THE POLITICS OF LOSS IMPOSITION: HEALTH CARE REFORM IN ONTARIO AND ALBERTA

by

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B.A.(Hons), The University of Western Ontario, 2008

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES

(Political Science)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

September 2009

Abstract:

Why are some provincial governments more successful at imposing loss than others? This thesis deals with interprovincial differences in loss imposition strategies by examining health care reform in the 1990s. To explain this variance, this thesis argues that loss imposition capacity is affected by the strength of opponents and how skilful a government is in neutralizing opponents. To test this hypothesis, it analyzes the health care reform experiences of the Ontario Progressive Conservative and the Alberta Progressive Conservative governments. It emphasises how the two provincial governments used different political strategies to deter opposition to its health care reform policies. Further, it describes why the opposition each government faced was so inherently different. A comparison of the two cases reveals that the Alberta government was much more successful at imposing loss. The empirical findings presented here have several implications for future study of provincial public policy and 'the politics of loss imposition'.

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Acknowledgements

The advice and support of several people were integral to the completion of this project. First and foremost, I would like to thank my thesis supervisor, Professor Allan Tupper, for being such an encouraging mentor over the past 12 months. I have benefited greatly from his knowledge and commitment to scholarship. I would also like to thank Professor Allan Jacobs, who provided me with such important methodological insight in the early stages of my research design. I would also like to thank Professor Cristine de Clercy at the University of Western Ontario, for introducing me to the understudied realm of comparative provincial politics. To my friends and colleagues at UBC, I have truly been in great company this past year. I would like to especially thank Afsoun and my brother Steve for their diligent editing in the final stages of this project. Any errors are naturally my own.

Finally, I would like to thank my family for always supporting me in my educational pursuits. I would especially like to recognize my mother, Joan Montgomery. Throughout all my endeavours, your guidance, and endless support have been so valuable. For this, I dedicate this thesis to you.

Introduction

Since the 1980s, advanced post-industrialized democracies have, in differing ways, altered their welfare states. Canadian governments participated in these changes but radical reform was relatively rare in Canada in the 1980s. By the early 1990s, however, things had changed considerably. Canadian governments faced heavy expenditure increases and major revenue declines during a severe recession. In response many Canadian governments began to see cuts to public spending as the best way to cope with changing public finances.

In the 1990s, social policy expenditures were a major component of public spending. As such, they became an obvious target for cuts. Since many social programs were under provincial control, provincial governments were at the forefront of retrenchment. Public expenditures on schools, universities and hospitals were all closely examined. As Tuohy (1999) points out, every provincial government established some type of commission to investigate options for cost containment in the 1990s. In response several provincial governments reduced public spending.

In the 1990s, political analysts labelled these types of welfare state reforms as 'loss imposition' policies. Such policies differed from other reforms because they involved immediate, visible costs for the public at large (Pierson and Weaver 1993). By contrast, the benefits conferred by such policies – deficit reduction and debt repayment – are diffuse and less visible.

In the 1990s, province governments also aggressively reformed the delivery of public services. These often reforms had adverse implications for stakeholders. Health care reforms in the 1990s well exemplify the politics of loss imposition. Interestingly

however, provincial governments varied considerably in their approaches to health care reform. This thesis discusses interprovincial differences in loss imposition strategies by examining health care reform in Ontario and Alberta in the 1990s. The purpose of this thesis is to shed light on the conditions that enable Canadian provincial governments to impose loss.

This thesis has six sections. First, it reviews the relevant literature on loss imposition. Second, the thesis outlines a hypothesis and briefly describes the cases being tested. Third, it highlights the major methodological issues. The fourth and fifth sections will review the Ontario and Alberta cases through a loss imposition lens. Finally, the thesis addressees the implications of the empirical analysis and advances questions for future research.

Loss Imposition: 'The Politics of Pain'

In recent years, political observers have been fascinated by governments' efforts to change welfare state programs. As Pal and Weaver (2003) suggest, given government's pre-occupation with re-election, loss imposition policies are seemingly counterintuitive. Such policies raise complex issues about voters' 'negativity bias'. That is, voters are much more conscious of policies that inflict 'pain' than those that produce 'gain' (Pal and Weaver 2003). Losers may punish governments in subsequent elections. Governments must proceed cautiously when they attempt to impose losses. One governmental strategy is to deter opposition in the first instance. In his seminal work "Dismantling the Welfare State", Pierson (1994) outlines several such strategies. These

strategies include dividing potential opponents, compensating opponents, and blurring responsibility for unpopular policies.

Many other scholars have investigated the subject of loss imposition. They have generally focused on the role of institutional arrangements (Pierson and Weaver 1993; Lascher 1998; Pal and Weaver 2003), especially the impact of parliamentary and congressional systems. The general view is that in congressional systems, where policy-making authority is dispersed, potential losers have greater capacity to prevent policy change (Jacobs 2008). In contrast, parliamentary systems probably have greater capacity to impose loss. Power is more concentrated in them (Pierson and Weaver 1993; Lascher 1998; Pal and Weaver 2003; Studlar 2003).

The literature's traditional focus on institutions has been fruitful but limited. The focus on institutions ignores some of the other pivotal dimensions of policy-making, namely the roles of government actors and their opponents. As Pierson observed, (1996) several causal pathways lead to loss imposition. One of the pathways Pierson identifies – a divided or fragmented opposition – is integral to the proposed hypothesis.

Hypothesis

If a government is seeking to introduce reform that incurs costs for groups, the likelihood of its success will be contingent upon two variables: [1] the strength of political opponents in the legislature; and [2] the tactics the government uses to defuse potential resistance. In order to test this hypothesis, data is used from two in-depth cases (n = 2). This thesis posits that both explanatory variables can account for the divergent outcomes in both cases.

This thesis will specifically examine the politics of health care reform. Health care restructuring is chosen specifically because of its highly contentious nature. In Canadian provincial politics, reforming health care presents a major challenge for governments. Health care has long been considered a highly significant social program in Canada. Public opinion data has consistently shown strong support for maintaining the current system of publicly insured physician and hospital care (Mendelsohn 2002; Cohn 2005). In effect, given what we know about negativity bias, we can anticipate that major losses might be disastrous for governments seeking re-election. As such, health care restructuring captures the idea of loss imposition and thus is a useful case for hypothesis testing.

The first case is Ontario's Progressive Conservative government between 1995-1999. The second case is Alberta's government between 1993-1997. In both Ontario and Alberta, governments attempted to transform health care delivery by introducing radical policy measures. The Klein government in Alberta implemented many of its health care reform goals, while the Harris government accomplished much less in Ontario. Both reform proposals included provisions that adversely affected professional groups and local communities. Taking this into consideration, the Klein government was more successful in imposing loss on these groups than the Harris government was.

