

Health Reform and Wait Times Policy in Alberta under the Klein Government

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Abstract

Precipitated by significant expenditure reductions in health care, wait times for surgical and diagnostic procedures in Alberta increased significantly during the 1990s. In turn, this made access to health services a major political concern. Within this context, the interplay of ideas, interests and institutions led political decision makers to opt for the development of an Internet-based, voluntary wait times registry. Bureaucrats played a crucial role in assisting politicians to understand that the policy issue required a more nuanced response than simply throwing money at the problem.

Introduction

Over a period of eight years (1995-2003), the Government of Alberta responded to the issue of wait times for major diagnostic and surgical procedures in a variety of ways: infusions of short term money to address immediate pressure points (a general approach to dealing with health care); public opinion surveys; the creation of a branch within the Ministry of Health to deal specifically with the problem and the introduction of a voluntary, electronic, wait-time registry. In this case study, we examine why Alberta ultimately chose to introduce the voluntary wait-time registry. Thus, the research question for this case asked why Alberta established a voluntary waiting list tracking system and not a centralized or decentralized waiting list management system?

This case study is one of six developed in Alberta as part of a cross-province study on the determinants of health reform in Canada. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content (Lavis, Ross, Hurley et al,

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2002). The case study around wait times is an example of the third category, where the policy issue relates to changes in how health care is delivered.

Pertinent documents and public records (e.g., government reports, secondary literature, media, Hansard) were reviewed to establish the background for the case study. These information sources were complemented with a number of semi-structured interviews with key informants. The data were analyzed using a coding framework developed from the literature that focused on key institutional, idea, and interest group concepts, as well as important external events that may have impacted on or shaped the policy making process.ⁱ After providing an historical overview of the basic chronology of events, we will examine the case in greater detail within the context of the conceptual framework.

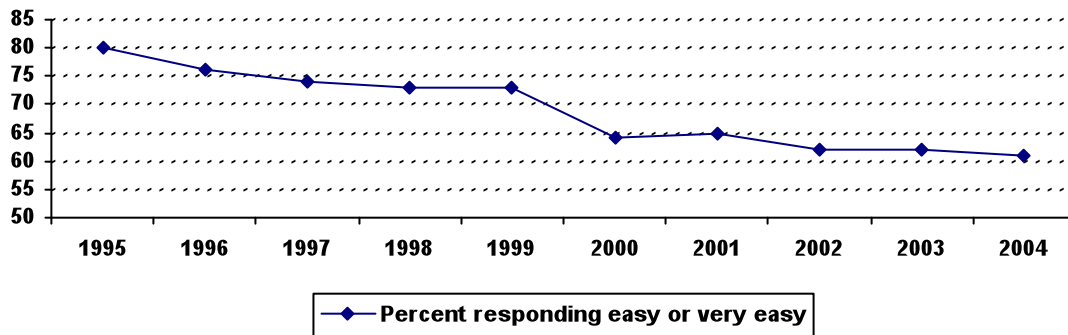
Historical Overview

During the 1990s, Albertans became increasingly concerned with access to health services (Virani, Kanji & Cooper, 2000). This concern was reflected consistently in annual public surveys commissioned by the Government of Alberta beginning in 1995. In particular, the public worried about access to major joint replacements, heart surgeries, diagnostic procedures such as MRIs, long term care, emergency rooms and family doctors. In this study, we look only at government policy response related to the first three of these health care services.

Wait times are not a recent phenomenon; however, they were pushed to unprecedented levels in Alberta as a consequence of the substantial health care funding cuts of the early to mid-1990s. A 13% reduction of expenditures between 1993 and 1995 (CIHI, 2004), coupled with the introduction of health regions, resulted in a significant downsizing of the acute care sector. For example, short-term care beds were reduced from 4.8/1000 persons in 1986/87 to 2.8/1000 persons in 1994/95, or a 35.4% reduction (Tully & Saint-Pierre, 1997); some facilities were closed entirely. A by-product of these major changes was increased wait times for a number of surgical and diagnostic procedures.

Albertans have consistently ranked access as their number one concern, "Accessibility to Alberta's health care system is the key factor associated with the ratings of the quality of the system." (HSUOC, 2003).ⁱⁱ Since the advent of regular annual public surveys in 1995, ratings on ease of access have shown a consistent decline. As Figure 1 demonstrates, the public grew increasingly concerned with access after the introduction of health reforms, with a notable increase in concern (i.e., a drop from satisfaction levels in the mid 70%-range to the mid 60%-range) during the height of the debate on privatization (1999-2000). By this time, physicians and the public were alerting the government and the health regions through correspondenceⁱⁱⁱ and surveys. Shortly after initial survey data was released, the Premier's Office became interested in the issue and held meetings with department staff.

Figure 1: Percent of Albertans reporting access to health care as “easy” or “very easy”, 1995-2004



Source: Alberta Health, *Public Surveys about Health and the Health System in Alberta*, 1995 through 2004.

Other sources of information also contributed to placing wait times on the government policy agenda. Consistently negative press put increasing pressure on government to respond (Esmail & Walker, 2003; Hansard, August 15, 1996; Committee of Supply, August 19, 1996, p.p. 2223-24, 2232). The annual Fraser Institute review of wait times in Canada received coverage by Alberta’s major media regularly from 1993; it was a source of many critical headlines (see Figure 2).

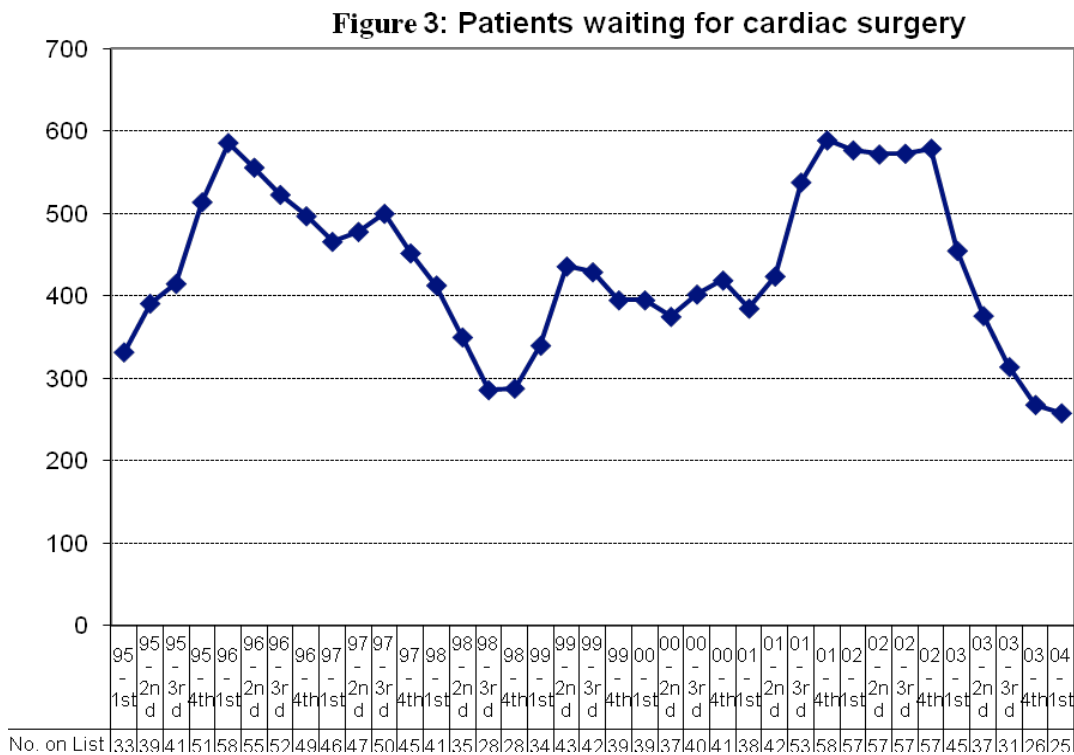
Figure 2: Media Coverage of Fraser Institute Wait Time Reports

