undoubtedly, the words, “American-style, two-tiered health care” are intended to provoke deep anxieties among Canadians, and the symbolic importance of health care reduces the persuasiveness of economically compelling arguments in favour of markets and private sector solutions to Canada’s health care woes.

None of this is to suggest, of course, that popular reforms always make the best policies. But because there are significant political constraints involved, a lot rides on having the correct strategy. In this *Public Policy Source* we show that:

- 1) It is possible for governments to make initially unpopular reforms to health care, but subsequently improve perceptions toward the system and not suffer politically as a result.
- 2) Many citizens associate the current problems in health care with factors other than allegedly inadequate public funds. Indeed, there is evidence to show that Albertans’ priorities regarding public spending have begun to shift and that many citizens are satisfied with current levels of government health care spending.
- 3) There are politically workable ways of moving beyond the status quo that do not incur the blanket resistance thrown up by concerns and anxieties relating to the symbolism of “two-tiered, American-style” health care. Some of these alternatives, such as a focus on disease prevention, are clearly amenable to market-based initiatives, and are at least as popular as a state-controlled and state-directed monopoly.

Data

Despite the federal government's numerous attempts to study health care, and the Ontario government's recent gesture to take the lead on this issue by calling for Ottawa and the provinces to begin a dialogue on health care reform, Alberta remains the leader in health care restructuring. When the Klein government embarked on its course of change, critics declared that Ralph Klein had signed his own political death warrant (Renouf, 1995). The critics, however, could not have been more wrong. Despite the controversy over health care, the most recent provincial election saw Premier Klein capture his third and largest majority government. Because of the achievements of the Klein government in health care reform, Alberta may well provide a useful case study for Canadians interested in fixing a system that is widely perceived to be broken.

The evidence is taken from four consecutive public opinion surveys—the 1995, 1996, 1999, and 2000 Alberta Advantage Surveys (AAS). The first two polls were conducted during the aftermath of the Klein government's initial budget cuts (in 1995 and 1996, respectively). The third survey was administered in January 1999, midway through the second electoral mandate and after

the government had successfully eliminated the deficit, reduced the debt, and begun to increase expenditures. The most recent one was conducted in November 2000, after the controversy over Bill 11, but prior to the government's response to energy deregulation and energy rebates.

Each survey was administered by telephone to a random sample of slightly more than 1,000 Albertans. The margin of error for each respective study is approximately $\pm 3\%$. Although these surveys are not panel studies where the *same people* are interviewed each time (a very expensive procedure), each questionnaire did contain several of the *same questions*. Thus, by comparing responses, it is possible to track aggregate public opinion over time.

The AAS are particularly useful in that they incorporate a variety of different measures designed specifically to probe people's attitudes toward the current health care system, its problems, and various prospective reforms. The majority of these indicators are comparable but are contained mainly in the 1999 and 2000 surveys; some indicators, however, extend as far back as 1995.

The Problem With the Status Quo

Many health care experts agree that over the long term, the current, publicly-funded and publicly-administered system is not sustainable. Health care costs in Canada have been steadily increasing over several decades and are now 70 percent higher than they were 25 years ago (CIHI, 2001). In 2000, the cost of health care was estimated to have risen nearly 7 percent over the previous year to over \$95 billion, and per capita

spending increased by \$175 to over \$3,000 (CIHI, 2001). One factor that may have contributed to this trend is a growing (and aging) population. Canada spent the highest proportion of health expenditures on seniors (48.9%) in 1993 compared to 11 other OECD countries (Dryden, 1999). Alberta, in particular, has experienced one of the highest rates of aging across the country; the projected annual population increase for seniors is expected to

be more than twice that of any other age group (Saunders *et al.*, 1999).

Other factors contributing to higher costs include increased prices for established services and treatments and the use of more intensive (and expensive) treatments for the same types of conditions (CIHI, 2000). An economic analysis of health care expenditures in Ontario showed that the aging population and the sharp rise in the cost of health care delivery after age 55 could combine to increase real (inflation-adjusted) provincial government expenditures from \$19.2 billion in 2000 to \$39.0 billion in 2020. The same study also showed that advances in technology and its impact on diagnoses and treatment are likely to increase at historically high rates (CBOC, 2000b).

One conclusion seems clear: even if the current system were publicly affordable, maintaining it is likely to mean either incurring deficit budgets or that other highly valued programs such as education and infrastructure development necessarily will be reduced. Contemplating trade-offs such as these—the choice between “investing,” chiefly in the young, or “paying dividends” to the elderly—may explain why the Alberta government recently attempted to chose both: “like health care, education continues to be a top priority of this government” (GOA, 4.10.01). In fact, however, making difficult choices and trade-offs is what political leadership is all about, and in this case a strong provincial economy may have only postponed what may be an inevitable decision to move toward privatization.

A second reason why increased expenditures in health care may not be feasible stems from the conclusion to which we were drawn in an earlier analysis (Kanji and Cooper, 2001): citizens place no natural or self-imposed upper limit on public funding for social programs, particularly when it comes to health care. Accordingly, no matter how much money *the government* spends on health

care, it never seems to be enough. It is unlikely, therefore, that we shall ever see the day when citizens demand that politicians quit spending so much on health care. For many people, it seems, the illusion of “free” health care has proven irresistible.

Consider, for example, that in fiscal year 1999-2000, health care spending in Alberta increased by 15.1 percent over the previous year—an increase of nearly \$2 million a day. Currently, the Alberta government spends nearly a third (32.4%) of its annual program spending on health care, which is 6 percent more than it did in fiscal year 1992-93, before restructuring (GOA, 6.29.00). Moreover, the current provincial treasurer, Pat Nelson, recently announced that the health sector would receive an additional \$737 million in new funding (*Calgary Herald*, March 24, 2001, p. A1). In spite of these spending increases, however, there has been no significant decrease in the proportion of Albertans who felt the government should spend more money on health care (86% in 1999, 85% in 2000). Even though most Albertans are satisfied with their government’s level of spending on social programs (67% in 2000), as far as program spending priorities go, health care still remains at the top (followed by primary education—78%, secondary education—76%, post-secondary education—72%, and social services and welfare—36%) (Kanji and Cooper, 2001).

These same sentiments are echoed by the results obtained from the government’s own *It’s Your Money* survey, which was conducted to find out how Albertans think the money saved from provincial debt payments and royalties from natural resource revenues should be spent. Eighty-one percent of respondents to the government’s survey said more public expenditures on health facilities and equipment is important, and 67 percent supported more funding for education facilities and equipment (GOA, 01.30.01).

The issue, however, is more complex. Given that increasing public expenditures seem to be the major problem with the existing system, but since at the same time it has become politically difficult to limit public expenditures, the option of limiting existing expenditures by making room for individual choice looks like an obvious alternative. That is, allowing individuals to spend some of their own (pre-tax) dollars on their personal health care rather than live under the illusion that someone else (“the government”) is spending money on them, when, in fact, “the government” is funded by taxpayers, would have the effect of curbing what appears to be an insatiable appetite.

A third reason the current system cannot be maintained is that, despite an emphasis on increased public funding, more money is not the best solution to existing problems with health care. For example, so far as the clearly measurable aspects of health care delivery (such as waiting times) are concerned, more money does not make much of a difference (Zelder, 2000b). Moreover, high levels of spending on health care do not correlate strongly with a robust and healthy population. For example, Japan is the healthiest country in the world (measured in terms of life expectancy and infant mortality rates), but spends three percentage points less of its GDP on health care than does Canada. On the other hand, the United States, which trails other industrialized

countries on several health status indicators, has the highest per capita spending on health care (CIHI, 2000). Furthermore, during the recent period of cutbacks to health care in Alberta, self-reported health status remained stable (The Advisory Group, 1995; Northcott and Northcott, 2000), as did infant mortality and life expectancy (CRHA, 1999). Other studies have also shown that health and health care spending are (within wide limits) independent of one another (Brownell, Roos, and Burchill, 1999; Sheps *et al.*, 2000; Lewis *et al.*, forthcoming, 2001; DeCoster *et al.*, 2000).

