HEALTH CARE REFORM IN NOVA SCOTIA:
A STUDY IN PRESSURE GROUP POLITICS, 1993 - 1996

by

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ABSTRACT

This thesis examines pressure group politics in the Nova Scotia Health sector (1993-1996) to determine the level of influence interest groups had in shaping public policy with respect to the Savage government's health reform agenda.

Through this examination, the author determines that group politics in this instance followed a pluralistic model. Interest groups had influence promoting and preventing public policy. However, the state was able to resist interest group pressure, which suggests that its autonomy is not significantly threatened by pressure group politics. Ultimately, the author determines that political leadership by state elites is sufficient to resist interest group influence.

ABBREVIATIONS

AOANS	-	Ambulance Operators Association of Nova Scotia
CRFSA	-	Canadian Restaurant and Food Services Association
DOH	-	Nova Scotia Department of Health
EHSNS	-	Emergency Health Services Nova Scotia (Agency)
EHS	-	Emergency Health Services
ETS	-	Environmental Tobacco Smoke
LIB	-	Liberal Party of Nova Scotia
MLA	-	Member of the Legislative Assembly (Nova Scotia)
NDP	-	New Democratic Party (Nova Scotia)
NSGEU	-	Nova Scotia Government Employees' Union
NSMS	-	Nova Scotia Medical Society
NSNU	-	Nova Scotia Nurses Union
NSRFSA	-	Nova Scotia Restaurant and Food Services Association
PC	-	Progressive Conservative Party (Nova Scotia)
QEII	-	Queen Elizabeth II Health Sciences Centre

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"If I have seen further, it is because I have stood on the shoulders of giants."
- Sir Isaac Newton

For my parents

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INTEREST GROUP/STATE DICHOTOMY: A THEORETICAL OVERVIEW

INTRODUCTION

The role interest groups play in the shaping of public policy has significant implications for democratic theory. In the Canadian context, pressure groups (special interest or interest groups) have a contested role in relation to the state which is open to various interpretations. Political theorists are often divided in terms of recognizing the legitimacy of pressure groups as actors in the political system. Pluralists would argue that their role is useful in preserving a viable system of representation which is fundamental to individuals' freedom of expression in accessing their government. The opposing view contends that interest groups operate outside the historical structure of parliamentary democracies and as unelected bodies are not legitimate because they do not have a mandate as representative organizations. As a result, they are largely unaccountable to legislatures and to the electorate. In short, the rise of interest–group politics clashes with the established political party dominant system.

This chapter will focus on defining pressure groups with particular reference to the Canadian experience. The implications of the rise of interest–group politics will be examined with emphasis on both the empirical and the normative aspects. What role do interest groups have? What role should they have? To what extent are they legitimate? I will argue that interest groups do have a role in the creation of public policy; however, they do not, significantly, impact on the autonomy of the state or adversely affect governability.

DEFINITION OF PRESSURE GROUPS

The core of what is termed "interest–group politics" are organizations formed by individuals to pursue their collective interest in the political arena. Pressure groups, or interest groups, include a diverse and large group of organizations ranging from business, labour and specialized "issue–oriented" movements. A succinct definition of a pressure group is provided by Dr. Greg Pyrcz in *Representative Democracy: An Introduction to Politics and Government*: "any group of citizens seeking to bring about or preserve their preferred state(s) of affairs by means of power, directly or indirectly affecting governments, without standing for elected office."[1]

The origin of pressure groups in the parliamentary system can be traced to seventeenth century Britain where various individuals hoping to influence government decisions would attempt to convince Members, in the parliamentary lobby of the House of Commons, of the validity of their position. The often pejorative word "lobbying" is used to describe everything from constituents seeking the counsel of their Member of Parliament to bureaucracies being contacted by lawyers representing professional associations.[2] Lobbying was defined by Walter Baker, MP, while discussing his private member's bill to set up lobbyist registration in 1977:

> I think of a lobbyist as someone who seeks, by means of contact with persons of power or influence, to have a significant effect on executive or legislative actions to be taken by the government of Canada. Lobbyists act directly for themselves, or on behalf of organizations which hire professionals to make their case. Lobbyists are, in short, special interest and pressure group publicists or their representatives.[3]

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[1] Greg Pyrcz, "Pressure Groups," in T. C. Pocklington (ed.), *Representative Democracy: An Introduction to Politics and Government* (Harcourt, Brace and Company, Canada, 1994), p. 328.

[2] Claude Emery, *Lobbying and Democracy* (Ottawa: Research Branch, Library of Parliament, 1992), p. 3.

[3] *Ibid.*, p. 2.

"Lobbyists" as pressure groups have a common element in that they are organized, which distinguishes them from "mob demonstrators" and "movements." A mob may make short–term political gains; however, they (mobs) cannot be sustained because they have no mechanisms for long–term existence. Conversely, a movement does exist over time, yet it is too generalized in its representation of public opinion to be characterized as a pressure group.[4] This capacity to be formally organized allows pressure groups to have a more sustainable impact on governments.

It is difficult to assign definitive characteristics to pressure groups beyond generic and broad generalizations. Nevertheless there are some uniting factors. All pressure groups have a formal organization which provides continuity; they articulate interests; they work within the political system to influence government action; they attempt to influence those in power rather than exercise the responsibility of governing and enacting policies themselves.[5] However, pressure groups are as diverse in structure and function as the society in which they originate. Mainstream pressure groups which represent large interests are easily recognized and classified. Groups representing large labour unions (e.g., the Canadian Labour Congress) and business interests (e.g., the Canadian Chamber of Commerce) have considerable resources and ready access to government decision–makers. At the other extreme are those single–issue advocacy groups which are located on the political "fringe". They usually have modest resources and limited access to decision–makers (e.g., "environmental illness" advocacy groups).

A group's effectiveness can be evaluated by the success it has in placing its issues on the government's agenda and having them adjudicated in the group's favour. Also, successful pressure groups often attain financial and technical resources which allow them to remain

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[4] Paul Pross, *Group Politics and Public Policy* (Toronto: Oxford University Press Canada, 1986), p. 4.

[5] Emery, p. 4.

"players" in the policy arena. Modern interest groups take a dual approach to advancing their interests: the first involves seeking access to key civil servants and politicians in hopes of influencing the decision–making process internally; the second involves attempting to influence public opinion by appealing to a mass audience. The specific tactics employed by pressure groups to achieve these goals vary widely. Some common strategies involve appealing to the public through the mass media with "public information campaigns," door–to–door canvassing, public demonstrations, and letter writing campaigns to newspaper and magazine editors. Groups will attempt to influence parliamentarians by lobbying constituents, by letter-writing campaigns directly to legislative members and by presenting briefs to parliamentary committees. Some groups take a more subtle approach and will attempt to "get close" to key officials by forming friendships and alliances with the official directly or through some close associates, enabling the relationship to be exploited for the group's advantage. This strategy of "networking" is low key and might be considered unethical; however, it certainly can lead to dramatic results.

In summation, a pressure group seeks to influence government by using levers inside and outside the formal structure to achieve the group's common objectives. Affecting policy outcomes is not limited to attempting to sway the view of parliamentarians directly; well–organized groups will attempt to influence public opinion through the mass media to mobilize constituents in selected members' ridings, and to contact relevant civil servants in an effort to present its policy preferences.

Finally, an important distinguishing characteristic of pressure groups is that despite their willingness to be politically active, they do not run candidates for political office. Political parties, for example, fit many of the aforementioned characteristics; however, they seek to shape the policies of government by placing candidates on the ballot. Pressure groups usually have interests that are too narrow to be attractive to the mass public, making it difficult to

form a large enough base to be competitive with mainstream political parties in an election campaign.

CANADIAN EXPERIENCE

Pressure groups in some form or another have always had a role in Canadian politics. Prior to the 1960s, their role was certainly less dramatic as compared to the United States. Despite some notable exceptions, such as the "on to Ottawa" trek of the unemployed in the 1930s, they were supportive of the state and not inclined to be confrontational.

Canadian interest groups up until the 1960s had their influence on the state overshadowed by political parties. Generally pressure groups were considered the "silent partner" of government. Operating under the belief that the Canadian parliamentary system concentrated power in the hands of the cabinet and senior officials, most groups worked behind the scenes with government. This strategy was followed so as not to risk any long–term damage in accessing the political élite by "unnecessary" public confrontations.

A proliferation of pressure groups became evident in the early 1960s. Professional associations, and business and advocacy groups increased in number and effectiveness. This dramatic shift in interest–group politics is attributed to changing social attitudes that had begun with the Depression.[6] Technological changes such as the use of television and changes in the mass media as a result of this new medium played a role. The influence of American movements and pressure groups also had an impact. It is almost certain that American interest–group politics were mimicked in Canada.

The Liberal government led by the Rt. Honourable Pierre Trudeau (1968–79/1980–84) encouraged the development of pressure groups through its "participatory democracy" policy. At a time when the legitimacy of closed decision–making processes was being questioned,

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[6] Lorna Marsden, *The Party and Parliament: Participatory Democracy in the Trudeau Years*, in Thomas Axworthy and Pierre Trudeau, *Towards a Just Society* (Toronto: Penguin, 1990), p. 263.

Trudeau responded with a commitment to include a wider and more diverse group of people in positions of influence on public policy.[7] This commitment included funding for pressure groups and increased access to the cabinet and other decision–makers. This increased legitimacy for pressure groups led to an expectation that Canada was adopting a "modern, pressure group, interest–based politics at the heart of its representative democracy."[8]

Pressure group politics received additional prominence in the debate surrounding the patriation of the constitution. Minority interest groups won hard–fought concessions in terms of recognition in the *Charter of Rights and Freedoms*, and still play an active role in seeking favourable interpretations in the courts. In fact, some political theorists argue that the adoption of the *Charter* has fundamentally and irrevocably altered the dynamics of interest–group politics. The notion of parliamentary supremacy is tested "by a new era of judicial activism ushered in by the *Charter*."[9] No longer is it necessary for interest groups to be confined in the political executive and senior bureaucracy to influence the decisions of government; with the rise of *Charter* politics, issues of public policy can now be decided in the courts.

Many precedents exist to demonstrate how interest groups have successfully used *Charter* litigation to achieve their policy objectives. Pro–abortion groups financially assisted Dr. Henry Morgentaler's successful challenge of Canada's abortion law in *R.* v. *Morgentaler* [1988].[10] In another case, the National Citizens' Coalition successfully challenged the *Canada Election Act* and overturned restrictions on non–party spending during elections.[11] It may be

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[7] Pross *The Pressure Group Conundrum* in James P. Bickerton & Alain-G. Gagnon (eds) *Canadian Politics* (Broadview Press, 1994), p. 179.

[8] Pyrcz, p. 349.

[9] Rainer Knopff and F. L. Morton, *Charter Politics* (Toronto: Nelson Canada, 1992), p. 20.

[10] *Ibid.*, p. 29.

[11] *Ibid.*, p. 27.

successfully argued that the adoption of the *Charter* has entrenched the prominence of interest–group politics in Canadian public life for the indefinite future.

Despite the rise of pressure–group politics in the Trudeau era, the pendulum swung in the other direction with the election of the Rt. Honourable Brian Mulroney in 1984. His government pursued policies that sought to reduce the influence of pressure groups on the state and to reverse the direction Trudeau had initiated with his "participatory democracy" policy. The Mulroney government (1984–1993) followed two strategies to constrain pressure–group politics. The first was to reduce their access to cabinet, and the second was to withdraw financial support vital to key groups.[12]

The first strategy effectively limited pressure groups' access to key policy–makers. The Mulroney administration reasoned that its electoral mandate should not have to endure influence from unelected groups which threatened the state's autonomy. Groups representing minorities and those who have been traditionally disadvantaged in Canadian society were particularly singled out.

The second strategy worked in conjunction with the first in that it worked to reduce the level of effectiveness of pressure groups by cutting off their established operating procedures. This particular strategy was rationalized under the administration's fiscal restraint policy which set forth the argument the government could no longer afford the luxury of funding special interest groups.

Whether this policy contributed to the ultimate rout the Progressive Conservative Party faced in the fall of 1993 is certainly a point of conjecture. However, what is clear is that the Mulroney government was not successful in eradicating the impact of interest–group politics in the Canadian political system; in fact, interest groups still play a significant role in the public policy process.

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[12] Pyrcz, p. 350.

INTEREST GROUP INFLUENCE AND THE AUTONOMY OF THE STATE: A DISCUSSION OF THE ANALYTIC FRAMEWORK

This thesis will address two main theoretical issues; the first is empirical, the second is normative. Empirically, we must determine the extent and nature of interest group influence. From here we can proceed to a normative discussionon what role interest groups should have in determining public policy and whether they are a threat to representative democracy.

Robert Dahl discusses the concept of "indirect" influence in his structural analysis of New Haven in *Who Governs?*; he argues that, "Indirect influence might well be very great but comparatively difficult to observe and weigh. Yet to ignore indirect influence in analysis of the distribution of influence would be to exclude what might well prove to be a highly significant process of control in a pluralistic democracy."[13] This sentiment is seconded by Paul Pross, who is equally critical of structural analyses that ignore non-state actors who may influence public policy. Pross pays tribute to the early works on interest group influence, such as Bentley's *The Process of Government* and Truman's *The Government Process.* However, he laments the lack of an analytic framework in the study of group politics, which has only been addressed substantively since the late 1980's.[14] Theoretical issues are important, because they provide a context for case studies, thus allowing for the possibility of discerning trends and predicting behaviour.

> ...We need to understand the reciprocal benefits involved in order to discover why some groups are so much more influential than others. By studying how, when, and where groups exert pressure on the system, we learn a great deal not only about groups, but about the system as well. Case studies teach us, for example, that the policy process is highly bureaucratic and that the most successful groups are those that know whom to talk to... by classifying the information of

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[13] Robert Dahl, *Who Governs? Democracy and Power In a American City* (New Haven:Yale University Press, 1989) p. 89.

[14] Pross, *Group Politics*, p. 13.

> case studies, we discover that different types of groups tend to follow predictable behaviour patterns that can be related first to what the political system expects of groups, and second to the resources that groups bring to the process. Case studies, then, help us classify; typologies help us find out why groups play the roles they do. By applying the analysis thus achieved to historical data, we can see how the roles of Canadian groups have changed over time and observe trends that are currently at work.[15]

The literature suggests that interest groups can develop their policy preferences and influence the state. As Pyrcz states "Pressure groups do not simply express their members' interests and opinions to government; they employ political resources to effect policies favorable to these interest and opinions."[16]

Pross generally describes the conditions which are sufficient for interest groups to influence public policy:

> ...they (pressure groups) are motivated by the limited resources available to groups and by the limited tolerance of members... to search out the most efficient means possible of identifying key decisions centres. Successful group leaders husband their resources and learn to understand the decision centres that can best effect the changes they desire: they do not waste time persuading the uninfluential... Pressure groups act to influence the decision centres that can best effect the changes they wish to bring about.
>
> ... the character of pressure groups in any particular system will be the product of interaction between the internal resources of the groups themselves and the political system in which they are found. The points of access to policy-makers differ in each political system, and because groups must avail themselves of the access points peculiar to the system in which they operate, pressure groups perform comparable functions differently in different systems. Collectively their patterns of adaptation will... indicate the location of power in the system. Individually their attempts to take advantage of appropriate access points or targets cause groups to adapt their behavior and structure to the conditions imposed by the sector of the political system in which they operate, so that particular groups stress some structural and behavioral patterns rather than others.[17]

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[15] Ibid., p. 15.

[16] Pyrcz, p. 341.

[17] Pross, Group Politics, p. 109.

Both Pross and Pyrcz imply that, in the Canadian parliamentary system, successful pressure groups exhibit some common characteristics. Pross classifys these groups as *institutional* and describes them as responsive and adaptive organisms. He identifies five criteria:

> **(i) They possess organizational continuity and cohesion.**
> (Sophisticated organizational structure with an efficient internal communications component.)
>
> **(ii) They have extensive knowledge of those sectors of governements that affect their clients, and enjoy easy communications with those sectors.**
> (Effective access to relevant members of the bureaucracy.)
>
> **(iii) There is a stable membership.**
> (Commitment to the organization must extend beyond "short'term" policy objectives.)
>
> **(iv) They have concrete and immediate objectives.**
> (A broad enough mandate to allow for the strategic or pragmatic use of negotiating tactics with governement.)
>
> **(v) Organizational imperatives are generally more important than any particular objective.**
> (Policy objectives are not achieved at the expense of extensively harming the rapport between the group and government, as well as other actors in the policy sector.)[18]

Developing an organizational capacity which can interact effectively with the bureaucratic/policy system is paramount for *institutional* interest group. A group enhances its access by becoming "adept at research in order to master the required technical detail; it acquires legal and public relations skills to ensure the effective

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[18] Ibid, p. 114-115.

presentation of its position; and it builds a capacity to monitor the implementation and further development of policy."[19]

A component, which is, surprisingly, missing from the practice of successful group politics is the use of the mass media to influence public opinion. Both Pross and Pyrcz state that the *institutional* groups are reluctant to use the media to advance their policy objectives (which is consistent with "criteria V" cited above) because of the potential for public confrontation with members of the bureacracy and elected officials. Obviously, protracted public debates with state elites may adversely effect access to the bureaucracy which would impair the interest groups "long-term" viability.

An attempt will be made to categorize the pressure groups examined to see if they meet the criteria for *institutional* groups. In addition, we will determine whether these pressure groups which meet the *institutional* criteria are more successful in influencing public policy

This thesis will attempt to identify the extent and nature of interest group influence on public policy, by contrasting the policy preferences of state actors with these articulated by affected interest groups. Specifically, we will examine the efforts of the Government of Nova Scotia, from 1993 to 1996, to reform the health care system to determine to what extent special interest groups were able to influence their development and implementation.

In relation to the state, interest groups have two objectives; either they wish to promote or they wish to prevent (or a combination of the two) government policy action in relation to their interests. Government policy actions for the purpose of this study may be defined as enacting legislation and/or regulations (orders-in-council passed by cabinet) or government department policy altered (e.g. restructuring a division, altered behavior when dealing with the enforcement of legislation). An important part of this analysis is to

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[19] Ibid, p. 110.

confirm, to the greatest extent possible that the government policy action cannot be attributed to other competing sources (e.g. the mass media, bureaucracy, the government caucus).

To determine if an interest group was successful in preventing a government action the policy issue must have been articulated by the government in its election platform, speech from the throne, a major policy document approved by the priorities and planning committee (sub-committee of cabinet) or the governement action must have been articulated in public by the premier or another member of the executive council. Furthermore, the interest group must have stated in its literature, through the media or another significant forum their intention to oppose the government policy action. Admittedly, as is the case in determining when pressure groups have successfully promoted a policy action, measuring the extent to which government policy was aborted due to interest group influence will be in some cases ambiguous, given other factors which influence the process.

A variety of methodological tools will be used in this thesis. Specifically, a textual comparison will be made between the election platform and the policy outcomes. Chapter two will address this undertaking in detail, including a comparison between relevant government documents and the election pledges. Where inconsistencies become evident an attempt to attribute the "gap" to the appropriate cause will be made. In each of the case studies, I will examine the media coverage, legislative debates, internal government documents, interest group literature and personal interviews. Wherever feasible, I will also draw on my own insights as the executive assistant to the minister of health, 1993-1996, in an attempt to determine the effect of group politics on the Savage government's health policy.

The case studies selected represent a diverse range of interest groups and health policy issues. Chapter three will examine the Nova Scotia Medical Society's reaction to

the Nova Scotia Department of Health's reform measures with respect to physician services. Chapter four investigates the relationship between the Ministry of Health and the Ambulance Operators of Nova Scotia and the controversy surrounding the Savage government's agenda with respect to emergency health services. Labor unions as interest groups are examined in chapter five which scrutinizes the Nova Scotia government's merger of four acute care hospitals into the Queen Elizabeth II Health Sciences Centre. Finally, chapter six analyses pressure groups interested in the Savage government tobacco control strategy. Both health promotion groups and those representing the hospitality and tourism industry are examined, particularly with respect to Health Minister Stewart's initiative to ban smoking in public places.

The normative question will be addressed in the conclusion (chapter seven) after an analysis of the original empirical question is completed.

PRESSURES GROUPS AND PLURALISM

So far in our discussion, we have focused on a description of pressure groups and generally how they operate in Canada. Some attention should be paid to the theoretical debate on interest–group politics as advanced by pluralists. We will examine the issue of representation and the dynamic between pressure groups and parliament. It is the central premise of this thesis that Canadian interest group politics exhibit pluralistic tendencies.

Advocates of interest–group politics argue that it is a fundamental right of citizens to associate freely and form groups to debate and influence government policy. The argument is made that the proliferation of pressure groups is the natural extension of a democratic system. With the ever–increasing demands on government and political parties, a modern society will turn to other groups to fill a role that traditional institutions are perceived to be incapable of meeting. Paul Pross argues that pressure groups have increased in prominence because they

are effective where parties fail.[20] The electoral system in Canada is based on the single member district with the plurality or the "first past the post" standard. This focuses political parties' attention along constituency boundaries and allows pressure groups to attract "sectors" of interests which cross constituency lines. Some argue that the constituency model is inadequate because it is not representative and cannot articulate society's requests of governments:

> Collective activity is always too complex to be able to be expressed through the single and unique organ of the state. Moreover, the state is too remote from individuals, its relations with them too external and intermittent to penetrate deeply within individual consciences and socialize them within. When the state is the only environment in which men can live communal lives, they inevitably lose contact, become detached and society disintegrates. A nation can be maintained only if, between the state and the individual, there is a whole series of secondary groups near enough to the individuals to attract them strongly to their sphere of action and drag them, in this way, into the general torrent of social life.[21]

Pluralists argue that pressure groups have an essential role in the preservation of democracy. "This theory promotes the development of social heterogeneity and regards voluntary groups in society as welcome agents. Some would argue that an absence of such groups would render modern government ungovernable."[22]

The theory of pluralism has its roots in classical liberalism. It holds a high regard for individual interaction with the state. Pluralists will argue that society can be defined as a dynamic of competing group interests. This notion has its basis in the Hobbesian "state of nature" thesis. In this "state," people are necessarily engaged in a constant struggle for power; however, individuals, being rational, understand that in order to avoid death (the primary law

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[20] Pross, "Pressure Groups: *Talking Chameleons*, in Whittington and Williams (eds.), *Canadian Politics in the 1980s*, p. 221.

[21] Emile Durkheim, "The Division of Labour," in Emery, p. 4.

[22] Emery, p. 5.

of nature) they must resolve to escape from the state of nature. As Hobbes explains, life in the state of nature is harsh:

> No place for Industry; because the fruit thereof is uncertain and consequently no Culture of the Earth; no Navigation, nor use of the commodities that may be imported by Sea; no Instruments of moving, and removing such things as require much force; no Knowledge of the face of the Earth; no account of time; no Arts; no Letters; no society; and which is worst of all, continual feare [sic] and danger of violent death; And the life of man, solitary, poor, nasty, brutish and short.[23]

As a result, the only reasonable course of action, according to Hobbes, is to enter into a social contract by which all parties renounce their "rights of nature" at the same time. Furthermore, to avoid falling back into a state of nature, individuals must agree to transfer their natural powers to a sovereign authority to protect themselves. Observing that humans are doomed to self–destruction, individuals agree to an extent for mutual survival. Such a social contract was not literally signed, but the state of nature is so unbearable that both parties agree to obey a third party more powerful than either of them.

Though members of society may surrender some individual freedom in an attempt to create social order, the pluralists accept that individuals must have the freedom to associate and petition the state. Group politics, on this account, is a desirable activity because it provides the rational individual with a vehicle for interest articulation and influence on the state. The liberal approach states that rational man/woman is the highest order of human evolution, and individual freedom is the only means to achieve this intellectual ideal. Allowing individuals to associate freely and having a rational discourse with the state is essential for the development of democracy.

An example of the supremacy of individual freedom as found in liberalism can be seen in Pierre Trudeau's articles in *Cité Libre Magazine*. One example is particularly revealing:

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[23] Thomas Hobbes, *Leviathan* (Middlesex: Penguin, 1978), p. 186.

> The state must take great care not to infringe on the conscience of the individual. I believe, in the last analysis, a human being in the privacy of his [sic] own mind has the exclusive authority to choose his [sic] own scale of values and to decide which forces will take precedence over others. A good constitution is one that does not pre–judge any of these questions, but leaves citizens free to orient their human destinies as they see fit.[24]

Interest–group politics as a means of engaging in participatory democracy is attractive to the pluralist. Rational individuals have a fundamental duty to participate in the political system. To paraphrase Plato, the liberal reasons that "the price people pay for not concerning themselves with politics is to be governed by people worse than themselves" and "a state in which the citizens take no interest in political matters is doomed to slavery."[25]

On this account participatory democracy involves, first of all, the removal or reduction of obstacles to active public involvement. Interest–group politics, as one of the means of increasing public involvement in the political system, is enhancing liberty and the viability of democracy.

So it is on the basis of classical liberal reasoning such as John Stuart Mill's defence of the freedom of thought and discussion in *On Liberty* that pluralists rest their case for advancing the cause of interest group proliferation. It is important to recognize that pluralists are advocates of pressure–group politics in that they act as an alternative or counterweight to other political "actors" such as elected politicians and other state élites.

Arthur Bentley was an extreme pluralist who argued that the state does not internalize interests in society unless they are sustained through some sort of group activity. On this account, the state is reduced to merely being a referee among interests and various group demands. The state does not independently articulate general or national policy preferences

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[24] Bruce Thordnson, *Trudeau and Foreign Policy* (Toronto: OUP, 1975), p. 55.

[25] George Radwanski, *Trudeau* (New York: Taplinger, 1978), p. 123.

which are not the result of group activity; all issues are determined by conflicting group pressures.[26]

Critics of Bentley and early pluralists focus on their definition of pressure groups as too broad and vague. As well, there was no requirement for groups to be formally organized which left individuals being defined as a "bundle of interests" which overlap and compete with each other. Another factor which is dismissed by Bentley is the role of the individual, especially state élites who may have particular goals and interests which they have the power to implement beyond the influence of group activity. For our purposes, it seems difficult to draw any viable conclusions from Bentley's vague distinctions in group activity. This is compounded by the fact that obvious counter–forces are ignored or discussed with no supporting explanation. If group conflict is the essence of political life, then a more reliable analytic tool is required for a credible analysis.

Pluralists, in reaction to critical attack from anti–pluralists including Marxists and others, began revising their original principles as expressed by Bentley and others. At the centre of this revision was the realization that the political system may not be as "self–correcting" as first supposed. A somewhat cynical view of the state (particularly in the United States where pluralism flourishes) as a network of élites engaged in a massive deception of the public and manipulation of the state apparatus for their own interests began to develop. Revisionist theory held that, yes, all individuals had the right to participate in group politics; however, the opportunity to do so was not equally shared. This notion stuck down the pluralist assertion of politics as a competitive marketplace and replaced it with a view of politics as a means for limiting competing interests for the privileged minorities.

The acceptance of élite–driven policy formulation in the interest group hierarchy, as in the state apparatus, has led to a new model in pluralism's account of group politics. E. E. Schattschneider, as a post–pluralist, reasoned that some issues are "organized into politics

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[26] Pross, *Group Politics and Public Policy*, p. 229.

while others are organized out, suggesting that conflict can be contained through the management of consensus."[27] This position is a compromise between pluralists and corporatists which emphasizes consensus management and the increasing role of the state in the policy development process. This is a fundamental recognition that state agencies have a role in managing the political economy.

For Canada, the evolution of post–pluralist ideology has focused on cabinet as the centre of political power and the development of policy communities (specialized interest groups). The policy community assists governments by providing specialized expertise on policy issues. In an era of decentralization and the proliferation of information technology, they play a supportive role for government agencies which have become increasingly far removed from the authority of the cabinet table.

The pluralist model seems to have direct relevance to the case study of health reform in Nova Scotia. Joan Price Boase, in her book, *Shifting Sands: Government–Group Relationships in the Health Care Sector*, argues that the Nova Scotia health system, during the 1980s and early 1990s, was not centrally well-managed or well-coordinated by the Nova Scotia Department of Health. The Department is characterized as having an "ad hoc," pluralist approach and of being "a traditionally organized department."[28] Boase uses evidence from interviews with departmental staff to strengthen this position. Staff claimed that "policy making was reactive, incremental, and gradual." One senior departmental official remarked that there was no policy, that government "stick handling" or ad hoc management had been fairly successful, and that enunciated policy might not improve the approach.[29] Although the circumstances which existed during Boase's work have changed significantly since 1993, there is still considerable evidence to sustain her argument.

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[27] Ibid, p. 235.

[28] Joan Price Boase, *Shifting Sands: Government–Group Relationships in the Health Care Sector* (Montreal/Toronto: McGill–Queen's University Press, 1994), pp. 117–119.