Year	Paper and Date	Headline
1994	CH Aug 17	Canadians face long waits
	EJ Aug 18	Waiting-list report called ‘misleading’
1995	CH Jun 28	Surgery waits grow shorter
1996	CH Aug 1	Albertans on longest waiting list
	EJ Aug 2	Waiting list stats wrong, Jonson says; ‘Problem already recognized’
1997	EJ Jul 26	Albertans waiting longer for hospital treatment; Waiting lists don't tell the real story, warns economist
	CH Jul 26	Alberta patients waiting longer: survey: Provincial health officials claim report is flawed
1998	CH Aug 13	Wait for specialists gets longer: survey
1999	EJ Sep 16	Albertans wait longest for MRIs, brain surgery
	CH Sep 16	MRI wait list worsens: survey
2000	CH Oct 12	Hospital wait times lengthen to 14 weeks
2001	CH Sep 26	Health care delays grow: Survey finds waiting lists surging in last two years
2002	CH Sep 19	Surgery wait-lists lengthen: Median wait 17.5 weeks in Alberta
	EJ Sep 20	Albertans have longest waits in Canada for heart surgery -- study: Capital Health disputes study's data collection, points to survival rates
2003	CH Oct 21	Health care delays growing
2004	CH Oct 20	Patient waits up 8 weeks since '93
2005	EJ Oct 19	Patient wait lists still long despite infusion of cash:

Published wait time data: Heart surgery

Cardiac surgeries in Alberta are delivered in two centres: Edmonton and Calgary. Doctors in these areas had previously been gathering information for their own needs, so it was readily available. In July 1995, Capital Health (the Edmonton-area regional health authority) began publishing data on both wait lists (number) and wait times (average length in four categories of urgency) for heart surgery. Data was reported back to June 1994, the effective date of health system regionalization in the province. The data showed a lengthening wait list (16% larger in June 1995 compared to a year previous), though time to treatment remained comparable (Capital Health Authority, 1995, graph). This data was presented as performance measures, though explicit targets were not indicated. The Calgary Health Region did not begin to consistently include data on heart surgery wait lists and wait times until 1997/98. Capital Health continued to report publicly on wait times and a variety of other performance indicators through these reports until 1998.^{iv} Because the report was publicly accessible, the information received press coverage and focused significant attention on cardiac procedures.

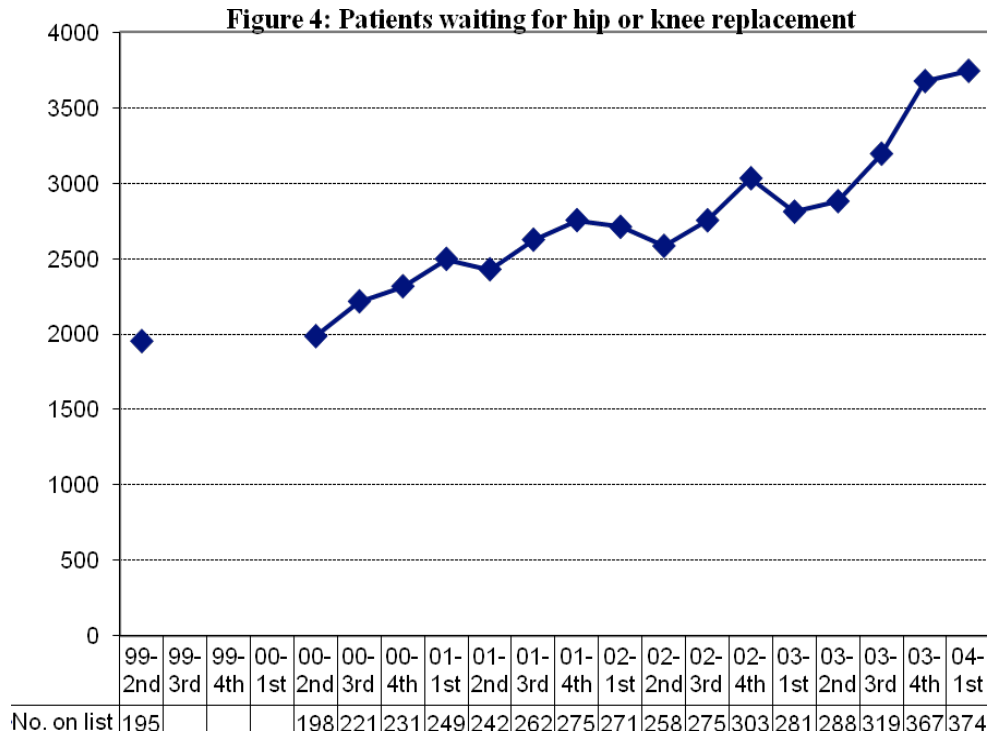
Starting with its 1996/97 Annual Report, Alberta Health began publishing its own information on quarterly cardiac surgery waiting lists in Alberta (with combined data from the Capital and Calgary Health Regions). This information was included in performance indicator publications targeted to a general public audience after November 2000 (see Figure 3).



Source: Alberta Ministry of Health and Wellness Annual Reports, 1996/97 to 2003/2004

Published data: joint replacements and MRIs

Available data on waits for joint replacement surgery (see Figure 4) was much sketchier than that for heart surgery. Initially, Capital Health contacted orthopedic surgeons’ offices to get a rough estimate of how many patients were on their lists. Capital Health’s 1994/95 performance report included data collected in May 1995 from a sample of patients currently waiting for treatment; it took until 1996 to have a system in place for reporting average wait lengths. Similarly, provincial data reporting was slow to emerge. Alberta Health published data on joint replacement wait times in its annual reports from 2002/03. Data initially included Calgary, Edmonton, and the Palliser, East Central and Mistahia RHAs.



Source: Alberta Ministry of Health and Wellness Annual Reports, 1997/98 to 2003/2004