Methodology

To investigate the central research question, data was gathered from two case studies: Ontario and Alberta. After compiling data, I then tested the predictions of my proposed hypothesis. Hypothesis testing is a vital part of social scientific inquiry. As

Przeworski and Teune (1970) posit, testing is a central goal of social science because it enables researchers to make accurate predictions. Thus to determine the validity of my hypothesis, I systemically compared the data from both cases and tested the proposed hypothesis. Data for this thesis was collected from a variety of sources, including: the secondary literature, legislative debates, media reports, government documents, and party campaign platforms. This approach was crucial because together these provide multiple accounts of the same events. Such diverse sources increase the validity and reliability of data (Davies 2001).

There is an underlying analytical advantage to the small-n comparative method. It enables the researcher to make multiple observations from specific cases. Such an approach provides a richer understanding of the mechanisms that link the explanatory and dependent variables. This type of analysis is called "process-analysis". It provides analytical leverage by uncovering causal mechanisms and sequential processing (Collier Brady, and Seawright 2004). Such leverage is minimized when a larger number of cases are selected.

While several advantages of this study's methodology have been outlined, there are certain drawbacks. First, no interviews were conducted for this thesis. Interviews would have been valuable sources of inferential leverage, as they might have corroborated data from other sources. Unfortunately, interviews were not feasible due to time constraints. Second, a caution about case study research ought to be made. While the cases selected did confirm the predictions of the hypothesis, as Geddes (1990) would argue, this does not necessarily make the hypothesis correct. In light of this, other

researchers are encouraged to challenge the findings of this study through further systematic inquiry.

The selection of the Ontario and Alberta governments as case studies was based on two methodological considerations. First, the cases chosen had to be relatively similar. That is, they needed to share some central systematic features so that comparisons can proceed (King, Kehone, and Verba 1994). Alberta and Ontario meet the criterion of unit similarity because their governments exercise identical policy-making power and share similar institutional arrangements.

Second, the researcher had to control for the variable of ideology. The Harris and Klein governments held similar neoliberal views of the state. Both sought to significantly limit the scope of government activity (Hughes, Lowe and McKinnon 1996; Jeffrey 2000). By holding ideology constant, the researcher ensures that this variable is not exerting an effect on the dependent variable. The selection of Alberta and Ontario also has an important analytical advantage. These governments were both elected on platforms that promised to institute sweeping reforms. In this regard, they were very much perceived to be 'revolutionary' governments. In many ways, these governments set the precedent for welfare state retrenchment in Canadian provincial politics (Urquhart 1997). Examining the experiences of Alberta and Ontario experiences is invaluable to understanding how other provincial governments later pursued loss imposition policies.

Ontario in the 1990s

Ontario is a very interesting case for understanding loss imposition in health care. In the 1990s, recession caused declining tax revenues at Queen's Park. Under the

leadership of Michael Harris, the province sought to reform various parts of the health care system. While the Harris government did achieve some of its health care reform goals, many reforms met little success. The Harris government succeeded in closing costly underused hospitals. But even here the government faced significant struggles. A careful examination of Ontario reveals a system resistant to restructuring. Two main factors explain the outcome. First, the Harris government's overall approach to reform was highly controversial and generated a wave of political problems. Second, the Harris government failed to neutralize critics.

The Background to Health Care Reform

In the early 1990s, the province of Ontario was in recession and was experiencing high unemployment and serious declines in economic output. In 1990, the newly elected New Democratic Party (NDP) government initially signalled that it would not cut public spending. For the NDP, social programs like health care and education were just too important. Interestingly though, the Rae government soon changed its mind. By 1993, the government was so concerned about the deficit that it announced plans to cut public spending by $4 billion (MacDermid and Albo 2001). The NDP's policy shift reflected a growing consensus that expenditure cuts and public-sector reform were central to the province's fiscal recovery. Under the government's proposed *Social Contract,* the Ministry of Health would see a total budgetary cut of $219 million for the 1993-1994 fiscal year. This budgetary cut led to a decrease in hospital administrative spending and the de-listing of services from the Ontario Health Insurance Plan (Fierlbeck 2001). Clearly this signified the Rae government's willingness to make changes in order

to alleviate fiscal concerns. Overall though, the NDP spared the Ontario health care system from fundamental change.

The Common Sense Revolution

In June 1995, the health care reform debate resumed with the election of Progressive Conservatives. After a 10-year absence, the PCs had returned to power. Under Harris, the PCs won 82 seats and garnered 40 per cent of the popular vote. By contrast, the heavily favoured Liberals received 30 seats, while the NDP under Rae retained 17 seats (Williams 2001). For the first time, a Canadian province had elected three different parties in three successive elections. In this regard, all three parties were relatively strong and had some level of experience with health care reform.

While the PCs had returned to power, the Progressive Conservative party was very different under Harris. In contrast to the party's centrist traditions, the Harris PCs were seen as 'right wing'. They ran on an ideological platform by Ontario standards. The PC's *Common Sense Revolution* (CSR), the party's pre-election campaign released in 1994 embodied its shift to the right. Its theme was that 'big government' was the problem. The Harris PCs vowed to cut spending on welfare; cut income taxes; restructure municipal governments; eliminate the provincial deficit; and create jobs. The Common Sense Revolution stated that health care and education spending levels would be frozen and that both systems would be reformed to function more efficiently (White 1998). The Harris government's cautious treatment of the health care – and education - underlined the difficulties of getting elected on a loss imposition policy platform. In the leadership debate, Harris went as far to say that it was not in his plans to close hospitals (Girard

1997). Once elected however, the Harris government quickly reneged on this commitment. In its November 1995 economic statement, the government announced intentions to cut hospital funding but did not specify the depth or timing of these cuts (White 1998). In the event, the Harris government identified the health care sector as a target for reform.

The Harris Government in Action

In the first two years of its mandate, the Harris government implemented many of its most important policies. From welfare reform to municipal amalgamations, the CSR was in every sense, a blueprint for change. Welfare recipients, municipalities, post-secondary institutions were all set to battle with the Harris government. In fact, the government faced broad opposition from across sectors and all quarters of Ontario. As Robert Sheppard (1996) suggested:

> "The Ontario government is battling with private and public-sector unions (over labour-law changes and privatization plans); with teachers and school boards (over benefit cuts and amalgamation proposals); [and] with municipal governments, particularly the big six in Metro Toronto (over funding cuts, off-loading and the "one big city" scheme)". (A13)

These broad tensions in Ontario politics deeply shaped health care reform. When governments engage in highly visible political battles with interest groups, two consequences flow. First, groups learned how the government interacted with other opponents. In doing so, health care professionals developed considerable knowledge about opposition strategies. Second, health care reform opponents benefited from the fact that the Harris government could only do so much at once. As a result, opponents had ample time to organize. In brief, the Harris government's decision to take on multiple

interest groups early in its mandate may have inadvertently strengthened the position of its health care reform opponents.