Health care experts and economists are not the only ones who believe that throwing money at the problem is not a remedy—many ordinary Canadians agree. A Canadian Medical Association survey, for example, showed that less than half (42%) of respondents believed that money injected into the health care system would bring noticeable improvements in the quality of care, and more than half felt the budget would have little impact on health care (CMA, 1999). Furthermore, consultations with various stakeholders, health care providers, and public representatives during Health Summit '99 reveal that in principle, most Albertans agree that the health care system should be both affordable and sustainable. So why, then, does the status quo seem so difficult to change?

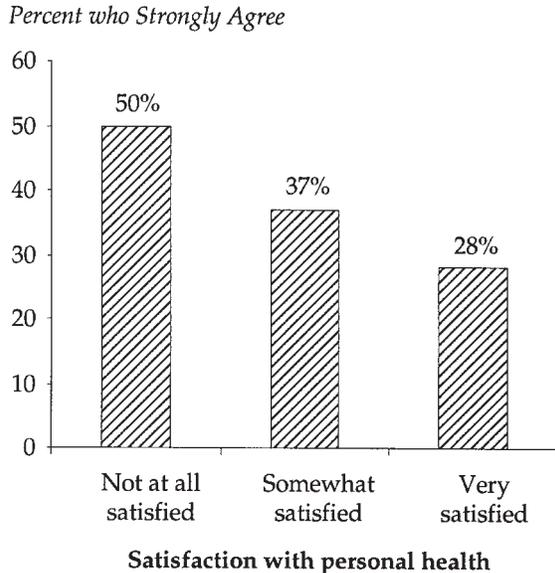
The Politics of Health Care

Despite the problems with the current health care system, attempts to change it frequently meet resistance. Certainly, changing health care is not a straightforward matter of being fiscally responsible and using common sense; the highly emotional context of symbolic politics, which requires a strategic approach in addition to administrative competence, must be considered

as well. To be sure, deficit reduction required considerable political skill, but several additional factors contribute to the distinctiveness of health care reform.

The health care system is said to symbolize a citizen's sense of “Canadian-ness.” According to one authority, “Canadians value medicare not just be-

Figure 1: Albertans Who Strongly Agree that "The Health System Needs to be Fixed" by Level of Personal Health Satisfaction



Source: 2000 Alberta Advantage Survey.

cause they need it, but because it brings them together as a national community" (Gray, 1996). Indeed, some zealous supporters of the current system have compared it to building the trans-continental railway. At a time when few national sources of attachment are said to exist for Canadians, medicare is often considered to be the most compelling symbol of the country—even more than the flag (Environics, 1996). The relatively widespread acceptance of this notion, despite its reliance on highly questionable economics, is testimony to its overall importance.

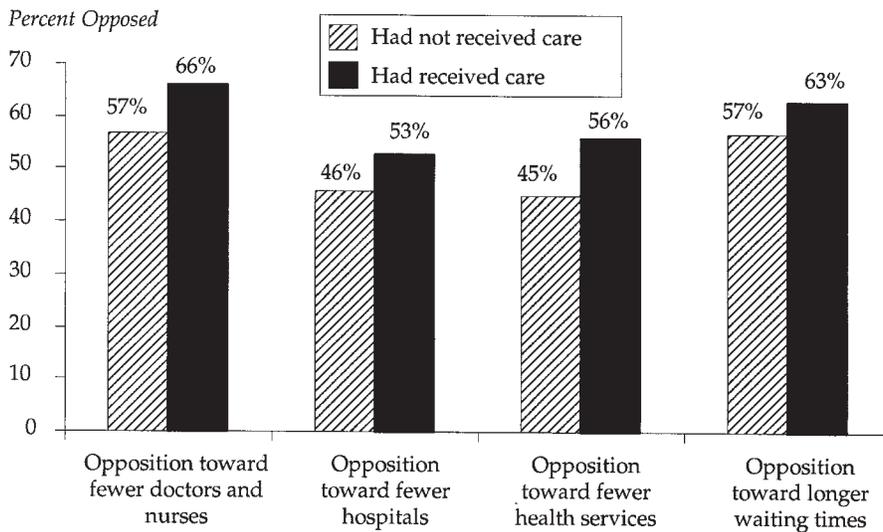
The apparent significance of the health care system to Canadians has been an integral component of recent election campaigns. The slightest hint of changing the current system seems to threaten serious and adverse electoral consequences. During the 2000 federal election, for example, one of the Liberals' criticisms of the Canadian Alliance was that they were "enemies of medicare," who, if elected, would exchange a virtuous "universal"

health care system for a vicious "American-style, two-tiered" system. This imagery of good and evil proved remarkably difficult to overcome (despite Stockwell Day's use of visual props during the leaders' debate), and may partly explain why the Alliance failed to make significant electoral gains in Ontario. When it comes to reforming health care, public perceptions are exceedingly important and there is a significant downside risk that challenging conventional perceptions will have detrimental results. This may explain the timidity of politicians, though it does not address the real issues.

Notwithstanding the sensitivity of health care, according to the 1999 and 2000 Alberta Advantage Surveys, most Albertans (85%) agree that the health care system needs to be fixed. For some, however, the problem is more personal than for others. Figure 1 shows that those who are less satisfied with their own personal health are more likely to agree on the need to fix the system. This is hardly surprising, because even though healthy people might be anxious about someday being sick and needing access to timely and reliable health services, such anxieties are understandably higher among those who are less healthy.

Attitudes toward spending cuts to health care budgets are ambivalent. Just before former premier Don Getty retired from office, 94 percent of Albertans said they supported spending cuts (Whyte, 1994). The realization that the deficit had to be controlled, said Premier Klein's labour minister, "gave (Albertans) the anaesthetic to take the temporary pain of the cutbacks" (Koch, 1994). Indeed, we have shown that in the early '90s, most people agreed that spending reductions were the best way to eliminate the deficit and reduce the debt (see Kanji and Cooper, 2001). But when it comes to health care, most people (more than 90 percent of Albertans according to the 1999 and 2000 AAS) believe that "proper health care comes before spending cuts." This is why, we suspect,

Figure 2: Opposition Toward Various Aspects of Health Care by the Extent of Direct Experience had over the Last Six Months



Note: The figures reported above represent only those who are "strongly opposed."
Source: 2000 Alberta Advantage Survey.

that even though most people (97 percent of Albertans according to the 1999 and 2000 AAS) agree that "efficiency and proper health care can go hand in hand," opposition to fewer doctors and nurses, hospitals, health services, and longer waiting times continues to mount, and most people make the assumption that public funding is needed to build hospitals or pay staff. Furthermore, figure 2 reveals that such opposition is even greater among those who have had recent experience with health care services, and the major concerns appear to be over inadequate staffing and extended waiting times.

Factors other than personal experience may also influence perceptions. Some claim that anecdotal reports and misrepresentation of issues in the media and by the "friends" and "foes" of medicare are to blame for the lack of public confidence in the system (Jacobs and Shapiro, 1997; Rachlis *et al.*,

2001; Roos and Brownell, 1998), especially when personal experience is lacking (Shapiro *et al.*, 2000; Pescosolido *et al.*, 1999). Others have shown that the public is inadequately informed about the health care system, and so argue that citizens have not received enough unbiased information to have a meaningful debate (Bernstein and Stevens, 1999). We may expect, therefore, that people's levels of knowledge and their experiences with the system both affect their views.

