CCARH Canadian Centre for Analysis of Regionalization and Health
CCARS Centre canadien d'analyse de la régionalisation et la santé

Regionalization: Where Has All the Power Gone?

A survey of Canadian decision makers in health care regionalization

Denise Kouri
Kelly Chessie
Steven Lewis

Saskatoon
December 2002
Second Printing

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Notes regarding the seconding printing:

There have been some changes in regionalization structures since the report was first printed. In this second printing, Table 1 on Page 2 has been updated as of April 2003.

Table 8 on Page 11 has been corrected from an error in the first printing. The percentage of ministry respondents saying the health reform had no effect on the quality of the health system should be 38% rather than 34%. This correction does not affect any of the commentary or conclusions in the report.

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Preface

The Canadian Centre for Analysis of Regionalization and Health (CCARH) is a national agency that studies health system regionalization. We are pleased to present *Regionalization: Where Has All the Power Gone?,* a report on the findings of our most recent survey of health care decision makers.

Many regionalized health systems throughout Canada are now close to a decade old and their decision makers have accrued significant experience. We surveyed them in the fall of 2001 and early 2002 to learn their opinions of regionalization to date. The survey is an expanded national version of one we carried out in 1997 in Saskatchewan. This publication is the first summary report of our findings. We plan to publish more analyses in the future.

The publication of these findings follows closely the recent release of the report of the Commission on Future of Health Care in Canada (Romanow report). The Commission's mandate was Canada-wide and it focused on national-provincial relations of authority. However, the issues of leadership, accountability and public trust, which were main themes of the Romanow report, are also relevant to provincial-regional levels of authority. They were the main questions in the last two surveys we have carried out and are the focus of this report. Indeed, leadership, accountability and public trust are relevant to all levels of the health care system.

We hope you find the report informative and invite your comments.

You can contact us at centre@regionalization.org or through our website www.regionalization.org for inquiries or extra copies of the report. A supplementary report, with tabulated responses for all survey questions by province is also available upon request.

Denise Kouri
Executive Director

Acknowledgments

We express our appreciation to the regional health authorities and provincial health ministries who assisted in the distribution of this survey to board members and employees. We also thank the respondents for taking to time to complete the questionnaire and provide us with your opinions.

This survey was funded by HEAL*Net* (Health Evidence Application and Linkage Network), a member of the Networks of Centres of Excellence Program, which is a unique partnership among Canadian universities, Industry Canada and the federal research granting councils.

Regionalization: Where Has All the Power Gone?

Summary

Many regionalized health systems throughout Canada are now close to a decade old and their decision makers have accrued significant experience. The Canadian Centre for Analysis of Regionalization and Health (CCARH) surveyed many of these decision makers in the fall of 2001 and early 2002 to learn their opinions of regionalization to date, on various topics. The survey was an expanded national version of one we carried out in 1997 in Saskatchewan.

Although regionalization is referred to as a single policy innovation, in practice there are wide variations in its implementation across Canada. In addition, there have been modifications over the last decade to the regionalization structures within provinces. The extent of devolution has been contentious and unstable in many provinces.

In some provinces, changes either under way or planned were bound to affect the response to our survey. Several of the changes were being announced or were in the process of being implemented just as we were distributing the questionnaires. We decided to capture the opinions of existing board members, before many of them left the system.

We surveyed board members and CEOs from all regional health authorities in Canada, and ministry of health senior managers in most jurisdictions. Response rates were 50% for board members, 52% for CEOs in RHAs and 38% for health ministry officials.

Our survey collected decision-maker opinions on selected issues in health system reform and regionalization. The report presents findings on questions of authority, local control and stakeholder involvement in decision-making, and assessments of the overall effects of reform. We report differences among decision maker groups and interprovincial variation. Where appropriate, we compare our current findings with those of other surveys.

Findings

Survey results indicate support among these decision makers for the directions of health reform. They deemed it financially necessary. They also believed the effects had been positive and that overall it had improved the quality of the system. Specific findings include:

- Survey respondents generally were pre-disposed to health reform. Only a minority agreed with the statement that there was no need for the extensive health reform of the 1990s.
- Respondents provided an overall positive assessment of the effects of health reform and for all three decision-maker groups, more were of the opinion that the quality of the system had increased than had decreased due to health reform. The majority believed that neither their specific region, in the case of boards and CEOs, nor RHAs in general in the ministry's case, had lost out with health reform.
- Nevertheless, about a third of the respondents assessed the changes in quality as negative – board members in particular.
- Board members who had served longer tended to be more positive in their assessment of health reform.

The majority of respondents were not satisfied with the clarity of devolution. This was particularly true of CEO and ministry respondents – only one-third agreed that the division of authority between regional health authorities and the province was clear, and large majorities felt that residents had a tendency to bypass RHA boards and present their concerns to the provincial government. Board members were relatively more sanguine on these questions, but only half felt the division was clear and just over half felt residents bypassed boards. Clarity issues have intensified over time. Saskatchewan results show a marked

decrease from 1997 to 2001 in the belief that the division of authority was clear among all three decision-maker groups.

A majority of RHA board and CEO respondents contended that devolution had not been fully realized – they believed that RHA boards had less authority than they should or than respondents had expected.

Ministry views differed from those of RHA board members and CEOs on the topic of devolution. Among the more notable differences:

- Ministry respondents did not agree that RHAs were too restricted by their provincial governments.
- Most ministry respondents thought that interest groups and vested interests had too big a say in board decisions.
- Although more respondents in each of the three groups indicated that health reform had increased rather than decreased local control over health care decisions, ministry respondents were far more likely to feel local control had increased, and board members least likely.

The pattern of responses among the decision-maker groups suggests that many issues may emerge more from the dynamics of regionalization than from specific developments in each province and territory.

- Overall, no province was consistently different from the rest.
- PEI respondents were the most positive across the three decision-maker groups about health reform having been for the best. However, all provinces responded positively on this dimension.
- In general, board members from western provinces assessed the impact on quality more positively than eastern ones. Moving east from a peak in Alberta, the rate of positive assessment dropped steadily to reach its lowest point in Nova Scotia. PEI respondents, however, were somewhat more positive than their Atlantic counterparts, consistent with their positive responses about health reform being for the best.
- PEI, Quebec and Saskatchewan board respondents were strongest in the view that the division of authority was unclear and that accountability to the citizenry unstable and confused. In this the ministry respondents were in agreement with their RHA counterparts, which in the case of Saskatchewan revealed a shift in perspective from 1997.

Implications

Survey findings may reflect the difficulties provinces have experienced in configuring authority over health care delivery. There have been many shifts in the authority landscape as provinces have sought a more satisfactory pattern.

The recently released report of the Commission on the Future of Health Care in Canada (Romanow report) focused on the themes of leadership of, accountability for and public trust in Canada's health care system. The Commission's mandate was national and it focused on national-provincial relations of authority. However, as our survey findings show, the same issues are present at provincial-regional levels of authority. Although the Romanow report was silent on the question of regionalization, the earlier Kirby report had recommended that the federal government encourage the devolution of additional responsibility to regional health authorities.

Survey findings show that there is considerable support for regionalization, especially in the provinces with the most established regionalization structures. However, if this potential is to be realized, provincial governments must provide more stability for regional health authorities and be clearer about what they expect from regionalization and why. It then follows that they should provide the mechanisms and support to enhance the legitimacy and effectiveness of regional health authorities within the context of a comprehensive health system.