The Harris government identified hospitals and physicians as major consumers of the Health Ministry's budget and as such, targets for reform. The first Harris initiative was restructuring of hospitals to be carried out by an independent commission, the Health Services Restructuring Commission (HSRC). Bill 23, *the Savings and Restructuring Act*, established the Commission, which empowered it to make binding decisions on the future of hospitals in Ontario. The second major initiative pursued by the government was significant changes to its agreement with the province's physicians. In hospital restructuring, local communities and health care employees would incur significant costs. In the case of physicians, unilateral changes would scale back the powerful position. In short, both initiatives sought to impose significant losses on stakeholders.

The Harris government faced strong opposition in reforming hospitals and physicians' income. The government faced stiff resistance from hospitals, physicians, and local communities. Second, two persistent opposition parties continually attacked the Harris government in the Ontario legislature. Ultimately, the strength of both opposition parties can be attributed to their own experience in government. Many opposition members had considerable experience in the two previous Ontario governments. In fact, of the 31 Liberal MPPs, 11 had served in the Peterson cabinet. Similarly, 12 of 17 NDP MPPs had served in the Rae cabinet. Furthermore, the opposition had extensive legislative experience. Among the Liberal caucus, nearly two-thirds of its MPPs were incumbents. In the NDP caucus, all 17 MPPs were incumbents. As such, they had considerable experience in parliamentary debate and extensive knowledge of each of the

ministry portfolios. By contrast, the Harris cabinet was primarily populated by electoral rookies. In fact, 61 of the 82 elected Conservative members were electoral rookies. In brief, the Harris government's efforts to structure health care were attempted in an environment where political resistance was ubiquitous.

Framework for Reform: The Savings and Restructuring Act.

In November 1995, the Harris government signalled its precise intentions for health care reform. The first step was Bill 26, *The Savings and Restructuring Act*. The bill was an omnibus one that proposed amendments to many pieces of legislation. According to White (1998), this type of "enabling legislation" created a legal framework for many reforms. With respect to health care restructuring, the bill included several provisions. First, it established a Health Services Restructuring Commission (HSRC). Second, depending on the recommendations of this commission, the bill also provided the Health Minister with the authority to "alter the financing and operation of public hospitals, including closure and amalgamation powers" (Leduc-Browne 2000, 43). This concentration of power was unprecedented and generated bitter political exchanges between the Harris government and legislature. As the commission itself admitted, it was given an "unprecedented and seemingly unconstrained authority to restructure public hospitals" (Sinclair, Rochan and Leatt 2005, 1). For the opposition, such powers were draconian. As Liberal MPP Mike Colle's stated during debate, "Bill 26 [gave] the Minister of Health dictatorial power to close down any hospital in this province with the stroke of his pen" (Ontario Hansard, 12 December 1995).

As John Ibbitson (1997) asserts, the omnibus bill allowed the "entire herd of opposition oxen could be goared at once, [and thereby] reduce the political fallout" (135). Ultimately however, the Harris government seriously underestimated the depth of Liberal and NDP opposition. To make matters worse for Harris, the bill's complexities meant that it was difficult to defend in public. The government's difficulty in defending its key bill was exacerbated by its limited governing experience. In contrast, many opposition members had significant experience defending legislation. In effect, the opposition found it easy to find flaws. In response to the oppositions concerns, the Harris government ended up making several adjustments to the bill. One controversial provision tried to eliminate Ontario Medical Association (OMA) as the doctors' representative in contract talks. In doing so, the Harris government sought to diminish the strength of the physician in fee negotiations. However, this provision was removed after strong resistance by the Ontario Medical Association and by opposition members (Montgomery 2002). After these amendments were introduced, Bill 23 was adopted into law in January 1996.

The Health Services Restructuring Commission (HSRC)

The Health Services Restructuring Commission was expected to investigate several hospitals across the province and determine which would remain intact, and which would be consolidated with larger facilities. The Commission comprised 12 volunteer commissioners, each of whom had considerable experience in either health care delivery or administration (Sinclair et al. 2005). The legislation also imposed important restrictions on the Commission's authority. First, the Commission did not have authority

over hospital personnel. Second, the Commission could not authorize government expenditures (Sinclair et al. 2005).

The bill asserted that the Commission was responsible to the Minister of Health. However, it also stated that the Commission's had the final say over hospital restructuring and closure decisions (Sinclair et al. 2005). Theoretically, this meant the Minister could not overturn Commission decisions to close a hospital. In practice, however, there were explicit signs of political involvement in the Commission's process on more than one occasion. If the Harris government was attempting to obfuscate its responsibility for hospital closures, political interference surely undermined this tactic.

The Commission had enough power to inflict serious pain on stakeholders. Hospital closures impose direct costs onto health care providers and local communities. In doing so, these groups could look to hold some popularly elected body accountable. The Harris government's decision to delegate authority to an arms-length body like the Commission was designed to insulate itself from highly controversial decisions.

Why did the Harris government devolve such authority to a supposedly independent body? Between 1974 and 1977, Progressive Conservative Health Minister Frank Miller was charged with the responsibility to close several small and underused hospitals. The public response was very negative, a response that almost cost the Health Minister his seat in the legislature (Montgomery 2002; Ibbitson 1997). In light of this experience, the Harris government knew that if it was going to close hospitals it needed to distance it from any political fallout. The Harris government thus tried to impose loss by empowering an independent body to make binding recommendations on the future of hospitals. As Montgomery (2002) asserts, "when the inevitable shouts of disapproval

were heard, Health minister Jim Wilson could simply say all decisions were up to the HSRC" (156). Pierson (1994) would argue that this represents obfuscation since it involves government trying to shift the burden politically unpopular decisions to other bodies. By creating this new type of institutional arrangement, the Harris government sought to blur responsibility for the controversial nature of hospital restructuring.

The Harris government's use of government organization is a widely used device in politics. In the 1980s, the United States established a very similar commission that was charged with the thankless task of closing military bases (Goren and Lackenbauer 2003). The American and Ontario cases are explicit exercises in blame avoidance. As R. Kent Weaver (1986) asserts, minimizing blame for unpopular policies is important to governments as is claiming credit for popular policies. Weaver also suggests that governments will employ many blame avoidance strategies to protect themselves. One of these strategies, 'passing the buck' involves shifting unpopular decision-making authority to another institution or body. In the case of Ontario, the creation of the Commission was a direct attempt by the Harris government to 'pass the buck'.