Moreover, health care differs from other social programs in that the provinces are bound by the principles of the Canada Health Act, which also influences perceptions, as do politically-motivated statements coming from successive federal health ministers indicating that Ottawa is determined to defend the elusive "spirit" of the Canada Health Act. Even though economic analyses show that Alberta and Ontario both could reform their health care systems and save money even if their contraventions of the Canada Health Act resulted in the extinction of federal money to these two provinces (Zelder, 2000b), and despite what a prominent group of Alberta academics and economists recently advocated—namely, that Alberta should indeed reject federal money for health care in order to free itself from Ottawa's dictates³—our data indicate that Albertans are not

3 The text of "The Alberta Agenda," an open letter to Premier Klein by Stephen Harper, Tom Flanagan, Ted Morton, Rainer Knopff, Ted Boessenkool, and Andy Crooks was published on January 24, 2001. It is available at www.thereport.ca, or *The National Post*, 26 January, 2001, p. A14.

Table 1: Regression Analysis—The Influence of Personal and Political Factors on Health Care Satisfaction (Beta coefficients)

Independent variables	Dependent variable = satisfaction with health care (very satisfied)
<i>Personal and political factors:</i>	
• poor personal health (not at all satisfied with personal health)	-.15**
• personal experience (used the health system within the last 6 months)	-.06*
• advocate a federal presence (provinces should report on how federal money for health care is spent)	-.18**
• low sense of financial satisfaction (not at all satisfied with personal financial situation)	-.15**
Constant	.87**
R-squared	.10

*Significant at $p < .05$;

**Significant at $p < .01$

Source: 2000 Alberta Advantage Survey.

yet ready to forego federal administrative control, although nearly two in every three Albertans (65%) believe that the provinces should have more say in how money is spent on health care.

A final constraint on introducing changes in health care policies follows from the ease with which sensible proposals for reform can so easily and so effectively be side-tracked by emotionally-charged rhetoric that awakens deep-seated fears. For example, when Ontario Premier Mike Harris said it was time to talk seriously about reforming health care, opposition leader Dalton McGuinty immediately responded by accusing the premier of undermining the Canada Health Act. McGuinty clearly hoped to polarize the electorate and effectively prevent serious and prudent discussions of any real alternatives.

Our data show that a growing majority of Albertans (now nearly 60%) agree that “if people are willing to pay the price they should be able to

use private medical clinics.” Support for this principle is highest (at 64%) among those who are satisfied with their personal financial situation. The fear, anxiety, and resentment associated with this particular cleavage are used by opponents of market-based alternatives to prevent serious change, or even the prudent discussion of change.

Table 1 reports the results of a regression analysis. Regression analysis is a statistical technique that allows us to compare a number of independent factors to explain what is causing changes in something else. In this case, regression analysis enables us to discover how different personal and political factors work to detract from overall satisfaction with the health care system. In this instance, regression analysis illustrates which of these potential constraints has the most powerful effects. Table 1 indicates that more or less all of the factors just discussed detract from overall satisfaction with health care. Support for maintaining a federal presence, poor personal health, and

low levels of financial satisfaction seem to be particularly limiting initiatives, whereas direct experience with the system, though significant, does not seem to have as powerful an effect.⁴ What this

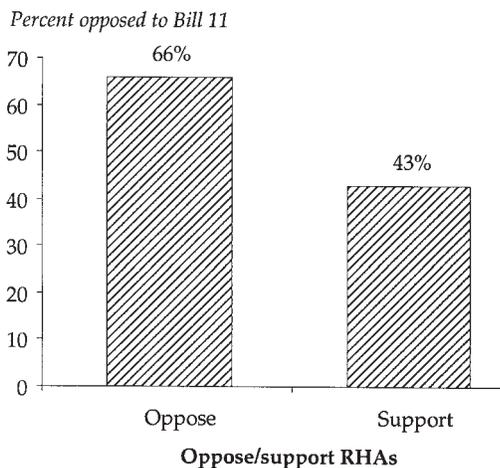
means, then, is that any serious attempt at health care reform must find strategic ways of keeping these obstacles at bay.

Prevailing Attitudes Toward Change

Attempts at health care reform are further hampered by what appears to be a general resistance to structural changes to the system. Despite the problems with the current health care system, Albertans, and Canadians more generally, seem almost instinctively to equate changes to the system with attempts to dismantle it. Even so, Albertans have arguably experienced some of the most assertive efforts to incorporate private health care into the current system, and attitudes

toward Bill 11 illustrate the relevance of this point. Provisions of this act allow the provincial Regional Health Authorities (RHAs) to contract with a private health service provider (either for profit or not-for-profit) for the provision of specified surgical services. The impact of this bill, according to its opponents, has been to increase scepticism about health care in the province. Evidence from the Alberta Advantage Surveys, however, indicates that Albertans have been almost equally divided. Figure 3 shows that opposition toward Bill 11 is much more evident among those who oppose other policies of the Klein government, such as the creation of the Regional Health Authorities. Thus, opposition toward restructuring the current system remains significant.

Figure 3: Opposition Toward Bill 11 by Opposition/Support for the 17 Regional Health Authorities



Source: 2000 Alberta Advantage Survey.

Currently, less than 30 percent of health care expenditures in Canada come from private sources such as insurance premiums and out-of-pocket expenses for services deemed medically unnecessary. This ratio of public-to-private expenditures is roughly equivalent to that in the average industrialized nation (GOC, 2000b). Many health experts consider that one way to maintain Canada's health care system is to increase private funding. For example, Albert Schumacher, president of the Medical Association of Ontario, argues that allowing Canadians to pay for some medical services might be necessary to revamp the "crumbling and ineffective" existing health care system. Further-

⁴ This may indicate that there may be some overlap between the indicators measuring "level of personal health satisfaction" and "extent of indirect experience."

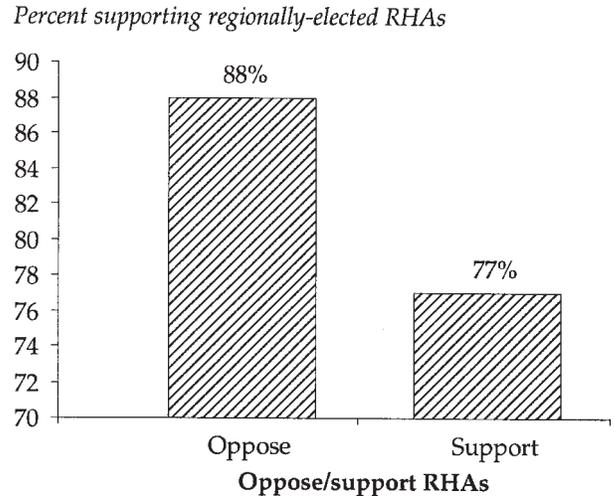
more, recent indications from Ontario suggest that Harris government may be poised to follow the Alberta model (Kondro, 2001).

Despite the latest overture made by Roy Romanow, currently heading the federal Commission on the Future of Health Care in Canada, that “rational men and rational women should look rationally at the options which might fit and... those which might not fit the Canadian system” (*National Post*, May 2, 2001, p. A1), the difficulty until now has been in simply having *any* reasonable, prudent, or unemotional discussion of health care. Some political leaders are no doubt persuaded that arguments in favour of introducing private health care as a way to deal with the significant and widely-acknowledged existing problems are sound. Even so, the anxieties of the public require an almost Solomonic statesmanship to move towards the objective of market-based alternatives and greater privatization.

Notwithstanding these difficulties, it bears repeating that the literature on medical economics indicates that introducing market-based, private-sector hospitals would, indeed, help improve health care delivery. Although studies have not shown a clear performance difference between for-profit and non-profit hospitals, clear and significant differences between private and public hospital performance has been shown to exist as a result of inefficiencies and lack of incentives in public hospitals (Zelder, 2000a). It would seem, therefore, that what is required for strategically-ordered change is less a matter of economic argument or the great postponer, “more research,” than of political courage and skill at persuading or priming the electorate. Albertans, at least, have reason to be optimistic: the Klein government has undertaken initially unpopular, but economically sound, changes before.