[29] *Ibid.*

In a more recent examination of the Nova Scotia Government's Health Reform Agenda, Bickerton argues that the Savage Government's strategic position has been compromised to interest groups who wish to defend the status quo:

> The budget pressures driving reform were greater than in British Columbia and demanded immediate savings rather than at some future point; moreover, Community Health Services in the province were much less developed than was the case in British Columbia when that province began its reform. Hospitals, the main item of Health Care expenditure, had to be the first and foremost target of cost reduction. At the same time, other reforms needed to begin simultaneously if there was to be any hope of mobilizing and maintaining a coalition of interests who stood to gain from changes to the Health Care System; otherwise entrenched interests who stood to gain from changes to the Health Care System; otherwise entrenched interests who opposed reform could focus political debate exclusively on cuts, reductions and threats to existing services, galvanizing opposition and creating the climate for a government retreat from its reform agenda.[30]

The underlying assumption in this analysis is that pressure groups have influence over public policy. In fact, Bickerton seems to applaud the increased democratization of administration and a move to more "people power", implicit in the Savage government's creation of community and regional health boards,[31] this further cements the pluralistic tendencies of the Nova Scotia Health Care System

On the normative level, this approach raises several ethical issues, including the legitimacy of policy communities as contrasted with the role of elected legislatures. Policy communities do not have a formal mandate from the electorate — is it appropriate that they influence the policies of government? Another serious concern is the issue of representation within policy communities and the process they use to bring policy preferences to the public agenda. It can be argued that pressure groups merely represent another level of élite tyranny. Pressure group élites have no accountability to the public outside of their specific group and

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[30] James Bickerton, "Health Care Reform in Nova Scotia: Redesigning Democracy?" A paper presented to the Annual Meeting of the Canadian Political Science Association, Brock University, Ontario, June 2-4, 1996, p. 16.

[31] Ibid., pp. 15-19.

the internal democratic structure of pressures groups varies widely and is certainly not readily accessible to public scrutiny. How can groups formed to articulate specific interests, mandated by a fraction of society, be in any way democratic? Post–pluralists argue that we are not ruled by the organized at the expense of the unorganized; pressure groups must respond to public opinion and remain accountable in order to be viewed as credible by the state. Consensus management, the foundation of the post–pluralist argument, states that adaptation and assimilation of a diverse public is essential for the sustainability of pressure groups. In summation, the argument is that pressure groups bring such a wide diversity of policy preferences into the agenda–setting process that they act as a counter–weight to the state and its related agencies, ensuring that political participation is maximized to the greatest extent possible.

Where the consensus–management model and the post–pluralist ideology suffer the strongest attacks is in the area of representation for the weak and disadvantaged. Traditionally, these segments of society have never had much success forming pressure groups with a lasting impact on the decision–making process. For the most part, groups which represent the poor and disabled lack the ability to communicate effectively with their constituency.

To the extent that we accept the post–pluralist view of state/pressure group dichotomy, we must conclude that interest–group politics has widened the spectrum of political participation and increased dialogue. Nevertheless, in the area of equal representation and advocacy for the underprivileged, it has seemed inadequate.

CONCLUSION

Our analysis has shown that group politics in Canada is an established and legitimate force in the political system and that it operates along pluralist lines. Although this legitimate role is recognized, the rise of interest–group politics has dramatic implications for parliamentary democracy. This thesis will be animated by a series of empirical questions. In particular, what role do pressure groups play in creating public policy, and what relationships do they have with the state? However, this work would not be complete without addressing the normative question of what role *should* pressure groups have in creating policy.

CHAPTER 2:

THE NOVA SCOTIA LIBERAL HEALTH PLATFORM AND POLICY OUTCOMES

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INTRODUCTION

In order to set the stage for the case studies on group dynamics and the development of the health reform process in Nova Scotia, it is necessary to establish the benchmark the government set for itself when it assumed office in June 1993. The Savage government presented its principles for health care reform during the election in a position paper entitled, "Liberal Health Care Policy." Within a year, Nova Scotia Health Minister Ron Stewart's "Blueprint Committee" released its agenda for health system reform. A progress report, "From Blueprint to Building," was released in April 1995 to provide an update on the reform process. These documents provide the cornerstone for our discussion in this chapter on the specific health care platform on which the Liberal government was elected. This proves useful as an analytical tool in that the government, by establishing its set objectives early in the mandate, allows us to measure their relative success in meeting this agenda. We can also clearly see in what areas the government altered or abandoned policy initiatives and attempt to determine the cause of these policy reversals.

This chapter will be divided into three sections. First we will examine the Liberal Party's health care platform of 1993, and any consultation the Liberals had with interest groups at this stage. However, this point is not overly significant in that the platform was endorsed by the electorate in the May 1993 elections. Yet it is a point of interest to examine briefly interest groups' efforts to influence the party process. Second, we will analyze the government

position papers to help clarify the health reform action plan. It is at this stage that attention must be paid to interest group participation in the shaping of the Blueprint Committee report, especially in areas where the Blueprint Report differs significantly from the Liberal health platform. This stage is crucial in our study, for if the health reform agenda is subverted in the beginning by interest groups involved in the report's consultation process, then it clearly can be shown that pressure groups play a major role in policy development. Of course, the counter argument is that the Blueprint Committee was structured to favour the policy preferences of the government and the health minister, which reduces the Committee's report to little more than a political tool to add legitimacy to the government's initiatives — both of these approaches will be examined. Finally, the chapter will conclude by examining the success of the health ministry in achieving the objectives laid out in the Liberal health platform. On this basis, we can begin to formulate a conclusion on interest group influence on health reform. If we see a high level of success in meeting the platform objectives, we may state that the government operated freely of interest group influence. Conversely, if we note a significant level of policy alterations or neglect, it may be possible to attribute this to a high level of interest group manipulation. This will be expanded upon in our more detailed discussion later.

NOVA SCOTIA LIBERAL HEALTH CARE POLICY, 1993

Formulating the Liberal Party's health care promises for the 1993 provincial election began in earnest at the Liberal Policy Conference held at Dartmouth High School in October 1991. It was here that Liberals gathered for a one–day policy workshop to establish the foundation and guide the Liberal caucus in formulating the platform. This process was

initiated by Liberal Leader Vince MacLean, who was subsequently defeated in a leadership review on February 28, 1992, and resigned as Leader of the Opposition on March 4th. The task of completing the development process was left to his successor, John Savage, who was elected Liberal Leader in June of 1992.

Following the consultation process with the general members of the party, a specific paper was produced by Liberal caucus research staff with direction from the Liberal Leader and caucus members. A senior advisor to Savage, who played a direct role in the shaping of health platform, confided in me about a number of key points concerning its development. Upon assuming the leadership of the Nova Scotia Liberal Party, John Savage engaged in a consultation "round table" with experts in the policy areas he wished to emphasize. Savage wanted the health platform rooted in the 1989 Royal Commission on Health Care as well as opinions from academics, physicians and health activists. The final position paper was prepared by caucus research staff and approved by the Liberal caucus. Caucus members[1] who had a keen interest in health matters played an active role in its preparation and presentation. The three physicians in caucus included John Savage, Jim Smith and Ron Stewart, who were instrumental in influencing the process. This is emphasized by the fact that all three participated in its release in a press conference on May 7, 1993.

The interesting question is how much did the "outside" consultation play in the formulation of the health platform? According to my source, not very much. These outside consultants did not prepare briefs or assist in the drafting of the position paper. Their role consisted mainly of "brainstorming" sessions, and there is no documented evidence that they contributed in any tangible way. In fact, the final health platform was primarily a document produced by two members of the caucus research staff which was ratified by the caucus

[1] Note that caucus members included nominated candidates and were not restricted to elected members, which is generally the case.

itself.[2] I cannot conclude that pressure groups had any substantive influence over its creation. In short, beyond the personal bias of the Liberal caucus — and that is mainly confined to the health policy "inner circle" and the research staff — there is no evidence to show that special interest groups "fixed" the results in their favour before the release of the position paper to the public during the election of 1993.

So what did the Liberal Party of Nova Scotia say it was going to do if elected to government in the area of health care? The Liberal health platform begins with a discussion of the role of physicians and the reform of primary health care. It states that "Primary health care in Nova Scotia continues to be both inefficient and costly because the system of delivery is physician–based rather than team–based." Clearly, the Liberal Party was prepared to confront an old and powerful institution representing doctors — namely, the Nova Scotia Medical Society. The traditional role of the physicians as the "gatekeepers" of the system was questioned in this document, with attention paid to increasing the role of nurses and introducing nurse practitioners, physician assistants and complementary health professionals into "mainstream" medicine. A team approach was emphasized with services being delivered in the community rather than the traditional institutionalized system.

Provincial Liberals adopted the World Health Organization's definition of primary health care as:

> ... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self–reliance and self–determination.[3]

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[2] Personal interview, anonymous source, 1996.

[3] Liberal Party of Nova Scotia, "Liberal Health Policy," 1993.

Also, in keeping with John Savage's emphasis on the 1989 Royal Commission on Health Care, Nova Scotia Liberals adopted that document's "guiding principles":

- a commitment to health policies that are oriented to health outcomes;
- the participation of citizens in the planning and management of the health system;
- a commitment to decentralization and regionalization;
- a commitment to accountability for the prudent use of limited resources; and
- a commitment to match resources to health needs.[4]

On the basis of this foundation, with the acknowledgement that primary care needed to be dramatically altered, Nova Scotia Liberals outlined the approach they would adopt as a government in a variety of areas. I will examine several of these areas with direct relevance to the case studies in the subsequent chapters which are emergency health care, hospitals and tobacco control.

Emergency health services (EHS) were addressed under the heading of "Ambulance Care" with a recognition that emergency medical assistance is a vital component of the health system. The Liberal health platform committed to the establishment of an "Ambulance Authority" which would be responsible for setting provincial standards for medical training and emergency vehicle design and operation. As a campaign aide to Dr. Stewart, the nominated candidate in the riding of Cape Breton–North, I personally designed campaign literature for both print and radio advertisements which committed a Liberal government to reforming the "outdated" EHS system in Nova Scotia and replacing it with a province–wide system of high quality.

A fundamental aspect of the Liberal health "vision" was the commitment to break the traditional power base of the system, which focused on hospital–based disease treatment, and

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[4] *Ibid.*

to replace it with community–based decision–making with attention to preventive health care. The Liberal health platform is quite succinct on this point:

> *Hospitals:* A Liberal Government in Nova Scotia will target reduced hospital stays and will redirect savings to more appropriate delivery of health care. By providing alternative, community–based health services, we will make the shift from institutional care to community care. This shift will be supported by a budget redirected toward prevention and health promotion.[5]

The structure of the health system in 1993 was centred on hospital boards, as well as other facility boards such as nursing homes, which reported centrally to the Department of Health. Boards which were located in health care facilities were criticized for being too narrow in their understanding of the effective allocation of health resources. The Nova Scotia Liberals pledged to establish regional health boards which would be granted decision–making authority through funding "envelopes" such as public health, home care, community clinics and disease prevention.[6]

The Liberal health platform also made a strong commitment to enhancing tobacco reduction initiatives in Nova Scotia. "A Liberal Government," they pledged, will restrict access to tobacco by minors through legislation, and will protect the rights of non–smokers by requiring all public buildings to be smoke free."[7] A significant reason why this promise was so progressive is because Dr. Ron Stewart was a prominent member of the caucus health policy "inner circle," and was a strong advocate of reducing the public health risk of tobacco addiction. In fact, Stewart frequently spoke to community groups about the dangers of this addictive drug and was the Medical Society's representative on Smoke Free Nova Scotia. The

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[5] *Ibid.*

[6] *Ibid.*, p. 5.

[7] *Ibid.*

senior advisor I quoted earlier stated that "Dr. Stewart was the only member of caucus who provided research staff with a written brief on what should be included in the Liberal health policy."[8] His written submission included a strong emphasis on tobacco control and he frequently spoke on this issue during the caucus platform sessions. In a personal interview, the Minister stated that he had strong input into the tobacco control pledges and that he was their primary author.[9]

Media and special interest group reaction to the announcement of the Liberal health platform on May 7, prior to the May 25 election date, was varied yet predictable based on who was providing the commentary. The incumbent Tory Health Minister, George Moody, criticized the Liberals for not providing enough specifics and for not having a budget. He stated in the *Kentville Advertiser* that "Nova Scotians deserve to know how the Liberals will pay for their program."[10] Moody added an emotional element to the debate by implying that the Liberals would adopt the "Oregon plan" which would leave terminally ill patients without treatment. "Can you imagine," complained Moody, "if it was your mother or your father that was ill and had to be rationed by a policy that was determined by Dr. Savage?"[11] The reference to the "Oregon plan" resulted from comments attributed to Liberal Leader John Savage about the possibility of adopting the state of Oregon's formula for rationing health services. The Liberals spent considerable time and advertising dollars distancing themselves from these comments, and there is certainly no mention of the "Oregon plan" to be found in the Liberal health platform.

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[8] Personal interview, anonymous source, 1996.

[9] Personal interview, Honourable Ronald Stewart, 1996.

[10] *Kentville Advertiser*, May 14, 1993.

[11] *Cape Breton Post*, May 10, 1993.

In terms of the reaction of special interest groups, one group was particularly effective in capturing media attention. Citizens for Choice in Health Care, an advocacy group dedicated to the public insurance of alternative medicine therapies, held a press conference critiquing the health platforms of the three provincial parties. They also mailed questionnaires to every candidate and demanded a response prior to the election so they could make their views public.

A spokesperson for this group, Jason Hoffman, told the *Halifax Chronicle–Herald* that "The Liberal health policy is saying all of the right things and we are encouraged by their stated policy.... But from my conversations with many people all over the province — with health advocates, community workers, and health care workers — there is a deep concern about the Liberal leadership and I feel compelled to voice that concern."[12] As an aside, Citizens for Choice for Health Care remained a vocal lobby long after the Liberals assumed office; however, their prime objective to have an amendment to the *Medical Act* recognizing alternative medicine as an insured service failed. Yet, their efforts were instrumental in having a new environmental illness clinic established in Fall River, Nova Scotia, and the Medical Society did recognize homeopathic medicine as a sub–specialty in their bureaucratic structure. Their intervention in the election of 1993 probably raised their public profile and increased their access to government ministers and the Premier.

Two high–profile health groups made interventions in the election campaign of 1993: the Nova Scotia Medical Society and the Provincial Health Council. The President of the Medical Society, Dr. Rick LeMoine, commenting on the Liberal health proposals and on Savage's controversial remarks regarding the Oregon plan stated, "We have rationed health care in Nova Scotia for years and we ration more and more every week. That's why we have

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[12] *Halifax Chronicle–Herald*, May 20, 1993.

waiting lists."[13] LeMoine's intervention on behalf of the Medical Society seemed to help soften the rhetoric the political parties were engaged in. LeMoine remained an informal advisor both to the Liberal government and Health Minister Ron Stewart even after his tenure as Medical Society President ended. In fact, the Minister would appoint him to the Cape Breton Regional Hospital Board and later to the amalgamated Cape Breton Health Complex. Both had grown up together in the same town in Cape Breton and their close association aided the government in managing several contentious issues.

The Executive Director of the Provincial Health Council, Mary–Jane Hampton, contributed to the election debate on health reform in a May 9th article in the *Halifax Daily News*. The Provincial Health Council was a ministerial–appointed council established following the recommendations of the Royal Commission on Health Care (1989) to provide advice to the Minister of Health. Commenting on the controversy surrounding the Liberal health ration policy, Hampton stated,

> ... health is such an emotional issue ... what if we decide that we don't want to spend 80 percent of our health–care budget on the last six months of people's lives? But when you personalize it, and say, "What if it were your child?" or "What if it were your mother or father?" ... there is a gut reaction that becomes defensive and protective that says, "It's unacceptable, I'm not even willing to contemplate such a change."[14]

This special interest group was appointed by the government that was seeking re–election. However, its spokesperson was careful to position itself in a way that endorsed the need for change without "attacking" the incumbent government. Yet Hampton did state that the government was involved in "smoke and mirrors" and "reform in health care has happened in Nova Scotia ... as much by default as by design."[15] Following the election of 1993, the

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[13] *Cape Breton Post*, May 10, 1993.

[14] *Sunday Daily News*, May 9, 1993.

[15] *Ibid.*

Provincial Health Council enjoyed monthly access to the Minister. However, by February 1996, the Council was dissolved and staff were seconded to the Department of Health. Two years earlier, the Executive Director was recruited by the Minister to be the Commissioner of Health System Reform. This position eventually evolved into a division in the Department called Health Systems Reform, which placed Hampton at the Executive Director level. The Minister revealed to me that some of the rationale used to justify dissolving the Council stemmed from his belief that it was élitist and undermined the effectiveness of the regional health boards. This is a rejection of the corporatist model in favour of a more pluralistic approach to health advocacy.[16]

To understand fully the commitment the Liberal government placed in its health policy it is necessary to examine briefly the government's literature on its health policy agenda. The three documents which will be analyzed are the *Speech from the Throne* (1993), *The Blueprint Committee's Report on Health System Reform* (1994), and its companion document *From Blueprint to Building* (1994).

The first Speech from the Throne following the May 25, 1993, election was presented by the Lieutenant–Governor, the Honourable Lloyd R. Crouse, on September 13, 1993. With respect to health care reform, the tone and the specific policy objectives outlined in the Throne Speech were very similar to the Liberal health platform. The government promised to

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[16] It may be argued that the Provincial Health Council was structured on a corporatist model of state/society relations. Corporatism is at the opposite end of the political spectrum of pluralism. In terms of interest groups, its central principle is the state should dominate in setting the policy agenda and interest groups should have formal links to the state apparatus. These controls can exist through direct funding, appointments by the state, licensing, and so on. Corporatists hold that interest groups should be few in number, formally structured, and be the sole representative of their particular interest.

Corporatism is rooted in conservatism, and thrives in oligarchical political structures. This model is based on the premise that "power is always conservative." It is ultimately in the state's interests, on this account, to have an orchestrated quality to group involvement in the agenda-setting process. Power is controlled by a central authority which will consciously attempt to create a system of group-state relations by which society can be guided.

change the structure of the system by shifting resources from facilities to community–based initiatives. It mentioned the creation of regional health authorities and Community Health Boards to govern the health system's regional programs. The government promised major initiatives in the creation of a new home care program, a revamped emergency medical service system and efforts to control tobacco addiction.

In the area of home care, the government said they would transfer in–hospital resources to a new Extramural Hospital Program. "Following the 'Hospital in a Home' concept, the extramural program will redirect existing institutional and home care resources toward the provision of more primary health care at home."[17]

The new government talked about creating a "first class" emergency medical service. By appointing a special advisor who would be charged with creating a blueprint for the development of the new system, attention was paid to creating a system of province–wide vehicle and training standards for the ambulance system.

In the area of tobacco addiction, the government was quite specific in what it would do in that legislative session:

- make illegal the sale of tobacco to youths under the age of 19;
- ban the sale of tobacco products from vending machines;
- require clearly posted health warnings in all establishments selling tobacco or permitting smoking on its premises;
- institute a system of more severe penalties for violation of sale to minors regulation; and
- institute a system of licensing for all tobacco vendors.[18]

It is clear that the Liberal health platform was certainly used as a reference for the Speech from the Throne. It is important to recognize that the Nova Scotia Liberal Party remained faithful to the general tenor of its health promises in its first Throne Speech after

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[17] Government of Nova Scotia, Speech from the Throne, September 1993, p. 11.

[18] *Ibid.*

being elected. After a four–month review by Health Department policy–makers, the platform was virtually unaltered when placed for the first time in a government document. Clearly the political agenda of the Premier and the Minister of Health had survived the transition from opposition to government; our next step is to determine if this agenda was also incorporated into the Health Department's strategic plan for health system reform.

BLUEPRINT REPORT

The most prominent and concise document on the government's health policy can be found in the Minister's Action Committee on Health System Reform. The "Blueprint Committee" was appointed by the Health Minister and began its work in earnest in January 1994; the final report was submitted to the Minister in April of that same year. Members of the Committee represented a broad range of interest groups, consumers, academics and government officials.

The principles on which the Committee was expected to base its recommendations were rooted in the Liberal health platform with some minor exceptions. This was most evident in the Blueprint Committee's terms of reference:

- develop a strategy for decentralizing the health system, including the role and structure of the Department of Health in a reformed system;
- develop a strategy for regionalizing the health system, including the role and governance of regional health authorities and Community Health Boards; establishing regional boundaries; designing regional funding envelopes; and equipping communities with the resources, systems and skills needed to take on greater planning and decision–making;
- find ways to shift resources to community–based programs with greater emphasis on primary care, and making the most effective use of health care providers through reallocation of existing resources;

- develop a strategy to shift emphasis in the health system from sickness treatment to wellness promotion and the enhancement of public health;

- consider a renewed role for the Provincial Health Council;

- develop a strategy for labour adjustment and retraining, minimizing job loss and maximizing the use of individuals presently employed in the health care system.[19]

With the exception of the discussion on the Provincial Health Council, the terms of reference virtually mirror the principles outlined in the Liberal health platform and the Speech from the Throne (1993). The final report is a comprehensive document with seventy–three pages of commentary and recommendations. It is not my intention to discuss the specifics of each policy recommendation but to demonstrate the link with the Liberals' desire to change the structure and the focus of the system The Blueprint Committee's stated principles provide an overview and suggest the tone of the rest of the document:

1. *Public policy must promote good health.*
   Nova Scotia's Health Goals will guide the development and implementation of the Blueprint for Health Care Reform.

2. *Health care must improve the quality of life, not only ward off illness.*
   Greater emphasis will be placed on wellness and on preventing disease and injury. Strategies will be developed to help Nova Scotians enjoy more years of active and healthy living.

3. *Health care must be consumer–, family– and community–focused, not facility– and provider–driven.*
   Health care providers will respect the whole person and strive to integrate body, mind and spirit. Integrated, seamless systems will be designed to accommodate the needs of individuals and communities. As Nova Scotians have a right to appropriate care, there will be a shift in emphasis from institutional care to community–based service.

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[19] The Minister's Action Committee on Health System Reform: Blueprint Committee. Government of Nova Scotia, April 1994, p. 71.

4. *Individuals have the right and responsibility to make choices about their own health.*
   The reformed system will support and enable people to make informed decisions based upon what is effective, sustainable and consistent with individual needs and values.

5. *Health is a community responsibility.*
   Local and regional structures will be established to give individuals decision–making authority. These structures will be accountable to the communities they serve. Appropriate supports must be put in place to allow Nova Scotians to actively participate in this decentralized, locally–controlled health system that meets provincially prescribed standards for programs and services.

6. *A comprehensive range of health programs will be provided through a publicly funded, single–tired system.*
   Standardized core programs and services consistent with the principles of the *Canada Health Act* and Nova Scotia's Health Goals will be available to all citizens, Nova Scotians will have access to high–quality, sustainable programs as close to home as possible. This will be achieved through the development of regional funding envelopes and health service plans that are based on an effective system of primary health care. As well there will be assurance of equitable access to secondary and tertiary/provincial programs.

7. *The reformed system will optimize and integrate the capabilities and skills of providers, patients, families and volunteers.*
   Health care services will be delivered by persons and multidisciplinary teams who can offer the highest quality care with the greatest efficiency and effectiveness. The system will work to develop effective partnerships between and amongst consumers and providers.

8. *Access to information about health and the health system is essential for effective decision–making to occur at all levels.*
   Informed consumers and providers will know how to achieve good health, how to make best use of the health system and how to participate in managing it. Providers have a responsibility to give consumers the information they need to make informed decisions, including providing easy access to their health records. At another level, data collection and analysis is essential to the evaluation process of the health system.

9. *Ongoing evaluation and outcome measurement will ensure the reformed health care system achieves value for money.*
   Programs and services that provide little or no benefit to health will be removed from the publicly funded health system so that new or better services can be funded. Health care reform will be achieved through a

process of transition. It will be a participatory process based on partnerships amongst stakeholders.

10. *A reallocation of health care resources is required to improve the health status of Nova Scotians.*
Access to necessary quality care must not be jeopardized while existing services are altered and new services established.

11. *People presently employed in the health system are recognized as a valued resource.*
While labour adjustment will be necessary as the system responds to the needs of Nova Scotians, the needs and aspirations of those employed will be respected. Displaced individuals will be redeployed and optimally utilized. Investment in people, planned change, participatory decision–making and collective bargaining principles, where appropriate, will guide this process.[20]

Mary Jane Hampton was the Executive Director of the Provincial Health Council (1991–94) and became the Executive Director of Health System Reform division in the Department of Health. Hampton was also a key staff person assigned to the committee who helped "wordsmith" the final document. In a personal interview, Hampton revealed that the Blueprint Committee was "not a product of original thinking." The Committee relied heavily on the background papers and the government's philosophy was certainly known and articulated around the table. The document was an exercise in "consensus–building" and a statement of first principles. She rejects any suggestion that the committee's report was "hijacked" or "cooked" by special interests. "All twenty–six members signed the report, which represented a diversity of opinion. There was a lot of give and take and it certainly was not easy. The Blueprint brought interest groups to a common forum; it was a process of education, not only for government, but for the groups themselves. It was a process of collaboration and negotiation based on a spirit of cooperation."[21] Hampton asserts strongly her

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[20] *Ibid.*, pp. 12–13.

[21] Personal interview, Ms. Mary–Jane Hampton, 1996.

disapproval of "squeaky wheel" interest group politics. Pressure groups left alone to deal with political élites can result in unsound public policy which is made in isolation of other elements of the system. Then, for Hampton, the key is to moderate special interests by placing them in a larger forum which is open to public scrutiny. This, in the last analysis, was the purpose of the Blueprint Committee, as a vehicle for moderating the influence of interest groups by building consensus for the government's agenda on health reform.[22]

The supplement to the Blueprint Committee's report is the document, *From Blueprint to Building: Renovating Nova Scotia's Health System*, released by the Department of Health in April of 1995. It reported on the government's progress in implementing the Blueprint and provided a "renovation" schedule or time–table for the implementation of the full report. It begins by reiterating the guiding principles stated above and highlights some of the policy initiatives the Department of Health had acted upon, such as the establishment of regional health boards, reorganization of the Department of Health, the introduction of Home Care Nova Scotia and Emergency Health Services Nova Scotia. The report is billed as "part of a continuing process of communicating the renewal of Nova Scotia's health system." The second sentence in the introduction credits the Liberal health policy (1993) as providing the "government's vision" for a renewed health system.[23] The report also lists the Liberal health policy in its appendix under "other information sources." This serves to illustrate that halfway

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[22] The drafting process for the Blueprint Committee seemed to exhibit corporatist tendencies. As discussed previously, corporatism suggests an orchestrated quality to group involvement in the agenda-setting process, which allows the state to create a system by which society can be controlled. However, despite the initial success in achieving a formal consensus for the Blueprint Report, several of its signators representing pressure groups abandoned this approach when they felt their interests threatened. On balance the Blueprint Report, as an attempt to placate interest groups and build a coalition of support for health reform, was not successful. This is further evidence of the pluralistic character of state/society relations in Nova Scotia.

[23] *From Blueprint to Building: Renovating Nova Scotia's Health System*, Nova Scotia Department of Health, April 1995, p. 3.

through its mandate, the Savage government still reflected its election platform in Health Department documents. The final section in this chapter will examine the actual policy outcomes to see how effectively the government was, not only in merely having its vision reflected in its literature, but also in putting its policy into practice.

POLICY OUTCOME ASSESSMENT

The following table and text represents the effectiveness of the Liberal government of Nova Scotia in achieving its health policy objectives as outlined in 1993. I have limited the analysis to policy objectives related to the case studies in the subsequent chapters. For analytical purposes I have included a code, referred to as the outcome rating (OR), to be used as an assessment tool to help measure the effectiveness of the government in implementing its policy. It is important to note that at the writing of this analysis, the government was approximately three–quarters through its mandate and further action on the following policy initiatives is still possible. The following is the legend used:

OUTCOME RATING

A. Indicates that the policy was implemented successfully including enacted legislation where applicable.

B. Indicates the policy has been partially implemented. Significant planning still needs to be carried out and/or legislative action is still required or failed.

C. Indicates that internal government planning process had been initiated; however, the policy is not evident "in the field" and few resources have been significantly engaged.

D. No significant legislative or internal planning processes have been engaged.

1. TOBACCO CONTROL

Policy:

1.1 Will restrict access to tobacco by minors through legislation;

1.2 Will protect the rights of non–smokers by requiring all public buildings to be smoke free;

1.3 Will introduce cessation programs for smokers at community health centres.

Outcome:

1.1 The Liberal Government passed *The Tobacco Access Act* in the fall of 1993, which prohibits the sale to tobacco products to those under the age of nineteen, bans tobacco vending machines and forces tobacco vendors to display health warnings (OR = A).

1.2 Draft legislation was prepared, a public information campaign was completed and consultation with stakeholders was carried out (OR = C).

1.3 A Tobacco Control Unit (TCU) has been created in the Department of Health and cessation programs are available but not exclusively through community health centres (OR = D). (The "D" rating is due to a strict interpretation of the policy objective, "At Community Health Centres" has not been implemented.)

2. REGIONAL HEALTH BOARDS

Policy:

2.1 Will decentralize the planning and delivery of health care, and will empower regions and communities to assess their unique health needs and priorities. Communities will be empowered to manage service delivery and to improve health care through change.