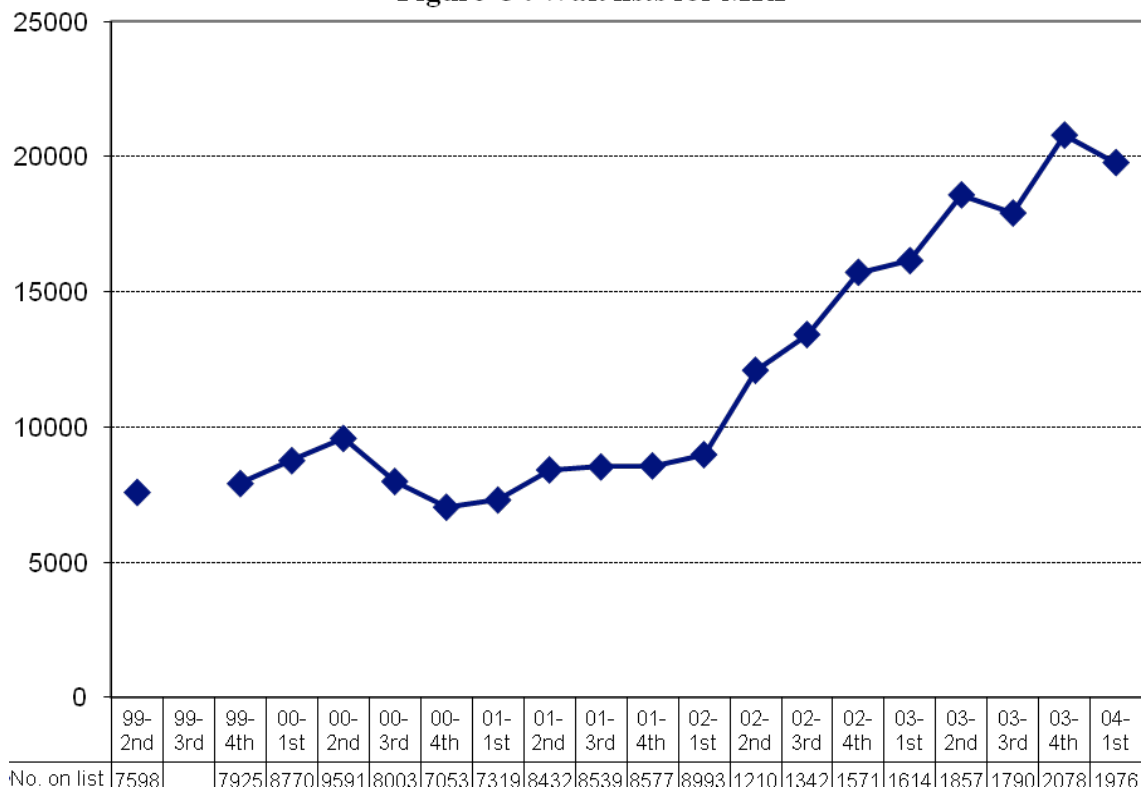
Capital Health began to present data on waits for MRI in late 1995, with data retroactive to January of that year. Again, province-wide data was slowly pulled together from the 5 regions that offered MRIs [Capital and Calgary; Chinook from July 1999, DTHR from April 2000, Mistahia from January 2001], with wait lists published by Alberta Health in its annual reports starting from 2000/01 (see Figure 5).

Initial Government Response

In response to the mounting public pressure and the growing evidence about the issue, an additional \$11.4 million in supplemental estimates funding to cut wait times for cardiac and joint replacement surgery and MRI testing was announced by the Premier during a televised

address (January 29, 1996). Then-Minister of Health Shirley McClellan referred to this as “a one-time investment in a set of programs that have been facing unusually high demand in the last few months. (Alberta Health, press release, January 30, 1996). Despite this claim, announcements of additional “unplanned” infusions of money into the health system seemed to recur about every six months from 1997 through to 2001. The exception to this pattern was the infusion of additional money in June, July and August of 1996. In total, the Government would eventually reinvest more money than it had actually removed during cut backs. Wait times for heart surgery did drop off significantly shortly after the infusion of this cash, although eventually they would rise again (see Figure 2). Most of the early attention on “hips and hearts” was issue specific and reflected a continuing lack of understanding of the systemic nature of the problem.

Figure 5 : Wait lists for MRI



Source: Alberta Ministry of Health and Wellness Annual Reports, 1997/98 to 2003/2004

In March 1996, Premier Klein and Lyle Oberg (a physician MLA), proposed a Health Charter that would guarantee Albertans access to key health services such as heart surgery and hip and knee replacements within defined periods of time. This was widely seen by the media as “one of the key planks of the party’s re-election platform” (Arnold, 1996). When the Charter was rejected by delegates at a Conservative party policy convention in September 1996, the government was perceived to be scrambling for an alternative proposal. This perception led to increased funding for province-wide services in the two major centres, and the November 1996 “Action on Health” program. ^v The announcement of the program and related funding preceded the provincial election which occurred in the spring of 1997. Public concern over health cuts, however, did not

prove to be a political problem for the government, as the Conservatives were re-elected with a larger share of both seats and popular vote.

While the initial reaction to public concern over the issue of access was the infusion of additional money, a more fundamental underlying issue began to emerge. As health regions evolved, decision makers at both the regional and the provincial levels began to see wait times as a systemic problem. Underpinning the problem was the lack of good data on the nature and extent of wait times. During public consultations in 1997, the Provincial Health Council of Alberta^{vi} noted that “concerns were expressed about the effect of health reform on the health of Albertans -longer waiting lists, fewer specialists, etc.” (PHCA, 1997, p.10). However, the Council continued, it had “been unable to find province-wide information on waiting lists for specific procedures and the effects of waiting on people who require health services.” (PHCA, 1997, p.14)

As the underlying issue about data reliability surfaced, Alberta Health responded through the creation of a specific unit to address the issue – Standards and Measures Development – under a newly created departmental branch.^{vii} Initially, Alberta Health argued that focusing on wait times, a conceptually “messy” problem, was not a good idea. Developing a better understanding of the problem by accessing existing data or creating new means of acquiring data was a necessary first step.

The issue of wait times was nested within the larger frame of access, which was itself part of the discourse on quality in health care as defined through a 1998 discussion paper entitled Health and Health System Expectations and Measures. (Alberta Health, 1998). As reported by the Provincial Health Council, the paper was introduced as one of the essential next steps in “furthering the accountability and continuous improvement in Alberta’s health system...for purposes of obtaining feedback on a proposed framework including six quality dimensions; criteria for setting priorities for the development of expectations and measures; roles and responsibilities of the various parties involved; and, processes to be followed in taking next steps” (PHCA, 1998, p. 13).^{viii}

While initially the issue of access had been associated with the impact of expenditure reductions in health care and the introduction of health regions, as health reforms unfolded and money was “reinvested” in the system, public concern began to focus on repeated musings from the political executive about increased opportunities for delivery of publicly-funded health care services by private providers. In part, this was seen by some politicians and private interests as a means of addressing growing wait lists. The strength of this sentiment was most clearly expressed in 1998 through the introduction of Bill 37 and the subsequent revised version, Bill 11, passed in 2000 (Church and Smith, 2006). In debate surrounding Bill 11, the Premier expressed the underlying logic of privatization as it related to the wait list issue:

“the Calgary regional health authority announced that it was contracting out for the services of privately operated MRIs. They’re doing this to reduce waiting lists and to make it easier and more accessible for people who need MRIs under insured services to get there much quicker.” (Hansard, March 6, 2000, 499-500)

The Leader of the Official Opposition challenged the government’s logic:

“why is the Premier of this province saying that private hospitals will be reducing waiting lists when the president of the 1,700-doctor medical staff in Calgary says that it will not reduce waiting lists?”(Hansard, March 6, 2000, 248-249).

The debate over privatization in health care would dominate the government agenda in health care until after the passage of legislation in March 2000. Nonetheless, concern over access and the related issue of wait times began to receive increasing formal recognition. For example, the 1999 Throne Speech identified improved services for surgeries and diagnostics as one of the priorities in health (Legislative Assembly of Alberta, 1999). One month later, the release of the Final Report and Recommendations from the Health Summit (Alberta Health and Wellness, April 1999) acknowledged waitlists as a continuing issue of importance.^{ix} In the Government’s response in 2000 – the Six Point Plan -- Point One called for “improved access to quality funded services,” and was backstopped by \$482 million in new money in the Health budget and an additional infusion of targeted money to reduce wait times in April, May and June.

In August 2000, the Government established the Premier’s Advisory Council on Health, PACH (i.e., the Mazankowski Committee), to provide advice on vision, strategic framework, approaches and sustainability. Once again, an underlying theme of the report was access to health services. The underlying issue of reliable and comparable data, previously publicly acknowledged through the 1997 Provincial Health Council public consultations, was re-emphasized in Mazankowski: “Although we frequently hear stories of long waiting times, the reality is, we don’t have reliable and consistent information on waiting times” (PACH, 2001b, p. 1). Mazankowski recommended implementation of centralized surgical bookings, an electronic internet registry of wait times information, and 90 day “care guarantees” for major procedures. While the notion of care guarantees was ultimately abandoned, in 2003, the Government announced plans to implement a voluntary electronic wait list registry. Pilot projects for some centralized booking, e.g., in orthopedics, were subsequently launched.