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A. INTRODUCTION

The 1990s were the decade of provincial health reform on a massive scale. Central to many reforms was the introduction of regionalization and regional health authorities (RHAs)[1]. By 2002, nine of Canada's ten provinces and the Northwest Territories had regionalized health care systems. Ontario was the single exception among the provinces. While largely the same in intent – to streamline the delivery system and make it more responsive to local needs – the regionalized systems vary in terms of scope (e.g., health services included) and structure (e.g., elected versus appointed boards, levels of authority and autonomy).

The Canadian Centre for Analysis of Regionalization and Health (CCARH)[2] is a national agency studying health system regionalization. Many regionalized systems throughout Canada are now close to a decade old and their decision makers have accrued significant experience. We were interested in their opinions about regionalization and variation among provinces and different decision-maker groups (i.e., RHA board members, CEOs, and provincial ministries). We therefore conducted a modified version of a survey previously conducted in Saskatchewan[3], which in turn was partly based on an earlier survey of board members in 5 provinces[4].

Many regionalized systems throughout Canada are now close to a decade old and their decision makers have accrued significant experience.

Although regionalization is often described as a single policy innovation, in practice there are wide variations in its implementation across Canada. In addition, in the last two years in particular there have been significant modifications to the regionalization models initially implemented in British Columbia, Alberta, Saskatchewan and Quebec. One important trend is that provincial governments appear to be taking back a portion of previously devolved authority, in the name of greater system coherence and accountability and better management of resources. In Quebec, beginning in 2002 regional CEOs are now hired by the provincial government and boards are appointed rather than (indirectly) elected. As of August 1, 2002, Saskatchewan boards are also all appointed, and both British Columbia and Saskatchewan have drastically reduced their number of RHAs. An exception to this trend is Alberta, which initiated elected boards in 2001. However, Alberta has recently announced its once 17 RHAs will be consolidated into 9 by April 1, 2003. Table 1 provides selected structural features of the various regionalized systems in Canada as they existed at the time of our survey in the fall of 2001, and any major changes that have since been introduced or announced.

Although regionalization is referred to as a single policy innovation, in practice there are wide variations in its implementation across Canada.

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1 For the purposes of our work, we define regionalized systems as those with sub-provincial, geographically defined areas with governance and administrative structures (e.g., Regional Health Authorities, District Health Boards, *Régies régionales de la santé et des services sociaux*, and Hospital Corporations) responsible for operating a defined range of services under guidelines and policies established by the province. The degree of latitude over resource allocation and policy varies across provinces. In non-regionalized health systems, provincial or territorial ministries control funding and governance of health services.

2 CCARH was formerly the HEALNet Regionalization Research Centre and before that HEALNet Regional Health Planning.

3 Kouri D, Dutchak J, Lewis S. *Regionalization at Age Five: Views of Saskatchewan Health Care Decision Makers*. HEALNet Regional Health Planning. Saskatoon. 1997.

4 Lomas J, Veenstra G, Woods J. Devolving authority for health care in Canada's provinces: 3. Motivations, attitudes and approaches of board members. *CMAJ* 1997; 156(5): 669-76.

Table 1. Structural Features of Regionalization in Canada*

	Established	Structural Features and Recent Changes
British Columbia (BC)	1997, restructured 2001	There are 5 RHAs (covering 16 Health Service Delivery Areas) and 1 Provincial Health Service Authority. However, at the time of the survey, there were 11 Regional Health Boards, 34 Community, Health Councils and 7 Community Health Services Societies. In December 2001, the province announced plans to restructure.
Alberta (AB)	1994	At the time of the survey there were 17 RHAs and one mental health authority. By April 2003 there were 9 RHAs. At the time of the survey, Board Members were all appointed, but knowing they were to be replaced shortly by a board that was 2/3 elected and 1/3 appointed. However, as of April 2003, board members are again all appointed.
Saskatchewan (SK)	1992, restructured 2002	There are 12 regional health authorities and board members are appointed. However, at the time of the survey, there were 32 health districts, with two-thirds of board members elected and one-third appointed.
Manitoba (MB)	1997 - 1998	There are 11 RHAs with appointed board members. At the time of the survey, there were 12 RHAs.
Ontario		Not regionalized
Quebec (QC)	1989 – 1992, restructured 2001	There are 18 RHAs. Board members and regional CEOs are appointed by the province. CEOs are accountable jointly to the Deputy Minister and the regional board. However, at the time of the survey board members were elected by a representative caucus of stakeholders and CEOs were appointed by the RHA board.
Nova Scotia (NS)	1996, restructured 2001	There are 9 District Health Authorities, with appointed boards (although two-thirds of the members are nominated by Community Health Boards.)
New Brunswick (NB)	1992, restructured 2002	There are 8 RHAs, which at the time of the survey were Hospital Corporations. Board members are appointed. (In 2004, boards will shift from being all appointed to 8 elected and 7 appointed members.)
Prince Edward Island (PE)	1993 - 1994	At the time of the survey, there were 5 RHAs. There are now 4 RHAs, with mixed elected and appointed members and a Provincial Health Services Authority responsible for secondary and tertiary acute care services.
Newfoundland (NF)	1994	There are 6 institutional health boards, 4 health and community services boards, 2 integrated boards, a Nursing Home Board and a Cancer Treatment and Research Board. Board members are appointed.
Northwest Territories (NT)	1988 -1997, restructured 2002	There are 7 health and social service authorities with appointed members.
Yukon Territory		Not regionalized
Nunavut		Not regionalized

* In this second printing, Table 1 has been updated as of April 2003.

B. SURVEY METHODS

The CCARH survey was conducted in late 2001 and early 2002. Three versions of a mail out survey were developed: one for RHA board members, one for RHA chief executive officers (CEOs) and RHA senior managers, and one for senior managers within the health ministries. The three surveys were largely the same, with slight wording variations to make the questions more appropriate to the target group. The surveys asked approximately 30 questions, covering a variety of topics. The surveys asked respondents their opinions on issues such as: RHA size, authority and accountability, health system reform, board decision making, health system funding, and board composition. Most questions were asked in a closed-ended format, with respondents circling a number on a Likert scale to indicate their opinions.

Three versions of a mail out survey were developed, one for RHA board members, one for CEOs and senior managers, and one for senior managers within the health ministries.

We sent questionnaires to all RHA board members, CEOs (with 9 extras to distribute amongst their senior management team and instructions for getting extras, if needed), and participating health ministries[6] between September of 2001 and March of 2002, depending on the decision-maker group. Respondents were given approximately three weeks to reply. We sent reminder post cards approximately two weeks after the initial survey mailing, and a second, duplicate survey to non-responders after the initial due date. Wherever possible, we sent questionnaires to named individuals with specific addresses, although in some cases we had a central contact who would then distribute for us. Appendix A provides a more detailed description of our survey methodology.

The recent changes in regionalization structures in some provinces affected our survey. Several of the changes were being announced or implemented as we carried it out. Alberta boards were in their transition from exclusively appointed boards to combined elected and appointed boards, which meant a large turnover in membership. We wanted to capture the opinions of existing board members, so we advanced our mailing date to ensure they would receive our questionnaire while still in their positions. In Quebec, the board members were still in their positions when the questionnaires were mailed, but they had received notice of the forthcoming changes. In Saskatchewan, board members were still in place, but had received notice of the intention to combine 32 health districts into 12 regions. In British Columbia, the announcement of the reduction to 5 RHAs came toward the end of the period the survey was in the field.

The recent changes in regionalization structures in some provinces carry implications for our survey.