The Decisions of the Health Service Restructuring Commission

What did the Commission recommend? And were its recommendations accepted and acted on? In short, was the HSRC an effective mechanism for Harris' health care reform?

During its first meeting, the Commission determined its first task would be to restructure hospitals in major Ontario cities (Sinclair et al. 2005). The Commission's approach seemed logical. After all, cities contained a majority of Ontario's hospitals and

population. Nevertheless, from the outset, the opposition parties criticized the urban focus as inspired by electoral politics (Ontario Hansard, 4 December 1995). The opposition's claim was based on the fact that the major cities were underrepresented in the Tory caucus. Despite such criticisms, the HSRC commenced its work in early 1996. It then spent the next 18 months examining various hospitals across the province. The Commission was deeply controversial. After a visit to Thunder Bay, the Commission ordered the closure of three of the city's five hospitals. Calls to save these facilities went largely unanswered by the Commission and the government (Rusk 1996).

Barriers to Reform: The Power of Mobilization

Despite its formal powers, the Health Services Restructuring Commission was forced to retreat several times. The Commission's authority was heavily challenged in Toronto when in March 1997 it announced its recommendations to close 11 hospitals in Metro Toronto. The HSRC was then quickly bombarded by legal and political challenges (Duncan et al. 2005). The Commission's attempt to close Women's College hospital and transfer its services to Sunnybrook Health Sciences Centre was deeply controversial. Women's College had long specialized in women's health and seen as a vital service (Girard 1997). The slated closure of Women's was seen as a significant loss for all women in Ontario. In response, supporters formulated the group *Friends of Women's College*. To voice its opposition, *Friends* employed many tactics including media appeals (Armstrong 1997); public demonstrations (Armstrong and Armstrong 1999); and legal challenges (Girard 1997). In addition, they aggressively lobbied at Queen's Park (Daly 1997a). *Friends* did not prevent a restructuring of the hospital but forced the Commission

to make several concessions. Moreover, *Women's* supporters built public support. A poll conducted by Strategic Counsel of Toronto Inc. showed that 72 per cent of Ontarians opposed the Commission's recommendation to close Women's College (Rusk 1997). Strong opposition was voiced in the legislature. In 1997, a PC backbencher introduced a private member's bill to prevent the closure of Women's College. With the support of both opposition parties and several PCs, the private member's bill was passed (Armstrong and Armstrong 1997). The division among the Harris caucus suggested there was major disagreement over hospital closures. In the event, the Conservative government asked the Commission to reconsider its recommendation for Women's College.

The Harris government's retreat on Women's is noteworthy on a number of levels. The passage of a private member's bill under a PC majority revealed a paradox. Why did Harris government backbenchers compromise the government's health care reform? One can speculate that the opposition was so strong – *Friends,* public opinion, opposition parties – that backbenchers did not want to take the blame for the losses imposed. Similarly, the government eventually gave into some of the demands of reform opponents.

Other hospitals were closed because they "had neither sufficiently strong community leadership nor sufficiently close links with decision-makers" (Armstrong and Armstrong 1997, 7). In these cases, the government was able to impose losses without having to deal with a militant opposition. Further, when the Commission announced plans to close two chronic care facilities in Toronto, Runnymede Hospital and Riverdale Hospital, it again was faced with strong opponents. The Toronto Health Coalition led the

anti-closure forces (Armstrong and Armstrong 1997) and the Commission reversed itself and retained both chronic care facilities. The cases of Women Colleges, Runnymede and Riverdale showed how a determined, well-organized interest group could deter loss imposition[1].

National Unity and the Montfort Hospital

In 1996, the HSRC announced the closure of Montfort Hospital in Ottawa. By its own admission, the Commission misjudged the perils of closing the sole francophone hospital in Ottawa (Sinclair et al. 2005). The closure of Montfort generated significant opposition at the local, provincial and federal level. As Tuohy (1999) notes, the proposal led to a "furious lobbying campaign, and provoked unprecedented public intervention" from Prime Minister Jean Chretien, and the Quebec Premier Lucien Bouchard (100). The involvement of other government officials underscored the political sensitivity of closing a francophone institution like Montfort.

Opposition MPPs vented outrage arguing the closure was not a matter of cost containment but of minority rights. As Liberal MPP, Gilles Morin stated in the legislature, "[i]t needs to be understood… the closing of the Montfort is not just about the closing of a hospital, but the beginning of the end of francophone rights in Ontario" (Ontario Hansard, 6 March 1997). The argument that the closure would impose loss to Charter rights was understandably controversial. In the event, Montfort was spared when the Commission released its final report for Ottawa.

[1] What is even more interesting is that this group continued to fight for Women's College even after Bill 51 was passed. Then in 2005, under the McGuinty government it was announced that Women's College would again be a self-governing acute-care facility.

A memo obtained by journalist John Ibbitson (1997) shows the Ontario government involvement in the Monfort case. According to Ibbitson (1997) a memo authored by then Deputy Minister of Heath Margaret Mottershead, urged the Commission to "reverse its decision to close Ottawa's French-language Montfort hospital," (197). The Harris government appeared to be reversing its own health care reform by pressuring the Commission.

Challenging the Commission's Independence

After the Commission made its urban recommendations for cities, it shifted its sights to rural hospitals. However, HSRC never completed this part of its mandate. It had intended to analyze northern and rural communities but was prevented from doing so by the government (Montgomery 2002). Opposition parties asserted that cabinet ministers had written to the Commission to delay or prevent hospital closures in rural ridings. The Liberals launched a series of attacks at Queen's Park. Health critic Gerald Kennedy frequently used Question Period as a mechanism to criticize the Commission:

> "You can't have it both ways. Are we to believe that this commission is independent? Are we to believe the commission for conflict, which says, "Parliamentary convention prohibits all ministers from personally appearing or advocating on behalf of a private party with any agency, board or commission"? We're sorry you haven't read that and you're not aware of it, but we're very interested in your conduct of your affairs and how you advocate in cabinet for the independence of this commission. (Ontario Hansard, 24 April 1997).

The Harris government's decision to intervene in the Commission was counterintuitive to its obfuscation strategy. The logic of obfuscation is that it insulates the government from the effects of unpopular decisions. However, the Harris government compromised its

policies when it altered the Commission's mandate. Government involvement undercut the claim that the Commission was 'independent'.

The Liberals also used tactics outside the legislature to oppose hospital restructuring. In a press conference, Liberal Leader Dalton McGuinty played segments of the 1995 leadership debate, where Harris denied any plans to close hospitals (Harder 1997). Through these tactics the Liberals conveyed the message that the Commission was simply a government cutback through stealth. The Liberals' efforts yielded dividends. The Harris government replaced Health Minister Jim Wilson with then Labour Minister Elizabeth Witmer. Within weeks of taking over this portfolio, Witmer promised to delay the pace of hospital closures (Daly 1997b). By early 1998, it was clear the government had backtracked from its ambitious hospital restructuring agenda.