Having outlined the case in general terms, the remainder of the paper will address the role of institutions, ideas and interests in shaping the policy choice.

The Role of Institutions

The withdrawal of significant resources from the health care system in a relatively short period of time (1993-1995) had a number of relevant impacts. First, the devolution of responsibility for service planning and delivery to health regions and the subsequent significant reduction or elimination of staffing in many program areas left the Ministry with little capacity or expertise about the day-to-day workings of the health system. Very few people were left who had a detailed understanding of either the clinical or operational management aspects of the system (Church and Smith, 2006).

Between 1994 and 2004 a total of eight Deputy Ministers were rotated through the department. Several reorganizations of the department also occurred. After 2000, when the entire senior executive was replaced, corporate memory and expertise in health policy became a significant problem, although senior executives and politicians were now more on a par in terms of detailed knowledge and thinking about the system. However, the department was preoccupied with reorganizing rather than dealing with issues.^x

This reduced capacity created a perception, if not a reality, that department staff were no longer knowledgeable about the operational aspects of health care. At times, this reduced capacity within Alberta Health led to over-simplistic views about issues and the possible solutions. Having said this, the creation of the Standards and Measures Branch in the late 1990s allowed Alberta Health to build new capacity around the wait times issue.

Outside of the Ministry, the reorganization of governance and management structures to create regions meant that a large cadre of senior hospital managers (e.g., CEOs) was eliminated. In general, the loss of experienced personnel throughout the system reduced the capacity of the system for quality assurance,^{xi} management and clinical service delivery. However, as resources were brought back into the system, the regions were able to acquire the necessary expertise to better address issues such as wait times.

Second, the withdrawal of resources (e.g., lay-offs of nurses and other essential personnel) resulted in the closure of hospital beds, and exacerbated wait times for diagnostic and surgical procedures (particularly elective procedures), primary care and emergency room visits, and access to long-term care beds beyond what was considered acceptable by providers or the public. One final challenge initially created by regionalization was the way in which boundaries were drawn.

A review of health region boundaries in 1997 noted that a number of the existing regions exported large numbers of patients to the two biggest regions (Edmonton and Calgary), but did not transfer equivalent resources: "It is extremely important from an economic, administrative, planning and patient care and access perspective that the boundaries of the RHA should properly reflect the hospital service boundaries of the region it actually serves." (Plain, 1997, p. 3)

Although the expenditure reductions did create a shortage of resources related to wait times, the introduction of regional structures also had the effect of allowing the problem to be understood in a new way. Where under the old system, the existence of wait times was only understood at the level of individual physicians or facilities, the introduction of regional governance and service delivery structures facilitated recognition of the problem as systemic in nature.^{xii}

Federal-Provincial Relations

At the federal level, several initiatives impacted on the Alberta approach. First, in 1996, the National Forum on Health recommended a transition fund to facilitate health reforms. In addition to recommending a transition fund, the Forum also identified quality and equal access as top public concerns, and the lack of a national health information system to facilitate evidence-based decision making and quality assurance. According to the National Forum on Health (1996), the recognition of the need for national health information systems stemmed from the earlier National Task Force on Health Information (which reported in 1991).

Second, the introduction of a federal Health Transition Fund (announced in the 1997 federal budget) provided a window of opportunity for an initial response (Western Canada Wait List project) to the wait time issue. The WCWL itself had little direct impact on policy responses to

the wait times issue, at least initially, although it may have bought governments time by allowing them to say the issue was being studied.

Finally, the release of the federal paper entitled, *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money*^{xiii} in 1998 brought attention to the issue from several directions and tended to galvanize opinion that something needed to be done.

In September 2000 (a year before the release of the Mazankowski Report), the First Ministers signed the *Communiqué on Health*^{xiv}, which called for reporting Comparable Health Indicators on agreed-upon areas within two years. The Performance Indicators Reporting Committee, a federal-provincial committee chaired by Alberta, spearheaded the initiative. Aside from recognizing that Alberta had significant issues, there was a larger issue of rationalizing information to arrive at common wait times for 14 jurisdictions, which could then be reported back to Canadians.

The Role of Ideas

While the concern about wait times emerged as a public issue, there was a concern within government that accountability measures needed to be developed and enforced to avoid slipping into a pattern of simply throwing money back into the system. Alberta Health had been working on developing an accountability framework and measures since the early 1990s (pre-regionalization). As early as 1989, the Department of Health (as it was then called) developed an internal discussion paper “to provide a common basis of understanding to facilitate a discussion of ‘accountability’ and ‘accountability mechanisms’ among a variety of players within the Department of Health.” (Gardner and Russell, 1989, Executive Summary) Some of this preliminary internal thinking was shared with other jurisdictions through the Minister’s speech at the F/P/T Conference of Health Ministers in September 1989.

In 1991, the way to achieve accountability included:

“planning for health services based on identified needs, goals and outcomes; enhancing health information that will assist in monitoring and evaluating the health system; increasing provider responsibility and accountability in managing resources; and facilitating consumer choice and responsibility in health resource utilization” (Alberta Health, 1991, p. 1).

Within this context, “measurement and reporting may range from on-going monitoring and quality assurance to large scale, periodic program evaluations and audits” (Alberta Health, 1991, p. 2).

By 1993, Alberta Health was contemplating defining accountability relationships among health providers, the Department and Government and drew heavily on the earlier concepts of accountability mechanisms and measurement. Thus, the arrival of business planning and annual performance indicators, as part of the reform process, was a natural progression in the Ministry’s thinking that dovetailed with the political agenda of the day (Goodkey, 2001; Peach, 2004). The bureaucratic idea of accountability was politically attractive too and aligned with the conservative philosophy.

The focus on fiscal accountability during and after initial cutbacks, and the introduction of devolved funding for health regions, necessitated some form of accountability measures. Business planning and performance targets began immediately after the introduction of health regions. Although initially fairly crude, a range of standard performance indicators, including some for wait times, was developed. In a more general sense, the passage of the Government Accountability Act and increasing interest in accountability by the Auditor General confirmed the direction in which the Department had been heading for some time. Having said this, the extent to which accountability was enforced by the Ministry remains debatable. In the case of the two largest health regions, the Ministry appears to be willing to fund whatever the regions propose, with little close scrutiny of efficiency and effectiveness at the program level.^{xv}

Accountability itself was tied to the reliable data issue in that meaningful accountability measures could not be developed until government could access reliable data. Although the idea of a registry was discussed within the bureaucracy at an early stage, the underlying data requirements precluded any serious consideration.

The Role of Interests

Bureaucrats and Elected Officials:

During the 1990s, the relationship between health bureaucrats and elected officials was transformed. Previously, particularly during the tenure of Nancy Betkowski, the relationship of the department officials and the Minister was largely positive. With the arrival of Ralph Klein as Premier, a growing level of distrust by the political executive of the motives of bureaucrats generally, and health bureaucrats in particular, surfaced. The thinking at the time was that bureaucrats and other experts – “knowledge workers” - had become too powerful and needed to be reined in by the politicians, who, after all, had been elected to make decisions on behalf of the public (Taras and Tupper, 1994). The depth of mistrust of Alberta Health officials became increasingly apparent throughout the 1990s, as the department constantly found itself in hot water with the Premier’s Office over the policy advice it offered. Ministerial statements or Department announcements were often contradicted by public statements from the Premier.