2.2 Will establish a set of outcome–based objectives so that the same quality of care will be available to all Nova Scotians, and will provide regional health boards with resources according to population size, demographic characteristics, and health status. Each region/community will then allocate its resources to provide the range of programs and services that best meet the health needs and priorities of the area residents.

2.3 Will provide administrative support and resources to regional health boards, whose memberships will be drawn from among providers and consumers of health care at the community level.

2.4 Will make the shift from institutional to community–based health care, and will spend health dollars more efficiently while maintaining a higher standard of health care.

Outcome:

2.1 *An Act to Establish Regional Boards* was passed in 1994. Four interim boards were created called the Northern, Western, Eastern and Central Regional Health Boards. They are mandated to construct community health boards and in cooperation with the Department of Health, "construction kits" were distributed in April 1996. This will eventually led to the decentralization of service delivery to the community and regional tier (OR = A).

2.2 Administrative structures and staff have been hired in all four RHB regions. RHBs are in the process of assuming control of regional funding "envelopes." Also, the Western RHB has "designated" the Valley Regional Hospital which dissolves the existing hospital board and replaces it with the RHB. Eventually, under this model, all hospital boards will be phased out and replaced by RHBs (OR = B).

2.3 The members of the interim regional health boards were selected by the Minister of Health from applicants who responded to media advertisements and recruiting through the public consultation process. Almost all RHB members reside in the region they represent and many are considered community activists on health–related issues (OR = B).

2.4 The move toward community–based health care can be seen in the shift toward regional and community health boards. The streamlining of administrative services in health care facilities is evident in the creation of the Queen Elizabeth II Health Sciences Centre which is the merger of four Halifax hospitals: the Victoria General, the Camp Hill Medical Centre, the Cancer Treatment Centre and the Infirmary. A similar project was initiated in Cape Breton with the merger of the Cape Breton Regional Hospital, Glace Bay Healthcare Corporation, New Waterford Consolidated and the Northside Harbourview Hospital into the Cape Breton Healthcare Complex (OR = B).

3. EMERGENCY HEALTH SERVICES

Policy:

3.1 Will establish an Ambulance Authority whose mandate will be to envelop a single accountable system for ambulance personnel and a common set of requirements for ambulance design, equipment and function.

Outcome:

3.1 Based on the *Report: Emergency Health Services Nova Scotia* (April 1994) prepared by Michael Murphy, MD, and Ann Petley–Jones, the government moved to establish Emergency Health Services (EHS) Nova Scotia. The government introduced *An Act Respecting Emergency Health Services*, in the spring of 1994 which received royal assent on June 30 of that same year. This Bill called for the creation of an EHS agency to operate at "arm's length" from government to administer emergency services in Nova Scotia. By April of 1996 this Agency had a commissioner, support staff and other administrative infrastructure. An ambulance fleet replacement scheme had been implemented providing 150 new vehicles for Nova Scotian communities. EHS Nova Scotia had coordinated the development of an Air Ambulance program (announced in June of 1996) as well as planning for province–wide regulations for EMT training, a first responder program and the implementation of a province–wide E–911 system (OR = A).

4. PHYSICIANS' SERVICES

Policy:

4.1 Will initiate meaningful health reform in consultation with members of the Joint Management Committee of the Nova Scotia Medical Society, professional health care organizations, community–based agencies, and the broader community.

4.2 Will review physicians' services with an eye toward saving costs and more rationally approaching fee–for–service payments.

4.3 Will find ways to attract physicians to rural areas, including "amenity packages" consisting of continuing educational opportunities and lifestyles benefits as tools for recruiting and retaining doctors in under–serviced areas.

4.4 Will initiate a program that involves government, the Medical Society, the Nurses' Union, the Dalhousie Medical School, and other professionals to find innovative ways to provide access to health care professionals in every region of the province.

Outcome:

4.1 The Minister of Health included stakeholders in the government consultation on health reform through the Blueprint Committee, a series of public meetings and an aggressive schedule of meetings with interest groups in the first year and a half of the mandate (OR = B).

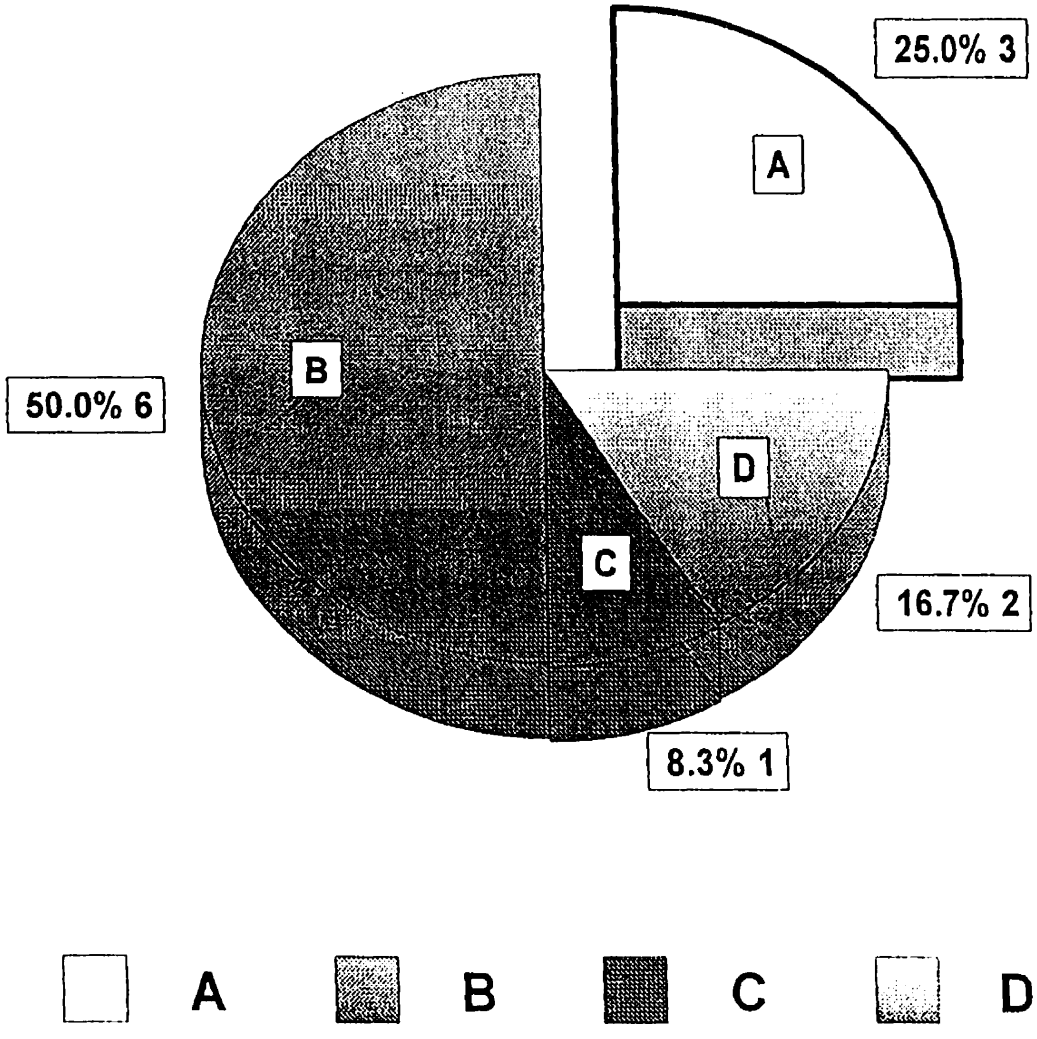
4.2 The Department of Health reached a two–year agreement with the Medical Society of Nova Scotia in March of 1995. The agreement involves a plan for physician resource management by restricted billing numbers in over–serviced areas and providing an incentive package for physicians to locate in under–serviced areas. It also included steps to manage utilization and streamline physicians' incomes through the gradual scaling of the Master Unit Value (MUV). A variety of other methods for rationalizing medical services was also agreed to (OR = B).

4.3 A rural recruitment strategy was part of the Medical Society/Department of Health agreement mentioned above. A Physician Recruiter was hired jointly by both of these parties to search actively for doctors willing to practice in rural Nova Scotia. An incentive package was created guaranteeing a minimum annual income of $120,000, continuing medical education and locum service to new rural physicians (in specially designated areas). *An Act Allowing Physicians to Incorporate* was passed in the fall/winter session 1995/96. A telemedicine program began development (summer 1995) to provide physicians in remote sites to receive specialty consultation via computer imaging (OR = B).

4.4 Besides some preliminary discussions with various stakeholders, no significant activity has taken place in this regard (OR = D).

LIBERAL HEALTH POLICY/GOVERNMENT POLICY OUTCOMES

OUTCOME RATING (OR)



Although the sample of policy initiatives is limited to twelve, a clear trend is discernible. The pie chart shown on the previous page clearly indicates that in the policy initiatives selected, the Savage government had significant success implementing its agenda. If the A and B outcome ratings are combined (nine total), this accounts for a 75% success rate in the government implementing its health policy. The B rating in isolation is still impressive at 50%, and the combined values of C and D (indicating a low level of success in implementing policy) is merely 25%. However, one of the D ratings is attached to the reform of the primary care system, which is a significant "pillar" of the Liberal health plan and a major structural impediment to health reform. Yet, it can be argued that this negative result is offset by the government's success in the creation of regional health boards and the creation of a new emergency health system, both of which are significant structural changes.

CONCLUSION

Through our analysis of the Liberal health platform and other related documents, we have seen that the guiding principles of this platform remained relatively intact in the Liberal government's publications on health reform. Through interviews with those involved with shaping the policy framework, we have noted that interest groups have had relatively little influence over its design and presentation. Furthermore, it appears the Minister of Health and Cabinet have remained committed to the election platform by including its central principles in the Speech from the Throne (1993), the Minister's Action Committee on Health System Reform (April 1994), and *From Blueprint to Building: Renovating Nova Scotia's Health System* (April 1995).

But what has this meant for actual policy implementation? Our initial analysis shows that the Nova Scotia Government has enjoyed a high level of success (75%) in implementing its stated health objectives. From this can we conclude that interest groups have been

ineffective in altering the Liberal health policy as it applies to the selected case studies? It is difficult to make that generalization at this stage. What can be stated with confidence is the government enjoyed relative success in policy areas which have significant implications for certain interest groups. Several explanations may account for this result beyond the ability of interest groups to alter policy. In order to avoid supposition and speculation on that point, it is necessary to examine in more depth the circumstances surrounding the various cases. The following chapters will focus on the specific policy initiatives to explore how the government succeeded in implementing its policy over the objections of interest groups; conversely, in areas where the government failed to reach its objective, we will attempt to determine why.

CHAPTER 3:
DEFENDING THE STATUS QUO?
THE NOVA SCOTIA MEDICAL SOCIETY

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INTRODUCTION

It can be successfully argued that for much of the history of the Canadian health care system, the single most dominant group has been physicians' associations. Organized medicine has been actively involved in the debate at the national and provincial level on the direction of health reform. The Nova Scotia Medical Society has been consistently successful in having its members represented in government policy development. Our discussion in Chapter 2 showed that the Nova Scotia Minister of Health was quite effective in implementing the government's agenda with respect to physician services. The Liberal health platform was a declaration for change from the institutional/disease treatment to community–centred preventive medicine model for the delivery of health services. This represented a significant threat to the traditional power bases of the system and was resisted vigorously by powerful camps within the Medical Society. Yet during its first three years, the Savage government renegotiated the original contract with the Medical Society to provide physician services and enacted various pieces of legislation directly applicable to how doctors function in the system. This "crowded" agenda certainly brought forward considerable controversy and public debate. The following discussion will examine the contract between the Medical Society and the Department of Health, *An Act Respecting the Practice of Medicine* (1996), *An Act to Continue the Medical Society of Nova Scotia* (1996), and *An Act to Permit Physicians to Incorporate for the Purpose of Carrying on the Practice of Medicine* (1996), as well as a

selected article from the *Sunday Daily News* regarding a physician's critique of health reform. Recognizing the pluralistic tendencies of government and group relations in Nova Scotia, it is startling that the Savage Liberals were able to achieve as much as they did given the stature of this particular group (Medical Society of Nova Scotia). The process of negotiating and confrontation will be the subject of the following discussion.

DOH/PHYSICIANS' AGREEMENT

One of the most dramatic confrontations between the Savage government and the Medical Society was the negotiations leading up to the March 13, 1995, Department of Health/Medical Society agreement on physicians' services. The authors stated it was "precedent–setting" and it would "transform the way medical services and physician resources are planned and managed in the province."[1] This was the accumulation of two years of negotiation which, toward the conclusion, was subject to heated political confrontations and public bickering. Before examining the process, it is necessary to examine briefly the highlights of this agreement to provide the context to determine why both parties viewed the outcome to be so vital to their interests.

The five main components of the agreement are:

- physician human resources issues
- master unit value and income stability
- utilization management
- Canadian Medical Protective Association (CMPA) dues
- managed/manageable care

[1] Press Release, "Medical Society and Department of Health Sign Agreement," Medical Society of Nova Scotia/Nova Scotia Department of Health, March 13, 1995.

Physician human resources issues:

To address the problem of physician surpluses in urban areas and physician shortages in rural areas, new billing numbers will be restricted to areas of need. Existing billing numbers will be restricted to the physician's current type of practice and geographic location.

An incentive package will be offered to physicians located in under–serviced areas of the province. The package will include a minimum signing bonus of $50,000 over five years, moving expenses, and priority access to billing numbers in other areas of the province upon completion of the contact.

The Department of Health will offer a billing number buy–out. The program will be offered to eligible physicians for each of the next four years. For example, a physician seventy–one years of age or older will be offered an amount equivalent to 60% of his or her average annual gross billings during the two previous fiscal years.

Master unit value and income stability:

Before this agreement, the Master unit value (MUV) was pegged at $1.55 across the board. (A routine visit to the doctor is about 10 MUVs.) Now part–time physicians billing less than $75,000 annually will be paid at $1.63 per MUV. Those billing between $75,001 and $140,000 will receive $1.72 per MUV. Those billing in excess of $140,000 will receive $172 for the first $140,000 and $1.55 for the next $60,000. In excess of $200,000, the MUV will be paid at $1.53.

A new $10 million transition fund payable over four years will cover physician recruitment, physician billing number buy–outs and a new "managed care" system of providing medical services.

Utilization management:

The overall cost of facility–based services over the next two fiscal years will be reduced by $2.8 million by reducing physician payments for diagnostic services.

Physicians will subscribe to a set range of daily billings based on professional standards of practice. Both parties will work together to develop a model to help achieve savings in the Pharmacare budget. About $5 million in savings will occur by de–insuring a number of current–covered procedures.

Canadian Medical Protective Association (CMPA) dues:

CMPA is an obligatory, not–for–profit insurance program for all Canadian physicians. To help retain needed physicians in Nova Scotia, particulary those providing specialty services, 90% of CMPA dues in excess of $1,500 will be paid by the province. This brings Nova Scotia physicians up to a comparable level of assistance offered to other physicians in Canada.

Managed care/manageable care:

The Department of Health and the Medical Society of Nova Scotia joined together in a leadership initiative to develop a new and innovative system for providing medical services to Nova Scotians. The following principles will be used to guide Managed/Manageable Care:

- improved health outcomes will be the goal
- rationale for changes to health care will be evidence–based
- physician accountability to patients and public will be preserved through rewarding quality and cost–effective outcomes
- a coordinated approach to educating and reassuring patients and physicians on standards and responsibilities is essential

- management mechanisms will be developed which may include integrated information systems, peer review and clinical practice guidelines

- a physician liaison committee will be established in each health region.[2]

The process for negotiating the agreement was lengthy (over two years) and often frustrating. We will examine the public posturing later; the actual mechanics of the process were quite simple. All Department of Health policy affecting physicians is unanimously approved by the Joint Management Committee, comprised of four physicians representing the Nova Scotia Medical Society and four individuals representing the provincial government — three from the Department of Health and one from the Department of Finance. Negotiations "bogged down" in late 1993/early 1994 and it was not until the appointment of Mr. Armand Pinard as Deputy Minister of Health that the negotiating process was "fast–tracked." Mrs. Lucy Dobbin had been appointed Deputy Minister of Health by the Premier in the fall of 1993. She was fired on October 7, 1994, for alleged conflict–of–interest breaches with respect to her husband's health care related consulting firm. Dobbin had no previous experience working in the Department of Health and her tenure as Deputy Minister could be described as turbulent.

As Minister of Health, Dr. Stewart seemed well positioned to win needed concessions from the Medical Society. Following the logic of "only Nixon could go to China," as a respected specialist physician with strong Nova Scotian roots, it seemed possible that Stewart was capable of providing the political capital to convince Nova Scotian doctors to trust "one of their own." Ronald Daniel Stewart was raised in the coal–mining town of Sydney Mines. After completing undergraduate work at Acadia University, he continued his studies at

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[2] This summary was provided jointly by the Nova Scotia Medical Society and the Department of Health as a "backgrounder" during the press conference announcing the agreement.

Dalhousie University, receiving his medical degree in 1970. Following general practice in Neil's Harbour, Ingonish, he left Cape Breton (influenced by a near fatal automobile accident that left him hospitalized for six weeks) to study at the University of Southern California, where he helped establish the paramedic program in Los Angeles County. He later founded the Center for Emergency Medicine at the University of Pittsburgh, an internationally recognized institute for the study and treatment of acute illness and injury. After several years as Head of the Emergency Department at the University of Toronto's Sunnybrook Health Sciences Centre, he returned to Dalhousie University as a full professor of Anaesthesia/Emergency Medicine.

Nominated as a provincial Liberal candidate for the riding of Cape Breton–North in 1992, Stewart went on to defeat the incumbent Progressive Conservative Cabinet Minister, Hon. Brian Young, by over 1500 votes. Prior to Stewart's May 1993 election victory, the Liberal Party had not held that seat since 1956. He was promptly named to Savage's Cabinet as Minister of Health, Registrar General on June 11, 1993, until his resignation on June 20, 1996.

Stewart's international reputation as an expert in emergency medicine led to several prestigious honours in his native Canada. In 1993, he was inducted as an Officer of the Order of Canada, the Federal Minister of Multiculturalism awarded him a Citation for Citizenship in 1992, and Acadia University granted him an honourary doctorate in 1990.[3]

Stewart's solid professional reputation and his demonstrated political success meant his cabinet colleagues would perceive him as an encouraging "champion," for the inevitable confrontation between the Government of Nova Scotia and its Medical Society. Organized medicine resisted any erosion of their income, and generally they supported some form of

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[3] I have drawn on my own insights and a feature in *Dalhousie Alumni Magazine*, Fall 1992, in providing an overview of Dr. Stewart's career.

user–fees. Efforts to move toward the managed care model with greater medical decision–making authority being given to nurses and other health care professionals was, in principle, opposed. Any attempt to restrict physicians' freedom to establish practices where they chose, and introducing accountability into the fee–for–service system, was, again, opposed vigorously. Stewart's task of "selling" unpopular reforms seemed daunting, yet many reforms were accepted. However, the following section will show that the agreement was not universally accepted and the government suffered political fall–out after the agreement was signed.

Media coverage of the announcement of the agreement clearly illustrated the dynamic of competing interests in medicine. Appraisals of the deal ran the spectrum from supportive to highly critical. Medical Society of Nova Scotia President, Dr. Rob Kimball, commented, "We've come up with a very creative way of stemming the tide, without as much money in it as I had hoped there would be, but still I think to most physicians this has got to look a lot better than what they were facing."[4] Health Minister Stewart added, "We are all the winners in this in the sense that I believe this agreement goes far to provide us with a stable and predictable climate for medical practice within the province — and the real fact that physicians as a group and as an essential element of our health–care system can now truly be partners in health reform."[5] The *Halifax Mail–Star* editorial congratulated both parties for recognizing "the need to provide physicians' services in rural areas."[6] Even New Democratic Party health critic, Alexa McDonough, conceded that the deal's strong point was forcing doctors to practice in rural areas.[7]

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[4] *Daily News*, March 14, 1995.

[5] *Ibid.*

[6] *Halifax Mail–Star*, March 15, 1995.

[7] *Daily News*, March 14, 1995.

Criticism of the deal came from factions within the Medical Society, labour unions and the Opposition. The President of the Professional Association of Residents and Interns—Maritime Provinces, Derrick McPhee, stated, "My fear is that their efforts to stabilize their [physicians'] own incomes will come at the expense of new physicians."[8] He cited several aspects of the agreement including restrictions of billing numbers for new physicians and attempts to limit physicians' ability to practice where they choose. McPhee raised the rhetoric to an alarmist level by asserting, "The people who are really going to suffer are going to be the patients."[9]

The Association orchestrated a button campaign protesting the deal. The slogan was, "Ignore new doctors and they will go away." Dr. Paul MacDonald, also representing this group, added to McPhee's comments by asserting that while they did not want to employ scare tactics; nevertheless "the agreement means new doctors will likely be forced to go to another province, or go to the United States."[10] McPhee personalized the issue by stating, "I was going to Boston for an educational year, and it doesn't look like I'm coming back at this point.... This basically amounts to the Medical Society eating its young."[11] McPhee recommended that the Association not support the deal, and he noted that they were contemplating suing the government for limiting billing numbers.

Discontent was also expressed by some rural physicians. Dr. Phillip Edgar told the *Digby Courier* that it is "flawed package.... Rural physicians do emergency and we do

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[8] *Halifax Chronicle–Herald*, March 11, 1995.

[9] *Ibid.*

[10] *Daily News*, March 30, 1995.

[11] *Halifax Chronicle–Herald*, March 14, 1995.

obstetrics, so in fact rural physicians are going to take another pay decrease which I see is going to cause more people to leave which is why I think it is a flawed package."[12]

The deal was also criticized by labour organizations such as the Nova Scotia Government Employees' Union. Union President Dave Peters said in a press release that "the agreement between doctors and the province will cost taxpayers millions.... I also find it abhorrent that the government would pay bonuses and allow the richest groups in our health care system to escape the consequences of wage restraint, while workers making less than one–tenth of doctors' salaries are forced to take wage cutbacks and layoffs."[13]

Opposition criticism was based on the notion that the deal was inconsistent with health reform. "They've succeeded in restoring the system to the status quo. Not only have they recaptured every cent that was taken out of physicians' payments ... but they've sweetened the pot on top of that," explained NDP health critic Alexa McDonough.[14] Progressive Conservative health critic George Moody implied that the deal was reached to avoid controversy leading up to Premier John Savage's leadership review scheduled for the summer of 1995. "They bought themselves out of a tough spot, John Savage could not afford ... to be at odds with physicians in this province and have that battle in the media and with the patients."[15]

Clearly the media coverage and discontent among its members had an effect on the Medical Society executive's ability to "sell" the package to the membership. Although the President had signed the deal, it still had to be ratified by the membership. Kimball wrote to member physicians informing them that the board would resign "en masse" if the deal was not

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[12] *Digby Courier*, March 22, 1995.

[13] *Daily News*, March 15, 1995.

[14] *Daily News*, March 14, 1995.

[15] *Halifax Chronicle–Herald*, March 14, 1995.

supported. Facing a growing level of discontent with the agreement, including resistance from interns and residents as well as the Pictou County branch of the Medical Society, Kimball told members that the board was "deeply uncomfortable" with its decision to sign the deal but felt it was necessary given the "increasing fragility of the political environment."[16]

On April 6, 1995, the Medical Society announced it had approved the deal with a 62% majority. Approximately two–thirds of Nova Scotia's 2,000 physicians voted. However, the Professional Association of Residents and Interns for the Maritime Provinces announced its members voted 95% against the deal, and they reiterated their threat to take legal action against the "agreement and against proposed legislation."[17]

As contentious and controversial as the ratification process was, it was overshadowed by the Medical Society and the provincial government's posturing during the negotiations. The Medical Society retained a communications expert, Camille Sobrian Finlay, to launch a public relations campaign targeting the government and personally attacking the Minister of Health. They purchased advertising space province–wide including billboards, print and electronic media. Billboards depicted Stewart as ravishing the health care system. One rather subtle billboard message depicted drops of blood with the caption, "Stewart's health care — death by a thousand cuts." Newspaper ads showed an operating theatre with the caption, "It's 3 a.m. Who's called in to perform emergency surgery? Dr. Jones or Ron Stewart? Who would you trust with your health care?" The ads also called on Nova Scotians to voice their opinions by calling the Premier, Minister Stewart or their MLA directly. Physicians also engaged in a "grassroots" campaign by lobbying patients and placing literature and posters in their offices.

The government responded by rebutting the arguments in the advertisements through press releases and speeches given by the Minister of Health and other government members.

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[16] *Daily News*, March 16, 1995.

[17] *Halifax Chronicle–Herald*, April 6, 1995.

The Department also attempted to provide government caucus members with confidential briefing notes in an effort to counter constituents' lobbying on behalf of the Medical Society "cause." It was a meek effort given the onslaught that was launched by the physicians' union and, at best, the government throughout the campaign appeared on the defensive.

Dr. Dan Reid, the Minister's Advisor on Physicians' Affairs, offered his insights as a member of the government's negotiating team. Reid also has experience from the other side of the table in that he served the Medical Society as the Chair of Occupational Medicine, was involved in general practice, served as President of the Pictou Branch as well as various positions spanning a thirty–year period. He classified the Medical Society as a "status–quo" organization. "They prefer health reform that goes slow, with no negative impact on their personal incomes."[18] Concepts which erode physician power bases such as the introduction of nurse clinicians are resisted. A former President of the Medical Society, Dr. Rick LeMoine (1993–95),[19] agrees with Reid: "Yes, they are a status–quo organization which tends to resist change. They have a dual role to serve the public and their members. However, they have a vested interested in representing physicians." On the issue of the contract negotiations with the province, LeMoine stated it was a "strategic decision by the executive to mount a public relations campaign against the minister."[20] He felt it was a successful campaign which provided an opportunity for the Joint Management Committee to address the contentious issues. However, recent failures by the Medical Society to address such issues as deinsurance and decreasing utilization rates have discouraged LeMoine, and he questions the Society's ability to participate in the reformed health system.

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[18] Personal interview, Dr. Dan Reid, 1996.

[19] During his tenure, Dr. LeMoine served as President–elect, President and past–President.

[20] Personal interview, Dr. Rick LeMoine, 1996.

On the general topic of the Medical Society as an interest group, LeMoine acknowledges that they are on the "upper end of the scale" in terms of their ability to access government and advance their agenda in determining public policy. Reid is a little more definitive in his assessment: "They are the most powerful lobby in Nova Scotia. They are politically connected and can do end–runs around the Department and the Minister. They ignore rules in support of their interests."[21]

An interesting example of the Nova Scotia Medical Society's subtle use of power was evident in a memorandum received by the Minister of Health (October 17, 1993 — four months after the Savage Liberals' election victory) from a senior member of the Premier's political staff. A senior Liberal Party official telephoned the Premier's office expressing his "fear" that the government had not been seen to have consulted regarding "proposed amendments to the Medical Act [peer review]."[22] As a legal agent representing the Medical Society, this individual was using his influence to convince the Premier (or his staff) to direct the Minister of Health to meet with specifically named personnel from the Medical Society.[23] This form of pressure was being exerted two years before the principle of peer review was enshrined in the Department of Health/Physicians Agreement, and three years before the Medical Act was introduced by the Savage government.

This case clearly illustrates the pluralistic model of group politics in Nova Scotia. The Medical Society resisted government intervention in its interests in a dramatic way and asserted its autonomy and confronted the government in every area where it felt its interests were threatened. Given that the Medical Society represents the most powerful interest in the

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[21] Personal interview, Dr. Dan Reid, 1996.

[22] Memorandum received from the Premier's office to the Hon. Ron Stewart, October 17, 1993, regarding amendments to the Medical Act.

[23] *Ibid.*

fractured health system, it is further illuminating that even within its own framework significant fractures exist. On a certain level, it can be argued that an attempt to erode the pluralistic model was being made by the government given its efforts to assume more control over physician resource management. The profound implications of this initiative make the Medical Society's hostile response all the more predictable.

The striking aspect of this case is that despite the intense pressure placed upon the government, the Medical Society made precedent–setting concessions in many areas such as physician recruitment, access to billing numbers and peer review. The dominance and influence of organized medicine can hardly be contested, yet even this group was forced to face the reality of diminishing resources and a particularly resilient provincial cabinet. Although this admission does not call into question the presence of the pluralistic model in this instance, it does demonstrate that factors external to group/government structure do have an influence, such as the political climate and the strengths and weaknesses of the élites at the negotiating table.

LEGISLATION AND THE MEDICAL SOCIETY

In examining the legislation passed by the Savage government in 1996 affecting physicians' services, I will argue that these bills affirm the pluralistic nature of the government/medical society relationship. Despite having considerable authority to regulate and monitor the practice of medicine, governments tend to cede this authority to organized medicine, by granting considerable latitude in drafting their own enabling legislation. This assertion will be examined in the following three bills which were passed by the Savage government in 1996: *An Act Respecting the Practice of Medicine*, *An Act to Continue the Medical Society of Nova Scotia* and *An Act to Permit Physicians to Incorporate for the Purpose of Carrying on the Practice of Medicine*.