The Conservatives' hospital restructuring initiative was only moderately successful. Ultimately, the Commission managed to close 43 hospitals by 2000 (Sinclair et al. 2005). On the other hand, there were a number of cases in which, organized political resistance led by restructuring opponents undermined the government's attempt to reform health care. In the end, the Commission backtracked from several of its preliminary recommendations.

The Harris Government and the Ontario Medical Association

A second major Harris government reform was an attempt to weaken Ontario's physicians. Part of the Harris' deficit and tax reduction plan also included a freeze on health care spending. To ensure health spending would not increase, the Harris government wanted to make significant unilateral changes to its agreement with

physicians. Unlike the government's mixed success with hospital restructuring, it efforts to weaken the doctors failed.

In November 1995, the PC government announced plans to take on the physicians. In fact, a provision in the Savings and Restructuring Act called for the elimination of the government's malpractice insurance subsidy for doctors. The subsidy – worth about $36M - meant that physicians were much more vulnerable in the event of a malpractice lawsuit (Montgomery 2002). The province's physicians condemned the announcement by the Health Minister Jim Wilson. In March 1996, fearing malpractice lawsuits, Obstetricians and Gynaecologists announced they would no longer take on patients with risky pregnancies (Ibbitson 1997). Their main concern was the financial loss associated with litigation. Since the Harris government was not willing to cover this insurance, these specialists refused to put themselves at financial risk. In the case of malpractice subsidies, the Harris government revealed its intention to impose losses on a very powerful group. However, these Obstetricians and Gynaecologists' 'indirect strikes' put the government in a difficult situation and caused it to back down. As Ibbitson observed (1997) when the doctors refused to bend, Wilson blinked and ended up temporarily restoring the malpractice subsidies. The physicians flexed their muscles when they withdrew crucial public services. As Ibbitson (1997) asserts, "unlike other parts of the public service, the services of physicians are essential and their withdrawal is deeply discomfiting for the employer" (198). In short, this initial attempt at reform showed the powerful position of physicians and their ability to resist loss imposition.

Health Minister Wilson then announced changes to the fee-for-service structure. Again the Harris government was trying to contain costs, this time by cutting physicians'

income. According to Montgomery (2002), the proposal was a 10 per cent clawback on physician's billings. The physicians' resistance was powerful. The president of the Ontario Medical Association commented, "[p]hysicains continue to take more and more and more of patients without more resources… We have to draw the line" (Schneider 1996). The statement by the OMA president was significant, as this body "represents the political, clinical and economic interests of the province's medical profession" (OMA 2009). In response to the proposed clawback, several Ontario specialists and general practitioners stopped taking new patients and refused to work evenings and weekends. Opposition grew stronger on December 5th, when the Specialists Coalition of Ontario called on doctors, except emergency service physicians to shut down their services on December 13 (Ibbitson 1997; Montgomery 2002). This aggressive move meant that if the Harris government were to persevere it would have take on Ontario doctors. In this sense, the government's attempt at loss imposition was particularly risky. The proposed policy move did nothing to mitigate political damage. The Harris government should have protected its relations with this powerful group by offering it some sort of compensation. According to Pierson (1994), when governments seek they impose loss, they will attempt to defuse potential opposition by compensating them adversely affected groups with positive benefits. By not offering anything to the physicians, the Harris government left themselves wide open to opponents. The powerful efforts of the physicians led the Harris government to believe that it had no choice but to retreat from reform.

After the Harris government backed off its proposed reforms, it then negotiated a tentative deal with the Ontario Medical Association. The proposed agreement eliminated the proposed clawback and restored malpractice subsidies. Despite the government's

policy reversals, the OMA's membership rejected the proposed in large numbers (Ibbitson 1997). It had apparently done grave harm to its relations with the province's physicians. The Harris government had little choice but to return the bargaining table. The government then presented a much more generous package to the members of the OMA. According to the agreement, the malpractice subsidy would be maintained permanently and there would be no clawback to billings. In fact, the government was forced to concede yearly 1.5 per cent increase in total billings for physicians (Ibbitson 1997). The members of the Ontario Medical Association agreed to the government's proposals.

The government's new agreement with the OMA was a complete policy reversal by Harris. The newly appointed Health Minister Dave Johnson estimated that the new deal with the doctors would cost the government an additional $150-million annually (Coutts and Mittelstaedt 1996). The physicians had won. They had defeated every reform attempt by the government and made significant gains. As Ibbitson (1997) concludes, "[t]he fight with the doctors represented another case of the government having to give in to more powerful interests" (204). The government's inability to weaken the physicians' position underscored the difficulties of imposing loss on such powerful, well-organized group. Physicians provide services that are immensely valued by the public. Doctors effectively utilized their leverage when they resisted reform through work-to-rule.

Several of the Harris government's attempts to reform health care were unsuccessful. The inability of the government to impose loss comes can be attributed to two primary factors. First, major reform initiatives encountered powerful opposition to loss imposition. The resistance tactics employed by these reform opponents were

particularly effective. Second, the government's strategic attempts to neutralize opposition failed. In hospital restructuring, the government tried to use obfuscation in order to blur responsibility. Several of the government's own actions effectively undermined this blame-avoidance strategy. In the case of the physicians, the government took a hard-line approach to reform and offered no gains to a very powerful group. In response, the physicians mounted an effective resistance campaign and the government was forced to retreat. In short, Ontario's experience with health care reform in the 1990s reveals conditions that undermine a government's capacity to impose loss.

Alberta in the 1990s

In the 1990s, the Conservative government in Alberta embarked upon an ambitious health care reform agenda. Similar to the Ontario case, the Alberta reforms included a mix of expenditure cuts and hospital restructuring. When comparing the cases, however, the Klein government was much more successful in imposing loss than the Harris government in Ontario. The following case explains the Klein government's capacity to impose loss. It emphasises the same two variables: the strength of reform opponent's resistance; and the strategies undertaken by the government to neutralize opposition.

Health Care Reform in Klein's Alberta: The Antecedents

Health care reform had certainly been debated prior to the Klein government's election in 1993. In the late 1980s, the Alberta government was concerned about escalating health care costs. Then Premier Getty established the *Premier's Commission*

on the Future of Health Care *for Albertans* and charged it with exploring different options for health care cost containment. The commission heard from experts, health care professionals and public servants (Church and Smith 2008). In 1989, it released its findings in the *Rainbow Report.* The Report recommended that the province abolish the existing 200 hospital boards that oversaw health care delivery. It called for a complete reorganization that would replace hospital boards with nine Regional Health Authorities (RHAs). These RHAs would help control costs by ridding the health care system of service duplication and bureaucracy.