6 The Alberta ministry did not participate.

Response Rates

Overall response rates for the decision-maker groups were as follows: 50% for board members, 52% for CEOs in RHAs and 38% for health ministries[7]. These rates varied across provinces (Table 2). In particular, Alberta and Quebec had low board member response rates, likely due to the transition issues described above. The Northwest Territories had particularly low response rates for boards and CEOs. In British Columbia only 24% of ministry staff responded, in Manitoba only 3 ministry staff responded and in New Brunswick none responded. The Alberta ministry had declined to participate.

Table 2. Response Rates by Province/Territory

	Board			CEO			Ministry		
	Rec'd	Total	Response Rate	Rec'd	Total	Response Rate	Rec'd	Total	Response Rate
	#	#	%	#	#	%	#	#	%
BC	85	157	54	6	11	55	18	75	24
AB	54	210	26	8	17	47	-	-	-
SK	229	330	69	21	33	64	10	20	50
MB	95	145	66	5	12	42	3	10	30
QC	95	349	27	7	18	39	8	20	40
NS	73	110	66	7	9	78	12	17	71
NB	67	102	66	5	8	63	0	15	0
PE	27	38	71	4	5	80	6	10	60
NF	85	153	56	6	14	43	8	24	33
NT	16	77	21	2	9	22	16	24	67
Unknown	9								
Total	835	1671	50	71	136	52	81	215	38

A small majority (54%) of board respondents were male and most were between 45 and 64 years of age (68%). A small majority had been with their board longer than three years (53%). Four in ten were past or present workers in the health care field (40%).

The large majority of CEO respondents were male (85%), between the ages of 45 to 64 years of age (85%). The majority of CEOs had been with their RHA longer than three years (57%), but fewer than half as CEO (41%). Four in ten had been employed as health care workers (39%).

A majority of ministry respondents were male (57%) and most were between 45 to 64 years of age (74%). Most respondents had been with their ministry longer than three years (68%), but only a third in their present position (31%). Almost four in ten had been employed as health care workers (37%).

[7] The RHA senior manager response rate, not shown in Table 1, was 35%, lower than the other three groups. It became evident that the distribution of the surveys to senior managers had not been consistent across the provinces. This problem, in addition to the relatively low response rates for this group, indicated more follow up work would be required. An initial comparison of the CEO and senior manager responses revealed that the responses of senior managers were similar to those of the CEO group. Therefore, for this report, the senior manager results have not been included in the analysis.

Survey Limitations

The main limitation of this survey is the low response rates in some provinces. Although these rates will have less effect on the representativeness of the findings for the pooled respondent data reported by decision-maker group in Sections C.1 and C.3, they have implications for the interprovincial variation reported in Section C.2.

The low board member response in Quebec and Alberta and the low to nil response for the BC, Manitoba, Alberta and New Brunswick ministries are important to bear in mind when reviewing the results of interprovincial variation. Although we considered completely excluding these provinces from the discussion of interprovincial variation, we concluded that the responses were of sufficient interest that we should report as much of the data as possible, along with this cautionary note. However, we excluded the Manitoba ministry responses, judging 3 respondents to be too few to report. We also excluded the Northwest Territories from the interprovincial comparisons, because two of the three decision-maker groups had very low rates. The Northwest Territories results are included in the pooled data, however.

Because of these issues with the response rates, we limited our discussion of interprovincial variation to a descriptive, rather than a statistical, analysis. However, we have reported statistical tests of significance in our analysis of the responses of the different decision-maker groups in Section C.1.

Because we surveyed all members in our population, response bias will not result from the sampling procedure, but rather potentially from differences between respondents and non-respondents. That is, it is possible and even likely that those who decided to respond to the survey would be those who have the strongest opinions on, or a particular interest in, the issues assessed in our survey. However given the nature of the survey it is difficult to speculate with confidence as to whether respondents' views are different in direction as well as intensity from those of non-respondents.

Finally, it is important to note that the changes underway in BC, Alberta, Saskatchewan and Quebec would likely have affected not only our response rate, but also the tenor of the responses we did receive. In Quebec, in particular, board respondents' comments carried a note of bitterness about the changes being introduced.

C. FINDINGS

Our survey measured decision-maker opinions on selected issues in health system reform and regionalization. The report first presents findings on questions of authority and accountability, then moves to questions of local control and stakeholder involvement in decision-making. We conclude with our respondents' assessments of the overall effects of reform.

In Section C.1 we report the findings for the three decision-maker groups, and discuss differences in response patterns. Where appropriate, we compare our current findings with those of our previous 1997 Saskatchewan survey and of the 1995 five-province survey conducted by Lomas et al. In Section C.2 we present selected results on interprovincial variation, and in Section C.3 we explore the board member findings on quality.

C.1 Differences by Decision-Maker Group

C.1.1 Accountability and Authority

The extent of devolution has been contentious and unstable in many provinces.

Although regionalization had many associated characteristics, its essential feature was the devolution of authority, a structural change intended to shift authority and accountability for at least a part of the health system away from the provincial ministry and toward the regional authority. Combined with this devolution was a centralization of authority at the regional level, with authority "devolved upward" from local programs, facilities, and boards. From this change was to flow more effective programming through better identification of needs and better resource allocation. As discussed, the extent of devolution has been contentious and unstable in many provinces, with provincial ministries appearing to "retake" devolved authority, or at least a portion of it. Provincial ministries have frequently overruled RHA decisions, either at their own initiative or in response to citizen advocacy. Our questions on accountability and authority sought decision-maker opinion about both the clarity and extent of the devolution.

Only one-third of CEO and ministry respondents indicated that the division of authority was clear, and large majorities felt that residents had a tendency to bypass RHA boards.

Only one-third of CEO and ministry respondents indicated that the division of authority was clear, and large majorities felt that residents had a tendency to bypass RHA boards (Table 3). Board members themselves were relatively more sanguine on these topics, being evenly divided on the question of clarity, and just over half agreeing that residents had a tendency to bypass the RHA board.[8]

8 For decision-maker groups, differences discussed were significant at a.01 probability level, most in a standard 2 X 2 Chi-Square table with 1 degree of freedom (items on local control and health system quality were 3 X 2 tables with 2 degrees of freedom).

Table 3. The Provincial-Regional Division of Authority

	Per cent of respondents in agreement[9]		
	Boards	**CEOs**	**Ministries**
Clarity:			
The division of authority between RHAs and the Ministry of Health is clear.	50[ab]	31	32
If residents of a region do not support a board decision they take their complaints to the provincial ministry or government.	58[ab]	87	96
Extent of devolution:			
Boards are legally responsible for things over which they have insufficient control.	77[b]	80[c]	59
Boards are too restricted by rules laid down by the provincial/territorial government.	71[b]	70[c]	30
Boards have less authority than I expected.	63[b]	64[c]	33

a = boards are significantly different from CEOs
b = boards are significantly different from ministries
c = CEOs are significantly different from ministries

The majority of board member and CEO respondents agreed that RHA boards had less authority than they should, while far fewer health ministry respondents agreed.

A different pattern emerged with respect to the extent of devolution and RHA authority. Here, the majority of board member and CEO respondents agreed that RHA boards had less authority than they should, while far fewer health ministry respondents agreed.

Trends in perceptions of clarity and extent of devolution

Saskatchewan results show a marked decrease from 1997 to 2001 in the belief that the division of authority is clear.