This increasingly chilly environment was punctuated in 2000 with the dismissal of the entire level of senior management, in the wake of the passage of the privatization legislation (Church and Smith 2006). When combined with the significant downsizing that had occurred as part of expenditure reductions and the continuous changes in department leadership and structure, department officials operated in a highly uncertain environment. Under these circumstances, the major challenge for bureaucrats was to determine how best to brief elected officials on the complexities of the issue, to get them beyond simply throwing money at the problem.

Although facing these significant challenges, the Ministry was instrumental in the initial and subsequent framing of the wait times issue and the resulting policy learning that occurred among elected officials. Bureaucrats were also instrumental in developing the policy tools that would support the eventual decision to develop a voluntary electronic registry.

The primary response from politicians to the issue was to allocate additional money during periods of increased public pressure (when lists grew beyond what was publicly acceptable). In part, this reflected a somewhat simplistic understanding of the issue. Politicians perceived the

issue as one of a shortage of money resulting from expenditure reductions. From the politicians' point of view, if money is the issue, why won't putting money back into the system fix the problem? For politicians, the infusion of money was something that they could do fairly quickly and visibly, a policy lever that they had not given away to health regions.

Given that politicians often reflect the views of their constituents, who in turn may have a simplistic view of the system, and that a major source of information for politicians on this issue was letters from constituents and media coverage, failing to grasp the complexities of the issue is not entirely surprising. This tendency was reinforced by the portrayal of the issue by the Official Opposition and the third party in the Legislative Assembly. Even the thinking around the electronic registry solution remained somewhat simplistic, not unlike approaching the check-out line at the grocery store and choosing the check-out clerk with the shortest line because access to the service would be faster and the quality would be the same. The early thinking on this is apparent in comments made in 1995 by the Minister of Health:

"We do encourage people, if they are waiting a long time, to ask their surgeon if they might consider referring them to someone else with a shorter waiting list or that they look at perhaps having that procedure done in another area."
(Hansard, May 3, 1995, 2197-98.)

Although the perspective of elected officials did appear to be overly simplistic, policy learning did occur as increased infrastructure was devoted to the issue. For example, by 1997, the Government response began to shift to talking about the establishment of performance measures and standards: "we are establishing standards to make sure that waiting lists are brought to, generally speaking, medically required or accepted limits" (Hansard, April 30th, 1997, 286). This links to the work on accountability and performance measures that had been ongoing in Alberta Health, as part of the overall business planning process that had been adopted across government.

By 2000, the response indicated a growing understanding by the Minister of Health of the underlying complexity of the issue:

"there are a number of different inputs that will help us reduce waiting lists: the people - that is radiation therapists in this case-equipment, and of course places for these people to work. People, plant and equipment are the three inputs that have helped reduce waiting lists in this province"(Hansard, November 16th, 2000, 1942).

In 2002, the Government appeared to have fully grasped the underlying human resource issue:

"over the last eight years we've doubled our health care budget to some 7.3 billion dollars...and notwithstanding these significant amounts of investment in health care, there continue to be issues with respect to access. Now we've said all along that money alone will not solve the access issues. There are a number of different solutions that need to be taken in tandem in order to have an effective solution. We have worked with the Department of Learning in terms of increasing the number of seats relating to health care professionals in our province. (Hansard, May 15th, 2003, 1673)

In some ways, the Mazankowski recommendations built onto the internal work that occurred in the late 1990s. For example, by the time Mazankowski arrived, targets had been developed for breast and prostate cancer and four categories of cardiac surgery. Mazankowski expanded this to 20 procedures and added the 90 -day guarantee. However, the Mazankowski Committee operated independently of the Ministry, reporting directly to the Premier's Office, and the emerging recommendations were based more on representations from major stakeholders and a review of experience in other jurisdictions (Sweden and New Zealand) than on Ministry input. The Ministry became more involved when recommendations had been made and the focus shifted to implementation feasibility.

Physicians:

Individually, doctors influenced decision making in a number of ways. First, as previously mentioned, a large number of letters from the public were received by both Alberta Health and Wellness and the Health Regions. The wording of these letters -- "I was speaking with my physician and he suggested I write to you about wait times..." -- indicated that patients and physicians were interacting with each other on the issue. Second, some physicians had unprecedented access to senior government officials, including the Premier's Office, and thus were able to bring their concerns directly to the attention of the most important decision makers. Third, local specialist groups were directly involved in the development of regional wait time registries. In some parts of the province, these specialists resisted involvement in any efforts to develop standardized wait lists. They didn't want to provide their wait times data to the region and the regions were very reluctant to use their authority.

At the regional level, in late 1996, the Capital Health Medical Staff produced a report documenting a variety of "problem areas", including "access to care and resources" and "quality of care". Within this, "long waits" were identified for specialist referrals, pediatric rehabilitation, audiology, orthopedic surgery, emergency rooms and other procedures. Many of these wait time problems were attributed to shortages of staff and resources (Region Ten Medical Staff, 1996). In essence, the medical staff report highlighted the complex nature of the problem. People who were on a list (planned) began to experience longer wait times because there were not sufficient resources (human or operating room time) to deal with the entire list.

In particular, a shortage of trained nurses as a result of layoffs, closure of the post graduate program in cardiovascular nursing and workload issues on individual units may also have contributed to the issue. Ultimately, the biggest bottleneck in the system occurred around the shortage of properly-staffed patient beds. Calgary had different capacity issues than Edmonton because it eliminated some physical facilities (literally blew them up). However, even Edmonton, which had converted patient rooms to offices, could not reopen closed beds without sufficient nursing staff.

Collectively, the medical profession focused attention on perceived problems with wait lists by regularly commissioning or conducting their own surveys to gather evidence on the point. For instance, "a 1996 national survey conducted by the College of Family Physicians of Canada showed that general practitioners were also concerned about the effects of waiting on the health of their patients" (College of Family Physicians of Canada, 1996). Almost 70 percent of family physicians felt that the waiting times their patients were experiencing were not acceptable" (cited by Esmail & Walker, 2003, p. 27). A 1997 CMA poll found that nearly two-

thirds of respondents felt that waiting times for surgery had grown and half felt access to specialists had become more difficult; these figures had grown from 53% and 40% respectively just one year before – a growth of approximately 20% and 25%, respectively (Sanmartin et al, 2000). When challenged in the Legislature on the implications of this report, the Minister agreed that wait lists were of concern to Albertans, and cited the government's efforts to bolster funding for both RHAs and province-wide services (Hansard April 30, 1997, 286).

The Alberta Medical Association produced its own survey data based on the perceptions of physicians and the public. The survey of physicians:

“revealed lengthy waits relative to what was defined as a reasonable wait for numerous urgent services, tests and procedures in the specialties of psychiatry and cardiology. Additionally, it was common for one or two services among the other specialty groups surveyed to have waits greater than three times the length of the reasonable waiting period noted by the specialists...Long waits for urgent access to magnetic resonance imaging (MRI) were of universal concern”(AMA, 1998, p.4).

In the survey of patients, “more than 80% said they had to wait for the health services they needed and too often their condition worsened while they waited” (AMA, 1999, p.2). Underpinning the survey data was a large inventory of qualitative statements from patients about their negative experiences with access to health services.

Individual physicians with requisite expertise were consulted by Ministry officials on an ongoing basis. A more formalized structure, the Provincial Advisory Committee on Cardiovascular Surgery, which had existed prior to regionalization, was later reconstituted in 1997 as part of the province-wide services initiative. The province-wide services initiative was undertaken to determine appropriate funding levels to reduce wait times for “critical procedures such as cardiac surgery.”

Subsequently, when Alberta Health began to look at a much broader range of performance indicators (post- Mazankowski), an Access Standards Committee was struck, including representation from the College of Physicians and Surgeons, the Alberta Medical Association, the Alberta Association of Registered Nurses and the health regions.