For instance, the consolidation of 200 separate hospital boards across the province into 17 new Regional Health Authorities was initially op-

Figure 4: Albertans who Agree that Regional Health Boards Should be Elected by Opposition/Support for the 17 Regional Health Authorities



Sources: 2000 Alberta Advantage Survey.

posed by both doctors and by other front-line health care providers. Often their reasons were self-serving (Cooper and Kanji, 2000), but given the generalized resistance to change, the government did well to persuade the public that any streamlining of the administration was desirable. Our data indicate that, despite initial criticism, support for the creation of Regional Health Authorities has remained between 50 and 60 percent over the last five years or so (between 1995-2000). Moreover, most Albertans, including those who support the creation of RHAs (see figure 4), agree that administrators who serve on these boards should be made more accountable through democratic elections. Partly as a result of public opinion on this issue, the government announced that by October 2001, 126 out of 189 regional health authority members across the province will be elected during municipal elections (GOA, 04.20.01).

Even so, the crucial point to bear in mind is that when we calculate the regression coefficients to indicate the relative weight of these political considerations, it turns out that policies designed and

Table 2: Regression Analysis—The Impact of Various Personal/Political Factors and System-Altering Policies on Health Care Satisfaction (Beta coefficients)

Independent variables	Dependent variable = satisfaction with health care (very satisfied)
<i>Personal and political factors:</i>	
• poor personal health (not at all satisfied with personal health)	-.13**
• personal experience (used the health system within the last 6 months)	-.06*
• advocate a federal presence (provinces should report on how federal money for health care is spent)	-.12**
• low sense of financial satisfaction (not at all satisfied with personal financial situation)	-.10**
<i>System-altering policies:</i>	
• the creation of 17 RHAs (strongly oppose)	-.12**
• Bill 11 (strongly oppose)	-.28**
Constant	1.0**
R-squared	.20

*Significant at $p < .1$;

**Significant at $p < .01$

Source: 2000 Alberta Advantage Survey.

intended to improve—and in any event alter—the health system detract from overall satisfaction with health care (table 2). In particular, the negative impact of Bill 11 has been more than double that of any other factor. This analysis indicates that just as traditions are hard to break, it is also difficult to alter the fundamental structure of the health care system without arousing an adverse reaction.

Because most politicians are in the business of being re-elected and because reforming health care threatens to make them unpopular, it is not difficult to see why the process of health care reform remains stalled. But given the existing system's highly precarious future, it is worthwhile to determine what factors might mitigate those negative effects and provide politicians with the flexibility to make sensible reforms.

Perceptions of the State of Health Care

Cross-national studies indicate that historically Canadians have been satisfied with their health care system (Blendon, *et al.*, 1990). In 1998, however, public confidence in Canada's health care system dropped to 20 percent from 56 percent where it stood a decade earlier (Donelan, *et al.*, 1999). Published discussions by academics, press releases by interested parties, and media horror stories have undoubtedly increased anxieties among the general public. A synthesis of survey results by the Conference Board of Canada (CBOC, 2000a) shows that since 1993, concerns about health care have been steadily rising, and health care is now identified as the top national issue. Concerns about health care seem to be prompted by the belief held by almost 80 percent of Canadians that the health care system is in crisis (Angus Reid, 2000). Further, surveys commissioned by the Canadian Medical Association found that among Canadians, Albertans were most likely to cite health care as the most important issue leaders should address (CMA, 1999).

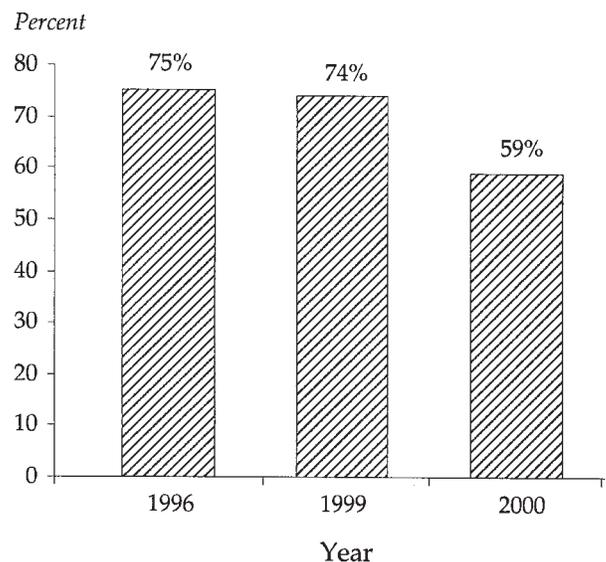
In spite of the political minefield surrounding health care reform, the Klein government has gone to great lengths to change the system—even though conventional wisdom said it would be “political suicide” (Farnsworth, 1995) to implement even the modest reforms of Bill 11. Contentious as these changes have been, Ralph Klein has not paid the price politically.

During the 2001 provincial election, both opposition parties tried to use Bill 11 as a means of mobilizing votes against the Tories. The results speak for themselves: popular support for the government increased, as did the size of the cohort on the government side of the Legislative Assembly. We have documented the reasons for the success of the Klein government elsewhere (Cooper and Kanji, 2000, ch. 5; Virani, Kanji and Cooper, 2000). What is important for our purposes here, how-

ever, is not simply to note the general political success of the Klein government, but to emphasize that electoral success has been accompanied by improvements in the general outlook of the Alberta public toward health care. Figure 5, for example, shows that compared to earlier years, Albertans in 2000 were significantly less likely to argue that the province had become a worse place for those who are ill. Indeed, over the past four years or so, the percentage of citizens indicating that Alberta has become a better place for those who are sick has improved by 17 percent.

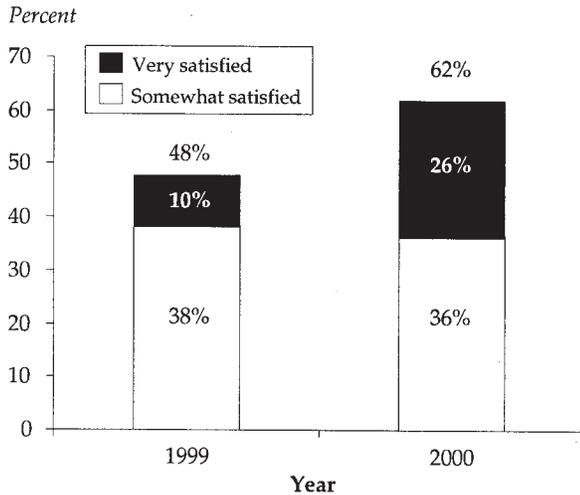
Figure 6 shows that general satisfaction with the health care system has also improved: today, 3 in every 5 Albertans (62%) are satisfied with health care, which is a striking 14 percent increase from 1999. Within this group, the percentage of Albertans who are very satisfied with health care has increased by an astounding 16 percent. Compar-

Figure 5: Albertans Who Say that Alberta is Becoming a Worse Place for Those Who are Ill or Sick



Source: 1996-2000 Alberta Advantage Surveys.

Figure 6: Satisfaction with the Health Care System



Source: 1999-2000 Alberta Advantage Surveys.

tively speaking, Albertans today are as satisfied with health care as they are with other social programs, such as education and welfare (see Kanji and Cooper, 2001).