Although these three bills were introduced and debated separately by the government, it is useful to consider them as a package. They are directly related to the aforementioned physicians' agreement in that much of their substance was the result of commitments made by the Department of Health during the negotiating process. It may be argued that these pieces of legislation were compromises or concessions on the part of the Minister of Health to help foster better relations and help heal some of the divisions caused by the protracted and often bitter negotiations. *Halifax Chronicle–Herald* reporter Dale Madill described the trilogy of bills as making Nova Scotia's doctors and patients "Better, happier and wealthier." In this same article, Stewart said the bills are, "three attempts ... at bringing modern realities into legislation [which] will be helpful in providing a more solid base, and a stabilizing effect."[24]

As described by Stewart, *An Act Respecting the Practice of Medicine*, "... sets standards and confines itself to the practice of medicine as that practice of medicine is defined in the bills and the previous Acts of this Legislature."[25] In setting the standards for the practice of medicine, this Act reconstituted the Provincial Medical Board as the College of Physicians and Surgeons, with the responsibility of reviewing complaints and adjudicating disciplinary procedures for physicians. Although it is tempting to launch into a detailed analysis of this legislation, especially as it relates to the composition of the College and its related process for ensuring a high standard for medical care, I will restrict our discussion to the interplay of group politics with respect to the shaping of this bill.

By addressing the implications of *Bill 59* for other health care professionals, Stewart anticipated the reaction of the opposition and government members to pressure group lobbying:

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[24] *Halifax Chronicle–Herald*, December 7, 1995.

[25] Hansard, Assembly Debates (Nova Scotia House of Assembly, December 12, 1995), p. 4356. Debate on Second Reading, Bill 59.

> We must, however, keep in mind what this bill does.... Nothing in this bill would prevent the further involvement and extension of practice opportunities on the part of other health care professionals, be it nursing, be it those who practice in terms of physiotherapy, occupational therapy and so on, who have need of further legislation and regulation in regard to self-regulating bodies themselves and also the extent of their participation.
>
> One of the committees which has been established and which is ongoing, as recommended by the Blueprint Report and referred to by the honourable member for Halifax Atlantic, is the committee that is dealing with the extended role of the nurse, the nurse clinician, the nurse practitioner, whatever, one who would want to use that, and also the primary care group that is working on the development of primary care teams and the role of those teams in the provision of primary care through community health centres and other avenues within the health system.
>
> Very clearly, that is supported in terms of the Blueprint Committee, it is not in any way a function of this bill to allow the extension of practice, the extension of participation by those groups in the health care system in the delivery of care. Referring specifically to midwifery, if one defines the parturition and the issue surrounding that particular condition as a medical problem alone — and I don't think anyone could argue that that is the case in modern terms — one would have a very restricting bill. This is not a restricting bill, it would not bar the development of midwifery as a profession within the province. We have made our thoughts known on that both during our election campaign and in terms of what we have said here in this House both through myself and through the Premier.[26]

Robert Chisholm, debating this bill on behalf of the New Democratic Party, made particular reference to the concerns regarding the impact this bill would have on midwifery. "There is also a question of the freedom to make choices about health care and who will provide that treatment. For example, many women want the right to choose either a midwife or a doctor to deliver their babies.... The whole question about the availability of different professions to provide similar services should be a choice that is available to all Nova

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[26] *Ibid.*

Scotians."[27] Chisholm took exception to the definition of the "practice of medicine" citing Clause 2 (w)(iii) "offering or undertaking to prevent or to diagnose, correct or treat in any means, methods, devices or instrumentalities any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person, including ... the management of pregnancy and parturition."[28] Chisholm reasoned that this clause would exclude midwives from being permitted to deliver babies by rendering them guilty of violating the Act by practising medicine without a licence.

The Association of Nova Scotia Midwives made representations at the Law Amendments Committee and met with Health Minister Stewart to protest the "offensive" wording. They had two specific objections, one being the provision that only a physician could "diagnose, correct and/or treat ... any disease illness, pain, wound." The second was the argument cited above by the NDP with the Association arguing that the "Midwives believe strongly that pregnancy is a healthy physical condition."[29] Based on these concerns and opposition pressure, the Act was amended by striking the words "including the management of pregnancy and parturition." The Canadian Press story ran with the headline, "Midwives breathe sigh of relief."[30]

Surprisingly absent from this debate was the Citizens for Choice in Health Care. As documented in Chapter 2, this group was quite active in the 1993 election campaign; however, it played a small role in the public arena during debate on *Bill 59*. Dr. William LaValley, a leader of this organization, joined the Liberal Party, participated in national media events and petitioned the Minister of Health directly in order to promote the inclusion of

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[27] *Ibid.*, p. 4348.

[28] *Ibid.*, p. 4351.

[29] *The Kentville Advertiser*, December 19, 1995.

[30] *The New Glasgow Evening News*, December 21, 1995.

complementary medicine as an amendment to the Medical Act. However, during the period in which this bill was being debated in the legislature, despite a few sporadic "Letters to the Editor," there seemed to be very little public interest in this cause. Tory health critic George Moody mentioned it as a criticism of the bill: "I don't see anything in here recognizing complementary (or alternative) medicine, and that's an avenue that an increasing number of patients are choosing."[31] Yet it was hardly addressed by either opposition political party during second reading debate and no really serious pressure was brought to bear on the government throughout the entire process.

Another Act in the trilogy, *An Act to Continue the Medical Society of Nova Scotia, 1996, Bill 57*, was not a particularly profound piece of legislation. Basically, it laid out the terms of reference and the general rules of conduct for society business. What is remarkable and relevant to our discussion is that this Act endured without amendment for 134 years. The original bill was introduced by a Mr. William Bennett Webster for Kings South in 1861 with Joseph Howe as Premier and Sir Charles Tupper as Leader of the Opposition. Stewart described the new bill as updating and modernizing the original Act. "It illustrates for us the changing relationship between the Ministry of Health and the Medical Society of Nova Scotia in a very real way, and I think in a very positive way. In fact, this legislation was developed in concert with the Medical Society of Nova Scotia and they participated very actively in its writing and its design and structure."[32] The Leader of the Opposition, Dr. John Hamm, concurred: "My reading of the bill is that it is an accurate reflection of the Medical Society's activities and their relationship with the province and with the government."[33]

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[31] *Halifax Chronicle–Herald*, December 7, 1995.

[32] Hansard, Assembly Debates (Nova Scotia House of Assembly, Monday, December 11, 1995), 4306.

[33] *Ibid.*, 4309.

It can be argued that this bill was merely "housekeeping" and that it really had no significant impact on the state or the practice of medicine. Conversely, this benign process may be used as further evidence to demonstrate the dominance of the Medical Society. Powerful interest groups in many instances may attempt to prevent legislative action affecting its members if the status quo is maintained in their interests. The Act itself is potentially a powerful tool for government to use in regulating and controlling the society's activities. In this instance, the bill was not threatening to the normal operations of this group and was in fact welcomed by the board. That a group as prominent as the Medical Society was able to resist government intervention in its activities for 134 years is certainly an indication of pressure group power.

Probably the most politically controversial of the trilogy of bills was *An Act to Permit Physicians to Incorporate for the Purpose of Carrying on the Practice of Medicine, 1996.* Stewart described it as "... self–explanatory. What this bill intends to do is to provide the ability for physicians as small business people to incorporate and achieve benefits therefrom."[34] The Minister defended the move by arguing that similar legislation exists for dentists, accountants, lawyers and other professionals. Perhaps the most revealing reasons given were, "We have agreed to go forward with it as per the contract with the Medical Society ... we want to provide a competitive edge, if you would, in attracting, both recruiting and retaining physicians, particularly specialists in this province."[35] The measure was expected only to be applicable to a minority of physicians who could derive some financial benefits from the corporate tax rates. This Act in no way limited the personal liability of individual physicians in practising medicine as captured in 11(1): "All persons who carry on the practice of medicine by, through or on behalf of a professional corporation are liable in respect of acts

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[34] Hansard, Assembly Debates (Nova Scotia House of Assembly, January 5, 1996, 4777.

[35] *Ibid.*, 4778.

or omissions done or omitted to be done by them in the course of the practice of medicine to the same extent and in the same manner as if such practice were carried on by them as an individual or a partnership, as the case may be, carrying on the practice of medicine."[36]

The opposition was quite aggressive in criticizing this measure, with Moody even questioning its timing: "I feel there are so many people with needs that could have been helped by some of the money that could have been collected." Tory MLA Brook Taylor added, "It's greedy, it's voracious, it's mean."[37] NDP MLA Robert Chisholm stated, "If you're going to start talking tax breaks, then let's expand it to people like public sector employees, who in 1992 had a taxable income of $32,000."[38]

As stated previously, the Nova Scotia Government Employees' Union attacked *Bill 58*, stating that it would cost taxpayers millions. NDP interim leader John Holm expanded on this theme and estimated, based on figures generated in an Ontario–based study, that incorporation would cost the province $7.5 million a year.[39] This figure was quickly contested by an accounting professor at Saint Mary's University who said the province's estimate of the cost of incorporation ($250,000) was probably more accurate. "You're just talking about the opposition rattling on as the opposition always rattles on."[40]

Medical Society President Dr. Leroy Heffernan responded to NDP attacks by countering their arguments in a letter to the editor in both major daily newspapers. Heffernan argued that the NDP was using faulty data and the measure was primarily designed to assist specialists to

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[36] *An Act to Permit Physicians to Incorporate for the Purpose of Carrying on the Practice of Medicine, 1996* 11(1).

[37] *Halifax Daily News*, January 6, 1996.

[38] *Halifax Daily News*, December 7, 1995.

[39] Hansard, Assembly Debates, Nova Scotia House of Assembly (Friday, January 5, 1996), 4802.

[40] *Sunday Daily News*, January 7, 1996.

prevent them from leaving the province.[41] The Medical Society of Nova Scotia also countered the NSGEU claim that incorporation would cost millions. In a prepared news release, the Medical Society said incorporation will benefit a minority of physicians, and it stated the union was incorrect in asserting that physicians had "escaped" wage cutbacks, citing wage rollbacks in 1992 and 1994.[42] Clearly on this issue the field became crowded with pressure groups competing with each other to defend their interests and advance their political causes. Despite this posturing, this bill was assented to on January 11, 1996.

A PHYSICIAN'S CRITIQUE OF HEALTH CARE REFORM — A PRESS ACCOUNT EXAMINED

An article which appeared in the *Sunday Daily News* on May 19, 1996, provides an excellent illustration of the true debate surrounding health reform; Shaune MacKinlay authored the piece entitled, "Too Little, Too Fast: Two Painful Years into Health Reform, Nova Scotia doctors say their patients are less safe." Featured is Dr. Robert Fredrickson, a Halifax general practitioner who states "I've had to provide third–class medicine." In the opening paragraphs, Fredrickson says he is encouraging a patient to sue him for not providing timely access to care. He does not stop there, though. He also wants Health Minister Ron Stewart and Premier John Savage named as co–defendants because "Somebody has to answer to the people of this province for what's being done to them."

Over the course of the next ten paragraphs, Fredrickson describes several tragic cases where potentially life–threatening diseases were left to wait for treatment or diagnostic testing. The specific waiting times are cited but no direct comment is made as to whether this delay is acceptable medically or not. He does state that it is difficult to tell a woman with

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[41] *Halifax Chronicle–Herald*, December 9, 1995.

[42] *Halifax Mail–Star*, March 17, 1995.

breast cancer waiting for treatment "that the tumor isn't growing every second in her breast." The implication is that in an ideal system she would be seen immediately, perhaps even admitted on an emergency basis. The article makes no attempt to define the appropriate waiting time for treatment of breast cancer. However, even a general discussion of waiting lists is inappropriate in this instance because the reader is not given any of the details regarding the case, and even the most gifted clinician cannot make a judgement on the appropriateness of the delay — cited at six weeks — without knowing the details of the case.

The article then shifts form Fredrickson to Nova Scotia Medical Society President, Dr. Cynthia Forbes, and the focus shifts from the discussion of individual patients to a scrutiny of the acute care hospital sector. According to Forbes, "The dramatic changes that we have seen have been reduction in service [and] reduction in facilities.... When you have overworked physicians and overworked nurses, the hospital is less safe." The final three columns of the article provide a discussion of the underlying discontent with the leadership of organized medicine has with respect to health care reform — that is, who has the power to make decisions and control the health care system. Medical Society President–Elect Kim Crawford complains, "Physicians feel that we have to do something. We need to try to be more effective in the changes that are going ahead."[43]

The following paragraphs from the article are extremely revealing about the role physicians feel they should have in the system:

> Doctors are positioned to have a greater influence on the kind of care the new, cheaper, health system delivers. That means gaining influence with the four citizen–run regional health boards as they assume responsibility for health–care delivery and spending.

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[43] The Nova Scotia Medical Society is structured in such a way that the President, the President–Elect and the Past–President are usually separate individuals who serve simultaneously.

> A medical society task force spent the past year asking doctors how service should be provided in a regionalized system. Its report, which has only been made public in summary form, was approved by the society's board February 10th.
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> "Physicians have not been consulted adequately and this is, in part, a response to that," says task force chairman Dr. Peter Littlejohn. The task force found the Health Department has given doctors too little information. As a result, doctors don't understand or don't believe the health–reform message.
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> "We're all groping around in the dark," Littlejohn says
>
> The task force says found doctors should "provide supportive leadership in the mists of chaos" by helping regional boards understand the jobs ahead of them.
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> By the fall, the society hopes to be in a better position to do that, with the establishment of new regional branches that match the health board boundaries. A central medical society headquarters will remain with strong support for regional efforts.
>
> The overhaul will allow doctors to watch every move the boards make. And, whether the boards like it or not, doctors will be offering their advice.[44]

This stance can be interpreted as quite radical. Would society accept such rhetoric from nurses, in–home support workers or laundry workers in hospitals? The leadership of the Medical Society told the *Daily News* that it was in essence going to infiltrate and badger the citizen–run regional health boards whether they like it or not. Of course, this ignores the fact that all four regional health boards have at least one physician.[45] Both the reporters and the physicians quoted imply that the RHBs need paternalistic guidance from physicians in order to function properly. The question is properly for whom? The evidence is clear that the since

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[44] *Sunday Daily News*, May 19, 1996.

[45] The lone physician on the Eastern Regional Board resigned in early 1996 for personal reasons. However, all the appointments for RHBs were due to be replaced or reappointed in September of 1996.

the introduction of Medicare, doctors have been the driving force and main beneficiaries behind the decisions made regarding the structure of the health system.

Physicians claimed not have been consulted in the reform process. However, a doctor chaired the Blueprint Committee, they are represented on every RHB, they are required by statute to be on the QEII hospital board, and they are represented on the Board of the Cape Breton Health Care Complex. Every decision affecting the provision of physician services must be unanimously approved by the Joint Management Committee (JMC), which is made up of members of the Department of Health and the Medical Society. No other professional association in Nova Scotia can boast of having such influence over government policy formulation. Finally, under the Savage government for the first three years a physician was the Minister of Health, the Minister of Community Services and the Premier. I leave the reader to judge if physicians have a voice in health care reform.

The remainder of the Daily News article is a discussion of the Department of Health's planning process with an emphasis on the pace of reform. The Minister of Health is given a few words at the end to defend himself: "Whether we did it too quickly, and the mistakes that we have made, I will leave for history to judge and the electorate to voice an opinion." If the electorate is bombarded with the unsubstantiated rhetoric that the Medical Society was permitted to espouse unchallenged in this article, they are likely to develop an unfavourable opinion of the Savage government.

CONCLUSION

The Medical Society of Nova Scotia certainly displayed pluralistic tendencies in its effort to secure its policy preferences. As a professional association, it has a vested interest in advocating on behalf of its members. I have argued that this group has been quite successful in shaping public policy, and I believe it is the most powerful interest group in Nova Scotia.

With reference to this particular case study, physicians were able to oblige the Department of Health to fast–track negotiations on their contract, and in an era where many other health care professionals are experiencing lay–offs and wage roll–backs, physicians have fared quite well. Even with respect to legislation, doctors were able to convince the government to pass a trilogy of bills to help meet their demands.

It is interesting to observe that even within the Medical Society structure, significant cleavages exist which became apparent during the ratification process, especially from interns/residents as well as rural practitioners. It is this commitment to pluralism which is both a source of empowerment and weakness for this group. Yet it is evident that hints of corporatism exist in the Medical Society's relationship with government through the Joint Management Committee (JMC) and the control of appointments by the Minister of Health to related Medical Society boards such as the College of Physicians and Surgeons.

The Department of Health did have some success in resisting the Medical Society's agenda and implementing its own policy preferences. The restriction of billing numbers, peer review, a cap on incomes and a commitment to reduce utilization rates were all concessions to the government. I have argued that the influence of individual élites involved in the process had an influence on the outcome. A politically resilient Premier and Minister of Health and the support of a the majority of the government caucus contributed to the Department of Health's success in the final agreement.

An overview of this chapter allows us to make some conclusions. The ability of the government to reform the health care system was challenged and in some areas thwarted by the Nova Scotia Medical Society. Although the political messages expressed often masquerade under the guise of proper patient care, the real issue is one of control and power. Organized medicine has felt threatened by health care reform as articulated by the Savage government. A move to decentralize services and decision–making, an emphasis away from

acute care institutions to community–based services, resources allocated to elevate other professions such as nurse practitioners and pharmacists all have profound implications for the traditional practice of medicine. Physicians' power over the system and the ability to generate wealth are eroded by health reform, and the Medical Society as a "status quo" organization cannot easily embrace this change. The ability to change the system to preserve its integrity and sustainability seems to be a government responsibility, yet this pressure group can muster the resources to impede its progress and in some cases determine its direction. While this affirms the pluralistic tendencies of interest group politics, in this case some may argue that it comes at the expense of the public good.

CHAPTER 4:
THE CLUB OF OSTRICHES? —
EMERGENCY HEALTH REFORM IN NOVA SCOTIA

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INTRODUCTION

The Savage government pledged in its 1993 health platform to reform the "Ambulance care" system and replace it with an emergency health system with strong central regulatory control and provincial standards. Health Minister Stewart, given his background as an emergency physician and recognition as an international expert in the design of pre-hospital care systems, was well positioned to act on this promise. However, significant impediments to change existed with the Ambulance Operators Association of Nova Scotia (AOANS) and their allies. We will examine the government's three-year reform agenda on emergency health reform with particular attention to pressure group politics and its influence on that agenda. The argument will be made that, despite meeting stern opposition, the Savage government was able to pass strong legislation and introduce a new bureaucratic structure under the Department of Health which represented a significant shift in power from the AOANS to the government.

THE AMBULANCE SYSTEM AND EMERGENCY HEALTH SERVICE IN NOVA SCOTIA: AN OVERVIEW

The emergency health system the Savage Liberals inherited certainly was considered deficient by health care professionals involved in pre-hospital care. In October of 1993, Dr. Michael Murphy, then-director of Emergency Medicine at the IWK Children's Hospital, was contracted to provide a report on the status of current services and to provide

recommendations for improvement. *Report: Emergency Health Services Nova Scotia*, or the "Murphy report," as it came to be known, was accepted by the Minister in April 1994. Its assessment of the ambulance system was disparaging:

2. The current agreement to provide ambulance service is a level of effort (versus performance) contract that requires "reasonable Ambulance Service." "Reasonable" is not defined in terms of:

    - response time
    - standards for medical care
    - charting standards or
    - any other standard considered essential in the medical service delivery industry

    It is simply an agreement to fund patient transportation. It also limits government funding for ambulance services to members of the AOANS ("The only Operators who are members in good standing and who comply with the bylaws of the Company shall receive assistance from the Department under the Program" and "That, unless another arrangement is agreed to by the Company and the Department, claims will be paid under the program only to the designated Operator in a service area, except where a specific Operator has been requested by the patient") ...

3. Compliance with the agreement is monitored by the Department through the claims evaluations process. A vehicle inspection program is contracted to the AOANS. (An AOANS member performs the inspections on another member's vehicles and submits a report to the Department.) The training program for ambulance personnel had been contracted to the AOANS and funded by the Department, although this is in the process of being moved to an independent training institute (Victoria General Hospital School of Allied Health) as recommended by the Ambulance Services Advisory Committee in 1991.

4. The degree of collegiality and accommodation afforded the AOANS by the Department of Health has not served the public interest in terms of contract development and monitoring, performance and patient care.

5. The Department has not undertaken comprehensive emergency health care system design nor the activities necessary to develop an infrastructure to support such a system. As a result, the Department has not developed an

> appreciation of the complex matrix of components that interrelate to deliver an essential service to the public, nor does it have the expertise to cultivate it.[1]

The Murphy report describes the structure of the ambulance services as being controlled by an "economically and political powerful" organization. It describes a strong association and individual operators administered centrally by a weak department with little "hands–on" management. Except for a few services which are excluded from the subsidy agreement, "... this organization controls, through its members, the provision of an essential public safety service." Approximately 59 private operators throughout the province respond to over 60,000 calls annually, including emergency, non–emergency, and "body removal" transports, and "estimated 17,000 non–subsidized, third–party pay transports are done annually by 130 subsidized and 31 non–subsidized vehicles. An additional 10–20,000 patient transports are done annually by non–association members ...."[2]

Speaking on the subject directly, Murphy is more critical in his assessment of emergency health services in pre–1994 Nova Scotia. "Fundamentally [it is] a transport service, a trucking system based on fee for service. It is operated with business objectives in mind with less emphasis on patient care issues. Even the Department of Health viewed it as such, there was no notion that this was a medical venture."[3] Although Murphy does concede that some individual operators provide quality care, generally "they are a poorly organized herd ... operating in a non–coordinated, profit–driven system. The Department of Health acts as a bill payer with no evaluation process and without a performance audit. There is no medical accountability at all."[4]

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[1] Michael Murphy, MD, and Ann Petley–Jones, *Report: Emergency Services Nova Scotia* (Nova Scotia Department of Health, April 1994), 19.

[2] *Ibid.*, 18–20.

[3] Dr. Michael Murphy, personal interview, 1996.

[4] *Ibid.*

Mr. Tony Eden, Fleet Manager Emergency Health Services Nova Scotia (EHSNS), provided a similar assessment of emergency services in Nova Scotia. His background is diverse in that he has government, hospital–based and private operator experience in ambulance service administration for over twenty years. Eden described the system as "chaotic at times because it was unregulated and had no leadership. The role of government was to fund the operators and it was timid when it came to addressing patient care issues. The AOANS had absolute control, some of its members are good–hearted individuals who do a pretty good job. However, there was no leadership; nobody had a vision. Government relied on the goodwill of individual operators who were in the business to make money with patient care being a secondary consideration. There was no central measurement of standards or patient–driven data collection. The 'ops' (AOANS) resisted documenting patient care cases because of the legal liability, and as well they were under no obligation to do so."[5]

Commenting on the historical evolution of the ambulance system, Eden described a patriarchal structure which had ambulance businesses being passed from father to son, similar to the medieval landlords who would bequeath their fiefdoms to their male heirs. "Traditionally, the ambulance business was inherited from their fathers; often it was related to other businesses such as funeral homes. Initially, funeral directors were the only people in the community which could transport people horizontally."[6] To illustrate the family–run nature of ambulance services, Eden described an operation in Truro which was managed by the father whose son was the operation manager, the son–in–law ran a remote ambulance base and the daughter was the office manager. The family also owned a gas station where it would be common to see ambulance attendants also working at the service station. Another example of ambulance operators aligning themselves with other businesses was evident in Sydney Mines,

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[5] Mr. Tony Eden, personal interview, 1996.

[6] *Ibid.*

Cape Breton. The town ambulance service is listed in the telephone directory as Clark's Taxi and Ambulance. Hopefully those who needed emergency would not spend to much time looking up the ambulance service under the letter "A." Attendants for this service have recounted incidents when employed in the related taxi business, where an emergency call would be received and they would have to drive their taxi to the ambulance station, transfer vehicles and then go out on the call. Obviously this would impact negatively on response times.

The President of the Ambulance Operators' Associations, Mr. Robert Schaffner, defends the private operator as a legitimate health care professional. He was instrumental in forming the AOANS in 1969 and has served as president for twenty–seven years. He argues that the primary responsibility for the quality of the system rests with government.

> The power is with the province to regulate the service being provided. In the past we did not focus on health care matters like they do today. It was only in the 1980s that ambulance services came under the Department of Health. In the past, we came under Social Services, and prior to that Municipal Affairs. Some of the ambulance operators were more money-minded than others. However, money was not the issue. The majority had a community-minded perspective. They were born and brought up in the community and they did their best to provide a good service. There were always faults in the system, but we are open–minded and felt we could improve to whatever standard the province wanted.[7]

Schaffner argues that the operators needed to have other businesses because an ambulance business on its own was not sustainable financially: "The ambulance service on its own would not carry itself; other business were needed to carry the ambulance side."[8]

The Minister of Health had long advocated that private business had little to contribute in operating ambulance services. In the summer of 1993, Stewart criticized the AOANS for

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[7] Mr. Robert Schaffner, personal interview, 1996.

[8] *Ibid.*

dictating pricing schemes to government, and stated, "No more. It will now be on our terms. The reforms (to ambulance service) will be very deep."[9] Stewart added that he fully expected opposition from the operators to his new initiative.[10] During the election and throughout the course of his term as Minister, Stewart often confided about his frustration with the structure of the ambulance system. He frequently referred to the AOANS as a cartel which was a barrier to quality care. His "vision" for Nova Scotia's emergency health system certainly did not include a role for the vast majority of members of the AOANS and as a structural entity he worked to have the association disbanded.

Eden, Murphy, and (not surprisingly) Schaffner all disagreed with this approach, as they viewed the AOANS as having a very tangible role. Eden argued that "there is a role for 'the ops' because local experience is important in keeping a viable system. Government's role is to oversee the system by establishing standards and measuring outcomes; they should not be the service provider."[11] Eden implied that it was unfair to blame the AOANS for the low performance of the system. However, he described them as a member of the "club of ostriches," which also included physicians, hospitals administrators, other health professionals and government. On this account, all of these groups had to share some of the responsibility. "The AOANS had the 'golden goose' — they didn't grow the goose–they just took the eggs."[12] Murphy agreed with Eden, "The 'ops' deliver the service and we [EHSNS] provide the direction and make policy."[13] Though Schaffner, as the AOANS president, argued for its

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[9] *Cape Breton Post*, August 27, 1993.

[10] *Ibid.*

[11] Mr. Tony Eden, personal interview, 1996.

[12] *Ibid.*

[13] Dr. Michael Murphy, personal interview, 1996.

continuing role in the system, he did concede that "government should highly regulate this service," and went to state, "I am very supportive of government standards and regulation."[14]

Government polling was not definitive on the public support for change. In a sample size of 500 throughout the province, Nova Scotians were asked whether they were confident in the level of service they were receiving and the value of that service.[15] Eighty–five percent of respondents indicated their preference for a coordinated province–wide system rather than the current system of 56–60 independent operations. Ninety–seven percent of respondents acknowledged that ambulance personnel should be required to meet a provincial standard for certification and licensure, while 60.4% disagreed with ambulance attendants being able to do other unrelated duties such as pumping gas, driving taxis, making deliveries, and so on. However, other data seemed to contradict this clear mandate for change. For instance, 65.5% felt that being a funeral director did not distract from being an ambulance owner/operator, while 57.3% rated their ambulance service in their area of habitation as either good or excellent.

From a public opinion standpoint, the way to proceed seemed murky. Public attitudes toward the AOANS did not appear to warrant wholesale change, but an increase in the standards and a stronger central presence were feasible. The tenor of the Murphy report, the stance of the Liberal health platform and the public and private position taken by the Minister of Health seem to have provided a sufficient political formula to generate change in Nova Scotia's emergency health system. Despite the resistance to the extreme position Stewart adopted with the AOANS, he was able to muster enough resources to begin the process. The

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[14] Mr. Bob Schaffner, personal interview, 1996.

[15] The survey was conducted by a consulting firm for the Department of Health in the fall of 1994. The sample size provided a 95% level of statistical confidence overall with a 4.5% margin of error.

following section will analyze the government's strategy and the response of the AOANS and other related interest groups.

THE IMPACT OF EHS REFORM

The policy implications of the Savage Liberals' attempts to reform the emergency health system really began with the drafting of the report on emergency health services in Nova Scotia (the Murphy report) and not with the passage of *Bill 96, An Act Respecting Emergency Health Services, 1994*, as one might expect. The impact of appointing Murphy as the Special Advisor to the Minister of Health on EHS was immediate. Schaffner described the period surrounding the introduction of the Murphy report and the passage of *Bill 96* as being a time of great instability in the ambulance industry. According to Schaffner, "There wasn't an understanding of the impact. I believe the public tender system is not the way to provide stability. We thought most of our members would be excluded from providing the service."[16]

Why were the ambulance operators so concerned? The Murphy report made sweeping recommendations in a wide variety of areas. In essence, Murphy advised the government to develop an Emergency Health Services Agency that would operate at "arm's length" from government. This new corporate body would be mandated to deliver emergency and outreach health services to Nova Scotians. The creation of a first responder program, enhanced EMT training, base hospital paramedic program, information systems/research and an air ambulance program would all flow from this new agency which would be accountable to the government through a board of governors which would report to the Minister of Health. The recommendations which caused the "instability" mentioned by Schaffner had to do with the ground ambulance program, outlined as follows:

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[16] Mr. Bob Schaffner, personal interview, 1996.