The clarity issues, in particular, have intensified over time. Saskatchewan results (Table 4) show a marked decrease from 1997 to 2001 in the belief that the division of authority is clear. This is the case for all three decision-maker groups. In 1997, Saskatchewan ministry respondents tended to disagree with RHA-based decision makers that boards were legally responsible for things over which they have insufficient control, that they had less authority than expected, and that they were not too restricted by government rules. By 2001 ministry respondents' views aligned more closely with the others on these questions.

Comparison with the 1995 survey by Lomas *et al.* at least partially confirms this trend in four additional provinces (BC, AB, PE and NS, as well as SK). In 1995, 49% of respondents agreed boards were too restricted by government rules. By 2001, 72% agreed.

9 The percentages of people agreeing with a particular item are based on the numbers who responded that they either "moderately" or "strongly agreed" versus those who "moderately" or "strongly disagreed". Those who did not respond or who had no opinion were excluded from the percentage calculation.

Table 4: Authority Issues over Time (Saskatchewan)

	Per cent of respondents in agreement[10]	
	1997	**2001**
The division of authority between RHAs and the Ministry of Health is clear.		
Board Members	53	37
CEOs/Senior Managers	29	10
Ministry of Health	47	10
Boards are legally responsible for things over which they have insufficient control.		
Board Members	76	82
CEOs/Senior Managers	84	90
Ministry of Health	36	70
Boards have less authority than I expected.		
Board Members	57	69
CEOs/Senior Managers	68	71
Ministry of Health	30	40
Boards are too restricted by rules laid down by the provincial government.		
Board Members	63	76
CEOs/Senior Managers	81	91
Ministry of Health	24	40
Board members BC, AB, SK, NS, PE (1995)	49	72

C.1.2 Local Control and Stakeholder Influence

Devolution of authority implies a shift in accountability. Regionalization was intended to increase regional control over health-care decision making, which would also imply increased accountability to regional constituencies. Some critics of regionalization have argued that regional control would result in local interest groups dominating decision making, that boards would not be able to withstand the pressure placed on them by vested interest groups, and that elections could activate single-issue constituencies (e.g., anti-choice lobbies, groups opposing facility closures, etc.) that would hijack boards and polarize communities. We were interested in decision-makers' assessment of a shift in local control and their opinions of the relative influence of different stakeholders on board decision-making.

Nearly seven in ten ministry respondents thought local control had increased, compared to slightly fewer than half of RHA respondents.

More respondents in each of the three groups perceived that health reform had increased rather than decreased local control (Table 5). However, nearly seven in ten ministry respondents thought that it had increased, compared to slightly fewer than half of RHA respondents. Board members in particular were somewhat skeptical about the effect on local control – roughly four in ten thought it had decreased. This latter opinion could be due to the fact that regionalization, while devolving provincial authority to regions, centralized the even more local authority of hospital boards and other facilities. This aspect of regionalization would likely be less palpable to ministry personnel. Board members might define "local" in narrower community terms, while ministry personnel may not distinguish between "regional" and "local" .

10 See footnotes 3 and 4 for sources. Note that 1997 Saskatchewan results include both CEOs and senior managers.

Table 5. Effect on Local Control

	Per cent of respondents in agreement		
	Boards[b]	**CEOs**	**Ministries**
Thinking back over the last few years, what do you think have been the effects of health reform in your province/territory on local control over health care services?			
Decrease	38	28	15
No effect	16	23	17
Increase	46	49	68

b = boards are significantly different from ministries

Over time, Saskatchewan respondents in all three groups have become less convinced that health reform has increased local control. Board members' agreement dropped from 63% in 1997 to 47% in 2001, CEO/senior managers from 66% to 57% and ministry respondents from 93% to 70% (these Saskatchewan-specifc results not shown in table).

Only a quarter of RHA board member and CEOs respondents felt that boards were unduly influenced by citizens, interest groups and vested interests (Table 6). By contrast, about three-quarters of Ministry respondents agreed that interest groups and vested interests have too big a say in board decisions and 43% felt that board members defer to citizen opinion even if it conflicts with what they perceive to be the right decisions.

The majority of ministry respondents believed that interest groups and vested interests had too big a say in board decisions.

Table 6. Citizen and Stakeholder Influence on Board Decisions

	Per cent of respondents in agreement		
	Boards	**CEOs**	**Ministries**
Citizens, interest groups and vested interests:			
Even if a decision is opposed by the majority of citizens in the community, board members support it if they believe it is the right decision.	83[b]	90[c]	57
Interest groups sometimes force boards to make decisions they would not otherwise make.	28[ab]	43[c]	82
Vested interests have too big a say in board decisions.	25[b]	27[c]	71
Provider influence:			
Physicians are more influential than other residents in influencing board decisions.	47[ab]	66	82
Nurses and other health care providers are more influential than other residents in influencing board decisions.	39[ab]	60	55

a = boards are significantly different from CEOs
b = boards are significantly different from ministries
c = CEOs are significantly different from ministries

Only a minority of board members felt that physicians or nurses had more influence on their decisions than other residents, while CEOs tended to agree that both groups were more influential. Ministry respondents were even more likely to report feeling that physicians had more influence than other residents, while attributing less influence to nurses.

These findings are consistent with those presented above on the devolution of authority. Ministry personnel tend to be skeptical of board abilities to withstand stakeholder influence. This is in stark contrast to board member self-evaluations, and to a lesser extent, CEO assessments of stakeholder influence.

Comparison with the Lomas *et al*. survey indicates that, at least for the five provinces included in that survey, boards' decision-making stance has remained consistent. In 1995, 84% of respondents agreed that they would support the right decision notwithstanding resident disagreement and in 2001, 85% agreed.

C.1.3 Assessment of Health Reform and its Impact

The 1990s saw major reform to all provincial and territorial health systems. Regionalization was one aspect of this reform (other components included health budget stabilizations or cut backs, shifting focus from disease and illness treatment to prevention and health promotion, and a shift from institutional care to community-based care). However, the two are often used interchangeably. Our survey, to be consistent with past surveys, asked respondents about their views of health reform.

Survey respondents generally were pre-disposed to health reform.

Survey respondents generally were positively disposed toward health reform. Only a minority agreed with the statement that there was no need for the extensive health reform of the 1990s (Table 7). However, the majority was of the opinion that health reform had more to do with dollars than with improving health. An even larger majority among all three decision-maker groups also agreed that any new money should go to promotion and prevention activities.

Table 7: Beliefs about Health Reform

	Per cent of respondents in agreement		
	Boards	**CEOs**	**Ministries**
There was no need for the extensive health reform of the 1990s.	22[a]	9	13
Health reform has more to do with controlling or reducing government spending than improving health.	62	65	55
If new money were to be made available to regional health authorities, the majority of it should be allocated to health promotion and illness prevention activities as opposed to those aimed at treating disease and illness.	71	70	81

a = boards are significantly different from CEOs

The majority of respondents believed the changes made with health reform were for the best.

Respondents were generally positive about the effects of health reform. The majority agreed the changes made with health reform were for the best (Table 8). For all three decision-maker groups, more were of the opinion that the quality of the system had increased than decreased. And the majority believed that neither their specific region, in the case of boards and CEOs, nor RHAs in general in the ministry's case, had lost out with health reform. Nevertheless about a third of the respondents expressed more negative views – board members in particular.

Table 8. Assessment of the Impact of Health Reform

	Per cent of respondents in agreement		
	Boards	**CEOs**	**Ministries**
In general, the changes made over the last decade with health reform have been for the best.	69[a]	84	66
Our region/the regions served by RHAs lost out with the health reform of the 1990s.	38[ab]	22	20
Thinking back over the last few years, what do you think have been the effects health reform in your province/territory on the quality of the health care system?	**Boards**[ab]	**CEOs**	**Ministries**
Decrease	36	13	22
No effect	18	26	38
Increase	46	61	40

a = boards are significantly different from CEOs
b = boards are significantly different from ministries

For all three decision-maker groups, more were of the opinion that the quality of the system had increased than decreased

About a third of the respondents expressed more negative views – board members in particular.