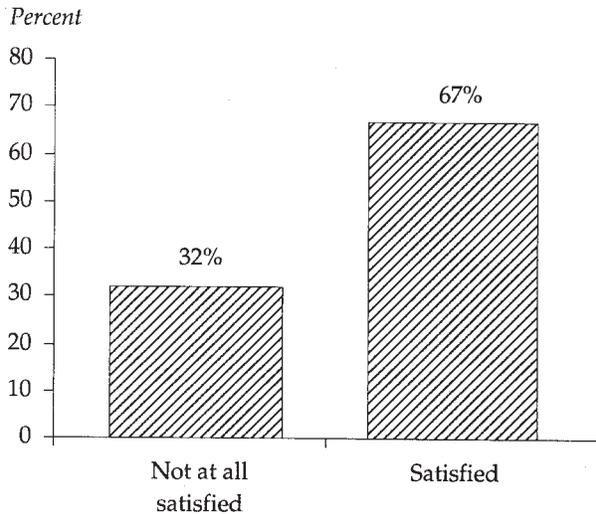
Theoretically, there are many ways of improving the economics of the health care system. The practical difficulty, however, is to find a “working prescription” for implementing politically risky structural reforms that at the same time improves general perceptions of health care and so maintains the political support necessary for change. The prescription metaphor suggests as well that, just as with medications administered to individuals, where the same pharmaceutical may have quite varied effects in different individuals diagnosed with the same ailment, something similar is true with policy prescriptions for the body politic. The treatment that worked in Alberta may not work elsewhere; the dosage may have to be adjusted to suit different needs and different political cultures. Even with all these qualifications, the Alberta example shows that it is possible to make incremental reforms to health care, improve overall satisfaction with the system, and at the same time avoid paying a heavy political price.

By claiming to use one-time targeted expenditures rather than giving in to demands for increases in long-term commitments of public funds, the Alberta government implemented an effective strategy that dampens or buffers the inevitable dislocation and associated transaction costs that come with any large administrative change. The objective of the strategy is to direct public resources to areas considered to be politically the most sensitive—to improve accessibility and to improve quality—but without falsely or unduly raising expectations, or spending over budget. The appropriate analogy in this case may be that of a “just-in-time” system of funding from public revenues.

For example, in April 2001, Health Minister Gary Mar announced a strategy aimed at doubling the number of MRI machines by providing one-time funding to regional health authorities to contract with private MRI providers (GOA, 04.09.01). Moreover, the government allocated additional money to upgrade and renovate existing facilities, including a new Children’s Hospital in Calgary (GOA, 06.05.00). Whether the money actually hits the target is another matter, but as of November 2000, reaction to the government’s strategy of “targeted spending” has been positive. Figure 7 shows that 2 in every 3 Albertans (67%) are satisfied with how much the government has spent on programs such as health care, and about a third (32%) said they are not at all satisfied. The downside risk is equally obvious: “targeted reinvestment” or “just-in-time” spending can easily become general long-term program funding, which introduces yet another kind of status quo. Fiscal conservatives have reason to be concerned that what the government calls reinvestment may in fact turn out to be the first step on a return to uncontrolled and unfocused spending.

While it is one thing simply to inject more dollars into the current system, it is quite another to make sure they are used in the right way. Thus, a sec-

Figure 7: Satisfaction with Spending on Priority Programs



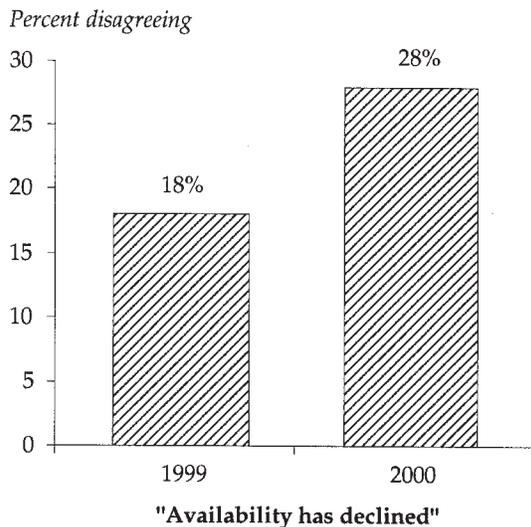
Source: 2000 Alberta Advantage Survey.

ond element in the strategy of the Alberta government has been to ensure that new spending is seen to be used effectively. And, in fact, the public opinion evidence indicates that there have been marked improvements in perceived accessibility of services. Figure 8, for instance, shows a significant increase in the number of Albertans who disagree that the availability of health services has deteriorated.

Moreover, as figure 9 illustrates, improving perceptions of availability has an enormous effect on perceptions of quality.

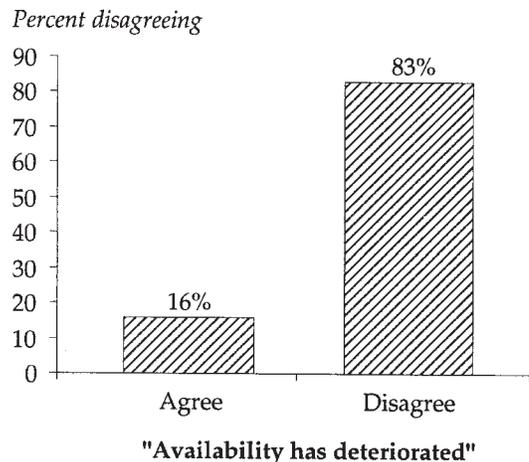
Perhaps the most important political effect is that, as of November 2000, all of these changes have been made without adding to anxieties over whether future public revenues will be able to sustain the system. However, as noted above, it remains an open question as to whether the recent round of spending is the beginning or the

Figure 8: Percentage of Albertans Disagreeing with the Claim: "the Availability of Health Services has Declined"



Source: 1999-2000 Alberta Advantage Surveys.

Figure 9: Percentage of Albertans Disagreeing with the Claim: "the Quality of Health Care Services has Declined" by those Agreeing/Disagreeing with the Claim: "the Availability of Health Care Services has Deteriorated"



Source: 2000 Alberta Advantage Surveys.

Table 3: Regression Analysis—The Determinants of Satisfaction with the Health Care System (Beta coefficients)

Independent variables	Dependent variable = satisfaction with health care (very satisfied)
<i>Personal and political factors:</i>	
• poor personal health (not at all satisfied with personal health)	-.08**
• personal experience (used the health system within the last 6 months)	-.01
• advocate a federal presence (provinces should report on how federal money for health care is spent)	-.06**
• low sense of financial satisfaction (not at all satisfied with personal financial situation)	-.07**
<i>System-altering policies:</i>	
• the creation of 17 RHAs (strongly oppose)	-.06*
• Bill 11 (strongly oppose)	-.13***
<i>Alberta's "working" prescription:</i>	
• spending on priority programs (satisfied)	.29***
• accessibility (very easy)	.26***
• quality (excellent)	.09***
Constant	.34***
R-squared	.41

Note: The analysis reported above also controls for various socio-demographic factors such as age, education, sex, and region.

*Significant at $p < .1$;

**Significant at $p < .05$;

***Significant at $p < .01$

Source: 2000 Alberta Advantage Survey.

end of fiscal conservatism as that term has come to be understood during the first two Klein administrations.

Two other significant findings emerge from the regression analysis reported in table 3. The first is that even after controlling for various socio-demographic factors, all three of these policy initiatives work to reduce the negative effects associ-

ated with health care politics and system-altering policies such as Bill 11. In particular, the system of "just-in-time" spending and improvements to accessibility appear to be the two most powerful positive influences on satisfaction with health care. This finding is consistent with the conclusions drawn from the 1999 Alberta Health Summit⁵ and the Alberta Health Surveys (Northcott and Northcott, 2000), namely, that perceived

5 Health Summit '99: Summary of Delegate Recommendations. Calgary, February 25-7, 1999.

**Table 4: Regression Analysis—
The Determinants of Accessibility to
Health Care Services (Beta coefficients)**

Independent variables	Dependent variable = ease of accessibility to health care services (very easy)
• access to doctors (better)	.25**
• access to surgery (better)	.16**
• access to specialists (better)	.01
• waiting times in emergency (better)	.11**
• waiting times for diagnostic tests (better)	—
Constant	.36**
R-squared	.18

**Significant at $p < .01$

Source: 2000 Alberta Advantage Survey.

problems with “accessibility and availability of services” best explain the lack of confidence with the health care system.