> An ambulance is defined as any conveyance utilized for the care and transport of a patient to or from medical care regardless of urgency. The final determination of whether a conveyance is in fact an ambulance should reside with EHSNS. It is recommended that all ambulances be staffed by two attendants. It is recommended that one must be a licensed EMT. Within three years of EHS System implementation, it is recommended that both be licensed EMTs. It should not be an allowable practice to hire non–EMTs in preference to suitability credentialed and licensed EMTs during the transition period. The level of training (EMT 1, 2 and 3) required in service areas should be determined and approved by the System Medical Director.
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> ... It is recommended that Ambulances entering service in the province would comply with these specifications, and would enter service in terms of a three–way lease, or alternate arrangement ensuring immediate, unencumbered and uncontested availability of ambulances and equipment to the Agency in the event of contractor failure or suspension. The goal here is to ensure the continuous provision of life–saving ambulance service to the public. It is recommended that all vehicles comply with this document within three years of EHS system implementation.
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> ... It is also recommended that licenses to provide ambulance services be awarded, usually by contract, by EHSNS. No ambulance would be operated in the province unless licensed by EHSNS.
>
> Performance based service contracts may be negotiated between EHSNS and the provider. These contracts for service may take several forms:
>
> 1. Volunteer services
> 2. Tendered services
> 3. Budgeted services
> 4. Fee–for–services
> 5. Any other model as determined by EHSNS
>
> Existing geographic monopolies may or may not be preserved depending on the funding system and the interests of involved parties.[17]

Although the wording is vague, the implications of the aforementioned to the AOANS were potentially severe. Given that the report was enthusiastically received by the Minister of Health, and knowing from past relations his position on the role of the AOANS in the

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[17] Murphy and Petley–Jones, *Report*, 47.

emergency health system, many operators assumed the worst. The references to performance–based contracts, tendered services and a veiled allusion to the "existing geographic monopolies" was enough evidence for stakeholders to assume the existing structure would be dismantled. Eden asserted that the instability in the industry created by the Murphy report nearly provoked a withdrawal of service on the part of the AOANS. "The 'ops' stopped investing in their vehicles and the banks stopped lending them money."[18] Murphy felt that the system was in danger of collapse during this period of transition, "We were just lucky nothing serious happened. It had the potential to be devastating."[19]

During this period, the concern over the AOANS withdrawing service became so acute, the government developed a contingency plan. The Minister received a dire warning from Murphy in a memo faxed April 18, 1994:

> The AOANS through their Executive Director have made it clear to me that they are contemplating a Province–wide withdrawal of ambulance services in response to the emergency health services report I am working on. Their concerns relate to a perceived loss of operational and financial control and the requirement to share information regarding the delivery of ambulance services.
>
> I perceive this threat as real, and one that may lead to the death and disability of Nova Scotians unless the Department considers and implements a contingency plan in the event that a withdrawal takes place...[20]

Similar situations occurred throughout the industry as various operators collectively or individually considered withdrawing service. An example of this occurred in January, 1994, when a Halifax–based ambulance company teetered on the brink of bankruptcy, forcing the Minister of Health to cobble together a metro–based contingency plan with the Victoria

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[18] Mr. Tony Eden, personal interview, 1996.

[19] Dr. Michael Murphy, personal interview, 1996.

[20] Memorandum from Dr. Michael Murphy to the Minister of Health, April 18, 1994.

General Hospital. In a letter to the President and CEO of the Victoria General Hospital, the Minister of Health requested immediate assistance should this ambulance operator declare bankruptcy:

> You are aware that a major ambulance service in the metropolitan area is in the midst of significant financial difficulty. There is a serious threat that this ambulance service may cease its services in the immediate future. The Department of Health is requesting the Victoria General Hospital to aid in its contingency plan for the provision of interim ambulance services in the metropolitan area in the event that the [service]... cease[s] operations.
>
> Costs related to the interim plan will be undertaken by the Department of Health, as invoiced to them by the Victoria General Hospital. ...[21]

Clearly, the Murphy report helped create instability in the ambulance industry which continued after the report was accepted by the Minister of Health. However, the most intense pressure came when Stewart introduced legislation in the 2nd Session, 56th General Assembly, 1994. *Bill 96, An Act Respecting Emergency Health Services* is the legislative interpretation of the Murphy report. It is enabling legislation which provides for the establishment of an agency designed to administer emergency services. Although the framework for the Emergency Health Services Agency is defined, the real "teeth" in the Act are the regulations which can be passed by the Governor–in–Council:

> 29 (1) The Governor in Council may make regulations
>
> (a) describing a region and determining its name;
>
> (b) respecting the employment of personnel by the Agency, including supervisor for each region;
>
> (c) respecting the employment opportunities for the employees of existing ambulance operators with persons entering into agreements to provide ambulance services and prescribing a period during which insufficiently qualified employees can obtain training and sufficient qualifications;

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[21] Correspondence from the Minister of Health to the President and CEO of the Victoria General Hospital, January 14, 1994.

(d) limiting the number of ambulances in a region;

(e) respecting the purchase or leasing of ambulances;

(f) establishing standards respecting the training of emergency personnel, staffing and communications;

(g) respecting tendering;

(h) setting fees for the use of ambulances;

(i) respecting the equipping of ambulances and other emergency vehicles;

(j) respecting inter–hospital transfers;

(k) respecting air ambulances, and without restricting the generality of the foregoing, applying any provision of this Act to air ambulances;

(l) regulating or exempting from any part of this Act or the regulations the interprovincial operation of ambulances;

(m) respecting the functions of the dispatch centre, including, without restricting the generality of the foregoing, the monitoring of the performance of ambulance operators;

(n) subject to any other enactment, respecting outreach programs, home care, co–ordination with the "911" emergency telephone system, an information line service, disaster planning and the provision of other health–care;

(o) subject to any other enactment, co–ordinating the designation and classification of hospitals for the provision of emergency services;

(p) establishing a Medical Control Board to the appointed by the Minister on the recommendation of the Commissioner and prescribing its functions respecting medical direction services for the Agency;

(q) defining any word or expression used by not defined in this Act;

(r) respecting any matter that the Governor in Council considers necessary or advisable to carry out effectively the intent and purpose of this Act.[22]

This Act allows the agency it describes to have sweeping powers in terms of administrative control over the provision of emergency services. It is a direct assault on the subsidy agreement between the AOANS and the Department of Health. Taken to its logical conclusion, the role of the AOANS as a key stakeholder in the system could not help but be diminished. What has prevented the demise of the AOANS, in its current form, and the

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[22] An Act Respecting Emergency Health Services, Ch. 8, Acts of 1994 (Statutes of Nova Scotia), 420 (1) a–r.

ascendency of EHS Nova Scotia has been the delay in the proclamation of the Act and its specific regulations as determined by Cabinet. Although it was assented to by the Lieutenant Governor on June 30, 1994, as of October 1996 it had yet to be proclaimed. Murphy has described this as a problem for the pace of reform. "Right now *Bill 96* can be used as a 'club' to convince operators to be supportive of EHS. Yet, legally, we have no authority to do what we are doing, but that could change on any Thursday at Cabinet."[23]

Despite the current "technical" problems, the Act, as a catalyst for dramatic change in this industry, has not been in dispute. The AOANS resisted *Bill 96* vigorously as an organized lobby, through the media, a direct presentation to the Law Amendments Committee, and advocacy by individual operators to various MLAs.

In the media, the AOANS positioned itself as a defender of local control of health resources and attacked the Murphy report and *Bill 96* for its lack of fairness in treating the existing operators. "This legislation would put everything in the hands of one man, with a powerful board that is answerable only to the Minister. We cannot understand how, when the rest of the health services are being decentralized, made more answerable to the public and are being made more cost–effective, this totally opposite service is being considered," explained Mr. Chris Roop, owner of Warren T. Roop Ambulance Service, primarily responsible for Annapolis County.[24] Roop asserted that much of the reasoning was foolish and that taxpayers would end up with a giant, much more costly ambulance bureaucracy and no say in how it operates. He did concede, however, that he was "glad" that the government was upgrading the expertise of emergency medical staff. He encouraged Nova Scotians to express their "worry" over this legislation by calling the Premier's "1–800" line.[25]

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[23] Dr. Michael Murphy, personal interview, 1996.

[24] *Mirror Examiner*, July 6, 1994.

[25] *Ibid.*

During the debate on *Bill 96*, Schaffner made the following statement to the media:

> We [AOANS] have a problem under the new system because a separate agency will lease the vehicles which we will use and the premises where they will be kept. To me, it is very close to a government takeover. ... The tendering issue is one of our main concerns, because it's a matter that will cause instability. For someone to make an investment and then two or three years later have it go up to tender for someone else, it's just not good.[26]

Business and economic issues were at the centre of the individual operators' concerns with the proposed new direction. As Mr. Layton Goodwin, owner of Sweeney's Funeral Home and Ambulance Service in Yarmouth, explains, "It looks as though we could be out of business. The sad thing is, we don't know what we're going to do. Speaking as a business person, it looks as if we may be out in the cold."[27] These comments were echoed by Mr. Glenn Diggdon, manager of the West Pubnico Funeral and Ambulance Service: "A lot of operators have built up businesses after years and years of hard work. I just hope they'll all be given a fair chance of staying in the business, that's important."[28]

As an association, the AOANS formally criticized *Bill 96* at the Law Amendments Committee and through correspondence to the Premier and the Minister of Health. Schaffner, representing the AOANS, told the Law Amendments Committee in June 1994 that several major amendments were needed for *Bill 96* to be supported by the ambulance operators. The bill was described as a "costly backward step" toward increased government control in a time when governments are encouraging privatization. The Bill had serious ramifications for the structure of the emergency health system and the AOANS position in it. Accordingly, these proposed amendments reflected the desire to maintain the status quo. Schaffner wanted

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[26] *Vanguard*, July 19, 1994.

[27] *Ibid.*

[28] *Ibid.*

section 14 of the Bill deleted so as to allow "the private sector to purchase ambulances and make arrangements for the housing of these vehicles."[29] Other proposed amendments followed a similar logic:

> Delete section 10(1) and allow the Ambulance Operators Association to continue to negotiate contracts with the Department of Health ...
>
> ... Replace the tender system with a formula that will ensure the province receives the most for their investment in ambulance services but one that will ensure stability for the operator.[30]

Schaffner argued that *Bill 96* could have a negative impact on the health of Nova Scotians which prompted a blanket condemnation of the legislation in the final paragraph of his brief.

> *Bill 96* in its present form is a government takeover of the ambulance services without compensating the current operators for their present investments. The proposed Act is seriously flawed and requires additional study and review before it is passed. I believe the Law Amendments Committee should not allow this Bill to proceed for third reading at least until the fall sitting of the House which will provide time to make the necessary changes to ensure Nova Scotians receive the best ambulance services possible.[31]

As an aside, another prominent interest group proposed changes to *Bill 96* — namely, The Nova Scotia Government Employee Union. While its submission was less defensive than the AOANS, it nevertheless called upon the government to strengthen the clauses protecting employee benefits and salaries under the new agency, with a focus on emergency personnel employed at the Victoria General Hospital. The NSGEU recognized that its members employed in emergency services at the VGH could face the possibility of having their status

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[29] Schaffner, "Proposed Amendments to Bill 96," submission to the Nova Scotia Law Amendments Committee, June 17, 1994.

[30] *Ibid.*

[31] *Ibid.*

changed if an amalgamated EHS system chose another union to represent their interests under the new agency. These proposed amendments constituted a pragmatic attempt to shore up support amongst members that could be affected by this Bill.

Previous to Schaffner's presentation to Law Amendments, he had written a nine–page critique of the Murphy report (and the legislation he knew was being drafted) to Premier John Savage. The letter, dated May 16, 1994, was a scathing analysis of Murphy's findings; Schaffner also lamented the march toward government control of the ambulance system and the loss of control of the AOANS. The correspondence mirrored the arguments made in their submissions to Law Amendments; however, what is interesting is Schaffner's subtle attempt to further his position by bargaining with Savage when he was vulnerable from labour unrest throughout the province.

> ... We have made this major effort to draw these concerns to your attention privately rather than having them brought forward in the media. We hope that this responsible approach by AOANS will be met with adoption by the Government of the amendments respectfully proposed by our Association to Dr. Murphy.
>
> We have also refrained from joining a coalition of public sector groups threatening to stage a province–wide work slowdown or stoppage.
>
> It is important not to underestimate, however, the pressure which AOANS is under to join such a massive province–wide work slowdown or stoppage ...[32]

As this letter and other tactics employed by the AOANS had little effect, Schaffner made one last effort to change *Bill 96* by appealing to Health Minister Stewart for a personal meeting with him. The request came by letter dated June 20, 1994 (ten days before *Bill 96* would be assented) marked "URGENT." The letter's tone sounded desperate. It opened with "*Bill 96* ... will cause personal tragedy for many individuals who have attempted to provide

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[32] Correspondence from R. Schaffner to Premier John Savage, May 16, 1994.

the sick and injured in their communities with the best ambulance service possible within the revenue that was available for that purpose."[33] Schaffner explained that his members were simply community–minded people who had no interest in profits. He accused Stewart of being rigid: "You are apparently convinced we are not the appropriate people to provide ambulance service in this Province and I'm not going to continue to try to convince you to change your mind on that issue."[34] By this time, all references to quality health care were dropped; it was clearly stated that the AOANS were opposed to *Bill 96* out of personal financial interest. The second last paragraph of Schaffner's letter clearly defines the ambulance operators' motives: "The purpose of this letter is to make one last attempt to meet with you to discuss how *Bill 96* in its present form will affect the present operators. I cannot believe the Province is intentionally passing a law that will cause such a major personal crisis for several of our members."[35]

Stewart responded by fax that same day. He refused a personal meeting, citing legislative and other business commitments, but asserted that his Bill was not discriminatory against the AOANS.[36] The Minister argued that, although *Bill 96* called for open tendering, that did not have to be interpreted as exclusionary for the AOANS: "I fully expect, and would encourage, firms (and combinations of firms), currently providing ambulance service to consider responding when the new agency calls for tenders for the provision of emergency services."[37] It seemed that the AOANS was arguing against open tendering and accountability.

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[33] Correspondence from R. Schaffner to the Hon. Ronald Stewart, June 20, 1994.

[34] *Ibid.*

[35] *Ibid.*

[36] Throughout his term, Stewart resisted meeting interest groups personally, a policy he was often criticized for. He countered that his goal was to "depoliticize" the health system, so he wished to discourage "end–runs" to the Minister's Office.

[37] Correspondence from Hon. R. Stewart to R. Schaffner, June 20, 1994.

Stewart was confident that the general public would not support a group of businessmen (there are no women ambulance operators) who received taxpayers' dollars and had never gone through a public tender process.

The Official Opposition, the Progressive Conservatives, defended the AOANS during debate on *Bill 96*. On theoretical grounds, this may not seem surprising given that the Conservative view generally holds that private enterprise is preferred over government ownership. Health critic George Moody described *Bill 96* as the forerunner to a "Cadillac system" that was an American–based model. He argued that the AOANS was capable of delivering the service. During the second reading of *Bill 96*, Moody accused Stewart of not consulting enough with his own caucus. He directly referred to Mr. Clifford Huskilson, the MLA for Shelburne, whose father Harold is an owner/operator of the local ambulance service. During this process, both Clifford and Harold Huskilson opposed the majority of Stewart's reforms for emergency health services and exerted pressure on the Minister directly in caucus and private meetings to change his approach.

Moody argued that the AOANS were not consulted adequately and they should be an integral part of the new system. It should be noted that during this debate, members of the AOANS executive were in the public gallery. He took the argument to the extreme by stating:

> I am not convinced that these people that have families in this province, that have lived in this province all their lives and been part of the community, that this government can say to them, you are no longer needed, you cannot be part of the changeover. We cannot make you part of the super system that we heard about and you will not fit in the system so you cannot be part of it. ... Is it that they are terrible people? Is it that they do not have the expertise or they cannot upgrade the standard of their ambulances? What is the problem? I have not been able to figure that out, what the problem is. They have not been consulted and all they are told is the system is terrible, we brought in these experts from England and North America and they have told us that this is best for Nova Scotia.[38]

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[38] Hansard, Nova Scotia House of Assembly (Debate on Second Reading Bill 96, June 14, 1994), 2686.

Moody's caucus colleague Dr. John Hamm followed this logic albeit in a little more tempered fashion:

> There was a cooperation that was built up on an interpersonal way between the ambulance attendants and the hospital workers. It was a system that evolved and it worked and as the governments of the day would see it, they improved the regulations, they made them stiffer and the independent operators responded ... I am not suggesting that the service was perfect, but I am saying that the independent operators did show a willingness to cooperate with the health care system and to improve the service.[39]

Not surprisingly, the New Democratic Party was more supportive of *Bill 96*. Through their spokesperson, Mr. Robert Chisholm, the NDP caucus called the government initiative "a step in the right direction and I will certainly be voting in support of the legislation ...."[40] However, Chisholm took some time during the debate to express his concern for the bargaining units representing the ambulance attendants and asked the government to strengthen the clauses in the Act effecting employee rights.

Before we can draw any definitive conclusions with reference to this case, it is necessary to spend some time examining a more subtle form of lobbying. To examine the formal legislative process and the "formal" actions taken by the AOANS to alter this Bill is not enough. Academic inquiry on pressure group politics must recognize the impact, and attempt to measure the effectiveness of "backroom" lobbying on the creation of public policy. Fortunately, this case study has some tangible evidence to suggest that this tactic was used in attempt to thwart *Bill 96*.

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[39] *Ibid.*, 2696.

[40] *Ibid.*, 2694.

In our examination of the political system, it is important to bear in mind that political leaders are people. It is easy to overlook that fact when one becomes engrossed in the study of process — yet it must be considered that the personalities, emotions and individual styles can have a profound impact on policy outcomes. Several members of the AOANS attempted to use their stature as business and community leaders to pressure individual government MLAs not to support emergency health services reform. For example, the previously discussed opposition of Shelburn MLA, Clifford Huskilson illustrated internal caucus friction.

One particularly aggressive Cape Breton ambulance operator began visiting MLAs soon after the government was formed. Mr. Leo Curry of Sydney Ambulance wrote the Hon. John MacEachern on September 2, 1993 (three months after the government was formed), stating the "new" Minister of Health had serious misunderstandings about the role of the AOANS.

> We have dealt with several difficult situations in the past 24 years and sometimes thought our existence was threatened because of lack of Government understanding of the financial burdens involved in providing a high level of ambulance service but we were able to resolve many of those concerns through discussions and negotiations with the Province ....[41]

The following paragraphs became more hostile and actually questioned Stewart's integrity:

> We must leave politics out of this issue and deal with the Minister himself. He is accepted as a leader in prehospital care and therefore provides a greater opposition than we normally encounter but his complete lack of knowledge of the services we provide and the financial position of many operators is of great concern to us ....
>
> Locally, Sydney Ambulance has the added concern of Ron Stewart's close affiliation over many years with Ken Caldwell of Rescue One Ambulance. We have a fear that he will develop a subtle form of patronage that will work towards the detriment of our operations ....

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[41] Correspondence from Leo Curry, Sydney Ambulance Service, to Hon. John MacEachern, MLA, September 2, 1993.

> I am asking you to keep a watchful eye on what is happening as to fairness and what is affordable and best for the people of Nova Scotia requiring our services.[42]

A less accusatory, but equally critical, letter was sent to the Hon. Ross Bragg almost a year later, as the government was about to pass *Bill 96:*

> Thank you for the opportunity to meet with you on Monday and discuss the ramifications of Dr. Stewart's Bill.
>
> This is a plan to nationalize the N.S. Ambulance Service by expropriation of the private operations without compensation.
>
> Our best estimates based on similar operations indicate that if this becomes law and the plan put in place *it will cost $60 million* (not the $33 million suggested in Dr. Murphy's report and four times the $15 million present cost to N.S.).
>
> The present services is far superior to what you have been led to believe ....[43]

Although many operators did not document their opposition to Dr. Stewart and *Bill 96* this thoroughly, I received several telephone calls from government MLAs who had been approached by their local ambulance operators as well as AOANS members themselves who wished to make their views known directly. As a result of the mounting pressure the base of caucus support seemed to weaken. In reaction to this Dr. Murphy was asked by Stewart to address caucus members individually as well as collectively. Also, health care professionals were asked to write the premier directly supporting the proposed changes. Excerpts from two examples of this intervention are cited here:

> On behalf of the Nurses for ACLS, I would like to extend our support for *Bill 96.*

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[42] *Ibid.*

[43] Correspondence from Mr. Leo Curry to the Hon. Ross Bragg, June 15, 1994.

> We see this Bill as a recognition of the serious lapses of care in our Nova Scotia ambulance system.
>
> We recognize this Bill as a serious and progressive attempt to right the wrongs of the present inadequate and perhaps questionable system whereby operators are paid more to transport dead bodies than they are paid to safely transport patients, or if you will, the living ....[44]

And:

> I am writing to you in my capacity as Head of the Department of Emergency Medicine at the Victoria General Hospital and Director of the Division of Emergency Medicine at Dalhousie University, to urge you to support the Blueprint for Emergency Medicine Services for Nova Scotia as developed by Dr. Michael Murphy.
>
> As department head of Emergency Medicine, I have been very frustrated over the last six years with the state of EHS in Nova Scotia. Despite the efforts of many good people ... the lack of an overall system has resulted in many instances of poor care ....[45]

Another interesting example of how pressure group politics can be employed by a small group of individuals on political élites was evident, in this case, when a public dispute erupted between Mr. Ken Caldwell, owner/operator of Rescue One Ambulance in Sydney, and Dr. Stewart. Initially, Caldwell had applauded the move toward EHS reform. As an independent operator excluded from the subsidy program and the AOANS, he viewed Stewart's attempt to change the structure as a beneficial move for the system and perhaps himself personally. Caldwell viewed himself as an agitator for the AOANS and assumed that an alliance with Stewart would pay dividends for his company.

Caldwell had been a friend and supporter of Stewart before the Minister's entrance into provincial politics. He had trained as a paramedic in a program created by Stewart in Pittsburgh and consulted him informally on the operation of Caldwell's ambulance service.

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[44] Correspondence from Ms. Mary Ellen Byrne, Coordinator ACLS for Nurses, to all MLAs. Government of Nova Scotia, June 16, 1994.

[45] Correspondence from Dr. Douglas Sinclair to Premier John Savage, March 12, 1994.

Caldwell actively campaigned for him during the 1993 provincial election and could barely restrain him enthusiasm in the media when he was named Health Minister.

Caldwell quickly became discouraged when his ambulance service, Rescue One, approached bankruptcy. His personal appeals to the Health Minister for financial assistance from the government were relentless. He would wait for Stewart at the Sydney airport when he knew he would be returning to Halifax; he frequently called Stewart's elderly mother at home; and he confronted Stewart in his constituency office in Sydney Mines and the Department of Health Office in Halifax. Caldwell attempted to exploit his friendship with Stewart by forwarding personal correspondence between himself and his wife, as well as other similar documents, demonstrating the hardships he was suffering because of the financial frailty of his business.

As it became apparent that Caldwell was unlikely to benefit financially from the ambulance subsidy program, he lashed out at Stewart in the media, through correspondence with the Premier, as well as the Ombudsman and the opposition caucus office.[46] He engaged the services of a security consultant and received a polygraph examination to convince observers of the validity of his position. In a five–page letter to the Premier, Caldwell engaged in a lengthy narrative on how Stewart had "misled ... or knowingly misrepresented the facts concerning the implementation of the new EHS system."[47] He further went on to express "grave concerns regarding Ron and whether he truly realizes the emotional roller coaster he has had me on for the past seventeen months."[48] Caldwell contended that over a one–year period, several visits with the Minister and discussions with senior staff (including

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[46] Stewart had made the political judgement that associating himself with Rescue One would allow the AOANS the ability to attack the political credibility of EHS reform. He did not take that risk.

[47] Correspondence from Mr. Ken Caldwell to Premier John Savage, May 15, 1995.

[48] *Ibid.*

myself) resulted in verbal assurances that Rescue One would receive financial assistance from the Department of Health.

The results of the polygraph report were tabled in the legislature by Conservative Health critic George Moody on May 18, 1995 (three days after Caldwell's letter was faxed to the Premier). The test results asserted that Caldwell believed that Dr. Murphy promised him $10,000 a month and I, as the Executive Assistant to the Minister of Health, had attained the authority to admit Rescue One to the subsidy program based on a budget surplus of $500,000 that, according in Caldwell's words, "Ron [had] found ... left over in the ambulance budget from the previous year."[49] Although many of the facts Caldwell alleged in his letter to the Premier and the polygraph test are true, including his recollection of meeting times and dates, as well as the general nature of the discussions, he made one indefensible "logical leap." Caldwell erroneously interpreted both Dr. Murphy's and my request for information about his service as a verbal contract. This assumption was false, no matter how fervently he believed it to be true.

Politically, Caldwell's intervention had little effect. The media eventually dismissed his assertions and his verbal threats to myself and Dr. Stewart had cost him his credibility within the Department of Health. His real impact on the process was the emotional strain he caused the Minister. The distraction caused by this "barrage" of rhetoric impeded Dr. Stewart's ability to act freely in EHS reform. There was always the question in the back of our minds as to "what was Kenny going to do next?" It is this intangible political force which can effect public policy that must be a factor in the equation. If Caldwell had been effective in his strategy, he probably would have seriously harmed Dr. Stewart's credibility and might have even forced his resignation. In the last analysis, Caldwell's actions may have diverted the

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[49] P. R. Woolridge Polygraph Services, Polygraph Examination Report, subject: Kenneth Duncan Caldwell, December 28, 1994.

Minister's political activity enough to alter the scope and time frame of EHS reform; however, that assertion can only be speculated upon.

It was political activity, such as the previously cited letter from health care providers, which countered the aggressive lobbying of the AOANS and the independent operators which allowed *Bill 96* to pass. The period in which this Bill was being drafted was when it was most vulnerable. Once it was introduced in the House of Assembly, its passage was almost assured given the public credibility at stake if the government was forced to withdraw it.

The AOANS and the Government of Nova Scotia fought a protracted battle for over a year. The passage of *Bill 96*, however, was not the end of this debate. As previously alluded to, the reforms encompassed in this law have proven difficult to implement. Proclamation of *Bill 96*, as of October 1996, had not occurred. With Dr. Stewart's resignation from Cabinet on June 28, 1996, there is some question whether the EHS "vision" laid out in the Murphy report and *Bill 96* will ever be fully realized.

The following section will examine briefly the future direction of EHSNS and the political obstacles it faces.

EHS IN NOVA SCOTIA: THE PRESCRIPTION FOR THE FUTURE

Michael Murphy, Tony Eden and Robert Schaffner all admitted that the passage of *Bill 96* facilitated a tangible shift in power from the AOANS to EHSNS (Department of Health). Schaffner states succinctly that there has been "a shift in power, government is more visible and the service is more highly regulated."[50] So what are the impediments to change? Murphy feels impeded by bureaucracy and government process, stating, "We will never deliver it [EHS reform] in the mechanism of government."[51] Murphy states that the passage of the

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[50] Mr. Robert Schaffner, personal interview, 1996.

[51] Dr. Michael Murphy, personal interview, 1996.

regulations through cabinet (proclamation) and the creation of the agency external to the Department of Health are critical. Although the AOANS will probably never been disbanded, as Stewart would have preferred, if Cabinet acts on proclamation, Murphy predicts EHSNS will be functioning properly in two years.[52]

A succinct account of the future "vision" for EHSNS is contained in minutes of the Standing Committee on Public Accounts. This committee met on March 27, 1996 to discuss issues related to the government's provision of emergency health services. During its deliberations, the committee questioned Dr. Michael Murphy, and in his opening statement, Murphy provided a glimpse of the activities he anticipated EHSNS to be involved in:

> ... One of the critical and fundamental aspects of Emergency Health Services that is, I think quite different now than it was in the past, is the understanding that it is fundamentally a medical enterprise so that the Medical Director of the program, in an acting position, is Dr. Ed Cain. When you are looking at developing an Emergency Health Services agency, you have to understand that, especially in rural areas, we need to implement advanced levels of medical care that are not always undertaken by physicians. They are undertaken by physician surrogates known as emergency medical technicians or paramedics in some jargon. Therefore, the ability to extend those advanced acts and surveille what goes on rests with the medical direction arm of the agency and that is why we have a very powerful, I think, infrastructure related to the delegation of medical acts and the extension of advanced procedures in the rural area where we think they are most effective in saving lives.
>
> We have several provincial programs that we will roll out, hopefully, over the next two years including such things as telephone advice and medical transport trauma program. You will see those detailed in the strategic plan. Marilyn Pike is an expert on program development and she has worked with us, at Emergency Health Services, as Director of Provincial Programs, in helping roll those things out and putting together the process under which they will be developed.
>
> Communications and dispatch is one of the fundamental aspects of ground ambulance transport and the integration of ground transport with air so that you allocate the appropriate resources to the appropriate need.