Comparison to previous surveys indicates that, in Saskatchewan, assessment of the effect on quality has remained relatively stable, and continues to be positive (Table 9). There were no comparable questions from the Lomas *et al*. survey.

Table 9: Assessment of Health Reform Impact over Time (Saskatchewan)

	Per cent of respondents in agreement[11]	
	1997	**2001**
In general, the changes made over the last decade with health reform have been for the best.		
Board Members	82	79
CEOs/Senior Managers	91	91
Ministry of Health	90	80
Our region/the regions served by RHAs lost out with the health reform of the 1990s.		
Board Members	27	29
CEOs/Senior Managers	21	18
Ministry of Health	-	11
Health reform has resulted in an increase in the quality of the health care system.		
Board Members	47	55
CEOs/Senior Managers	53	57
Ministry of Health	49	63

11 See footnotes 3 and 4 for sources. Note that 1997 Saskatchewan results include both CEOs and senior managers.

C.2 Interprovincial Variation

Overall, no province was consistently different from the rest.

In this section, we examine the interprovincial variation in opinions about devolution of authority and the impact of health reform on the quality of the system. We first present the findings graphically to illustrate the interprovincial patterns. At the end of the chapter, we summarize the findings by province in a single table.

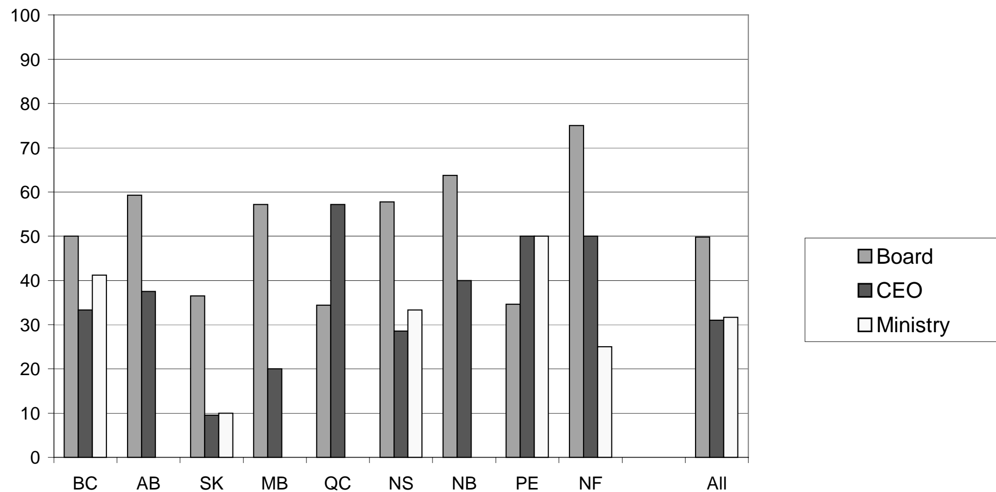
The discussion is more descriptive than statistical and we have noted the more salient differences[12]. However, although there are some interesting patterns, overall there was no indication of a single province being a consistently different from the rest.

We remind the reader to bear in mind, when reviewing the results of interprovincial variation, the low board member response rates in Quebec and Alberta and the low to nil response for ministries in British Columbia, Manitoba, Alberta and New Brunswick. We have not included the Manitoba ministry respondents because they were too few. In addition, Northwest Territories results are not included at all in the inter-provincial tables because two of the three decision-maker groups had very low response rates.

Saskatchewan, Quebec and PEI board respondents felt that the division of authority is not clear.

In the last section we saw that exactly half of board respondents across Canada agreed that division of authority between RHAs and the ministry of health is clear. However, Figure 1 shows that in Saskatchewan, Quebec and PEI, only a minority of board respondents felt it is clear. These three provinces have the most long-standing regional systems; they are also where electoral systems were in place at the time of the survey. Further, as we noted above, Saskatchewan and Quebec were changing to all-appointed boards around the period the survey took place.

Figure 1: Percent of respondents agreeing that the division of authority between RHAs and the ministry of health is clear, by province[13]



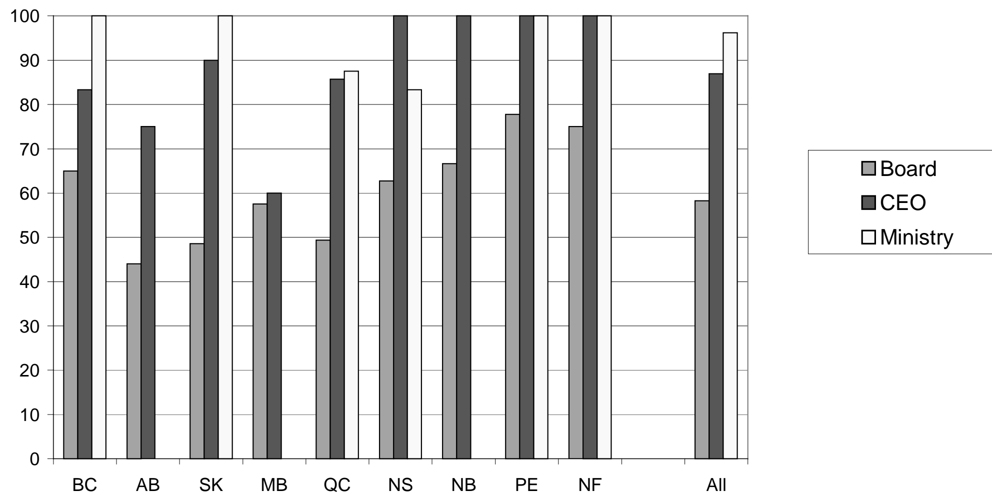
[13] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons. In Quebec, none of the eight ministry respondents agreed with the statement.
.

The national finding discussed in the preceding section – that CEO and ministry respondents perceived less clarity than did boards – was true for most provinces. However, in PEI, the situation was reversed – ministry and CEO respondents perceived more clarity than board respondents. In Quebec, CEOs were more convinced of clarity than boards, but Quebec ministry respondents were aligned with other ministry respondents in feeling the division of authority was not clear.

At least 80% of ministry respondents in all provinces (where ministries responded) believed residents take their complaints to the ministry over the RHA.

There was a widely held view, with little provincial variation at the ministry or CEO levels, that residents take their complaints to the ministry, bypassing the RHA (Figure 2). The finding was especially strong for ministry respondents – at least 80% in all provinces (where ministries responded) agreed that residents take their complaints to the ministry over the RHA.

Figure 2: Percent of respondents agreeing that if residents of a region do not support a board decision they take their complaints to the provincial ministry, by province[14]



In Alberta, only a minority of board members agreed that residents take their complaints to the ministry over the authority of the RHA.