The *Rainbow Report* also advocated a new role for the Alberta Health, the key provincial department. In the report's view, the ministry "should concentrate its efforts on setting long-term goals" (Alberta 1989). Following this logic, the Health Ministry was to be a general manager not a service provider, a reform that would supposedly make the system more cost-effective. But the government chose not to act as it felt that the reform was not politically palatable. Many rural constituencies spoke out against "regionalization" fearing a loss of local control. Rural Alberta mattered greatly to the governing political coalition. In light of this potential conflict, the Getty government chose the status quo.

Klein's Rise to Power: An Agenda for Reform

Health care reform was re-energized with the election of Ralph Klein as PC leader. In December 1992, Ralph Klein won the PC's leadership race and succeeded Don Getty. He promised to be a prudent fiscal manager who would balance the province's budget without tax increases. In 1992, the Alberta's deficit was $3.4 billion.

Comparatively, this figure, on a per capita, was much higher than Ontario's comparable number (Fierlbeck 2001). Klein promised to eliminate the deficit over four years by reducing public spending by 20 per cent across-the-board. Given the number of interests – both public and private - that would oppose cuts of this magnitude, Klein's plan was ambitious.

After serving just 6 months as premier, Klein prepared for his first election in June 1993. The PC campaign was very similar to the Klein leadership platform and emphasised deficit reduction and debt management. In the end, the Klein PC's were returned to Edmonton with a majority, capturing 51 seats. The Klein PCs had actually seen a decline in seats and only had marginally increased its share of votes. Replacing the New Democrats as the Official Opposition, the Alberta Liberals won 32 seats and captured almost 40 per cent of the popular vote (Tupper 1996). The Liberals gains are particularly significant. The party managed a fourfold increase in seats from the 1989 election.

One can argue that the PC's loss in seats - from 58 to 51 seats - signified public opposition to its platform. A closer examination of the 1993 election reveals a different interpretation. The Alberta Liberals, like the PCs, had also campaigned on a platform of major reductions in government spending. As Allan Tupper (1996) points out, "[t]he principle difference between the two parties was their ideas about *how to cut spending*" (467, emphasis added). In other words, there was consensus among two of three major parties that Alberta had a significant "spending" problem.

The NDP, the only party to reject massive spending cuts lost all its seats. The rejection of the New Democrats suggested that Albertans wanted a balanced budget.

Hughes, Lowe and McKinnon (1996) interpret the election results similarly, when they asserted that the 1993 election signified "the electorate's willingness to embrace a brand of fiscal conservatism that [was] radically new" (268-269). In short, the 1993 election saw Albertans coalesce around two parties that vowed to eliminate the deficit through public spending cuts.

The Seeds of Health Care Reform

In August 1993, the Klein government decided health care would be one of its first public sector reforms. It announced a major expenditure cut to the Ministry of Health. In the 1992/93 fiscal year, health spending was $4.2 billion. Klein announced that by the 1994/95 fiscal year, spending would decline to $3.5 billion (Plain 1997). To implement such cuts, the Klein government announced it would overhaul the health care delivery system. As was illustrated by the Ontario cases, major health care expenditure cuts are a bold undertaking for provincial governments. The Klein government were cognizant of this challenge and this was evidenced by its approach to health reform. In the 1993 election, Klein ran on the campaign "He listens, He cares," (Hughes et al. 1996). This rhetoric was designed to evoke an image of responsiveness to public opinion. To facilitate dialogue, the government established a *"Roundtable on Health"* in August 1993 that was co-chaired by two MLAs. It invited physicians, health care professionals, and selected members of the public to offer input. On the surface, the roundtable was established to get input from street-level bureaucrats and health care consumers. Conversely, as most political observers suggested, the roundtable was nothing more than

a "well-scripted exercise… designed to sell Albertans on the new political agenda" (Church and Smith 2008, 233).

The Roundtable served an important political purpose for the government. The 'consultative' nature of the process provided the government with ample political cover for future problems in the health care system. The government could avoid blame for the effects of the reform since the policies were being "shaped by Albertans themselves" (Hughes et al.1996, 271). In addition, the roundtable exercise allowed the government to exclude opposition parties. As such, these critics were denied a major public outlet.

The Roundtable released *Starting Points,* a report that echoed the recommendations of the *Rainbow Report.* It argued that Alberta should move toward a regionalized model of health care delivery, while the Ministry of Health retained a macro-managerial role (Philippon and Wasylyshyn 1996). Further, the report discussed how the system would have to adapt to expenditure cuts. It stated, "given the need to reduce health funding, it is imperative new ways be develop to fund services… health regions must work to limit their costs by reducing unnecessary overhead" (Alberta Health Planning Secretariat 1993). This report implied several things for the future of Alberta's healthcare system. First, regionalization would fundamentally alter health care delivery by removing decision-making authority from local hospital boards (and the ministry). Regionalization enabled the provincial government to hold a local body accountable for planning, management and delivery of regional health services. Resistance from hospitals boards and local communities was to be expected. Second, since RHAs would be allocating budgets to the hospitals, it meant that they would make the tough decisions associated with cost-containment. The latter point resonated with the Klein government.

As it saw it, such an arrangement would provide them with political distance. In the end, the Klein government accepted the recommendations of the roundtable report. The Minister of Health, Shirley McClellan, created the Health Plan Coordination Project (HPCP), a body charged with creating a viable action plan for implementation of a regionalization plan (Church and Smith 2008). To ensure the HPCP operated efficiently, it was given a deadline of fifteen months to complete its work.

The Klein government's decision to adopt a regional model of health care delivery raises fascinating considerations about loss imposition capacity. Regionalization enabled the government to cut public spending while 'forcing' the RHAs to determine precise cuts. The government would not directly decide such issues as hospital closures and lay-offs. It could thus carry out its loss imposition agenda indirectly. As Pierson (1994) argues, such institutional arrangements were an attempt by the Klein government to use 'obfuscation' to blur responsibility. Klein's regionalization proposal was a political move designed so that the: "implementation of the funding cuts [as well as their announcement] would now be made by appointed managers rather than by politicians, thereby shielding the latter from political resentment and discontent" (Fierlbeck, 157). By devolving itself of authority, the government sought to deny responsibility for the negative implications of its policies. The creation of regional boards is a classic example of blame-avoidance (Weaver 1986).

The Regional Health Authorities: Restructuring Governance

A major task for the Klein government was to determine the number of regions that would be created and their boundaries. Accordingly, 15 regions were proposed in

March 1994. Due to concerns over the size of several regions, some areas urged the government to subdivide the proposed regions (Philippon and Wasylyshyn 1996). Shifting responsibility from 200 boards to 15 regional boards was very significant change that had the potential for significant opposition. In response, the government decided to subdivide two of the proposed regions, leaving the province with 17 Regional Health Authorities (RHAs).