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[52] *Ibid.*

> One of [the] things that we are doing, along with the players in the field, is to try to put together a rational system of effectively delivering an advanced life–support–capable ambulance to the scene where it is required as quickly as possible and that very much rests with central coordination and dispatch. ...[53]

One of the following witnesses, Mr. Bernie White, representing the Canadian Union of Public Employees, Local 3264 (Employees of Metro and District Ambulance), confirmed the positive aspects of the changes in EHS but lamented the slow pace of these reforms:

> The system over the last 25 years like Mr. Schaffner said, has not kept up with the changes in technology and education that are out there. We are looking forward to seeing more changes happening. We have some new ambulances on the road; these are very good ambulances and it is nice to have a nice tool to work with out there ....
>
> We are looking forward to the changes, but we only wished they had come a little quicker, especially here in the urban areas ....[54]

Though Murphy and the government of Nova Scotia had been criticized for the time frames of EHS reform, significant changes had been implemented by the summer of 1996. Most importantly, the structure of the emergency system had changed and a new administrative structure was created in the Department of Health to implement the EHS "vision." One hundred and fifty new ambulances were on the roads of Nova Scotia and on June 13, 1996 the government announced the introduction of a new "specially–equipped air ambulance" — a fully–equipped helicopter with a full flight crew comprised of aeromedicine critical care doctors, nurses, paramedics and respiratory therapists which is designed to reduce response times and provide a critical link between urban emergency centres and rural communities. These developments can certainly be cited as significant progress in realizing

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[53] Hansard, Nova Scotia House of Assembly Standing Committee on Public Accounts (March 27, 1996), 3.

[54] *Ibid.*, 4.

the "vision" outlined in the Murphy report and a testament to the political success the government had in fostering change in this industry. It is likely that the next three years in EHS reform will not be as difficult or as volatile as the first three.

CONCLUSION

Generally, it can be deduced that the pluralistic nature of the pressure groups examined here is confirmed. The autonomy of the AOANS to act as an agent for its own interests against the political will of the government is clearly evident, despite the fact it failed to reach its political objective in this case.

The Savage government's success in implementing its agenda for emergency health system reform, despite the opposition of the AOANS, can be attributed to several factors. First, the political tenacity of the Minister of Health and his recognized expertise in this area carried significant political weight with his caucus colleagues. Secondly the appointment of a Halifax–based expert in emergency medicine to "create" the plan and agree to implement it was vital. Murphy added credibility to the venture and was critical in enlisting the support of other health professionals to counter the lobbying of the AOANS. By tempering the more extreme views of Stewart with the more moderate ones of Murphy, a useful "shield" was provided to deflect the AOANS "foil." Third, the lack of coordinated strategy on the part of the AOANS contributed to their inability to launch an effective lobby. Their key message did not have a broad appeal: focusing on the financial needs of individual business owners, seemingly at the expense of quality emergency health care, did not create the public support necessary to stop the government's legislation. Although they executed the elements of an effective lobbying campaign fairly well, such as the use of the media, petitioning legislators, and so on, there was no overall coordinated strategy which anticipated the actions of the

government, given the AOANS reliance on the media and its inability to access the appropriate "power centre."

This case offers encouragement to those who defend the autonomy of governments, to implement their election platforms. Despite intense pressure, political élites can press forward with their agenda and enjoy a relatively high level of success. However, this success cannot be attained without extracting a political toll in personal energy and, perhaps, public popularity.

CHAPTER 5:
CREATING A "SUPERHOSPITAL" —
THE QUEEN ELIZABETH II HEALTH SCIENCES CENTRE

CHAPTER 5:

CREATING A "SUPERHOSPITAL" — THE QUEEN ELIZABETH II HEALTH SCIENCES CENTRE

INTRODUCTION

On a bright and sunny morning on the steps of the Veterans' Memorial Building of the Camp Hill Medical Centre, in August of 1994, Queen Elizabeth II remarked to Nova Scotia's Minister of Health, "Good luck with your merger — if that's the proper word for it." Moments earlier, at the invitation of the Government of Nova Scotia, she had unveiled a plaque proclaiming the merger of the Victoria General Hospital, Cancer Treatment and Research Foundation, Camp Hill Medical Centre and the Nova Scotia Rehabilitation Centre into the Queen Elizabeth II Health Sciences Centre. With this simple ceremonial gesture, Her Majesty had profoundly altered the administrative structure of health care in Halifax and unleashed a flurry of interest group activity in response to this structural change. Our analysis in this chapter will focus on organized labor unions. In particular, we will review the Nova Scotia Government Employees' Union and the Nova Scotia Nurses' Unions attempt to obstruct and amend the government's hospital merger initiative. Other issues which will be examined briefly include the competition between these unions and their ties to the New Democratic Party.

This case will demonstrate that organized labor is a potent political force which will act to defend its own interests; despite the government's success in passing its "merger" legislation and implementing its policy, the unions cited above were able to create political unrest and distrust, eroding, to some extent, the political credibility of the Savage government.

THE MERGER PROCESS

The project itself was quite ambitious. Previous administrations had limited themselves to transferring the Victoria General Hospital from a civil services hospital (directly run by the provincial government) to an autonomous corporation funded by government.[1] In contrast, the Savage government asked the Queen to begin a process that would have much greater implications. Some basic statistics of the major institutions involved in the merger are as follows:

Camp Hill Medical Centre
Staff: 2600
Beds: 585
Net operating cost:
94/95: $88,799,200
95/96: $86,427,771 (–2.7%)

Nova Scotia Rehabilitation Centre
Staff: 275
Beds: 70
Net operating cost:
94/95: $11,972,300
95/96: $11,782,982 (–1.6%)

Victoria General Hospital
Staff: 3000
Beds: 600
Net operating cost:
94/95: $171,610,100
95/96: $167,425,737 (–2.4%)

[1] The majority of hospitals in Nova Scotia are run by an autonomous board of directors. Health reform suggests they all will be "designated" and come under the governance of Regional Health Boards (RHBs).

Cancer Treatment and Research Foundation
Staff: 115
Beds: Contained within the Victoria General Hospital
Net operating cost:
94/95: $6,023,200
95/96: $5,938,784 (-1.4%)[2]

After the merger was announced, an interim board was appointed in September, 1994 with the mandate of preparing the facilities for legislation by making the necessary administrative changes in advance. Progressive Conservative health critic, Mr. George Moody, was quick to criticize the Liberals' approach: "I think someone thought that it would be nice when the Queen was here, so I think [without] any thought it was done. So, they had a nice little ceremony with the Queen, and that was it."[3] Moody had two main criticisms, that the decision was hurried and that it would not save money: "We looked at it [when Moody was Minister of Health 1992–93] and all the studies that were done in Ontario and other provinces told me that any hospital over 500 beds became inefficient, and not effective to run and it just got so big that you spent more money than you needed to."[4]

Over the next four months (September–December 1994), the government came under sharp criticism because of the slow progress and the lack of supporting studies suggesting the merger was sound public policy. During this period, the QEII interim board had only met four times and had not appointed a chief executive officer. One factor which may have contributed to the Board's inactivity was the process used in their appointment. The Deputy Minister of Health, Mrs. Lucy Dobbin, asked the four facilities (the new Halifax Infirmary was still under construction at this point) to nominate candidates to represent their interests under the new

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[2] *Globe and Mail*, January 6, 1996. Financial data provided by ministerial briefing notes, Department of Health, March 1996.

[3] *The Daily News*, September 24, 1994.

[4] Ibid.

structure. I was a critic of this approach in that members who had a history of serving on the boards that were to be amalgamated might find it difficult to set aside their previous loyalties to their "home" institutions. Furthermore, the actual process of appointment was rushed; the Deputy Minister approved the names and contacted the successful candidates all in one afternoon. This was on a Wednesday, and this board was "walked–in"[5] to cabinet the following morning. There were candidates that were approved, by Cabinet, to be placed on the board even though the DOH was not able to contact to confirm their willingness to serve in this capacity until after the fact. In my view, this board was never properly vetted and it was sheer luck that an embarrassing scandal for the Minister of Health did not result. In mid–December Mr. Jim Moir was replaced as Chair of the Board by Mr. Sterling Eddy. Eddy moved quickly to establish a planning process and by mid–January the Board announced the twelve–month appointment of Mr. Neil Roberts as President and CEO.

In the January 20, 1995, edition of the "merger memo" Roberts told staff that, "The first item of business on the agenda will be to appoint a transition team. Working with a small committee of the Board, I hope to have a structure approved and individuals named to various positions within a month. Then the team can begin the task of bringing our four institutions together."[6]

The appointment of Roberts brought some controversy in that he was employed as the President and CEO of the Camp Hill Medical Centre, one of the institutions to be merged. Staff tension rose in the other facilities who feared that Roberts would be inclined to favor administrators and staff from the facility he previously led. These concerns were a contributing factor to the labor unrest which would follow a year later.

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[5] "Walk–in" refers to Cabinet submissions which are not vetted by the Priorities and Planning Secretariat.

[6] Merger Memo, January 20, 1995. The Merger Memo is an internal publication of the Queen Elizabeth II Health Sciences Centre designed to keep staff informed on "merger developments."

Roberts moved quickly to consolidate his position and by February 10th the Board of Directors approved his proposed organizational structure. On February 28th, the new "senior management–transition team" was announced with their appointments effective immediately:

- Stephen Jensen, Vice–President of Diagnostic and Therapeutic Services
- Richard Underhill, Vice President of Finance and Corporate Services
- John Theriault, Vice–President of Hospital Services
- Kevin McNamara, Vice–President of Human Resources
- Dr. Doug Sinclair, Vice–President of Medical Services
- Christine Power, Vice–President of Nursing Services
- Maura Davies, Vice–President of Planning and Quality Management[7]

Whether it was by design or coincidence, the senior staff were almost evenly divided between those who originated from the Victoria General (4) and those who came from Camp Hill Medical Centre (3). The fact that senior staff were weighted slightly towards those who originally worked at the Victoria General may have helped heal the division caused when the CEO position was awarded to Roberts.[8]

It was not until almost a year later that significant structural changes were announced. Specifically, in November of 1995, several major developments occurred. The results of the competition for director positions were revealed; a clinical program plan was finalized; a labor adjustment strategy was introduced by the provincial government; and finally, the Health Minister introduced *Bill 47*, the *Queen Elizabeth II Health Sciences Centre Act*, in the legislature.[9]

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[7] Merger Memo, February 28, 1995.

[8] Roberts was selected over Dr. Bernard Badley, the CEO of the Victoria General Hospital, which surprised many observers including some senior staff at the Department of Health.

[9] The short title was cited above, the full title of the Bill is *An Act to Amalgamate the Victoria General Hospital at Halifax, the Camp Hill Medical Centre, the Nova Scotia Rehabilitation Centre Corporation and the Cancer Treatment and Research Foundation of Nova Scotia to form the Queen Elizabeth II Health Sciences Centre.*

For staff of the QEII, the appointment of senior directors ended what some considered to be a long period of anxiety. With the "middle management" structure in place, employees now had a clearer understanding of how the merger would proceed, and they had a "face" in the position that would make decisions concerning their positions.

The announcement of the finalized clinical program plan was a significant step in the merger process. The plan, in essence, was a "blueprint" for the delivery of services at the QEII, and it realigned the locations of clinical programs. The Steering Committee of the Task Force on Clinical Program Rationalization began its work in May, 1995. After six months of planning and consultation, the clinical plan was approved by the Board of Directors and submitted to the Department of Health on November 30, 1995. The significance of this to our case study is that the new plan created tension and instability as the previous structure was altered in favor of the new approach, with the point of contention being job security and the potential for layoffs. While discussing the plan with the media, Dr. Doug Sinclair, QEII Vice–President of Medical Services, admitted layoffs were inevitable: "We don't have the answers on that .... We know whatever we do there is still going to be job loss, but again, [we] have to do what we think is right for patient care. The issue of how many jobs will be lost is unknown right now."[10] Sinclair went on to describe the radical change the plan created: "Some people are shocked when they first see [the plan] because it's so different from what they expected."[11] The discontent which often accompanies structural change suggests that the new clinical plan was a contributing factor to the labor unrest which almost immediately followed.

The labor adjustment strategy announced by the provincial government also contributed to staff frustration and confusion. The limitations of this case study prevent a detailed analysis

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[10] *Halifax Mail–Star*, October 4, 1995.

[11] *Ibid.*

of this package, but in summary it was a multi–million–dollar "early retirement" buy–out designed for health care workers throughout the province. The obvious implication of this package was its intent to reduce the workforce in the health care field. This realization obviously contributed to employee tensions at the QEII.

The focus of this case surrounds the political activity related to *Bill 47, The Queen Elizabeth II Health Sciences Centre Act.* The following section will address this issue in greater detail.

BILL 47, QUEEN ELIZABETH II HEALTH SCIENCES CENTRE ACT, 1995

Health Minister Stewart introduced *Bill 47* on November 23, 1995, which legally enshrined the creation of the Queen Elizabeth II Health Sciences Centre as was first announced by the provincial government in August of 1994. The Bill itself is not a weighty document; it is merely ten pages covering some twenty–six clauses. The structure of the new corporation is discussed, and, as well, the previous Acts regarding the merged institutions are revoked. With respect to employees of the new corporate body, this issue is largely captured in section 18:

> 18 (1) In this section, "employee at a predecessor hospital" means a person employed by
>
> (a) the Camp Hill Medical Centre;
> (b) the Cancer Treatment and Research Foundation of Nova Scotia;
> (c) Nova Scotia Rehabilitation Centre Corporation; or
> (d) the Interim Board,
>
> immediately before this *Act* comes into force but does not include a person employed by the Interim Board at the Victoria General Hospital at Halifax.
>
> (2) On the coming into force of this *Act*,

(a) every employee at a predecessor hospital becomes an employee of the Corporation; and
(b) every employee of the Corporation who was an employee at a predecessor hospital immediately before the coming into force of this *Act* is employed by the Corporation on the same terms and benefits as those under which the employee was an employee at a predecessor hospital and until changed by collective agreement or contract of employment.

(3) In clause (2) (b), "benefits" means benefits contained in a collective agreement or contract of employment.

(4) Every employee of the Corporation who was an employee of a predecessor hospital is deemed to have been employed by the Corporation for the same period of employment that the employee was credited with as an employee at a predecessor hospital.

(5) For greater certainty,

(a) nothing in this section means or shall be construed to mean that there has been a termination of the employment of an employee at a predecessor hospital; and

(b) benefits accumulated by an employee at a predecessor hospital while employed at a predecessor hospital are vested in the employee, and the employee is entitled to receive those benefits from the Corporation.[12]

Although this Bill was introduced by Stewart, it also has implications for the Department of Human Resources and its Minister, the Honourable Jay Abbass. Both Ministers were charged with "stick–handling" this issue through the legislature and with the media. Stewart stated the merger "will end needless duplication in services and produce better and more cost–effective care for the 34,500 patients admitted by the hospital a year."[13] When the media interviewed Stewart, stating that *Bill 47* would force the Nova Scotia Government Employees' Union and the Nova Scotia Nurses' Union to battle each other to see which union

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[12] *Queen Elizabeth II Health Sciences Centre Act*, Chapter 15, Act of 1995–96, Statutes of Nova Scotia.

[13] *Globe and Mail*, January 6, 1996.

would gain the right to represent all the nurses under the merger institution, Stewart replied, "That's the way it ought to be, because it puts people most affected — unions and management — into the driver's seat in a real way."[14]

In moving the Bill for second reading, Stewart provided his rationale for the merger:

> Merging these four institutions into one corporation called the Queen Elizabeth II Health Sciences Centre will reflect the role and mission on a community, on a provincial and on a regional level. As we have seen from the clinical program outlined in recent weeks, the merger will provide to the citizens of the province a more cost efficient way of providing services — both in Halifax and to the regions of the province — to all Nova Scotia.
>
> Clinical programs will be grouped according to specialty in order to enhance patient care. Consolidating these programs means that this institution will avoid the duplication of equipment, of supplies, of inventories and programs and will generate savings and operating funds that will be put toward the provision of services to people.
> The care of people in need can be better planned through setting priorities in terms, for example, of scheduling surgical procedures, the development of standards and protocols, the reduction of waiting periods and an increased opportunity to provide specialized knowledge in terms of medical research.
>
> The merging of four honoured and respected facilities and institutions into one health care facility is an example of where health change and health reform is heading. By this merger we will provide more efficient care, certainly. We will also have the ability to attract to that facility and to that institution, both research and clinical resources and human resources that can more fittingly and better serve the needs of the community.
>
> This legislation allows for the preservation of those elements of the hospital system which are operating well, while enhancing those areas in which improvements must be made. Through taking the steps towards merger, we are again putting action on words that we have heard in the past of improving clinical facilities and reducing duplication in all of those things that have, in fact, been spoken of for several years. It is an approach, I might say, that emphasizes a gradual and sensible shift to community–based programming. It emphasizes the role of even this large

[14] *The Daily News*, November 24, 1995.

> facility in the provision of community–centered services such as home care. It is a clear and forward move, Madame Speaker, in health reform ....
>
> The legislation, Madame Speaker, as well, is a product of two ministries of government working closely together; the Department of Human Resources and the Department of Health ....
>
> Within this legislation is an attempt woven through it to ensure that employees of all of the facilities and all employees are as equally and fairly treated as possible. As well we have given great attention to emulate the work that has been done by those at site to improve the quality of patient management and to foster research and teaching ....[15]

The opposition political parties were scathing in their criticism as it related to collective agreements and cost savings. The Bill was introduced in late November during a session that had been in progress for about two months; debate on this measure extended the 3rd Session, 56th General Assembly into the Christmas break and, after a brief adjournment, into the month of January 1996. *Bill 47* did not receive royal assent until January 11th, largely because of the opposition's tactical approach in the legislature.

Tory health critic George Moody argued that the merger would not improve health care for ordinary Nova Scotians. He based his reasoning on testimony he heard from "frontline workers" at the law amendments committee stage of *Bill 47*, "trek" through the legislature process. "If we really want to know what's going on in the health–care system, we have to get out and talk to people who are affected by it. And I'm afraid that's not being done by this government .... They didn't paint the picture that the minister has .... What I heard half scared me to death."[16] New Democratic Party health critic Robert Chisholm followed a similar

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[15] Hansard, Nova Scotia House of Assembly (Assembling Debates, November 27, 1995). 3386–3388.

[16] *The Daily News*, December 19, 1995.

argument: "When I leave this chamber — this fantasy land — and talk to my constituents and health–care workers, I get a totally different picture than what I get from the minister."[17]

During debate on second reading of the Bill, Moody gave a more detailed argument on the weaknesses his party had with the legislation and the overall approach:

> Now he announced this [the merger] over a year ago, Madam Speaker, and at that time I asked in this Legislature why he wasn't bringing in legislation after the big announcement, with the Royal Visits because he wanted to be front and centre and he had a vision and a plaque to put up. Never mind the details, we will work those out later ....
>
> Now we finally get the bill at the very end of this session and I have to ask about the motive as to why it comes in so late. It isn't as if they knew this bill had to come in a week ago, two weeks ago, the Minister announced during the summer that he made the mistake and this bill was going to come in this session. So the government figures if they can come in at the end of the session, because the Premier said we have to get out of here before Christmas, we are going to bring this legislation in so that the workers won't have a chance to understand, in actual fact, how this legislation is going to affect us. To me, that is not being up–front with anybody ....
>
> Now, is the Minister saying that this is part of the renewal or is it part of the cost–cutting measures by this government? There is a great deal of difference between cost–cutting in health care and renewal or reform in health care. It isn't clear to me that one could get up and argue that by reading this legislation that in actual fact this government is going to have reform. When you lay off 800 to 1,000 people you are going to take many benefits, as I see this bill, away from some people. There are workers under the *Civil Service Act* who very clearly are going to lose benefits, let alone what other benefits we don't know about that management and others are going to lose and even the other workers, then I don't see anything in this bill that guarantees a worker that he will have the same tomorrow as they have today. We all understand that through collective bargaining that may change, but it is not fair for government to come in through a piece of legislation and say, we are going to take this away from you, without any bargaining whatsoever....[18]

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[17] *Ibid.*

[18] Hansard, Nova Scotia House of Assembly (Assembly Debates, November 27, 1995), 3390–3392.

The New Democratic Party, represented primarily by Robert Chisholm on this issue, attacked the government legislation, using similar arguments to that of the Progressive Conservatives. In his opening address on second reading, Chisholm outlined his main arguments which he would repeat for the duration of the proceedings:

> Madam Speaker, as far as I am concerned, the principle of this bill, and I will focus some attention on that this afternoon, this is a bill intended to cut money out of the health care system in Nova Scotia, to cut people out of the health care system in Nova Scotia, to reorganize how health care is delivered here in Halifax, in the metro area, and how that will affect people from one end of this province to the other. I will contend and argue that this decision was reached on the basis simply of the need to cut costs out of the system, that there is absolutely no linkage between the decision to merge these hospitals and any evidence that it will mean an improvement in quality of care to Nova Scotians. I will also suggest that there is absolutely no evidence to conclude that this merger will actually lead to a reduction in costs, to a saving of money ....
>
> [The Minister of Health] is ... taking all of the employees, up to 7,000 employees, Madame Speaker, in each of those four institutions and bringing them together and doing it in such a way that it is putting in jeopardy many of the rights, benefits and privileges that these employees have bargained collectively and fairly for over so many years. That is being done with the stroke of a pen ....
>
> .... So now we are dealing with a process of ensuring that at least the people that work within the institution are dealt with as fairly as is humanly possible.
>
> The way we will do that, Mr. Speaker, is to bring to your attention and to the attention of all members of this Legislature that there are provisions in this bill that take away, that legislate civil servants out of the civil service and do not provide any protection until they come under the protection of the *Trade Union Act*.[19]

Toward the end of his address Chisholm accented his disdain for the Bill by moving an amendment "that words after 'that' be deleted and the following be substituted therefore: 'Bill

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[19] *Ibid.*, 3398–3408.

No. 47 be not now read a second time but that it be read a second time this day six months hence."[20] After five hours of debate which ended at 9:30 p.m., the proposed amendment was defeated by a margin of 29 to 10.

The linkages between the NDP and organized labor were very tangible during this process. Two examples of this occurred when Chisholm, representing the NDP, appeared with Nova Scotia Government Employees' Union President Dave Peters to announce at a press conference that he had filed a 48–hour strike notice with QEII hospital management.[21] Chisholm frequently followed NSGEU rhetoric in debate in the House as well as his public stance in the media. After the Bill was passed, but during the campaign to see which union (NSGEU or the NSNU) would represent QEII nurses, Ms. Jean Candy, as President of the Nova Scotia Nurses' Union, attended a provincial NDP leadership candidates debate where she delivered a charged political speech attacking Health Minister Stewart personally, stating, "He spends more time out of the province looking at the US system than looking at what is going on in Nova Scotia."[22]

It is easy to assert that both the Nova Scotia Government Employees' Union and the Nova Scotia Nurses' Union strongly opposed *Bill 47*. (The NSGEU represented over 15,000 public employees in Nova Scotia, 3,000 of whom were employed in the hospitals comprising the QEII Health Sciences Centre. The NSNU represented registered nurses and certified nursing assistants at the Camp Hill Medical Centre and the Nova Scotia Rehabilitation Centre, over 9,000 RNs and CNAs.) Both unions presented fairly substantial briefs to the Law Amendments Committee re: *Bill 47*, which outlined their concerns about the process and the Bill's contents. The NSGEU called *Bill 47* "completely inadequate" and urged the Committee

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[20] *Ibid.*

[21] *Halifax Chronicle–Herald*, December 8, 1995.

[22] *Ibid.*

to amend the Bill in accordance with "agreements reached between management and the Nova Scotia Government Employees' Union."[23] During the legislative process, management of the QEII had been meeting with executive members of the NSGEU to produce a "Memorandum of Agreement" (December 4th and 9th) which would cover aspects of employee benefits and rights that the government felt would not be appropriate to enshrine in legislation. For example, both parties agreed that only joint applications would be made (union and employer) to the Labour Relations Board to alter or amend any provision of a collective agreement. Furthermore, the Memorandum suggests that the QEII Health Science Centre agreed to be bound by the Pay Equity Agreements "and shall, as of the Amalgamation Date, assume all outstanding rights and obligations of the Province under the Pay Equity Agreements with respect to all employees ...."[24] The NSGEU were unsuccessful in having the Memorandum of Agreement recognized in the Bill. In fact, of the seven amendments proposed, the Government did not adopt any of the suggestions into the final Bill.

The Nova Scotia Nurses' Union proposed amendments similar to those proposed by NSGEU. However, of the four amendments NSNU supported, none were included in *Bill 47*. The NSNU submission did take exception to an amendment proposed by NSGEU which it felt was merely an attempt by the NSGEU to preserve its status as the bargaining unit:

> We understand the amendment being proposed by the NSGEU is as follows:
>
> 17(2)
>
> (b) On the coming into force of this Act, each bargaining unit in the civil service that includes employees of the corporation is and is deemed to be two separate bargaining units, namely,

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[23] NSGEU, "Brief Presented to Law Amendments Committee Re: Bill 47" (December 12, 1995), 12.

[24] *Ibid.*, 3–4.

> (i) a non–civil service bargaining unit composed of members of the bargaining unit who are employees of the corporation *and those employees of the corporation performing work of a similar nature at the Victoria General Hospital, except* where those employees are included in a bargaining unit represented by another bargaining agent.
>
> (ii) The civil service collective bargaining unit composed of members of the bargaining unit who are not employees of the corporation.
>
> and the collective agreements so affected shall be deemed to be amended accordingly and shall be given effect as if the bargaining units were always separate.
>
> It is our view that this amendment would simply reflect the Government's own intention to preserve the existing collective bargaining status of the NSGEU, subject of course to changes in representation that may occur through runoff votes to determine the bargaining agent for all RNs and CNAs in the amalgamated hospital.[25]

Clearly, this remark foreshadowed the impending confrontation between the NSNU and the NSGEU.

These labor groups also protested *Bill 47* through a media campaign, as well as threatening strike action by the NSGEU. Four days after Stewart introduced the *Queen Elizabeth II Health Sciences Centre Act*, the NSGEU held three emergency meetings with its members, and Union President Peters declared, "I'm not here to inflame them into walking out, but I am here to inform them of my serious concerns .... for a large number of our members, this has serious consequences."[26] One day later, Peters told the media his union would hold a strike vote "to pressure government into changing the hospital amalgamation bill."[27] Peters characterized his members as being angry: "The members are strongly

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[25] NSNU, "Bill 47 (1995) Queen Elizabeth II Sciences Centre Act, a Presentation to the Law Amendments Committee of the House of Assembly of Nova Scotia" (December 7, 1995), 4–5.

[26] *The Daily News*, November 27, 1995.

[27] *Halifax Mail–Star*, November 29, 1995.

determined that enough is enough, not just in health care. They're just fed up. I mean, this government's record on labor relations has not been good."[28] The *Mail–Star* article which carried this interview also made reference to a similar tactic employed in the previous week by the Nova Scotia Teachers' Union to force amendments to the *Education Act.*

Human Resources Minister Jay Abbass "took the lead" from the government's perspective and told the media that the "lawyers may want to argue over how many angels can dance on the head of a pin ... but this bill is tightly crafted and there won't be significant changes to the act."[29]

In his most scathing criticism of *Bill 47*, Peters asserted that the "Savage government's real intent in the legislation is the wholesale gutting of the collective agreements of hospital workers."[30]

To complement Peters' extreme stance, the NSGEU placed paid advertisements in the provincial papers asking Nova Scotians to judge *Bill 47*: "You be the judge," the headline read, and then went on to quote Abbass' defence of the Bill followed by a critique of that defence. Here is an excerpt:

> ... FAIRNESS
>
> Mr. Abbass has stated:
>
> "... This government cannot give one union a privileged position over another. The Bill treats all employees and all unions fairly."
>
> This is not true. [bold print]

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[28] *Ibid.*

[29] *Chronicle–Herald*, November 28, 1995.

[30] *The Daily News*, December 1, 1995.