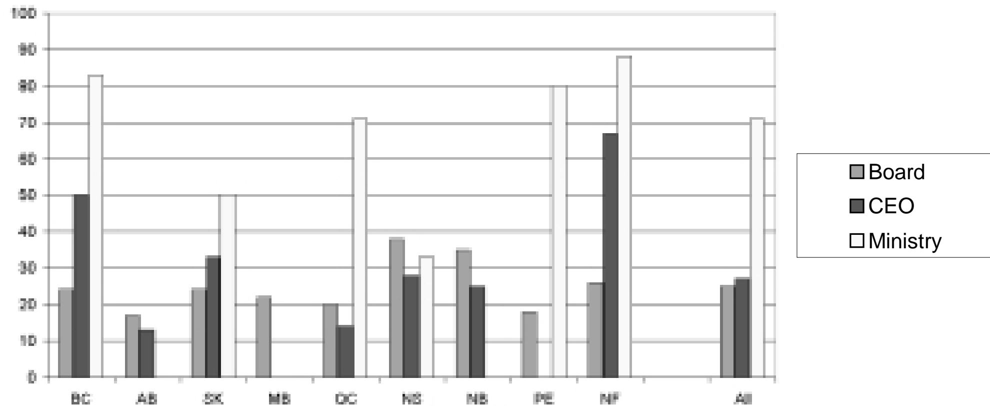
There was, however, some interprovincial variation at the board level. In Alberta, only a minority of board members agreed with this view. And only half of Saskatchewan and Quebec board members agreed.

There was a similar pattern in the perceptions of vested interests having too big a say in board decisions. Two-thirds of all ministry respondents, but only a quarter of RHA respondents believed vested interests have too big a say in board decisions. This finding was consistent across most provinces (Figure 3), with the exceptions of Nova Scotia, where only a third of ministry respondents held this view and to a lesser extent Saskatchewan, where half the ministry respondents held this view.

[14] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons.

Most ministry respondents believed vested interests had too big a say in board decisions.

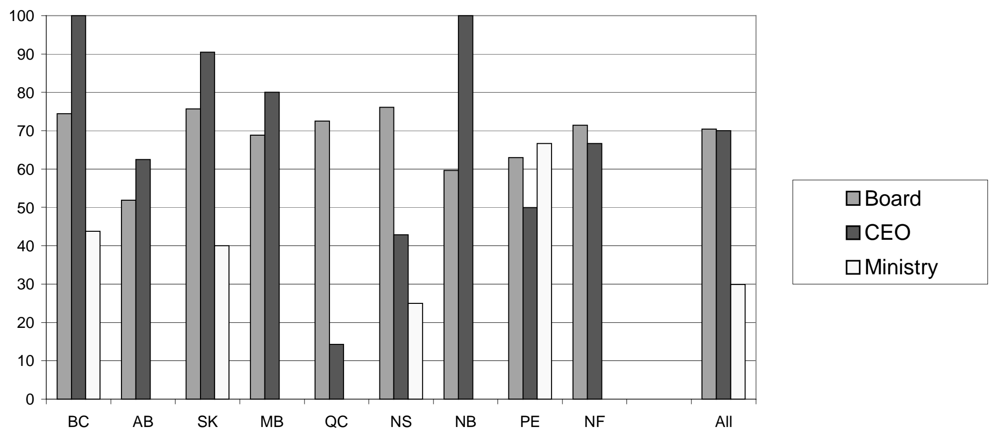
Figure 3: Percent of respondents agreeing that vested interests have too big a say in board decisions, by province[15]



Nationally, although a majority of board and CEO respondents agreed that boards are too restricted by rules laid down by the provincial government, most ministry respondents disagreed. This pattern was true for most provinces (Figure 4). Exceptions were PEI and Quebec. In PEI, ministry respondents' views were closer to those of their RHA counterparts.

Quebec CEOs and Quebec ministry respondents did not believe that boards are too restricted by rules laid down by the provincial government.

Figure 4: Percent of respondents agreeing that boards are too restricted by rules laid down by the provincial government, by province[16]



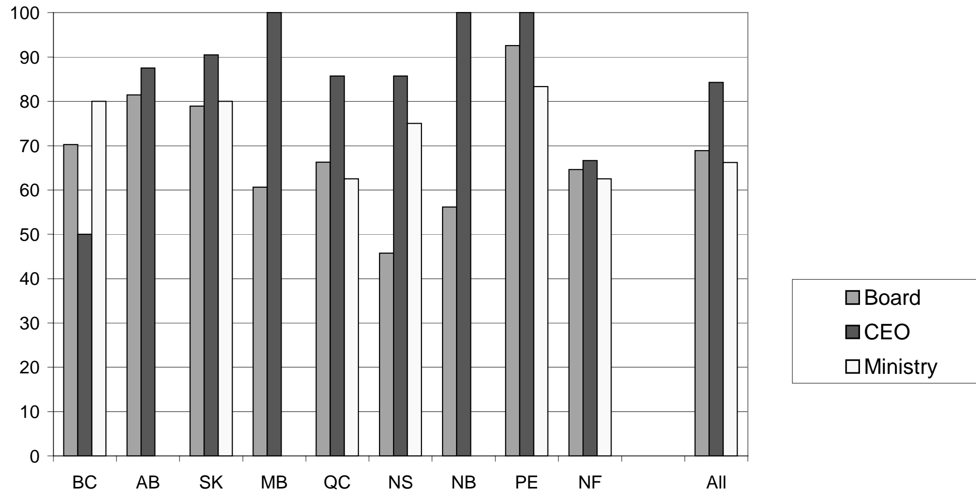
In Quebec, it is the CEOs who are most distinct from their counterparts across the country. Only a small minority believed that boards are too restricted by rules laid down by the provincial government. Their views align more closely with those of most ministry respondents across Canada including their own. None of the Quebec ministry respondents agreed that boards are too restricted.

[15] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons.
[16] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons. In Quebec and Newfoundland, none of the ministry respondents agreed with the statement.

PEI respondents were the most positive across the three decision-maker groups about health reform having been for the best (Figure 5). Saskatchewan was the next consistently most positive. No province had on balance a negative view, and Nova Scotia board respondents were the only group where fewer than half agreed that health reform was for the best.

PEI respondents were the most positive about health reform having been for the best. However, no province deviated from a generally positive pattern.

Figure 5: Percent of respondents agreeing that health reform was for the best, by province[17]



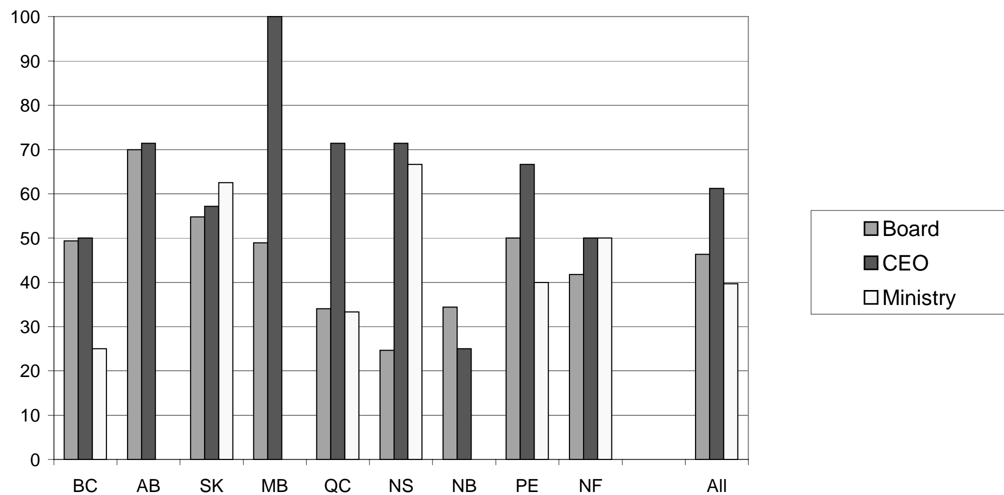
All three decision-maker groups were also positive, on the whole, in their assessments of whether health reform has resulted in an increase (versus a decrease or no effect) in the quality of the health care system (Figure 6).