Table 4 provides additional support for this interpretation. It shows that perceptions of accessibility are driven mostly by factors such as improved access to doctors, timely surgery, and shorter waiting times in emergency rooms. Thus, it is not surprising that the Alberta government has recently attempted to target these areas (GOA, 12.01.00; 01.17.01). Even the Alberta Medical As-

**Table 5: Regression Analysis—
The Determinants of the Quality
of Health Care Received
(Beta coefficients)**

Independent variables	Dependent variable = quality of care received (excellent)
• quality of community care (better)	.19**
• quality of hospital care (better)	.19**
• quality of home care (better)	.06
Constant	.52**
R-squared	.13

**Significant at $p < .01$

Source: 2000 Alberta Advantage Survey.

sociation ratified an agreement with the government designed to “keep Alberta competitive in attracting and keeping doctors” (GOA, 02.27.01).

In much the same way, the regression results reported in table 5 show that overall evaluations of quality pertain more to some aspects of the system than to others. What matters most is how people appraise the care they receive in their communities and in hospitals, and not so much the quality of care they receive at home—although better home care also works to improve the perception of the overall quality of care. By directing resources toward important areas of public perception, the Alberta government appears to have derived the biggest bang for its buck.

Is the Health Care Cow Sacred No More?

Public opinion analysts and advocates of the status quo in health care have long asserted that health care is too important or too fragile to change in any fundamental way. Some sentiments and anxieties may well be beyond refutation by evidence and reasonable argument, but the preceding analysis has shown that it is possible to make modest system-altering changes to health care in spite of the highly symbolic politics involved. Moreover, the Klein government has been able to make these changes in the system while at the same time improving popular perceptions about the system and thus retain its strong popular support.

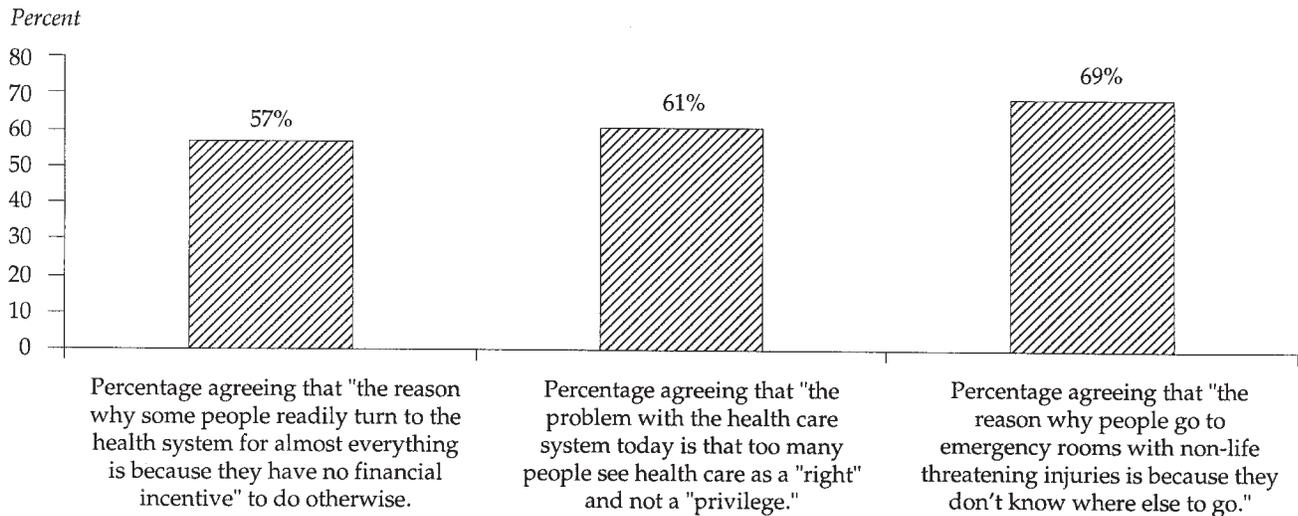
There remains, however, an important question that health care experts agree needs to be answered to overcome the obstacles to reform: why bother? (Casebeer and Hannah, 1998). After all, there is a big difference between implementing minor changes or tinkering around the edges, and undertaking major and meaningful change. Bill 11 illustrates the problem. It is true that the Klein government was able to pass Bill 11 and not suffer at the polls, but the legislation was explicitly designed not to offend the Canada Health Act (CHA), which is arguably the greatest obstacle to a serious improvement in health care delivery. Thus, it remains debatable whether the legislation has made any difference at all. The question therefore arises: was it worth the effort?

Before its implementation, Bill 11 was subject to 47 hours of debate in the legislature—the longest discussion for any bill in provincial history. Sixty MLAs rose to consider its provisions, and representations were received from doctors, nurses, health authorities, the public, and other concerned parties (GOA, 05.10.00). Even after the Health Care Protection Act was proclaimed into law in the spring of 2000, a proposed set of new regulations that apply to the provision of surgical

services was sent to a wide range of health care stakeholders for review and comment in two phases (GOA, 09.28.00). Then, following all the drafts, discussions, and amendments, it is still far from clear that the structure of health care delivery has been fundamentally changed. The foundation of the CHA has not yet been disturbed. Hostile federal politicians could say nothing more than that, perhaps, Bill 11 conflicted with the “spirit” of the CHA. Whatever that recon-dite term may mean, an appeal to the spirit of the law is a clear admission that the legislation does not violate the letter of the act. But if the CHA is part of the problem, then not violating both the spirit and, more importantly, the letter of the CHA simply avoids the real problem. Indeed, this issue has already arisen in the initial stages of Roy Romanow’s nation-wide commission on health care.

If reform attempts amount to hardly any change at all and are likely only to get bogged down in arguments over levels of public funding, or to be portrayed as nothing but underhanded attempts to dismantle a piece of Canada’s national heritage, then those interested in establishing market-based alternatives to the Canada Health Act have to ask: what is the point in attempting to change the status quo? Is it even possible, as Ontario Premier Mike Harris said, for Canadians to “think outside the box?” Our evidence has, in fact, demonstrated several good reasons to go on with further restructuring.

One reason identified in this study is that up to November 2000 most Albertans were satisfied with the amount of public money the Klein government devoted to health care. Of course, there are still those who favour even more public funding; as far as program spending priorities are concerned, health care remains high. But priorities are shifting. Not only has the demand for public

Figure 10: What Explains the Problems with Health Care?

Source: 2000 Alberta Advantage Survey.

funding shifted to other program areas such as education, but support for greater program spending in general has declined (see Kanji and Cooper, 2001). That is, Albertans have been persuaded of the advantages of affordable government. At the same time, the government has responded to an unprecedented budgetary surplus with what is presented as an increase in one-time, targeted spending, chiefly on health care and education, but also on infrastructure. This approach has been unquestionably popular, but fiscally conservative critics might well be concerned about whether it is desirable because the policy also implies continuing efforts to sustain the system from public funds.

Whether Ralph Klein remains faithful to the general objectives of fiscal conservatism and smaller government that animated his earlier mandates is still unknown. With respect to health care policy, however, our analysis shows that many Albertans believe that the current problems with health care are not just attributable to a lack of public funding (see figure 10). For instance, 69 percent of respondents to our most recent survey said the reason why people go to emergency rooms (ERs) with non-life threatening injuries is because they

don't know where else to go. In fact, studies have shown that an increasing number of Canadians use ERs for primary care when primary care providers are unavailable (Weil, 1993). In a study of ER use at the Peter Lougheed Hospital in Calgary, only 32 percent of participants thought their conditions were emergencies. For 21 percent of participants, their usual source of care was closed, and 11 percent visited the ER because they thought they would need diagnostic services (Tink *et al.*, 2000).