The government had to ensure that the RHAs would carry out the proposed cuts. One way of doing this was to determine criteria for Regional Health Authorities. Alberta residents were eligible to apply to sit on the Regional Health Authority boards and were to be appointed for a two-year period. However, there was one important exception, those that were employed and/or funded by the health care system were ineligible. The exclusion of health care professionals was to guarantee that those with "personal agendas or professional turf to protect" did not thwart the government's reforms. Many physicians were unhappy, they feared a loss of control in the new control system. As Philippon and Wasylyshyn (1998) suggest, an important government consideration was to ensure that RHAs did not become 'internal' opponents. To ensure this outcome, the Klein government appointed members that "could be trusted to move forward without question in implementing the new structures" (Church and Smith 2008, 232). Under this system, board members were left to make unpopular decisions, while the "direction and substance [were] determined by the government" (Wilson, 106). Despite the appearance of devolving decision-making power to the RHAs, the Klein government was still in control. Apolitical board members seemed to make decisions. In reality, the RHAs were a mechanism of government loss imposition.

In 1994, the government tabled Bill 20, the *Regional Health Authorities Act*. The bill stressed the basic prerogatives of the authorities. In the ensuing debates, the government made some technical changes to the bill but the underlying direction of the policy was left and the legislation was passed (Philippon and Wasylyshyn 1996). The lack of opposition by the Alberta Liberals is significant. Part of the Liberals' weakness may be attributed its lack of experience in debating and critiquing legislation. Out of the 32 Liberal MLAs, 24 members were electoral rookies. Second, the Liberals had not been in government since 1921. As Fierlbeck (2001) notes, "the official Opposition agreed with the need to cut health-care costs, and limited their criticism to the particular nature of the cuts" (158). The only substantive Liberal criticism was that under the proposed system, the health authorities would be preoccupied with acute-care facilities and thereby ignore the needs of such facilities as children hospitals or senior long-term facilities.

The Liberals' internal problems may also account for its effectiveness in the legislature. According to Lisac (1995), there were clear signs of left-right tensions within the party. These divisions may have undermined the Liberals ability to function as an effective opposition. Lisac (1995) also argues that there were concerns over Laurence Decore's leadership. With respect to loss imposition, the weakness of the Liberals had immense implications. As Pierson (1996) asserts, when governments seek to introduce loss imposition policies, they will do so when they face a fragmented or weak opposition. The logic is that governments are less concerned about re-election because it is unlikely the public will replace them with a weak and divided party. In the case of Alberta, the inept Alberta Liberals are stark contrasts to the strong legislative opposition in Ontario.

Minimizing Opposition Outside the Legislature

The Klein government's introduction of RHAs had major implications for interest groups. Resistance was anticipated from adversely affected groups. Despite the weakness of the Liberals, public opposition to the government's health care reform was widespread. The provincial government faced opposition but overcame it easily for two reasons. First such opponents as hospital boards, nurses and other health care workers struggled to find an effective vehicle of opposition. To make matters worse, these groups could not rely on the weak Official Opposition to give them voice in the legislature. Opponents had to mount their opposition outside the legislative arena. Second, the Klein government was effective in defusing resistance through various political strategies.

The Klein government health care reforms generated some opposition among physicians. As an RHA administrator suggests, "whereas physicians dominated hospital boards for decades…this has now changed and they are proving reluctant to accept the change" (Kneebone and McKenzie, 1997,181). Regionalization meant hospitals and physicians could lose autonomy and expenditure cuts would force them to work with smaller budgets. The government recognized physicians' power was and negotiated a deal with the Alberta Medical Association. The agreement included a provision that established a $7 million "support fund" for physicians. Essentially, the fund was set up to ensure doctors that funding would not be clawbacked over the next three years. The physicians agreed to the deal and there seemed to be an 'understanding' that the AMA would not impede the government's health care reform (Wilson 2000). The acceptance of the fund was central to the success of the Klein government's attempt at health care reform. As Wilson (2000) suggests, the $7 million was a ploy "to win the acquiescence of

the most powerful interest" (107). The decision to avoid conflict with the province's physicians is significant. In other public sector reforms, the Klein government did not show such restraint. It imposed losses on several other powerful groups such as university professors, teachers' unions, and other public service unions. In the case of health care, the government recognized how integral the physicians' support was to reform.

Other adversely affected health care groups did not fare as well under the Klein government. The Canadian Union of Public Employees who represented other hospital workers were completely outraged by this "sweetheart deal" between the Klein government and the AMA (Fierlbeck, 2001). The decision to allocate these positive benefits to the physicians was inherently strategic. As Pierson (1994) argues, the physicians' deal was 'compensation' since reforms would adversely affect the interests of physicians. In other words, the government knew the physicians would be opposed to its proposed expenditure cuts and reorganization so it provided modest initial compensation to physicians.

The Alberta government made deliberate decisions that effectively avoided conflict with the powerful Alberta Medical Association. It exempted the physicians' fee-for-service structure from its proposed health care reform. The government's original proposal would have downloaded physician services to the RHAs. However, the AMA had a distinct preference, the status quo of direct bargaining with the province (Church and Smith 2008). The Alberta Medical Association feared that its power would be reduced if it were forced to negotiate with seventeen RHAs. The Klein government eliminated these concerns by continuing the status quo. The policy reversal was significant because the Klein government forfeited its opportunity to weaken the power

of the physicians. The government's decision to retain the existing bargaining arrangements was a major concession. The government knew any significant losses imposed on physicians could generate significant opposition. As Church and Smith (2008) posit, "[w]hile government was able to make significant institutional change, compromise with the dominant interest was necessary to achieve this change" (234). The concession helps explain why the physicians never organized a campaign to oppose the government's health care reform akin to that in Ontario. The government used several tactics – compensation and policy reversal – to defuse physicians' opposition.

The Alberta PC government was not as generous to other health care interests. When RHAs across the province announced plans to close several hospitals, the province did not intervene. Nevertheless, hospital closures are risky political endeavours. As such, a hospital closure can easily generate considerable backlash. The government encountered such resistance when the Capital Health Authority (CHA) announced plans to close the Grey Nuns Hospital in Edmonton. Following this announcement, the community assembled a massive protest on the steps of the Alberta legislature attended by around 15,000 people (Helmer 1995). The opposition to Grey Nuns was not an isolated event. In fact, Cooper and Kanji (2000) assert there were similar public protests after the RHAs had announced the slated closures of other hospitals in Calgary and Edmonton. Unlike Ontario however, the government did not overturn the RHA closure decisions. In the case of Grey Nuns hospital, the Health Minister ignored protests and assured the media that the government would not intervene (Helmer 1995). The government's decision not to intervene in hospital closures demonstrated that the Regional Health Authorities were 'apolitical'. As R. Kent Weaver (1986) and Pierson

(1994) note, the refusal to publicly engage with these RHAs was nothing more than 'buck passing' or 'obfuscation'. By distancing itself from unpopular hospital closures, the government escaped the political costs of loss imposition.