Overall, the various avenues through which Alberta physicians, both individually and collectively, influenced political decision making on the wait times issue mirrored to a significant extent the description of the profession in Canada presented in 1960 (Taylor, 1960).

Mazankowski Report

The issue of wait times was brought into much sharper focus through the Mazankowski report. The Report emphasized that “in spite of significant investments in the past few years, waiting times for selected services continue to be too long and people worry that the health system may not be there when they need it” (PACH, 2001a, p. 21). In identifying access as a major public issue, the report cited Alberta Health and Wellness statistics on waits for cancer treatment, open heart surgery, joint replacement, ER, MRIs, and access to GP and specialist services: “access to health care services and waiting times are people's number one concern with the

health system” (PACH, 2001a, p.21). Similar to what the provincial Health Council had said several years earlier, Mazankowski described wait lists as complex and not comparable across regions, leaving “most people confused by waiting lists” (p.19). The last point suggested the need to develop a solution that would better educate the public. Ninety-day care guarantees, centralized booking and posting wait times on the Internet were recommended as ways of addressing the problem (PACH 2001a, p. 43).

The following rationale for the posting of wait times was provided:

“Instead of waiting on an *unknown* [our emphasis] list, patients would have access to waiting times for selected procedures for each hospital and each physician in the province. People could check the website, then could consult with their family physician about getting referred to another physician or facility in their region or in another region with shorter waiting times.”(PACH, 2001a, p. 44)

The source of thinking about this approach seemed to stem from experience in several international jurisdictions, especially Sweden. In particular, a study of the use of the Internet to “empower” Swedish consumers in the area of waitlists, commissioned by a think tank in Manitoba, seems to have influenced the thinking about an Internet-based registry and its purpose; this was one of the very few references cited by Mazankowski (Hjertqvist, 2001).^{xvi}

The notion of a 90-day care guarantee emerged through a discussion about how to develop some measurable outcomes that could then be used to hold health regions more accountable for what they were contracted to do. However, the concept lost its lustre once the potential political and legal ramifications of care guarantees became more apparent. In addition, government did not want to commit to access standards because of a lack of data on the costs associated with meeting these standards. In addition, it was recognized that there will always be individuals who can't be treated within the desired time frame. Over time, the language shifted, with care guarantees being softened to access targets. The number of procedures for which targets have been developed was also narrowed, in part because of the practical necessity to start somewhere.

Other Jurisdictions

Diffusion of policy innovations across provinces also impacted on the choice of policy options in Alberta. In deciding on which specific approach to choose, Alberta looked at other jurisdictions and opted for the British Columbia approach to the on-line registry. Alberta learned from BC that the technological solution was relatively straight forward. The bigger challenge lay in building consensus among major stakeholders about implementation of the solution. In this respect, the major difference between BC and Alberta was that BC had taken five years before it started posting wait times, whereas Alberta was expected to be up and running in 18 months. BC had also hired physicians in-house to work with practitioners to manage wait times, something Alberta did not do.

The Ontario Cardiac Care Network was one of the earliest examples of developing wait time indicators around specific procedures. Thus, when Alberta began to produce reports for the Minister on cardiac wait times, they often went on the Ontario website to do some comparisons

with the targets that they had set. The early work of the Cardiac Care Network in Ontario and subsequent work by WCWL on wait time indicators served as the basis for the access standards (prioritization protocol) developed around coronary bypass grafting, one of the first set of guidelines announced by the Ministry. As early as 1996, the Review of Province-wide Health Services in Alberta had cited the cardiac waiting time standards developed by David Naylor, the Director of the Institute for Clinical Evaluative Sciences in Toronto (Alberta, 1996, Appendix 4).

Policy Choice

As mentioned in the background discussion of this case, Alberta Health had argued initially for a focus on the availability of meaningful data and the development of targets, rather than other possible focuses, such as care guarantees. This thinking resonated with political decision makers because of their concern with the issues of quality and access. From this approach emerged a better understanding of the problem and the eventual decision to develop a voluntary provincial wait times registry. As the previous discussion of the legislative debate over several years suggests, the work of the department undoubtedly contributed to the increased recognition of the complexity of the issue and the nature of the solutions – increased human resources and plant.

Inherent in the decision to create the voluntary registry was the underlying political culture assumption that government policy should avoid being exceedingly coercive or prescriptive. In other words, government should seek voluntary cooperation from major stakeholders, rather than imposing a solution. This stems from two policy legacies. The first policy legacy is the “weak state” approach to health policy in Alberta (Boase, 1994). Historically, Alberta has been reluctant to adopt a state-centred approach to health policy (Church and Smith, 2008, p.224). For example, during the run-up to the introduction of national medical care insurance, the Social Credit Government under Manning led the opposition to the compulsory federal Medicare scheme (Barr, 1974, p. 135). The Government of Alberta made its position perfectly clear in its submission to the federal Royal Commission on Health Services:

“We believe that only by maintaining a system in which private enterprise and individual initiative and personal responsibility combined with whatever financial subsidization is required from society collectively, can the best interests of our people in the field of health be successfully and adequately served.” (Alberta, 1962, Submission, p. 4)

A residual view of the role of the state has since continued to permeate Alberta government thinking around social policy and health care reform. This emphasis is notable in major government documents addressing these issues (see Figure 6).

In the case of wait times, the personal responsibility theme translated into leaving patients with their choice of provider. The logic underpinning this approach was that even if they chose to wait longer to get the surgeon they wanted, they would be satisfied because they had the choice. In addition, this might be attributed to the rhetoric associated with the privatization debate, in that the government argued that privatization would give people more options for care while reducing wait times for services provided through public facilities. Again, the notion of choice appears to be deeply rooted in Alberta’s political culture, tied to the notions of

personal responsibility and an overall, “residual” approach to social policy (Bella, 1978: Guest, 1997).

Figure 6: Personal Choice/Individual Responsibility as a theme in Alberta government documents related to Health Reform

Source	Comment
Caring and Responsibility: A Statement of Social Policy for Alberta (1988)	“It is the role of the Alberta government to ... foster individual self-reliance and provide positive opportunities for individuals to achieve their personal goals, to take responsibility for their actions, and to be contributing and caring members of Alberta society.”
As reprinted in Rainbow Vol III, p. 63	
Rainbow Report --1989 Our Vision (Vol I, p. 6)	“Albertans will enjoy the privilege of choice, have the capacity to recognize that which is just and proper, and master the balance between individual right and societal good. Albertans will take greater responsibility ... we will exercise greater control ... we will be more accountable for our actions and personal well-being.”
Partners in Health 1991 Gov’t response to Rainbow Overview: The vision. p.8 Health Goals for Alberta: Progress Report 1993	“The health system of the future in Alberta will ... facilitate consumer choice and responsibility in health resource utilization.” The government’s vision for health “emphasizes the importance of taking more responsibility and being more accountable for our personal health and well-being”
As cited in Prov Health Council, Our Understanding of the Vision of the Alberta Health System, c. 1996 Alberta Health Planning Secretariat, <i>Starting Points</i> , December 1993	“Given the need to reduce health funding, it is imperative that new ways be developed to fund services. This should include consumers paying for those services determined to be non-essential ... consumer choice must be respected...the private sector should be allowed to provide services, if the services meet or exceed health standards.” “The future health system must be wellness-based. It must promote greater personal and community responsibility for health ...”
Alberta Health Three-Year Business Plan February 1994	
Preamble (p.3) Health Summit ’99 Final Report p.25	“Participants at Health Summit ’99 agreed that individuals have responsibilities in protecting and preserving their own health and they identified what those key responsibilities are. At the same time, there was a clear view that responsibility for health lies not only with individuals. It is a shared responsibility.” “Albertans are concerned about ... Giving Albertans more control and more responsibility for their own health.”
Mazankowski report --2001 Highlights (p.10)	

The second policy legacy relates to the original bargain between governments and organized medicine during the introduction of Medicare to protect professional autonomy (Lavis, 2002). As previously described, individual surgeons controlled their own wait lists and were not in all cases willing to surrender that information to the health regions or government. Given the boundaries placed on decision makers by these two policy legacies, two other options -- the notion of either *requiring* physicians to share data from their wait lists or establishing a system of centralized booking at the provincial level (Mazankowski) -- were not politically feasible.