The Calgary Regional Health Authority (CRHA) has successfully reduced ER load somewhat through media campaigns designed to educate the public on the appropriate use of emergency services, and has also proposed the creation of alternative services such as diagnostic and treatment centers and after-hours care to ease the pressure on emergency rooms (CRHA, January 2001). Given that 72 percent of our respondents agree that "people with non-life threatening emergencies should be redirected to their community clinic," such initiatives are likely to be well-received by Albertans, and we suspect by Canadians more generally. Of course, these kinds of improvements do not address the dysfunc-

tional basis of the CHA, though they do prime electorates on the desirability of change *per se*, and indicate that it can be done.

Other evidence indicates more basic changes may be possible as well. For example, “personal responsibility for appropriate use of health resources and health choices” was one of the core health care values that emerged from discussions with Canadians through the National Forum on Health (GOC, 2000b). Our study suggests that most Albertans consider that this “core value” has not been upheld by the existing system. Sixty-one percent of respondents said that too many people see health care as being a “right” and not a “privilege,” and 57 percent said the reason people turn to the health system for almost everything is because they have no financial incentive not to. Such evidence indicates clearly enough that the public agrees with claims made by health care experts that the chief defect of our collectivist health care system is that there are no disincentives for abuse (Ramsay, 1998; Gratzner, 1999). The positive news, however, is that evidence from the AAS indicates that intermediate measures that will ease the transition to a more economically rational system are likely to be acceptable.

The chief political difficulty is how to manage the transition. To simplify somewhat: if the problem is that the existing collectivist system is unworkable, and the solution is to introduce market incentives through private sector involvement (which means both that private facilities can supply medical services and private individuals can pay for them), then the question is: how to get from here to there? Supporters of the existing system are bound to invoke the usual range of symbolic defenses. This tactic, as we have indicated, makes matters worse both by postponing and preventing improvements in the system, and by preventing any serious consideration of genuine change.

On the other side of this issue, advocates of economically sensible changes are fully aware that the persuasiveness of reason and common sense is often limited, especially when opponents are on the defensive and can rely on the traditional, though economically irrelevant, symbols of “nationhood,” or “compassion,” or other high-sounding things.

On other policy issues, however, the Klein government was able to prevail in the face of symbolically powerful criticism. In the mid-1990s, Ralph Klein was accused of wrecking the educational system, destroying a “caring” society by reducing the number of recipients of social welfare, and so on. One of the reasons for its earlier successes stemmed from the Alberta government’s ability to prime the electorate by getting the message out not only with respect to what the problem was, but how to deal with it. Because of the high political risks surrounding changes to health care, the willingness of Albertans to change course is much more sensitive. To determine the flexibility of Albertans on this issue, the 2000 AAS asked respondents whether they supported various measures for health care reform. As expected, the symbolic importance of “universal” health care was strongly confirmed, as were several non-controversial options—such as changing the emphasis of the health care system to focus more on the prevention of disease, increasing the amount of community-based care, or redirecting people with non-life threatening emergencies to their community clinics in order to relieve the access bottleneck. All of these proposals are amenable to market-based alternatives, though they have not, as yet, been proposed.

The most significant finding, however, was that a sizeable majority (79%) of respondents to our survey agree that “there should be penalties for those who abuse the system.” Health Minister Gary Mar has proposed that people who take greater health risks should pay higher premiums than those who do not. Forty percent of respon-

dents to our survey agreed with the minister's proposal, which suggests that Canadians are willing to entertain significant departures from existing practices. It also suggests that, with a certain amount of government priming, further changes can be made.

We also asked respondents whether they agreed with the statement that "too many people see health care as a 'right' and not a 'privilege.'" Among those who agreed, nearly half (44%) wanted to encourage the creation of private clinics, while fully 85 percent thought there should be penalties for abuse of the system. There is obviously room for more fine-grained analysis of the data, but in general, it appears that respondents widely agree with health economists and other policy experts who say that major problems within the system have nothing to do with the question of public versus private funding, administration, and delivery. The fact is, there exists a broad spectrum of acceptable options for health care reform—whatever respondents think is

wrong with other aspects of the system. For some of these alternatives, such as a focus on disease prevention, market-based programs such as immunization travel clinics are obvious options. What is important in this context, however, is not the details of any particular proposal but the discovery that *any* change in the current system is likely to introduce a sense that experimentation is acceptable and that Canadians can "think outside the box" after all. Looked at in the broader national perspective, Bill 11 was probably worth the trouble. It did little to change the basis of health care delivery in Alberta, but it may well have given Premier Harris the encouragement he needed to take the next step. Indeed, it seems likely that, in the absence of the modest changes introduced by Bill 11, Premier Harris would have been more reluctant to introduce changes in Canada's largest province. Recent comments by Liberal Senator Michael Kirby (*National Post*, July 3, 2001, A1) indicate, *mirabile dictu*, that even the federal government may at last be willing to consider changing the system.

Conclusions

We began this *Public Policy Source* by suggesting that health care reform poses a real challenge for policy makers. Many experts contend that the status quo cannot be maintained over the long-term for several different reasons: costs are up, the appetite for more public funding seems insatiable, and increased public funding does not address the real problems. Our public opinion evidence indicates that in Alberta there is plenty of room for well-considered and economically rational changes. This is just as well because, if change is not anticipated, events will always come as a surprise—often a shocking one. Under such circumstances, governments are vulnerable and can do little but react rather than lead.

The obstacles to sensible change can easily be over-estimated. Some people are always going to view advocates of health care reform as having either ulterior motives or a hidden agenda. Of course private health care practitioners are interested in getting a fair return for their efforts, but so are doctors and nurses who currently operate under a publicly-funded and state-administered system. Talk of hidden agendas may appeal to conspiracy buffs and the politically paranoid, but such personal predispositions do little to address a challenge common to policy makers across the industrial world. Besides, the agenda is not hidden: the objective is to maintain sensible social programs, to reduce the perverse incentives that almost invariably accompany government inter-

vention, and to leave more hard-earned dollars in taxpayers' pockets. What's more, there is ample evidence that voters in democracies everywhere support political parties that are fiscally prudent, limit spending, and cut taxes. The welfare state is on the defensive, not market-based health care reform.

Even so, it remains an open question whether even Alberta and Ontario will be able to move beyond the status quo on health care policy. The symbolic charge attached to health care alone makes any changes politically risky. Individual anxieties that surround illness and injury are inherent and add to the difficulties surrounding innovations of any kind. It is true that the strategy of long-range persuasion and "priming" the electorate worked well for the Klein government in other areas (Cooper and Kanji, 2000; Kanji and Cooper, 2001), but the agenda still remains regrettably dominated by advocates of hearsay and fear mongering.

Voters see health care as unlike other social programs. What the Alberta experience shows is that by controlling and minimizing the stresses on the existing health system through prudent measures such as "just-in-time" spending in major trouble spots, and by maintaining an acceptable level of accessibility, it is possible for a government to bring changes to the system, and to implement initially unpopular reforms, while still remaining politically viable. Indeed, the Klein government has shown it is possible for a government to grow in popularity and to improve the public's outlook toward the entire system. Yet doubts remain concerning the value of spending time, energy, and political capital in order to make small and incremental changes. But endless debate over public funding levels has solved nothing. It seems inevitable that eventually the economic rationality of a market-based health care system will prevail. Our data indicate that Albertans (and perhaps Canadians) are more willing to experiment along those lines than previously has been admitted by opponents of change or hoped for by advocates.

The kind of spending the Klein government has so far put in place is one-time targeted funding, not continuing blanket public funding that commits governments to support the existing status quo or create a new program that is just as unacceptable. Such a spending program is flexible, which is always a plus, but it also requires innovation, imagination, and the courage to say "no" to continuing demands. No government, including the government of Ralph Klein, enjoys saying "no." In particular, when it comes to health care, spending cuts alone are not likely to effect significant structural reform; they were accepted, or at least tolerated, when governments had deficits to reduce, but at the first sign of surpluses demands for more public funding grew and intensified. Any government that fails to deliver what voters want is likely to be punished by them. The challenge, therefore, is for governments to walk the fine line that enables them to make changes to the system, but not at the cost of being voted out. It is clear that the Alberta government is an electoral success, but it is less clear that its changes to health care have constituted a policy success. As we have noted, not much has yet changed.