> The NSGEU has proposed 20 amendments to ensure Bill 47 does not modify existing agreements, and that employee benefits and entitlements remain intact.
>
> So far, the government has rejected all of these amendments.[31]

In the government's defence, they placed similar advertisements responding to the NSGEU's assertions:

> QEII Act protects Collective Agreements
>
> ... The QEII Act ensures the employer will respect the current collective agreements of NSGEU members and all other employees ....
>
> Much time and effort went into developing legislation that would treat all employees and unions fairly.
>
> The QEII Act respects established labour relations principles — and lays the foundation for continuing equitable practices in the years to come ....[32]

The Nova Scotia Nurses' Union also produced advertisements similar in tone to the NSGEU ads:

> WE CARE. A LOT. ABOUT OUR PATIENTS. ABOUT OUR JOBS. ABOUT OUR FELLOW NURSES.
>
> We're very concerned about the harm that Bill 47, the QEII Act, will do to our members at Camp Hill Medical Centre and the Nova Scotia Rehabilitation Centre ....
>
> We're asking the Honourable Joy Abbass, Minister of Human Resources, to make fundamental changes to the Act ....[33]

By December 2nd, the confrontation had reached the point where the NSGEU had held a strike vote and some employees were apparently determined to confront the provincial

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[31] *Ibid.*

[32] *Ibid.*

[33] *Halifax Chronicle–Herald*, December 8, 1995.

government. "I've suffered a two per cent cutback with five days off without pay, and then a three per cent cutback. I decided when that happened, it was the last time that I was going to take it without fighting back. I think a lot of people are in the same position," said Ms. Deborah MacKay, a nurse in the Victoria General's neurology intensive care unit.[34]

Of the 2,050, out of a possible 2,632, eligible voters, 83% voted in favor of strike action. Peters claimed that "Our members have clearly indicated that they do not accept the Minister of Human Resources' claim that their rights and benefits are protected."[35] The following Thursday, the union served a 48–hour strike notice to the hospital administration. "The VG just won't be in business the day that the workers walk off the job. It's unfortunate it has to come to that. It should never have come to that," Peters said.[36] Candy said the NSNU supported NSGEU, but she never committed to holding a strike vote.

The Victoria General prepared for a possible strike by cancelling some outpatient clinics and elective surgery. Medical Services Vice–President Doug Sinclair said, "the 587–bed hospital hoped to reduce the number of patients from about 550 ... by cutting back on admissions and discharging others."[37] The provincial government remained firm in its stance not to amend *Bill 47*. Abbass continued to assert that he would not meet with union representatives under the threat of a strike. Human Resources Minister Abbass and Health Minister Stewart wrote NSGEU President Peters, dated December 7, 1995, clearly stating their position on the pending strike action:

> Dear Mr. Peters:
>
> We acknowledge receipt of your letter of December 7, 1995.

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[34] *Halifax Chronicle–Herald*, December 2, 1995.

[35] *Sunday Daily News*, December 3, 1995.

[36] *Chronicle–Herald*, December 8, 1995.

[37] *The Daily News*, December 9, 1995.

> As you know, any withdrawal of services at the Victoria General Hospital will be illegal. Furthermore, it will be totally unwarranted: Bill 47 protects and respects employee benefits and all existing collective agreements and the collective bargaining process.
>
> The laws of this Province on illegal strike activity are clear. The Government of Nova Scotia is prepared to enforce those laws.
>
> You and your executive have a responsibility and are accountable for ensuring that all of your members report to and remain at work as scheduled. Your continuing support for and sanctioning of illegal activity, is already, by itself, a serious breach of your legal obligations.[38]

As it became evident that the two sides had reached an impasse, Peters seemed to "soften" his position: "If we can get the comfort some other way, then we wouldn't hold out for the amendments to the bill. We think the legislation is wrong, but we would have our most serious concerns put to rest," Peters told the media a day before the notice of strike action expired.[39] The "comfort" came in the form of the previously discussed memorandum of agreement between the QEII Health Sciences Centre and the NSGEU and "last minute" negotiations between the two seemed to satisfy the union's leadership. On December 9th, the NSGEU withdrew its strike threat and the hospital resumed normal operations, rescheduling cancelled elective surgeries on December 12th. NSGEU Vice–President Mr. Neil McNeil stated after this announcement, "The government would not meet with us all week and we decided to explore other options and get comfort some other way. It was not necessary to hold out for amendments to the bill."[40]

Abbass implied that the NSGEU was not really serious about calling a strike because the issue was not really the wording of *Bill 47* but rather union posturing anticipating a "turf war"

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[38] Correspondence, from the Hon. Jay Abbass and the Hon. Ron Stewart to Mr. Dave Peters, December 7, 1995.

[39] *The Daily News*, December 9, 1995.

[40] *The Sunday Daily News*, December 10, 1995.

at the QEII.[41] This sentiment was echoed by Halifax *Chronicle–Herald* editorial writer Jim Meek:

> ... the QEII Act itself stipulates that collective agreements will be honoured until they expire. And Mr. Peters also has his special agreements with hospital management, which are morally if not legally binding.
>
> What's this all about?
>
> I'd suggest it is first and foremost about the NSGEU's determination to become the union of choice at the new superhospital.
>
> None of QEII's workers will be paid by the province, and it will be a tough fight to retain the benefits enjoyed by current VG employees. Still, both the NSGEU and the Nova Scotia Nurses' Union would like to represent Halifax health care workers — and collect their dues.
>
> Thus Mr. Peters' decision to position himself as a tough guy in his current fight against the Halifax hospital's legislation.[42]

In fact, one of the first issues both the NSGEU and the NSNU addressed in the media after Stewart introduced *Bill 47* was the potential union "turf war." Neil MacNeil stated, "We are very keen on maintaining the members we have right now. Our contracts are superior, dollar for dollar. Our pay is higher, particularly with the nurses, our benefits are superior."[43] Replying on behalf of the NSNU, Ms. Pat Thomas stated, "I guess our biggest selling point is that we're a union of nurses. We not only address labor issues, we also address patient–care issues .... There is going to be a vote and one union will be selected. We know from talking with management that they're not willing to deal with two aspects of nurses' unions."[44]

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[41] *Ibid.*

[42] *Halifax Chronicle–Herald*, December 8, 1995.

[43] *Halifax Chronicle–Herald*, November 24, 1995.

[44] *Ibid.*

The run–off vote was completed on April 26, 1996, and the results were released in early May. The NSGEU captured 83 percent of 1,600 votes, easily winning the right to represent the 2,150 QEII nurses. For the NSNU the defeat was particularly troubling, not only were the numbers reduced by about 700 but Union President Jean Candy, as a nurse at the QEII, was forced to resign her presidency as she now became a member of NSGEU.[45] Media reports suggested as the campaign was nearly completed it turned particularly bitter with Peters accusing Candy of misleading members about his union's ability to represent nurses.[46]

As an aside, the NSGEU by early June of 1996 was able to win the right to represent all the 6,000 unionized employees at the QEII Health Sciences Centre. The NSGEU defeated the Canadian Union of Auto Workers to represent the hospital's 1,000 general employees. This vote also represented a certain level of apathy as only 36 percent of the eligible voters cast ballots. The final total was 432 to 342. Peters attributed the win to the union's "presence in the Victoria General Hospital."[47]

The Queen Elizabeth II Health Sciences Centre Act was proclaimed February 27, 1996. The interim board was extended until the end of May; the Minister of Health replaced this board on May 28th and of the eight Governor–in–Council appointments none of them were members of the interim board. Under the "permanent" board, the merger process is expected to be consolidated and completed.

CONCLUSION

The evidence is clear that NSGEU and the NSNU leadership worked to protect their interests and were accountable to their membership. Defending the autonomy of labor unions and their pluralistic tendencies is not difficult in this case.

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[45] *The Mail–Star*, May 9, 1996, and *The Daily News*, May 5, 1996.

[46] *The Daily News*, May 5, 1996.

[47] *The Daily News*, May 5, 1996.

Both unions, but particularly the NSGEU, played a significant role in placing the government in a defensive position and created a political dilemma for the key political élites involved. The Savage government was successful in passing *Bill 47* and resisting labor demands for amendments because of strong leadership, particularly on the part of the Minister of Human Resources and the Minister of Health. However, the government certainly paid a political price in terms of the level of anxiety created within the QEII Health Sciences Centre and a general heightening of distrust among union members. The exact toll the merger will have on the government's longevity is difficult to measure, but it is sufficient to state that some political support was lost among the 6,000 QEII employees.

Another factor in the NSGEU acquiescence on its demands with respect to *Bill 47* has been the argument that the intended goal of the Union's leadership was merely to position itself for the ensuing run–off vote, not provoking wholesale changes in the legislation. This is an example of competition among pressure groups who see their interests threatened. Clearly, in such a circumstance, issues of public policy and the integrity of government legislation are a secondary consideration to defending union "turf."

CHAPTER 6:
BUTTING OUT IN NOVA SCOTIA — TOBACCO REDUCTION POLICY AND THE SAVAGE GOVERNMENT

CHAPTER 6:

BUTTING OUT IN NOVA SCOTIA — TOBACCO REDUCTION POLICY AND THE SAVAGE GOVERNMENT

INTRODUCTION

One of the most specific "planks" in the Savage government's health platform was the commitment to reduce tobacco addiction. In its 1993 health platform, Nova Scotia Liberals promised to pass legislation which would restrict access to tobacco by minors and ban smoking in all public buildings. The task of implementing this initiative was left to Health Minister Stewart, whose personal and political commitment to addressing this issue was total. He viewed tobacco addiction as the number–one public health problem, causing an estimated 1,400 deaths in Nova Scotia annually.[1] As was documented in Chapter 2, Stewart was actively involved in anti–tobacco advocacy before entering provincial politics. He viewed the government's attempt to reduce society's use of this addictive and potentially lethal drug as an important component in the move toward the preventive health care model. His initiatives were not intended to address those already addicted to nicotine but rather to prevent the use of tobacco by youth and protect the rights of non–smokers to breathe clean air in public buildings. While the legislative efforts to reduce the access to tobacco by youth were generally supported, Stewart's attempts to introduce legislation banning smoking in public places, including bars and restaurants, were vigorously opposed, especially by pressure groups representing the hospitality industry. We will examine the interest group politics of groups both supporting and opposing this strategy, to determine their impact on public policy.

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[1] Nova Scotia Department of Health, 1996.

BACKGROUND

The negative health effects of tobacco use is well documented in the medical literature. As a result, tobacco has evolved from a socially acceptable product to one which has been internationally condemned by public health officials, medical scientists and governments. Clearly, the Government of Nova Scotia recognized this public health epidemic and pledged in the legislature to deal strongly with the issue. An example of the rationale for the government's tobacco reduction strategy was revealed by the Health Minister in one of his first major addresses to the legislature on health care reform, in October 1993:

> We must attack, with vigour, the number one public health problem in this province which is tobacco addiction. The average age of addiction in this province to tobacco is twelve years of age. Twenty–five percent of fifteen–year–old girls smoke regularly in this province. It is time to say no. It is time to understand what will work to protect their lives, their young lives and we must do this.
>
> Since our meeting yesterday when we adjourned, five families in Nova Scotia have known the loss of a loved one because of tobacco–induced illness. We know, too, that 1,400 Nova Scotians per year die young and needless deaths because of tobacco addiction. We know, too, that sixty–four percent of tobacco vendors in this province will sell to children. We must take heed, and we must do something — and this government will. We must stop aiding and abetting those that will addict our youngsters. We must speak for those who can't speak today, the youngsters of the province. We must realize that whereas we lose 1,400 a year in terms of tobacco–related illness in this province, we lose less than one percent of total deaths due to illicit drugs.
>
> We need to get serious. We need to understand that when we see tobacco–sponsored programs still allowed in this province, whether it be DuMaurier horse riding or whether it be Players Limited car racing, insidious and worse fashion appealing to young women, yet sponsored by tobacco pushers. It is time to get serious. It is time to understand that the choices that these young people will make will shorten their lives. In fact, this year, in this province, no longer is breast cancer the number one killer of women — it is lung cancer, which, at the turn of the century, was a medical rarity. You read it, perhaps a paragraph in the textbook. It is now the number one killer of women in this province. Shame, shame

> on us all who have not responded to this. We will get serious and we will do something about this, Mr. Chairman.[2]

It is not the purpose of this case study to debate the validity of Stewart's and the government's assertions; however, in order to maintain the integrity of the argument we will examine briefly the medical literature's general assessment with regard to smoking and health. There exists within North America a scientific consensus which indicates that tobacco use is directly related to the development of lung cancer, heart disease, chronic bronchitis, emphysema, and low birth weight babies. Smokeless tobacco is linked to oral cancers and can cause tooth abrasion, gum recession, and leukopeakia. Tobacco–related deaths in North America are greater than accidents, alcohol, AIDS, homicides and suicides combined.[3]

The toxicology of tobacco is particularly alarming. The United States Environmental Protection Agency has classed tobacco as a Class A carcinogen, a distinction reserved for some of the most virulent forms of cancer–causing toxins. Thousands of individual compounds have been found in cigarette smoke, including toxic agents such as nicotine and mutagens and carcinogens such as polycyclic aromatic hydrocarbons.[4]

Particularly relevant is the health effects of tobacco smoke on adolescents given the Savage government's legislative attention to tobacco and youth. Regular use of tobacco has been linked to significant health problems for young people. Smoking reduces the rate of lung growth and decreases lung function. Fitness levels of adolescent smokers are generally inferior to non–smokers, with smokers more likely to suffer from shortness of breath, phlegm

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[2] Hansard, Nova Scotia Assembly Debates, Committee of the Whole (Supply) (October 21, 1993), 417.

[3] David Kesler, MD, Nicotine Addiction in Young People, *The New England Journal of Medicine* (July 20, 1995), 186–187.

[4] US Department of Health and Human Service, Preventing Tobacco Use Among Young People: A Report of the Surgeon General, Atlanta, Georgia (US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994), 15–16.

production and wheezing. Also, adolescent smokers have a greater risk of developing atherosclerotic lesions which often leads to cardiovascular disease.[5] Related to health outcomes for adolescents is the issue of smoking during pregnancy. Mothers smoking during pregnancy retards fetal growth and may cause fetal death late in pregnancy as well as infant mortality. The risk of spontaneous abortion increases with the amount of smoking and the risk of sudden infant death syndrome is increased by maternal smoking.[6]

Including the immediate impact of smoking on adolescents, those who continue to use tobacco suffer the negative health effects of adult smokers. Attempting to prevent adolescents from taking up an addiction which may very well shorten their lives is effective public policy from the perspective that more than 80 percent of all adult smokers have tried smoking during their youth and more than half of those had become regular smokers by the age of eighteen. The literature in North America indicates that if people do not begin to smoke as teenagers or children, it is unlikely they will ever do so.[7]

TOBACCO ACCESS ACT, 1993

The first "prong" of Stewart's tobacco reduction was aimed at reducing tobacco accessibility to minors (anyone under the age of nineteen). *An Act to Restrict the Access to Tobacco Products by Minors*, or *The Tobacco Access Act*, was assented to on November 25, 1993. However, it was not proclaimed until April 15, 1994 (excluding section 8) and the regulations were not approved by Cabinet until January 16, 1996. Stewart faced several

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[5] *Ibid.*, 7, 16–30.

[6] *Ibid.*, 28.

[7] US Department of Health and Human Services, "Fact Sheet: Children and Tobacco the Facts," August 10, 1995. This brief was provided as background information to US President Bill Clinton's announcement of his administration's initiative to reduce tobacco addiction amongst youth.

obstacles to this initiative; yet, compared with later attempts to ban smoking in public places, the process was quite "painless." Opponents of the bill were scarce and unorganized, and despite the controversy over section 8, which will be discussed later, Stewart enjoyed all–party support.

The legislative intent of *Bill 62* was quite simple: to protect the health of young persons by "restricting their access to tobacco and tobacco products; and protecting them from inducements to use tobacco."[8] It made illegal the sale of tobacco products to anyone under the age of nineteen, banned tobacco vending machines, restricted the size of cigarette packages to no less than twenty (preventing retailers from selling "singles" to youth at a reduced cost), and prohibited the sale of any product designed to appear as a tobacco product. *Bill 62* also allowed the government to make regulations with respect to image, requiring tobacco vendors to display material regarding the sale of tobacco and the effects of tobacco on health, as prescribed by the government to be determined in the regulations. Finally, the summary conviction for those found guilty of violating the Act is a fine not exceeding two thousand dollars for a first offence, five thousand for a second, and ten thousand for a third offence. Vendors also face the prospect of losing their ability to sell tobacco for a period between seven days and twenty–four months.

Bill 62 was supported by both opposition parties during debate in the legislature. Opening the debate on second reading, Stewart explained the significance of this measure and used a similar tone to the one used when he addressed the house committee on supply earlier:

> We would not suggest for one moment, none of us in this house, that a government would ignore an epidemic of meningitis, an epidemic of tuberculosis, that we would ignore the toll of accidents on our highways or that we would look over the illicit drug use that happens in our society, but, Mr. Speaker, we have consistently in this country and even in this province under–estimated and under–responded to an epidemic that is the most serious issue of drug dependency in Canada.

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[8] *Tobacco Access Act, 1993*, Chapter 14, Act of 1993, Statutes of Nova Scotia, 2(a) and (b).

> What government would not respond to an epidemic that has claimed, world–wide, eight times the number of casualties of World War II, that claims in this country 200 times the number of deaths than those dying from illicit drugs? ...
>
> ... That drug is tobacco and we must not mix messages in this place ... but, we must, with every compassion, with all due regard to the freedom we all enjoy in this country, say that it is time to protect our children ...
>
> The dreadful thing of this, Mr. Speaker, is the fact that we permit or we look the other way when the tobacco product sellers specifically target our children for this addiction, at an age which in Nova Scotia approaches an average of eleven years. We have smokers in this province seven years of age, regular smokers, nine years of age, regular smokers.
>
> Addicting little people before their age of maturity, and before the life experience allows them to make a more informed choice, is criminal. We must, with this bill, make the statement that we have had enough ...[9]

Progressive Conservative health critic, Mr. George Moody, expressed his support for *Bill 62* and stated that he was considering doing the same thing when he served as Minister of Health, but he had concerns about how this type of legislation could be effectively enforced. Moody also questioned why the legislation did not make it illegal to smoke under the age of nineteen, only for vendors to sell tobacco to those under the age of nineteen. He speculated that *Bill 62* was not as strict as Stewart would have liked because the government caucus would not support stricter measures:

> This is moving in the right direction. We have to restrict minors because if we are going to be successful, we have to try to take away that opportunity from them to take that first puff which leads to many more puffs. When they become an adult at age 19, they can have that choice with alcohol but they can't have that choice now with tobacco because it is not illegal. So I am not sure we are sending out the right message. As I said to the people who came and said we needed legislation, I said, yes, we do but I am not going to grandstand with it. Either I believe in it and I will go all the way, or I won't do it.[10]

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[9] Hansard, Assembly Debates, Nova Scotia House of Assembly (November 8, 1993), 2245–2246.

[10] *Ibid.*, 2251.

The New Democratic Party Leader, Ms. Alexa McDonough, also expressed her support for *Bill 62* but also hoped for stronger legislation:

> ... I think the Minister is deserving of some credit. It has not been an easy thing to stand up to the tobacco lobby and I can't say, nor would it be fair to judge, whether the reluctance of the previous government to move on this was partly because of the power of the tobacco lobby. ... I guess the only thing that is fair to say is at least the Minister has been successful in getting his colleagues to support these measures as far as they go.[11]

As discussed previously, the *Tobacco Access Act* was assented to by the Lieutenant Governor on November 25, 1993, but it was not proclaimed until April 15, 1994. Furthermore, the vital regulations were not introduced until over a year later in January of 1996. Several factors accounted for the delay, including the time required to create a Tobacco Control Unit in the Department of Health to administer the Act, and the need to wait the outcome of a Supreme Court of Canada case with regard to tobacco advertising; and the controversy over the *Tobacco Access Act*'s provision to ban candy cigarettes from store shelves.

The most damaging of these factors was the "candy cigarette" issue. Stewart wished to "deglamourize" tobacco and reduce the media images which promoted tobacco as a socially acceptable drug. Despite the fact that the Act was passed by the legislature with its anti–candy cigarette clause intact (section 8), when the public realized the government's intent, they suffered humiliating criticism. The media was dismissive of this approach and editorial cartoons depicted Stewart as an "anti–tobacco zealot." Anti–tobacco lobbyists were ineffective in defending this initiative and Stewart was unable to convince the Cabinet to proclaim the Act with section 8 included.[12]

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[11] *Ibid.*, 2254.

[12] The proclamation order for the *Tobacco Access Act* excludes section 8.

Ms. Nancy Roberts, Manager of Tobacco Control for the Nova Scotia Lung Association and a former project coordinator for Smoke Free Nova Scotia, was highly critical of the anti–tobacco lobby at that time.[13] Although initially, groups like Smoke Free Nova Scotia encouraged Stewart to proceed with banning candy cigarettes, when they saw the political controversy that this created they "backed off." "The executive [of Smoke Free Nova Scotia] met during this time and decided to walk away leaving the Minister to fend for himself."[14] Roberts is critical of the structure of both provincial and federal advocacy groups working on tobacco issues: "They don't work together well. There is considerable in–fighting and jealousy which prevents coordination to meet common goals. They have to be 'bottom–up' to be effective — line staff has to have authority." She expands on her analysis by asserting that the internal structure of reporting to volunteer boards is inefficient and leaves decision–making to political neophytes and amateur advocates. "They need to learn more about how government works and how the media shapes public opinion. Right now they tend to set off 'bombs' they don't understand."[15]

An example of how poorly planned advocacy can have harmful (if not embarrassing) results was evident when Smoke Free Nova Scotia President, Ms Anna Freeman, wrote Premier Savage during the hiatus between the *Tobacco Access Act*'s proclamation and the approval of its regulations. In her letter to Savage, she called the Act "impotent" and a "joke" and she encouraged the government to proceed quickly with the regulations; Freeman also copied the letter to NDP leader Alexa McDonough. McDonough used this opportunity to criticize the Premier during question period which placed him on the defensive. "Savage said he didn't know the reason for the delay and referred questions ... to Health Minister Ron

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[13] Smoke–Free Nova Scotia is a coalition of health groups committed to reducing tobacco addiction, largely funded by the Department of Health.

[14] Ms. Nancy Roberts, personal interview, February, 1996.

[15] *Ibid.*

Stewart...."[16] The media attention and the political point "scored" by the NDP seemed to surprise Smoke Free Nova Scotia. For some reason, Freeman apologized for the letter and its consequences: "We in Nova Scotia are also most fortunate to have the most knowledgeable, committed and respected Minister of Health on this issue in this nation. I apologize for any confusion caused by my letter, and I regret that it was interpreted as a complaint of inactivity on the part of the government. We are aware that this is not the case," Freeman wrote to McDonough on May 10, 1995.[17] This reversal prompted a response from the *Daily News* in an editorial, "Guess who's changed sides? Now, Smoke Free Nova Scotia president Anna Freeman sings the praises of the government.... This lets the government off the hook (why, one wonders darkly), it hangs McDonough out to dry, and presents a story to the public that just won't wash."[18] The sum total of Freeman's venture into this debate cost her group some precious credibility, embarrassed an opposition party trying to promote their (Smoke Free Nova Scotia's) interests, and confused the media covering the story.

Despite the media and interest group criticism surrounding the delay in implementing the *Tobacco Access Act, 1993*, the law was finally given its "teeth" by Cabinet on January 16, 1996. Stewart described the newly "minted" regulations as "the most stringent in Canada," claiming that by March 1, tobacco inspectors would start enforcing the law.[19] The regulations provided the framework necessary to carry out the enforcement of the Act. Inspectors were authorized to visit retailers and ensure compliance by issuing warnings and fines. As well, the Health Department was empowered to hire teenagers to engage in what the media termed "sting" operations to ensure retailers were not selling tobacco to minors by having "undercover" youth attempt to purchase cigarettes. The regulations also required retailers to

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[16] *Amherst Daily News*, May 10, 1995.

[17] *Halifax Daily News*, May 12, 1995.

[18] *Ibid.*, May 13, 1995.

[19] *Halifax Daily News*, January 17, 1996.

display Health Department signage, warning patrons of the health effects of tobacco use and explaining the sale of tobacco products to anyone under the age of 19 years as unlawful.[20]

Despite this political success, Stewart privately confided that he was disappointed that the regulations did not include any provisions restricting tobacco sponsorship and advertising. This was largely due to the Supreme Court decision in *RJR–MacDonald Inc.* v. *Attorney General of Canada* and *Imperial Tobacco Ltd.* v. *Attorney General of Canada and Attorney General of Quebec and Attorney General for Ontario, Heart and Stroke Foundation of Canada, Canadian Cancer Society, Canadian Council on Smoking and Health, Canadian Medical Association, and Canada Lung Association*, rendered September 21, 1995. This decision in summary struck down certain sections of the *Federal Tobacco Products Control Act*, which banned tobacco advertising, because of its infringement on section 2 of the *Charter of Rights and Freedoms*. This decision was a blow to health promotion groups and governments in Canada wishing to restrict tobacco advertising, which directly impacted on Stewart's desire to use the *Tobacco Access Act, 1993* to limit tobacco promotion.

SMOKE FREE ENVIRONMENT ACT?

During the summer and early fall of 1995, Stewart realized that if legislation restricting smoking in public places was going to have any hope of being enacted during the Savage government's first mandate, he would have to act in the fall session (1995) of the legislature. Approaching what many assumed would be an election year, the possibility of the premier and his cabinet endorsing a political controversial bill was an unlikely possibility. Despite the fact that smoke–free public places legislation was promised in the Liberal health policy of 1993, by 1995 the government was experiencing "reform fatigue." Significant structural

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[20] Order–in–Council 96–29, Regulations Made pursuant to section 13 of the *Tobacco Access Act*, SNS 1993, c. 14 (January 16, 1996).

changes in the Department of Health, Education, Municipal Affairs, as well as controversial labour legislation had exhausted the Savage government's front benches and created an atmosphere of frustration for the public, especially those affected by the government's changes. In short, the political climate in 1995 was not inviting to those in government proposing destabilizing change.

Despite the resistance from within the government caucus, as well as from some within the Department of Health and pressure groups in the hospitality sector, Stewart instructed his staff to produce a bill for the fall session (1995) that would meet the political commitment made in 1993. The bill was entitled *An Act Respecting a Smoke–Free Environment in the Workplace and in Public Places in the Province* or *The Smoke–Free Environment Act.* The drafting process was frustrating for both Stewart and Department of Health staff in the Policy and Planning Division. As well, the Legal Services Branch, on at least two occasions, produced documents that were unacceptable to the Minister despite his specific instruction on the bill's intent. By October 1995, after direct intervention in the process by myself at the Minister's request, a final draft of the bill was approved, except for one outstanding issue — what to do with restaurants and bars? The draft act called for a compromise that would allow restaurant and bar owners to construct "smoking rooms" which would be separately ventilated. However, this still did not satisfy Stewart as this provision did nothing to protect the health of employees required to work in such areas. Stewart asked me to begin a round of consultations with key stakeholders and government members to try to "test the waters" to see if this could be strengthened.

The definition of public places in the draft act was quite comprehensive. It stated that it was an offence to smoke in the workplace or a public place, a public place being defined as follows:

1. (g) "public place" means a place that is normally open to members of the public and located in an enclosed area included

(i) the part of

(A) an office building,
(B) a retail store or other commercial establishment,
(C) a gallery, library, museum or theatre;

that is normally open to members of the public, or

(ii) a part of a health care facility that is normally open to patients or members of the public;

(iii) a part of a day care centre or nursery school that is normally open to children of members of the public;

(iv) the building and grounds of primary, elementary and secondary schools and the buildings of any other educational institution or education facility that is normally open to students or members of the public;

(v) a part of an eating establishment, whether or not the eating establishment is a licensed premise or a portion of a licensed premises that is normally open to members of the public;

(vi) in the case of licensed premises that are not and do not contain an eating establishment, the part of the licensed premises that is normally open to members of the public;

(vii) in the case of a licensed premises containing an eating establishment, the part of the licensed premises, other than the food establishment portion, that is normally open to members of the public;

(viii) a vehicle used for carrying passengers for compensation, such as taxi cabs;

(ix) THIS CLAUSE WAS STRUCK.

(x) common areas in multi–unit residential and commercial facilities, including elevators, escalators, stair wells, and public rest rooms;

(xi) bus shelters;

(xii) public conferences or assembly rooms, bingo halls and polling areas;

(xiii) private clubs, privately owned banquet rooms, church halls, service club buildings, and any other private facilities to which access is

> restricted by requirements of membership or otherwise when two or more members of the public are present, either gratis or for a fee.[21]

Stewart felt confident that the measures proposed in the aforementioned bill would be supported by the general public. This assumption was based largely on a public opinion survey commissioned by the Department of Health and a generally positive tone in the media and from constituents.[22]

The public opinion survey was conducted by Omnifacts Research and completed in September 1995. Interviews were conducted with 404 Nova Scotian adults aged 19 and older, proportionally distributed over the four health regions. The results indicated that non–smokers preferred a complete ban on smoking in almost all areas mentioned with percentage of agreement highest for school buildings (94%), public transportation (92%), hospitals (90%), and indoor sports facilities (88%). For non–smokers, only three areas fell below the 50% agreement level: hotel/motel rooms (48%), prisons (43%) and bars and other licensed facilities (38%). The level of agreement among smokers was significantly lower in all areas, although over two–thirds agreed with complete bans in school buildings (83%), public transportation (74%), hospitals (67%), and indoor sporting facilities (66%). Again the lowest levels of agreement were for hotel/motel rooms, prisons and bars (see Table B).[23]

Armed with this data and the virtually completed draft bill, Stewart instructed myself and the Director of the Tobacco Control Unit, Mr. Merv Ungurain, to seek input and build support for the bill. This process began on October 6 when we invited the government members to come to the Minister's office to discuss the proposal. Members were asked to come in small groups of between five and ten to hear the Minister present his proposals

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[21] *An Act Respecting a Smoke–Free Environment in the Workplace and in Public Places in the Province, 1995*, DRAFT, prepared by the Honourable Ronald D. Stewart, OC, MD, Minister of Health, Government Bill.