Avoiding Accountability: The Use of Institutional Mechanisms

Many scholars have suggested that part of Klein's government's success was its populist' appeal. However the Alberta PCs often engaged in practices that run counter to populist ideals. On several occasions during the health care debate, the government used orders-in-council to avoid legislative debates (Jeffrey 2000). The government's disregard for legislative accountability suggests why the Alberta Liberals were ineffective in opposing health care reform.

As Brooke Jeffrey's (2000) findings illustrate, the Klein government also invoked closure 21 more times than any other Alberta government. In doing so, the government weakened the Liberal opposition. The government's avoidance of legislative accountability strengthened its capacity to impose loss[2]. Since the debate in the legislature was limited there were increasingly limited mechanisms for critics to oppose the government's health care reform.

The ease with which the Klein government was able to avoid accountability underscores the Liberals' weakness. The Harris government likely could not have imposed restrictions on legislative debate. Had it tried, the Ontario government would likely have generated a substantial uproar from the two opposition parties. In this sense, the Klein government's capacity to impose loss was further strengthened by Alberta's

[2] I should note here that the use of such practices completely undermines the deliberative and democratic virtues of parliamentary debate. Nevertheless, the aim of this thesis is not to question the normative dimension of loss imposition.

weak legislative opposition, a weakness that was reinforced by the government's tactical use of accountability avoidance measures.

The Alberta Conservative government reformed its health care delivery system in the early 1990s. The creation of RHAs was the government's main mechanism to carry out loss imposition policies in the health care sector. The government also faced obvious obstacles to loss imposition: organized interests and opposition parties. Nevertheless, it easily overcame these barriers. The Klein government's success can be attributed to its own political skill and the weakness of its opponents.

Ontario and Alberta: An Analytical Comparison

The Ontario and Alberta governments' experience with health care reform in the 1990s can be examined through a loss imposition lens. According to my hypothesis, a government's capacity to impose loss is determined by: [1] the strength of political opponents in the legislature; and [2] the tactics the government uses to defuse potential resistance. Accordingly, these variables are necessary but not sufficient conditions for loss imposition. The comparison of the Ontario and Alberta confirms the predictions of my hypothesis. The Alberta Progressive Conservative government embarked on an ambitious health care reform agenda that sought to incur costs on many different groups. The Klein government's achievement of loss imposition can be attributed to its skilful use of political strategy and the underlying flaws of reform opponents. In the legislature, the Klein government faced a weak and ineffective official opposition whose ability to resist Klein's health care reforms was minimal. Outside the Alberta legislature, the government encountered resistance from health care reform opponents. In contrast to the

Ontario case, however, the Alberta government was able to overcome its opponents. The Klein government showed a marked ability to neutralize its opponents. The Alberta PCs used a three-pronged strategy to contain opposition. First, it avoided responsibility for loss imposition by delegating the implementation of expenditure cuts to appointed, 'apolitical' Regional Health Care Authorities. Second, it disarmed physicians by 'compensating' the Alberta Medical Association with modest benefits. Third, it used its majority power to avoid legislative accountability. In effect, the opposition's capacity to resist the government's reform was even further weakened.

In contrast, the Ontario government was unable to achieve many of its proposed health care reforms. The Harris Conservative government could not impose losses. Several pertinent differences stand out in the Ontario case. First, the Harris government faced a much stronger legislative opposition. Both Liberals and NDP had recently formed governments and thus had extensive experience handling health care issues. The opposition's edge over Harris' relatively untested cabinet was made apparent in Question Period. The effort by the opposition to blunt health care reform was especially evident in hospital restructuring. When the Harris government made the mistake of engaging with the 'apolitical' Health Services Restructuring Commission, the opposition seized the political opportunity to embarrass the government. While the government had attempted to avoid responsibility for hospital closures, the opposition parties undercut this blame avoidance strategy.

The Harris government also failed to devise effective strategies to weaken its opponents. In the case of hospital restructuring, the Commission was forced to reverse many of its closure recommendations. The efforts of several well-organized opponents

forced the Commission's policy reversals. In the case of Alberta, however, in the face of opposition, the Regional Health Authorities and Klein government refused to overturn the RHAs decisions. The inability of the Harris government to contain opposition is also exemplified in its attempt to scale back the power of the province's physicians. When the Conservative government tried to make unilateral changes to its agreement with the physicians, its attempts at reform were defeated by a massive resistance campaign. The Harris government's approach to its relations with physicians was confrontational. In Alberta case, the PC government recognized the need to gain physicians' support. The Klein government compensated the doctors in order to gain this group's support.

The Alberta and Ontario cases support the predictions of my loss imposition hypothesis. Governments have a greater capacity to impose loss when they face weak legislative opponents and when they employ tactics that undercut and blunt opposition messages.

Conclusion

The findings of this thesis have practical implications for the future of social policy. The current recession has seen an unparalleled surge in government spending. After the dust settles, governments will seek to balance their budgets and pay off debts. If the recession of the 1990s is any indicator, significant service cutbacks are likely. The types of loss imposition policies examined in this analysis could be more common in the future. The findings presented in this thesis will come to become more commonly employed.

My central findings also raise fascinating questions about loss imposition. The most important question pertains to the proposed hypothesis. Will my hypothesis hold up when other social programs, education and income assistance as examples, are studied? If not, is there something unique about health care that affects loss imposition capacity? Health care is a vitally important policy area - my findings might overestimate the difficulty of imposing loss in other policy areas.

Do governments learn about loss imposition by watching the experiences of other governments? In British Columbia, the Campbell government implemented many of the same loss imposition policies as Harris and Klein including in health care. Did Premier Campbell learn from Klein and/or Harris?

The power of organized medicine is another major and perennial issue. Physicians can be a significant barrier to health care reform. Given the immense power of physicians to shape public policy, it would be useful to investigate whether any other interest group holds similar levels of influence in another social policy realm.

Finally, Canadian federalism requires more analysis. In health care, the federal government plays a central fiscal role and enforces certain principles through the Canada Health Act. Does the fact that health care involve both levels of government protect it from retrenchment? Does federalism provide more opportunities for blame-avoidance? More generally, how does federalism shape governments' capacity to impose loss?

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