[17] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons.

Western province board respondents expressed more favourable assessments than eastern ones.

Moving east from a peak in Alberta, the rate of positive assessment by board members drops steadily to reach its lowest point in Nova Scotia.

Figure 6: Percent of respondents agreeing that health reform has resulted in an increase in quality of the health care system, by province[18]



Generally, CEOs were most positive in their assessment, followed by boards, then ministries. However, there was some interprovincial variation on this question. In Saskatchewan, ministry respondents were the most positive group of a generally positive overall response. And Nova Scotia ministry respondents were the most positive of all the provinces in their assessment of the impact on quality.

In Quebec, CEO respondents were the only group with a favourable assessment – only about a third of Quebec RHA and ministry respondents believed health reform had resulted in an increase in quality of the health system.

Board responses follow an interesting pattern. Western provinces expressed more favourable assessments than eastern ones. Moving east from a peak in Alberta, the rate of positive assessment dropped steadily to reach its lowest point in Nova Scotia.

Nova Scotia board members were the most negative in their assessment, in contrast to the very positive CEO and ministry respondents from that province. In New Brunswick, neither board nor CEO respondents had favourable assessments (New Brunswick did not have ministry respondents). PEI board respondents, however, were somewhat more positive than their Atlantic counterparts, consistent with their positive responses about health reform being for the best.

[18] There were no ministry respondents in Alberta and New Brunswick and Manitoba ministry respondents were too few to be included in the interprovincial comparisons.

Table 10: Response Overview by Province

Prov-ince	Selected features, from Table 1	Response overview
BC	RHAs were established in 1997, and restructured in 2002. In December 2001, the province announced plans to restructure to 5 RHAs.	BC generally followed the national pattern on the five questions discussed in this section: • Board members did not have strong opinions about the clarity of the division of authority and a majority did not believe vested interests had too big a say in board decisions. Most believed that residents tended to bypass RHAs in taking complaints to the ministry of health. Most also believed boards were too restricted by the provincial government. They were more positive than negative about health reform impact on quality. • Most CEOs believed the division of authority was not clear and that boards were too restricted but they were very positive about impact. • Most ministry respondents felt the division of authority was not clear. However, they did not agree that boards were too restricted and they felt vested interests had too big a say in board decisions. They were more positive than negative about impact.
AB	RHAs were established in 1994. Shortly after the survey was administered, 2/3 of board members were replaced with elected members. Board survey respondents were from the pre-change era but aware of the planned change.	Alberta respondents were more positive than most, board members in particular. • Most board members believed the division of authority between province and RHA was clear, and the majority did not believe residents tended to bypass RHAs. They were very positive about impact. And only a small majority believed that boards were too restricted. • Most CEOs believed the division of authority was not clear and that boards were too restricted, but they were very positive about impact. • There were no Alberta ministry respondents.
SK	RHAs were established in 1992, and restructured in 2002, from 32 to 12 in number, replacing most board members. RHA survey respondents were from the pre-change era but aware of planned change.	Saskatchewan respondents were positive about impact but negative on clarity. • Most board members did not agree the division of authority was clear, but only half believed residents tend to bypass RHAs. Most agreed that boards are too restricted by the provincial government. However, their assessment of impact was positive. • Most CEOs believed the division of authority was not clear, and that boards were too restricted, but they were very positive about impact. • Most ministry respondents were negative about the level of clarity, and all agreed that residents bypass RHAs. However, most did not agree that boards were too restricted and only half believed vested interests had too big a say in board decisions.. They were very positive about impact.
MB	RHAs were established in 1997 and 1998.	Manitoba respondents were positive about impact but negative on clarity. • Most board members believed that the division of authority between province and RHA was clear, but believed that residents tended to bypass RHAs. They were more positive than negative about impact. However, a majority also believed that boards were too restricted. • Most CEOs believed the division of authority was not clear, that boards were too restricted and were very positive about impact. • Ministry respondents were too few to report.

Table 10: Response Overview by Province (contd)

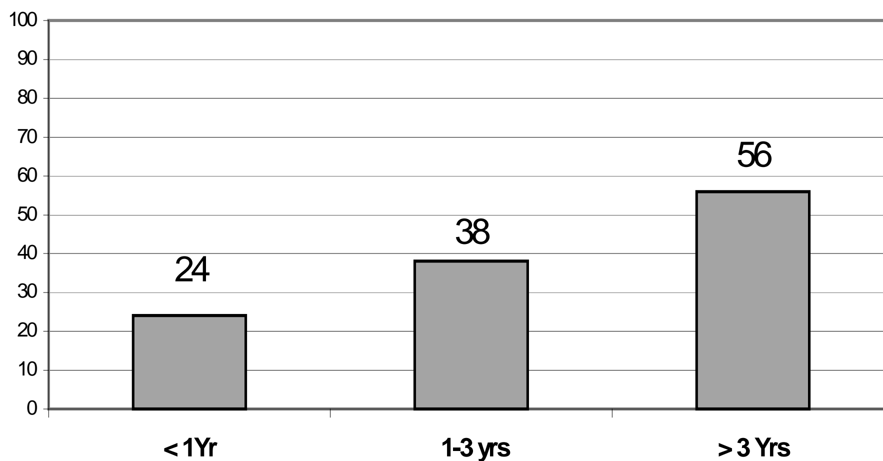
QC	RHAs were established in 1989. In 2001, it was announced that all board members would be replaced with appointed members and CEOs appointed by the ministry. RHA survey respondents were from the pre-change era but aware of the planned change.	Only Quebec CEO respondents were positive in their assessments. Board and ministry respondents were not. • Most board members did not agree the division of authority was clear, but only half believed residents tend to bypass RHAs. Most agreed that boards are too restricted by the provincial government. Their assessment of impact was more negative than positive. • Most CEOs believed the division of authority was clear, but most also believed that residents tend to bypass RHAs. Most did not believe boards were too restricted, and they were very positive about impact. • All ministry respondents were negative about the level of clarity, and most agreed that residents bypass RHAs. However, none believed that boards were too restricted. Half were negative and half positive about impact.
NS	RHAs were established in 1996, but restructured in 2001. RHA respondents were from the post-change era.	Nova Scotia board members were negative in their assessments but CEO and ministry respondents were positive. • Most board members believed that the division of authority between province and RHA was clear, but believed that residents tended to bypass RHAs. Most agreed that boards are too restricted by the provincial government. Their assessment of impact was more negative than positive. • Most CEOs believed that the division of authority was not clear. However, most did not believe boards were too restricted. They were very positive in their assessment of impact. • Like the CEOs, most ministry respondents did not agree that the division of authority was clear, but most did not believe boards were too restricted and only a minority agreed that vested interests had too big a say in board decisions. They were also very positive about impact.
NB	A form of regionalization was established in 1992 but with less formal integration than in other provinces.	New Brunswick respondents tended to be negative. • Most board members believed that the division of authority between province and RHA was clear, but believed that residents tended to bypass RHAs. Most agreed that boards were too restricted by the provincial government. Their assessment of impact was more negative than positive. • Most CEOs did not agree that the division of authority was clear. However, all respondents felt that boards were too restricted. They were more positive than negative in their assessment of impact. • There were no ministry respondents from New Brunswick.
PE	RHAs were established in 1993 – 1994 with mixed elected and appointed members.	Prince Edward Island respondents were negative on clarity but somewhat positive on impact. • Most board members did not agree the division of authority was clear and most agreed that boards are too restricted by the provincial government. Their assessment of impact was positive. • Only half the CEOs believed the division of authority was clear, and all believed that residents bypass RHAs. Only half believed that boards were too restricted, and they were very positive about impact. • Only half the ministry respondents were negative about the level of clarity, and all agreed that residents bypass RHAs. Most believed that boards were too restricted, but they were positive about impact.
NF	A form of regionalization was established in 1994, but with less formal integration than in other provinces.	Newfoundland respondents were equivocal. • Most board members believed that the division of authority was clear, but that residents tended to bypass RHAs. Most agreed that boards were too restricted. As many were negative about impact as were positive. • Only half the CEOs believed the division of authority was clear and all believed that residents bypass RHAs. Most believed that boards were too restricted but most assessed the impact of reform positively • Most ministry respondents did not agree the division of authority was clear and all believed that residents bypass RHAs. As many were negative as positive about impact.