At a more technical level, the choice of the voluntary wait-list registry was the result of the recognition that there was not consistent information on wait times for major surgical and

diagnostic procedures. For example, while Alberta Health did have good data in some areas, such as heart surgery, where only two hospitals in the whole province were providing the service and had been collecting their own data, in other areas, such as joint replacement and MRIs, where seven regions were doing joint replacement (in some cases at multiple sites), there was little consistency in how data was collected. The fact that data was non-standardized and controlled by various stakeholders in the system made a voluntary approach the most feasible.

Thus, the goal/purpose of the registry was to present standardized information in a way that decision makers and the general public could understand. In choosing to post wait times at the 90 percentile, instead of the average wait time, Alberta hoped to present a more accurate picture (especially to the public) of what actual wait times might be.

Most provinces have chosen to use the average wait time. Another key difference in the policy choice seems to be that Alberta's data covers the time from 'decision to treat' to received treatment, while other provinces' data covers the time from 'scheduling surgery' to received treatment.

From an implementation perspective, the political imperative was to make the information publicly available as quickly as possible, under the assumption that a public discussion would evolve. Thus, the policy choice was motivated by a desire to find something that was already developed and could be up and running quickly. In the end, the existing policy legacies and the technical constraints also shaped the overall strategy to addressing the issue of wait times prior to the choice of the voluntary registry. Decision makers hoped that an incremental approach would allow for policy learning while not upsetting major interests, especially physicians.

Conclusion

During the mid-1990s, the Government of Alberta became increasingly concerned with the issue of wait times. Although access to services is always an issue in health care, initial health reforms, which included significant expenditure reductions and organizational restructuring, contributed to increasing wait times for surgical and diagnostic procedures. The policy choice to introduce a voluntary, Internet-based wait list registry was influenced by institutions, ideas and interests.

The cut-backs that occurred between 1993 and 1995 created a shortage of physicians and nurses through lay-offs and decreased funding for post-secondary health sciences education. In particular, nurses who were essential to staff beds associated with surgery, were in short supply. The significant downsizing and reorganization of bureaucracy at the provincial and local level created a significant policy capacity issue, especially at the provincial level. The loss of human resources, organizational memory and policy expertise, meant that the ability of the government to respond to the issue in a meaningful way was delayed. As resources were reintroduced into the system, bureaucratic capacity at both levels was gradually restored, although provincial bureaucratic capacity has probably never been fully regained. Within this context, the relationship between provincial bureaucrats and elected officials had chilled significantly. In particular, the political executive exhibited a disdain for Alberta Health officials.

Although there was a significant level of distrust between these two interests, the bureaucracy did play a significant role in assisting politicians to better understand the issue because of two major prerequisite policy changes. The first, which was government-wide, was the emergence of

performance management during the 1990s. In health care, while initially politicians understood the issue as a shortage of money, provincial bureaucrats argued successfully that the issue was complex, including a lack of reliable and comparable data on wait times, a shortage of equipment, and a shortage of human resources. This fit well within a larger ideation context that was focused on business planning, quality assurance (outcomes measurement) and access, especially in health care.

The second major policy change, which was specific to health care, was the restructuring of health care delivery through regionalization. Through this, bureaucrats and politicians gained a new understanding of wait times as a system-wide issue. Thus, regionalization created a new policy lens through which bureaucrats and political decisionmakers could view an old policy problem.

As evidenced through debates in the provincial legislature and decisions made about resource allocation, both within the provincial bureaucracy and at the regional level, politicians did come to understand the complexities of the issue. Over time, the information available to politicians shifted from media reporting, polling and anecdotal letters from constituents, to performance measures on appropriate wait times developed by the bureaucracy through the experience of other jurisdictions and the increased integration of expertise from the department and the field. The drive to develop performance indicators stemmed both from the policy learning about the specific issue and the more general push by the Alberta Government to implement a business planning model, including measurable performance indicators at the departmental level.

Physicians played a significant role in shaping the final policy choice. Collectively, professional associations at the national and the provincial levels documented the extent of concern about the issue among the profession and the public. At the regional level, the medical staff in Edmonton documented the extent of problems with one of the two major health regions. This was supplemented by data on wait times publicly released by the health region.

At the individual level, physicians encouraged their patients to make the government aware of their concerns about access and wait times. Some physicians enjoyed unprecedented access to senior political decision maker. Of even greater importance, individual surgeons controlled the information on their wait lists. In some cases, they were not willing to surrender that information to either the regions or the provincial government. All of this underlines the nature of the core bargain between organized medicine and government that has been the basis of Medicare in Canada.

Within the historical political context specific to Alberta, for at least the past 50 years, the prevailing ideology shaping politics in Alberta has given preference to minimal government intervention in social policy, personal responsibility and choice, and a strong role for the private sector. All of these ideological elements were apparent in the case of wait times. The underlying logic of the registry was to provide all stakeholders, including patients, with accurate and understandable information. In turn, patients and/or their physicians would be able to make appropriate choices about the best way to access the necessary services. The voluntary aspect of the registry ensured that individual physicians were not coerced to surrender control over local information about wait-times. It also recognized the disparity in data collection capacity across different regions and around different surgical and diagnostic procedures. Finally, in taking a voluntary approach the Government avoided appearing overly interventionist. Activities

occurring in other jurisdictions provided Alberta with the necessary policy tools to respond within the boundaries of the various policy legacies and emerging contingencies with which political decision makers were presented. At the end of the day, the boundaries within which a policy choice could be made necessitated an incremental approach to policy development and implementation.

Endnotes

- ⁱ The framework is discussed in the introductory article to this special edition.
- ⁱⁱ As several study participants noted, access to services is always the number one issue. Any minister that ignores this, does so at their peril.
- ⁱⁱⁱ The character of the correspondence often suggested that surgeons were encouraging their patients to write to the government about the issue.
- ^{iv} Coincidentally, in 1998, the CEOs, board chairs, some board members and other senior staff were replaced in Edmonton and Calgary.
- ^v The Action on Health program continued the access framing, with its first key direction being “to ensure that all Albertans, young and old, have access to quality health services when they need them.” It noted that “Waiting times for critical services such as heart surgeries, joint replacements and specialized tests are too long” and promised additional funding. This was presented as a combination of money for staffing, specialized equipment, and general funding. The province appeared to argue that wait list pressures were due to diversion of funds to province-wide services at the expense of other needs, and so promised additional money for such services to reduce the ‘trickle-down’ effect. The new population-based funding formula was suggested to give RHAs the flexibility they needed to tackle remaining pressure points.
- ^{vi} The Provincial Health Council of Alberta was established in 1995 under ministerial Order #195/95 (Minister of Health) as a publicly nominated 16 member advisory body “to provide the Minister ... with advice regarding the performance of Alberta’s health system and the health status of Albertans, relative to the province’s health goals, the Alberta Health multi-year business plan and the regional business plan.”
- ^{vii} This occurred with the arrival of a new Minister and Deputy Minister.
- ^{viii} The six dimensions of quality, adapted from the work of the Canadian Council on Health Services Accreditation, are appropriateness, effectiveness, safety, efficiency, accessibility and acceptability.
- ^{ix} In subsequent Throne speeches after 1999, wait times would be mentioned as a priority.
- ^x In contrast, Saskatchewan had attempted to maintain its Ministry’s capacity, in part because they started with a large number of Districts (32), which themselves did not have much more capacity than the previous hospital boards. Thus, the ability of the Ministry in Saskatchewan to act in a more directive fashion on the wait list issue was enhanced.
- ^{xi} For example, prior to regionalization, a number of hospitals in the province were engaged in some sort of significant quality improvement initiatives, especially in major urban centres.
- ^{xii} One notable exception to this was a provincial cardiac care wait times committee that collected data on cardiac care. With the introduction of health reforms in the mid-1990s the group was disbanded.
- ^{xiii} Summary available at http://www.hc-sc.gc.ca/english/media/releases/waiting_list.html. This report served as a counter to the Fraser Institute reports.
- ^{xiv} This commitment was reiterated in the Feb 2003 Health Care Renewal Accord. The number of indicators was expanded, and grouped to reflect themes of the Accord. This work done by Advisory Committee on Governance and Accountability of the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, led by Alberta.
- ^{xv} Important to note here is that in 2008, Alberta consolidated the remaining nine regional health authorities into a single, province-wide, governance structure – Alberta Health Services.