Second, the Alberta experience illustrates the fact that it is difficult to change the status quo (for all the reasons given above) by persuasion alone. For example, after tabling Bill 11, the Klein government temporarily deployed its so-called "truth" squads to try to counter the bill's critics by setting the record straight on what the proposed legislation was really intended to do. The result: more Albertans became opposed to the legislation, and there was plenty of critical attention in the media.

The other way to convince people that it is acceptable to experiment, to try alternatives that have not been tested, to anticipate a certain amount of difficulty and disappointment, is by example. After all, that is the purpose of political leadership—to lead by example. In the larger context, federalism is particularly well suited for these

kinds of policy experiments—what a *National Post* editorial once called “competitive federalism” (December 3, 1999). In any event, it seems clear that the fears and anxieties surrounding even modest achievements such as Bill 11 will not be reduced by truth squads and shouting matches, but by “priming by example.” A sure way to remove fear from the unknown is to show people in practice that changes to the old ways can actually be an improvement.

In one sense this has already happened, though not in Alberta. In the absence of the modest changes introduced by the Klein government, it is highly unlikely that Ontario Minister of Health Tony Clement and Ontario Premier Mike Harris, let alone Senator Kirby, would ever have suggested that the private sector could do a better job than the existing public system. Prior to the Klein

reforms, the premier of Ontario would not have said: “there can’t be any sacred cows. You’ve got to look at everything. It doesn’t mean that you’re going to do everything, but you have to be at least prepared to look at everything” (*National Post*, April 27, 2001, p. A1). Nor would Tony Clement have declared that “the logical argument here is if the private sector can deliver better, cheaper, safer, more effective health care than a public sector deliverer of that public health care, then we should at least have a look at that” (*National Post*, April 28, 2001, p. A5). The Klein government took the first step by opening the debate. The Harris government took the second one by reaffirming the need for change and by pointing to the private sector as the place to look for it. Perhaps at long last the federal government, which guards the sacred CHA cow, will take Senator Kirby’s advice and put it out of its misery.

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Appendix: Question Wording and Coding

Health system needs to be fixed

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: The health care system needs to be fixed? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Level of personal health satisfaction

Taken together, how satisfied are you with things these days? Are you very satisfied, somewhat satisfied, or not satisfied at all with: Your own health? (very satisfied = 0, somewhat satisfied = .5, not at all satisfied = 1)

Opposition toward various aspects of health care

How supportive are you of the following? Do you strongly support, support, oppose or strongly oppose:

- Fewer doctors and nurses in Alberta? (strongly support = 0, support = .33, oppose = .66, strongly oppose=1)
- Fewer hospitals in Alberta? (strongly support = 0, support = .33, oppose = .66, strongly oppose = 1)
- Fewer health services? (strongly support = 0, support = .33, oppose = .66, strongly oppose = 1)
- Longer waiting times in hospitals for needy patients? (strongly support = 0, support = .33, oppose = .66, strongly oppose=1)

Extent of direct experience

In the past 6 months, have you: received any health care services? (no = 0, yes = 1)

Principle of private health care

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: If people are willing to pay the price, they should be able to use private medical clinics? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Subjective sense of financial satisfaction

Taken together, how satisfied are you with things these days? Are you very satisfied, somewhat satisfied, or not satisfied at all with: Your personal financial situation? (very satisfied = 0, somewhat satisfied = .5, not at all satisfied = 1)

Health care satisfaction

Taken together, how satisfied are you with things these days? Are you very satisfied, somewhat satisfied, or not satisfied at all with: The health care system? (not satisfied at all = 0, somewhat satisfied = .5, very satisfied = 1)

Advocate a federal presence

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: The provinces should have to report to the public on how they spend federal health dollars? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Opposition toward Bill 11

How supportive are you of the following? Do you strongly support, support, oppose or strongly oppose: Bill 11, which gives RHAs the legal authority to contract out certain services to private

facilities? (strongly support = 0, support = .33, oppose = .66, strongly oppose=1)

Opposition/support for the 17 Regional Health Authorities

How supportive are you of the following? Do you strongly support, support, oppose or strongly oppose: The 17 regional health authorities that determine how the health care budget is spent? (strongly support = 0, support = .33, oppose = .66, strongly oppose=1)

Regional health boards should be elected

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: Regional health boards should be elected by the people? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Alberta is becoming a worse place for those who are ill or sick

Thinking back over the past 7 years or so, do you think that Alberta has become better or worse for those who are ill or sick? (worse = 0, no change = .5, better = 1)

Spending on priority programs

Taken together, how satisfied are you with things these days? Are you very satisfied, somewhat satisfied, or not satisfied at all with: The amount of money the Klein government has reinvested back into social programs such as health care and education? (not satisfied at all = 0, somewhat satisfied = .5, very satisfied = 1)

The availability of health services has declined

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: The availability of health care services has deteriorated? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

The quality of health care services has declined

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements: The quality of health care services has declined? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Accessibility to health care services

How easy or difficult is it to get the health care services you need when you need them? Would you say it is: very easy, easy, a bit difficult, very difficult? (very difficult = 0, a bit difficult = .33, easy = .66, very easy = 1)

Quality of health care received

Overall, how would you rate the quality of care you personally have received in the past 12 months? Would you say it was: excellent, good, fair, poor? (poor = 0, fair = .33, good = .66, excellent = 1)

Access to doctors, access to surgery, access to specialists, waiting times in emergency, waiting times for diagnostic tests, quality of community care, quality of hospital care, quality of home care

For each of the following, could you please indicate whether you think things have gotten better or worse, or whether there has been no change.

- Access to doctors when you need them (worse = 0, no change = .5, better = 1)
- Access to surgery when you need it (worse = 0, no change = .5, better = 1)
- Access to specialists when you need them (worse = 0, no change = .5, better = 1)
- Waiting times in emergency rooms (worse = 0, no change = .5, better = 1)
- Waiting times for diagnostic tests such as x-rays and MRI services (worse = 0, no change = .5, better = 1)
- The quality of health care services in your community (worse = 0, no change = .5, better = 1)
- The quality of health care services in hospitals (worse = 0, no change = .5, better = 1)
- The quality of health care services received at home through home care (worse = 0, no change = .5, better = 1)

Problems with health care

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

- The reason why some people readily turn to the health system for almost everything is because they have no financial incentive not to? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- The problem with the health care system today is that too many people see health care as being a “right” and not a “privilege”? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- The reason why people go to emergency rooms with non-life threatening injuries is because they don’t know where else to go?

(strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

Spectrum of potential alternatives for health care reform

Could you please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

- There should be limits on how many times a year one can visit the doctor? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- People who smoke, don’t exercise and take risks should have to pay extra in health care premiums? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- Doctors should not be paid on a per patient basis; rather, they should be paid according to a fixed salary? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- People who go to emergency with non-life threatening injuries should be redirected to their community clinic? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- There should be some sort of penalties put in place to deal with those who regularly abuse the health care system? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)
- The focus of our health care system should be on trying to prevent disease before it happens? (strongly disagree = 0, disagree = .33, agree = .66, strongly agree = 1)

How supportive are you of the following? Do you strongly support, support, oppose or strongly oppose

- Encouraging the creation of private user pay health clinics in the province? (strongly sup-

port = 0, support = .33, oppose = .66, strongly oppose = 1)

- A universal health care system where all Canadians are guaranteed the same level of access and level of service (strongly support = 0, support = .33, oppose = .66, strongly oppose = 1)

- A more community-based and home-based health care system (strongly support = 0, support = .33, oppose = .66, strongly oppose = 1)

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