[22] Omnifacts Research, Smoking Ban in Public Places Survey, #95155 (September, 1995), 1.

[23] *Ibid.*, 3–6.

followed by a group discussion. (Stewart participated directly in this session; the sessions with interest groups were chaired by myself or Ungurain.) Six of these sessions were held throughout the day.

Several of the government caucus members were not convinced of the health risks of second–hand or environmental tobacco smoke (ETS). Stewart argued that the Department of Health estimated that 180 non–smokers died in Nova Scotia annually due to exposure from ETS, and he quoted the *Journal of the American Medical Association* (1994), which stated waitresses have the highest rate of lung cancer of any female occupation.

Government caucus members displayed various levels of support throughout the day's discussion. A member from a Halifax riding asserted that the government could little afford the "rumblings on election day"; however, he was an opponent of the government–endorsed casinos, and he hoped this measure might cut into their business. Some members brought forward anecdotal evidence against the bill stating they had "heard" of several businesses going smoke–free and then losing money. One member from the South Shore asserted that a "Mahone Bay restaurant lost business." The evidence seemed to contradict these assertions: Studies of restaurant profits in jurisdictions that were smoke–free indicated sales either remained the same or actually increased.[24] Stewart also distributed a list of over 500 businesses in Nova Scotia, who, despite having no legal reason to do so, voluntarily imposed a smoke–free policy.

One prominent cabinet minister asserted that the ban should only apply, in the hospitality sector, to establishments that serve food. He also wished to see the measure move slowly: "The measure should be phased in with the section being proclaimed separately.... It is good politics to move in pieces. We should exempt premises which do not serve food."[25] This

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[24] Glantz and Smith, "The Effects of Ordinances Requiring Smoke–Free Restaurants on Restaurant Sales," *American Journal of Public Health* (July 1994).

[25] The Government Caucus member quoted here, and the others quoted beforehand, were taken from notes I have transcribed from the consultation meetings held on October 6, 1995. I have decided to keep the identity of the members quoted confidential.

position seemed to me to be self–serving; the regulations regarding liquor control in Nova Scotia require that all premises which serve alcohol must also serve food. The lone exception to this policy was the government–endorsed casinos in Halifax and Sydney. The member in question who made the suggestion to exempt "bars" which do not serve food was a strong supporter of the casino initiative and might, therefore, oppose any measure which Sheraton Casinos would view as restrictive. The "casino issue" played a role in having the proposed *Smoke–Free Environment Act* defeated in the Cabinet Sub–committee, which considered what bills would be introduced by the government on the floor of the House.

Stewart assessed the consultative meetings with the caucus as being successful. He realized his main obstacle would be convincing the Cabinet that the political timing of this bill would not risk government popularity as an election neared. Ultimately, however, Stewart was unable to muster the needed support.

During the last two weeks of October, Ungurain and myself met with several groups in a comprehensive consultative process. We did not reveal the contents of the draft bill or even admit to its existence, as that would have compromised Cabinet confidentiality. However, we did discuss the issue in general terms and asked for feedback. Over twenty groups were consulted, representing universities, other provincial government departments which would be effected, Health Canada, hospital administrators, the Nova Scotia gaming corporation, and various groups representing tourism and hospitality interests. Those who were most critical and provided the greatest barriers were the Tourism Industry of Nova Scotia (TIANS), the Lounge and Beverage Association, the Nova Scotia Gaming Corporation, and the Nova Scotia Restaurant and Food Services Association. In summary, these groups all argued that this measure would hurt their businesses collectively and individually. They virtually all rejected the Department of Health's assertion that their sales would not drop and expressed reservations about how a ban would be enforced. Of those groups which did not support banning smoking in public places, the Lounge and Beverage Association was most

accommodating, stating they supported the principle of safe, cleaner air in their establishments, but preferred other methods of achieving this goal rather than banning smoking. The other extreme was the Nova Scotia Restaurant and Food Services Association who would barely concede that ETS was a health risk; their position was that market forces should determine their business environment and government had no place in regulating their businesses. The spokesperson for this delegation vowed to fight us (the Department of Health) "tooth and nail."

Some insight into the tactics which were employed by the restaurant lobby to stop the *Smoke–Free Environment Act* was provided by Mr. Luc Erjavec, Government Affairs Manager–Atlantic Canada, Canadian Restaurant and Food Services Association. Before joining this organization, Erjavec was the Executive Assistant to the Honourable Jay Abbass when he served as Minister of Labour and for some of his tenure as Minister of Human Resources. As the chief lobbyist for the Canadian Restaurant and Food Services Association in Atlantic Canada, Erjavec claimed to have "coached" Ms. Denise Burns in her capacity as the Executive Director of the Nova Scotia Restaurant and Food Services Association in her attempt to block the Smoke–Free Environment Act. "I fed the provincial group research and advice on how to handle the media. We highlighted the issue for the media; it is easy to get them turned on to a story."[26] He also approached individual MLAs and encouraged them not to support Stewart's effort: "I didn't discuss the health issue [health risk of ETS]. I brought it to the political/tactical level. I asked them why would they want to piss off more people for no political gain. My background as a former executive assistant helped. I spoke with fifteen or twenty of them [MLAs] personally."[27] Erjavec viewed his role as a lobbyist as a legitimate part of the political system: "My mandate is political advocacy. It is our mission statement — getting the government to listen to you. Our preferred tactic is not to protest but get involved

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[26] Mr. Luc Erjavec, personal interview, 1996.

[27] *Ibid.*

with the civil servants and influence policy before it gets to the political level. It is important in my job to understand governmental process. This is even more important than being affiliated with a political party."[28]

Media coverage of Stewart's attempt to have the *Smoke–Free Environment Act* placed on the government's agenda seems to confirm Erjavec's summary of the restaurant association's media strategy. Stewart began his public posturing on this issue early in August 1995, when he told reporters that he wanted to make a ban on smoking in restaurants and other public areas a legislative priority in the fall session: "It's my priority. I hope I can convince them it's theirs [referring to Premier Savage and his Cabinet]."[29] Burns, representing the Nova Scotia Restaurant and Food Services Association seemed surprised by Stewart's statement: "I call them on a monthly basis to see if there are any discussion papers circulating, [and] if they have any draft legislation available, and the answer is invariably no.... For some people that's just unacceptable, when government steps in and tries to legislate a social behaviour." Dr. Drew Bethune, the President of Smoke–Free Nova Scotia, who replaced Freeman, countered Burns' argument by asserting that smoking as a social behaviour is a killer: "I don't think non–smokers should have to be exposed to cigarette smoke in the workplace or elsewhere."[30] In October, restaurant owners increased their rhetoric by stating they would defy any law that would ban smoking. Mr. Mike Collis, co–owner of Mexicali Rosa's in Halifax, stated, "We won't actually be enforcing it. People who pay to have a meal, a drink and unwind with a cigarette should be able to do so. I'd hate to take that privilege away from them."[31]

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[28] *Ibid.*

[29] *Halifax Daily News*, August 4, 1995.

[30] *Ibid.*

[31] *Halifax Chronicle–Herald*, October 13, 1995.

As the media and the opposition political parties began to realize that Stewart was losing his battle to have the *Smoke–Free Environment Act* placed on the order paper, speculation over this failure was reported. "Perhaps the most important bill Ron Stewart will ever introduce sits on his desk all dressed up with no place to go," wrote Mr. Dale Madill, the provincial reporter with the Halifax *Chronicle–Herald.* He expanded on this point by stating, "a brilliant emergency medicine specialist and a determined advocate of preventive medicine, Mr. Stewart hasn't been able to convince a select committee of Liberals, including House Leader Richie Mann, that his smoking bill should be a government priority."[32] The New Democratic Party Leader, Mr. John Holm sounded indignant: "If the minister can't convince his colleagues that keeping Nova Scotians healthier is a priority, then there is a problem, and I don't know if it's with him."[33] Stewart played the "good soldier" during question period in the legislature. When asked by the opposition where his bill was, he responded, "I, again, would only pledge my efforts to carry forward legislation in as fair a priority as we can manage, knowing full well that the government will set the agenda for the legislative session."[34]

Stewart was never able to convince "the government" to support the *Smoke–Free Environment Act* either in the fall session or the following spring session of 1996. Eight days after Stewart's resignation from Cabinet, June 28, 1996, his successor, the Honourable Bernie Boudreau, the author of the *Gaming Control Act*, which established casinos in Nova Scotia, and one of Savage's most influential ministers, placed the issue of ETS in context during his watch as Minister of Health: "It's not high on my priority list. There's no plan for immediate action. I'm not even thinking about legislation."[35]

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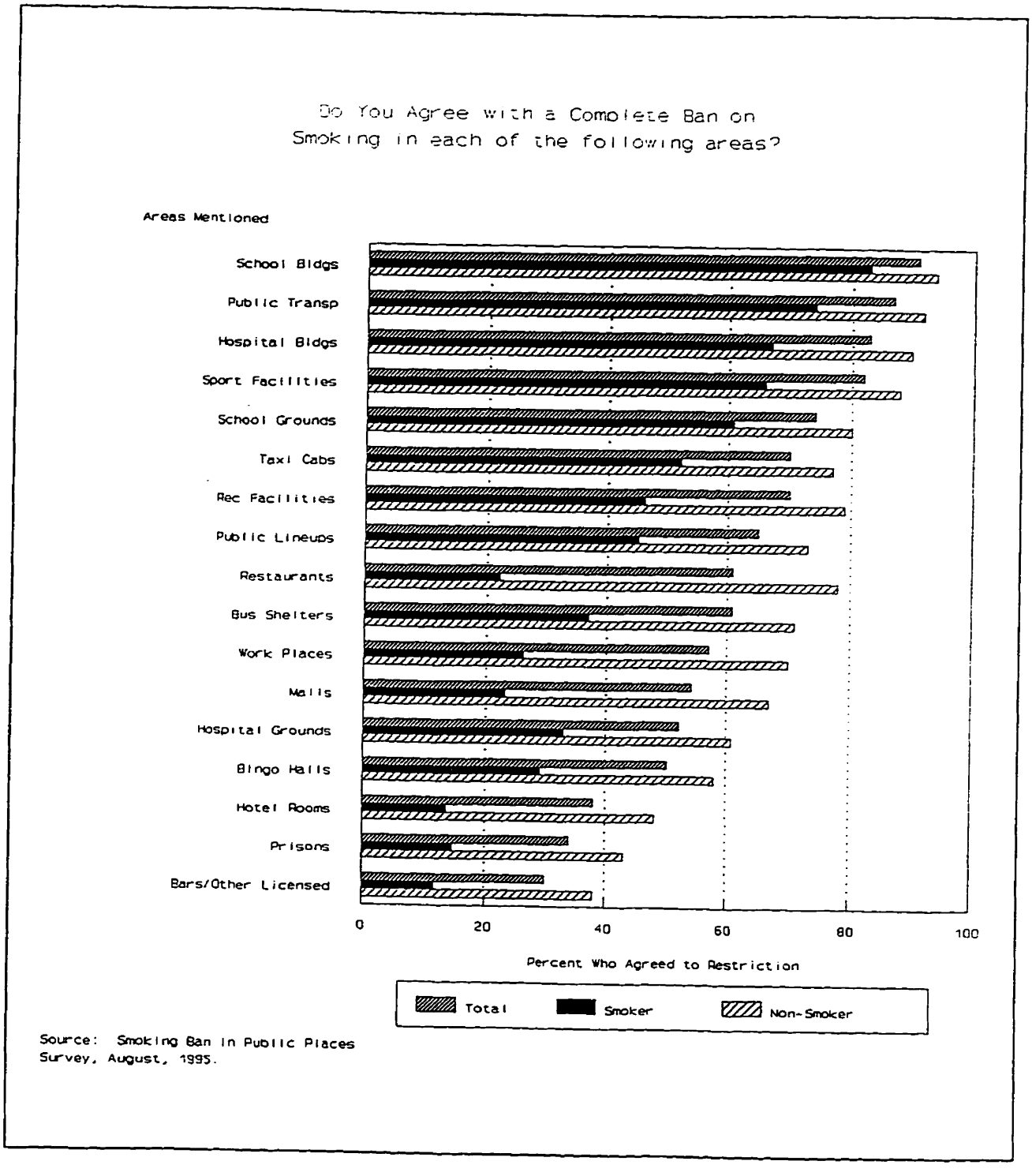
[32] *Halifax Chronicle–Herald*, December 6, 1995.

[33] *Ibid.*

[34] *Ibid.*

[35] *Halifax Chronicle–Herald*, July 5, 1996.

TABLE B



Source: Omnifacts Research Limited, "Smoking Ban in Public Places Survey," August, 1995.

CONCLUSION

A recurring theme throughout this thesis has been the pluralistic tendencies of the interest groups examined. Certainly this holds true for the groups examined in this chapter. Both the health promotion groups, despite being partly financed by the state, and those representing the hospitality industry acted as autonomous entites solely concerned with their own interests.

The *Tobacco Access Act, 1993* managed largely to avoid the pressures of interest group politics, mainly because a coherent, organized group did not exist to oppose the law, and it was supported by the opposition political parties. Furthermore, in 1993, Stewart was at the height of his political power, being cast as the saviour of the health system and a man with impressive credentials with the credibility to carry almost any measure he wished. However, the embarrassment created over the "candy cigarette" issue served to portray Stewart as an anti–tobacco extremist which may have harmed his credibility in later tobacco reduction efforts.

The *Smoke–Free Environment Act* failed for a variety of reasons. By 1995, severe budget restrictions and structural changes in the health system had eroded Stewart's popularity and credibility. The government was "reformed out" and was ill–equipped to face another onslaught of pressure group politics as the result of a government–led initiative. The Canadian Nova Scotia Restaurant and Food Services Association benefitted greatly from the advice and manoeuvring of Mr. Luc Erjavec, who, as a former executive assistant in the Savage government, understood the bureaucratic process and knew how to manipulate the political climate. This lobby played a key role in preventing this measure. Furthermore, the relatively ineffective tactics employed by health promotion groups, such as Smoke Free Nova Scotia

(allied with Stewart to see this measure enacted) prevented them from making any substantive contribution to the Health Ministry's effort.

Also, I have argued that the operation of the government–endorsed casino operations played a role in preventing the smoke free environment Act. Sheraton Casinos contributed $25 million to the Nova Scotia Governement coffers for the privilege of providing Nova Scotians with gambling entertainment. Championed by the powerful Minister of Finance, the Honourable Bernie Boudreau, it was unlikely that the government would impose any restrictions which would impuge upon its corporate partner.

The Savage government was successful in implementing half of the stated objectives in its health platform regarding tobacco addiction. However, the failure of the proposed ban on public smoking is an excellent example of how pressure group politics can have an impact in preventing a policy objective supported by a government cabinet minister.

Chapter 7:
CONCLUSION

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PART I

The results of the textual comparison between the Savage government's health platform and the policy outcomes, as well as the four case studies indicate some clear trends. Pressure group politics in the Nova Scotia health policy sector clearly follows a pluralistic model. Interest groups have influence promoting their interests and shaping public policy. This influence is not restricted to government; it also includes the media and the general public. However, in the majority of cases, the Savage government was able to implement its policy preferences, despite substantial opposition from interest groups. Based on this, we can conclude that political leadership by the government elite is sufficient to resist pressure group politics.

The pluralist model is evident throughout the case studies, including interest group/interest group competition (chapters three, five and six), internal divisions within interest groups (chapter three) and in every case, interest group/state competition (chapters three, four, five and six). However, corporatist tendencies were also evident in a couple of cases. Specifically, there are corporatist features to the relationship between the Nova Scotia Department of Health and the Nova Scotia Medical Society, particularly when the role of the Joint Management Committee and its direct role in the creation of public policy with respect to physician services is considered. Yet even within this context, the Nova Scotia Medical Society's internal factions resisted directives from their own leadership and frequently disagreed (and voted against) officially endorsed policy. The ability of the NSMS elite to "deliver" on its agreement with the provincial government is certainly debatable. To a lesser extent, the Ambulance Operators Association of Nova Scotia and the Department of Health

entered into a "corporatist type" agreement to deliver ambulance services. However, chapter four demonstrated the privileged position of the AOANS was structurally weak (i.e. loose "contract" with no supporting legislation to protect the arrangement). This vulnerability allowed a determined minister of health to dismantle this structure and replace with it the government's alternative, leaving the AOANS in a considerably weaker position.

Chapter one discussed a model for identifying interest group influence on government policy defined as enacting legislation/regulation or altering department policy. To determine if an interest group was successful in preventing a government action, the policy issue must have been articulated by the government in its election platform, speech from the throne, a major policy document approved by the priorities and planning committee (sub-committee of cabinet) or have been articulated in public by the premier or another member of the executive council. Furthermore, the interest group must have stated in its literature, through the media or another significant forum their intention to oppose the government policy action. In defending the assertion that interest groups do have influence and the Savage government was able, for the most part, to resist interest group pressure, we will briefly examine each case against the criteria established in chapter one.

Case study one - the Nova Scotia Medical Society

This case study is the most difficult on which to give a clear analysis. The Nova Scotia Medical Society is an established organization which uses power in a subtle and strategic manner. An example of this "informal" or subtle use of power is documented on page 64 with the use of a legal agent connected to the hierarchy of the Liberal Party to access the premier and the minister of health on behalf of the NSMS. The informal use of power is difficult to identify and document. A clear theme throughout this chapter was the ability of organized medicine to mobilize public pressure and use professional resources to undermine government initiatives and defend their interests.

Two policy initiatives which can tangibly be identified as demonstrating that the medical society does exert influence are:

1) the prevention of the Savage government's health platform pledge "... to find innovative ways to provide access to health care professionals..." - a clear reference to the minister of health's attempt to reform the primary health care model, including fee for service method of physician remuneration. As important as changing the method of reimbursement (probably to an annual salary or blended formula system) is to containing costs and preserving the viability of Nova Scotia's universal health system, it was taken off the agenda of the physician's agreement negotiating team and was never seriously addressed at the Joint Management Committee level. This constituted a clear failure on the part of the minister of health to "win" this concession.

2) The promotion of NSMS policy by playing a direct role in the drafting *of An Act to Continue the Medical Society of Nova Scotia, 1996.* Health Minister Stewart admitted to the legislature that the bill was "developed in concert with the Medical Society of Nova Scotia and they participated in its design and structure." (chapter three, p. 69) This may not be overly significant in that many organizations are consulted by government departments wishing to revise legislation dealing with professional standards and their associations. It is, however, a clear example of an interest group directly involved in drafting legislation.

Structural evidence that the Medical Society has influence exists with the composition and mandate of the Joint Management Committee. Public policy affecting physicians must be unanimously approved by the Department of Health and the Medical Society members (four each). For example, the rural recruitment strategy enshrined in the DOH/Physicians agreement actually has the resources to implement the strategy housed in the Medical Society

offices. It is difficult to find an equivalent professional body which has such a direct control over government policy.

Case study two - The Ambulance Operators of Nova Scotia

Chapter four discussed the Ambulance Operators Association of Nova Scotia's attempt to block or significantly amend Bill 96, *An Act Respecting Emergency Health Services, 1994*. In this regard, they were totally unsuccessful. Although this chapter did document delays in implementing EHS reform, it does not appear that this can be meaningfully attributed to the AOANS, but rather administrative and fiscal barriers.

Case study three - The Nova Scotia Government Employees Union and the Nova Scotia Nurses Union

The efforts of the Nova Scotia Government Employees Union and the Nova Scotia Nurses Union to prevent or amend Bill 47, *Queen Elizabeth II Health Sciences Centre Act, 1996*, was the main focus of chapter five. Given that none of the amendments proposed by either of these unions were adopted, it can be generally concluded that they had no influence on this government policy action. We can speculate that the government did not propose certain policies for fear it would enflame opposition. However, I found little tangible evidence to support this.

Case study four - Tobacco control: Nova Scotia Restaurant and Food Services Association and the Canadian Restaurant and Food Services Association.

The most dramatic example of successful interest group influence was evident in this chapter. The Savage government committed in its 1993 health policy to banning smoking in public places, a pledge reiterated by his minister of health on numerous occasions in the subsequent years. Yet, it is apparent that the *Smoke Free Environment Act* (DRAFT) was prevented from being introduced by pressure group influence from private sector hospitality groups. Specifically, the Nova Scotia Restaurant and Food Services Association and the

Canadian Restaurant and Food Services Association seem to have influenced the premier and the executive council to the extent that they no longer supported a proposition they had endorsed and publicly presented in the election campaign of 1993.

The successful tactics of these two interest groups are documented in chapter six; however, it is plausible that other competing sources provide a clearer explanation of why the *Smoke free Environment Act* was abandoned by the government. However, the only other sectors which seemed to oppose this measure were certain members of the government caucus and mild opposition from the bureaucracy. Both the media and the public were generally supportive, through positive editorials and public opinion surveys. NSRFSA and the CRFSA admitted to lobbying directly, both members and civil servants close to this issue. It is reasonable to assume that these interventions had some impact. In the last analysis, I would advance that the internal government struggle was a result of the interest group pressure against this measure described in chapter six.

The assertion has been made that the Savage government was successful in implementing its health platform in the majority of the cases examined. I would direct readers to the outcome assessment in chapter two which shows that in the twelve policy initiatives selected, the government achieved a seventy-five percent success rate in implementing and partially implementing its health platform. This is not only indicative of the governement's resistance to interest group pressure but also resistance to other pressures such as the mass media and the civil service.

I would further conclude that those pressure groups which closely exhibited the characteristics of "institutional" groups, as defined by Pross in chapter one, seemed to be the most successful. Only three groups were "strong" enough in all five categories to warrant this classification: the Nova Scotia Medical Society, Canadian Restaurant and Food Services Association and the Nova Scotia Restaurant and Food Services Association

Most of the other pressure groups examined exhibited several, but not all, of the "institutional" characteristics. For example, the AOANS is a cohesive organization with an extensive knowledge of their related policy sector. However, they failed to produce concrete and immediate objectives and, more importantly, they did not enjoy "easy communication" with the policy sector. In short, they lacked effective access to the power centres which impacted on their interests.

Political inquiry, with respect to pressure group politics, is not complete without some consideration for the impact of human agency and idiosyncratic variables on policy outcomes. To understand fully the dynamic between the state and pressure groups, it is helpful, to consider the psychological construction and personality traits of the actors involved. Furthermore, the impact of the process of governing on state and non-state actors provides a significant area for analysis.

For example, the Minister of Health faced personal attacks from the NSMS advertising campaign (Chapter 3); a personal friend, Mr. Ken Caldwell, embarked on a vendetta to attack Dr. Stewart politically at every conceivable opportunity (Chapter 5); finally, Stewart faced death threats, a physical threat against his 80 year-old mother, and being forced, at times, to travel with armed escorts in a province that has rarely required its political elite to endure such extreme security measures. Admittedly, it can be difficult to establish a tangible link between idiosyncratic variables and policy outcomes; however, considered in total, the environment in which political actors operate and the personal abilities (including psychological stamina) they bring to their role has an impact on the government's effectiveness. Including idiosyncratic variables in the analysis increases its sophistication and explanatory power.

Throughout this thesis, I have attempted to include an analysis of the impact of human agency. I do not wish to overstate the impact of idiosyncratic variables but merely to assert that political inquiry benefits from recognizing the impact of such variables on the policy-making process.

For comparative purposes extrapolating these findings to other jurisdictions is possible. Health care systems operating in a pluralistic/democratic environment, which are publicly funded and universal should produce similar results. Obviously, policy outcomes will vary and interest group influence will fluctuate, largely based on the type of political leadership being exerted by state elites. The results here indicate that strong, innovative leadership is sufficient to resist interest group pressure. Comparisons to other Canadian provinces should be valid. The further removed the government/health system from the above model, the less reliable the results will be. For example, we could speculate that pressure group politics would be more effective in the United States, given the private sector dominance of the health system and the structural impediments restricting federal and state governments, which seem to foster a more pluralistic environment.

The timeframe which is the setting for the case study may accent and demonstrate the role of group politics in a dramatic way. The 1990s are a period of government downsizing and contraction, suggesting a high level of interest group pressure; as interest groups become more vulnerable, we would expect them to be more confrontational when interacting with government. For the study of pressure group politics, this has certain advantages in that the informal or subtle use of power will be overshadowed by a more virulent form of group activity, which is easier to identify and measure.

In terms of extrapolating data from the health policy sector, it should be possible to make cross-sector comparisons. Many of the organizations which participate in health group politics are also involved in other policy sectors such as community services/welfare and economic/business. Furthermore, the diversity of the pressure groups examined in the case studies include groups which are not usually involved in influencing health policy. In short, the broad range of issues examined coupled with the diverse nature of the groups examined (labor unions, private sector/business, professional associations and single-issue advocacy groups) help to reduce any concerns about the representativeness of the sample.

PART II

Pressure group politics is a legitimate component of the democratic process. Our empirical analysis has shown that interest groups can influence and alter government policy. Despite having this power, pressure groups do not represent a sufficient threat to the autonomy of the state to warrant restricting their participation in the democratic process. The pluralistic model which dominates group politics in Nova Scotia's health system is appropriate and perhaps even complementary to the more traditional party-dominant parliamentary system. This is not to suggest that group activity does not adversely affect governability. The political success of a government can often be gauged by the state elite's ability to mediate, placate and "manage" interest group activity related to the government's agenda. Governability can be affected in a time of rapid change when group activity becomes increasingly aggressive and critical. Pressure groups can generate sufficient negative publicity to cause the state to lose legitimacy. However aggravating this may be for government elected officials, the costs of restricting interest group influence would be significant. The opportunity for individuals to petition and lobby the state through group activity creates stability by empowering individuals and reinforcing the perception that they can exercise authority over their elected representatives. Freedom of association and expression are popular democratic rights which cannot be tampered with lightly. Only under extreme circumstances where the government's ability to function is at risk of being paralyzed by group politics should measures be considered to reduce interest group influence. Pressure group politics can also increase government accountability in that state elites are often required publicly to defend policy initiatives as a result of interest group pressure. Increased public accountability is, for the most, a positive side-effect, but it can lead to increased anxiety amongst the general public particularly, when the group/state dialogue becomes overly confusing, and misleading.

I have attributed the Savage government's success in "delivering" on the majority of its health platform to political leadership which was prepared to oppose pressure group influence in order to promote the government's election platform. The ability of governments to deliver its platform is affected by group politics, since it can have a draining effect on state elites. The personal toll individual ministers and a premier must endure in a period of sustained negative interest group pressure is exhausting. It is evident that although Health Minister Stewart enjoyed several "tactical" victories over pressure groups in advancing the government's agenda, the resulting unpopularity which accumulated over a three year period of challenging interest group influence had a personal and political effect. The psychological strain of constant criticism by interest groups, largely through the media, created much of the political hostility of the general public toward Stewart, which certainly contributed to his early exit from the Savage Cabinet. The danger in this lies in the political system's ability to attract "quality" candidates to stand for elected office. As the adversarial and sometimes vicious nature of the pressure group/state dialogue increases, observers who may be interested in elected public service may question the personal sacrifice politics now demands, perhaps convincing some that it is simply not worth it. The government's ability to advance its policy preferences is dependent on strong political leadership especially when pressure is exerted by parochial interest groups. If quality leadership becomes scarce because of the political climate in which state elites operate, the possible consequences for representative democracy could be severe.

In summary, despite friction between the state's ability to govern and pressure group politics, reforming interest group activity is not justified. Strong political leadership is sufficient to advance the government mandate in spite of, or complemented by, group activity.

THE FUTURE

As pressure group politics increases in influence, as it has since the 1960's, the ability of government elites to administer public policy effectively will be reduced. With the perceived problems associated with the representativeness of political parties, and as governments become more aggressive in changing existing power structures (often as a result of fiscal restraint) it is likely that more individuals will pursue interest group activity to exercise power over the state. Currently, Canadian governments have sufficient autonomy to enact their policy preferences. However, as popular culture advocates movement towards direct democracy, coupled with the rise of charter politics some erosion of state governability seems inevitable. In addition, as governing becomes more difficult and the personal "toll" on elected officials becomes greater, the ability to form effective cabinets with innovative "thinkers" will decrease. Democracy can be characterized as a delicate balancing act between the state's ability to govern and the public's desire to participate and be consulted; the rise of interest-group politics has the potential to upset this equilibrium and render society ungovernable.

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