^{xvi}This document was likely brought to PACH's attention by Council member Brian Crowley, who along with Hjertqvist was an advisory member of the pro-market Winnipeg-based Frontier Centre for Public Policy.

References

- Alberta. *Hansard*. May 3, 1995.
- Alberta Health. press release. January 30, 1996.
- Alberta. *Hansard*. August 15, 1996;
- Alberta. *Committee of Supply*. August 19, 1996.
- Alberta. *Review of Province-wide services.*, October 31, 1996,
- Alberta. *Hansard*. March 6, 1997.
- Alberta. *Hansard*. April 30, 1997.
- Alberta. *Hansard*, November 16, 2000.
- Alberta. *Hansard*. May 15, 2003.
- Alberta. *Submission to the Royal Commission on Health Services*, 1962
- Alberta Health. *Accountability in Alberta Health*.
- Alberta Health. *Health and Health System Expectations and Measures: A Consultation Paper.*, March, 1998.
- Alberta Health and Wellness. *Thinking About Health: Final Report and Recommendations*. April 1999.
http://www.health.gov.ab.ca/resources/publications/think_health/final_report.html.
- Alberta Medical Association (AMA). *Doctor's Asked Albertans to Talk About Health Care* (Brochure). 1998.
- Alberta Medical Association (AMA). *Executive Summary, Report of Findings: "Waiting for Health Care."* 1999.
- Arnold, T. (1996). "Cabinet eyes more cash for health," *Edmonton Journal*. October 8. A6.
- Barr, J. J. (1974) *The Dynasty: Rise and Fall of the Social Credit in Alberta*. Toronto: McClelland and Stewart.
- Bella, L. A. (1978) *The Origins of Alberta's Preventive Social Service Program*. Funded as a Welfare Research Project by Health and Welfare Canada.
- Boase, J.P. (1994). *Shifting Sands: Government-Group Relationships in Health Care*. Montreal: McGill-Queen's University Press.
- Capital Health Authority. *A Year in Review: Capital Health Authority Performance Report*. June 1994-June 1995.
- Canadian Institute of Health Information (CIHI), National Health Expenditures database, 2004.
- Church, J. and Smith, N. (2006). "Health Reform and Privatization in Alberta" *Canadian Public Administration* 49:4, pp. 486-505.
- Church J. and Smith N. (2008) Health care reform in Alberta: The introduction of regional health authorities, *Canadian Public Administration*. 51:2, 217-238.
- College of Family Physicians of Canada (1996). "Advocating on Behalf of Patients Survey." *News Release* (April 24).
- Esmail, N., & Walker, M. (2003). *Waiting Your Turn: Hospital Waiting Lists in Canada*. 13th edition. Vancouver, BC: The Fraser Institute.
- Gardner, L. and Russell, A. (1989). *The Concept of Accountability: A Discussion Paper*. Policy Development Division, Alberta Department of Health, MSS013U.RPT.29/RL r29/3/89.
- Goodkey, R. (2001). "The Alberta Perspective," in Luc Bernier and Evan H. Potter, eds., *Business Planning in Canadian Public Administration. New Directions*, Number 7. The Institute of Public Administration of Canada, 69-79.
- Guest, D. (1997). *The Emergence of Social Security in Canada*. Third Edition. Vancouver: University of British Columbia Press.
- Health Services Utilization Outcomes Commission Survey (HSOC) 2003, p. 37.

- Hjertqvist, J. "The Internet Empowers Swedish Healthcare Consumers, Waiting list info shapes patient choices." *Policy Frontiers Swedish Health Care in Transition*, Number 2. Winnipeg: Frontier Centre for Public Policy, May 2001.
- Lavis, J.N. (2002). "Political Elites and their Influence on Health-Care Reform in Canada," *Commission on the Future of Health Care in Canada*, Discussion Paper 26.
- Lavis, J.N., S.E. Ross, J.E. Hurley, J.M. Hohenadel, G.L. Stoddart, C.A. Woodward, and J. Abelson. (2002). "Examining the Role of Health-Services Research in Public Policymaking." *Milbank Quarterly*, 80(1). 125-154.
- Legislative Assembly of Alberta. *Speech from the Throne*, February 16, 1999.
- National Health Forum (1996). *Canada Health Action: Building on the Legacy, Volumes I and II*.
- Peach, I. (2004). "Managing Complexity: The Lessons of Horizontal Policy-Making in the Provinces," The Scholar Series, Saskatchewan Institute of Public Policy, 1-35
- Plain, R.H.M. (1997). Working Together: the Reform of Regional Health Authority Boundaries Within Alberta, Presentation to the MLA Committee on the Review of Health Region Boundaries, August 5.
- Premier's Advisory Council on Health (2001a). *A Framework for Reform*. (PACH)
- Premier's Advisory Council on Health (2001b). *Context Paper, How Long Do People Wait?* (PACH)
- Provincial Health Council of Alberta (1997). *Health Check-Up on the Journey to Health Reform: Report Card on the Status of Health Reform in Alberta*. (PHCA)
- Provincial Health Council of Alberta (1998). *A Report on the Adequacy of Measures and Standards for Health Reform – Technical Report*. October. (PHCA)
- Region Ten Medical Staff (1996). *Report of the Critical Assessment Committee*. October 22.
- Sanmartin, C., Shortt SE., Barer ML., Sheps S., Lewis S., & McDonald PW (2000) "Waiting for Medical Services in Canada: Lots of Heat, But Little Light." *CMAJ*. 162(9): 1305-10.
- Taras, D. and Tupper, A. (1994) "Politics and deficits: Alberta's challenge to the Canadian political agenda." In D.M. Brown and J.Hebert ,eds., *Canada! The State of the Federation*. Kingston: Institute of Intergovernmental Relations, Queen's University.
- Taylor, M.C. (1960). "The Role of the Medical Profession in the Formulation and Execution of Public Policy." *Canadian Journal of Political Science*, 26, 1, 108-27.
- Tully, P., & Saint-Pierre, E. (1997). " Downsizing Canada's Hospitals, 1986/87 to 1994/95." *Health Reports*, 8:4. 33-39
- Virani, S., Kanji, M., & Cooper, B. (2000). Why Bill 11 Won't Hurt Ralph Klein. *Policy Options* . May. 36-41.