C.3 Board Members and Health System Quality

For board members, those with a longer period of time on the health board tended to have a more positive assessment of health reform's impact.

In the preceding section, we described the interprovincial variation in respondents' assessment of the impact of health reform. In this section, we explore individual factors in relation to respondents' assessments. We found that members with longer tenure on the board tended to have a more positive assessment of health reform's impact (Figure 7).[19] The relationship was evident in all provinces, although stronger in some than others.

Figure 7: Percent of board respondents agreeing that health reform has resulted in an increase in quality of the health care system by length of tenure on the board[20]



There was also a strong relationship between a positive assessment and board members' support for health reform. For example, of those who agreed that health reform was not needed, only 16% felt system quality had improved with health reform, compared to 56% of those who believed it was needed.

The factors contributing to respondent assessments of quality will be the topic of further study. Findings so far suggest that respondents' assessment of the impact on quality may be related less to what has actually happened in their health authority than to their expectations and commitments. Those board members more committed to health reform may be more patient with system flaws and those with more experience in the system may have more sober expectations. Those with longer experience would certainly have different comparators than the others, and be more likely to compare the current and pre-reform situations.

These notions are reflected in respondents' answers to a question at the end of the survey, asking for comments on any aspect of the survey or of their experience with the health system. Although only a few of the comments dealt specifically with the

[19] Because the large majority of CEO and ministry respondents had been with the health sector for more than 3 years, we could not compare the relationship.
[20] Differences by length of board tenure are significant at the .01 level.

quality of the health system, the following excerpts illustrate the relationships discussed above.

In the first example, the following two board respondents both strongly agreed that health reform was necessary. However, the first had been a board member in the health system for 14 years and believed the quality of the health system had improved with health reform.

> Our region functions quite well and has been visited by other regions interested in improving their situation. Our region includes nurses, doctors, other health care providers and consumers in its strategic planning sessions. Health care teams determine patient care and it seems to work well. Our region has integrated acute care, long term care, public health, prevention services and mental health under 1 board. This was achieved through regionalization. Our board meetings are televised and the community we serve seems very happy with services even in the difficult times that exist.

The second, a board member for three years, believed that quality had decreased.

> During the past three years as a regional health board member I feel I have not been able to improve the quality of health care in my region. We spend each meeting discussing budgets and finance, (or lack thereof). As a board member I expected to be able to influence the quality of health care in my region but that has not been my experience. It leaves me with doubts as to whether Health Boards are an efficient way to run health care.

The second example below illustrates how length of tenure is mediated by predisposition to health reform. The first respondent is a long-term board member who felt there was no need for health reform and believed that it decreased the quality of the system.

> Regionalization of health care was made to the detriment of small hospitals. The change was made drastically, not taking into account the local strength so that it may be positively exploited.

By contrast, the following board member had been in his/her position for less than one year, but agreed that health reform was necessary and also believed it had increased the quality of the system.

> Public expectations are too high at times about what health care services can be provided. The expectations do not match provincial funding. Regionalization has a lot of pluses. However, this is not always obvious to the public.

D. IMPLICATIONS

Survey results indicate support among these decision makers for the directions of health reform.. They deemed it financially necessary. They also believed the effects had been positive and that overall it had improved the quality of the system. This support will be important to draw on in continuing reforms.

However, about a third of the respondents had a negative assessment – board members in particular. Among board members themselves, those with longer experience on the board tended to be more positive in their assessment of the impact of health reform. This was perhaps not surprising. More experienced members may understand the system better. It could also be that those who are supportive are more likely to be reappointed or stand for re-election.

Nevertheless, a majority of RHA board and CEO respondents contended that RHAs were too hampered by government restrictions. For them, devolution had not been fully realized. Further, the dissatisfaction with instability surrounding authority and accountability is growing.

In general, respondents from PEI, Saskatchewan and Alberta were the most positive in their assessments of health reform. However, PEI and Saskatchewan also strongly perceived the division of authority as unclear and that accountability to the citizenry was unstable and confused. In this the ministry respondents agreed with their RHA counterparts, which in the case of Saskatchewan revealed a shift in perspective from 1997.

There was an interesting difference on several questions between ministry respondents, and RHA board members and CEOs. Although there were exceptions in some provinces, overall, ministry respondents were more skeptical of the ability of regional health authorities to withstand public and stakeholder pressure. Ministry respondents as a group did not agree that RHAs were too restricted by their provincial governments.

The pattern of response among the three decision-maker groups suggests that many issues may have arisen more from the dynamics of regionalization than from specific developments in each province and territory.

Survey findings might reflect the difficulties provinces have experienced in configuring authority over health care delivery. There have been many shifts in the authority landscape as provinces have sought a more satisfactory pattern. The question of the appropriate division of authority has two dimensions, one about providing effective and efficient health care services and the second about accountability and legitimacy of the system. The second dimension has been more contentious than the first.

The recently released report Commission on the Future of Health Care in Canada (Romanow report) focused on the themes of leadership of, accountability for and

public trust in Canada's health care system[21]. The Commission's mandate was national and it focused on national-provincial relations of authority. However, as these survey findings show, the same issues are present at provincial-regional levels of authority. Although the Romanow report was silent on the question of regionalization, the earlier Kirby report[22] had recommended that the federal government encourage the devolution of additional responsibility to regional health authorities.

Survey findings show support for health reform, especially in the provinces with the most established regionalization structures. However, if this potential is to be realized, provincial governments must provide more stability for regional structures and be clearer about what they expect from regionalization and why. It then follows that they should provide the mechanisms and support to enhance the legitimacy and effectiveness of regional health authorities within the context of a comprehensive health system.

Finally, the differences in perception among the decision makers about the effects of regionalization and health reform reinforce the need for evaluative research to assess these effects, on both health system quality and accountability.

[21] Commission on the Future of Health Care in Canada. *Final Report: Building on Values: The Future of Health Care in Canada*. Ottawa. 2002.
[22] Senate Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians – The Federal Role. Final Report on the state of the health care system in Canada. Volume Six: Recommendations for Reform.* Ottawa. 2002.

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Appendix A. Survey Methodology

Three versions of a mail out survey were developed, one for members of RHA boards, one for CEOs and Senior Managers, and one for senior managers within the ministries of Health. The three surveys were largely the same, with the exception of slight wording variations to make the questions more appropriate to the target group. The surveys asked approximately 30 questions, covering a variety of topics. In addition to basic demographics, the surveys asked respondents their opinions on issues such as: RHA size, authority and accountability, health reform, decision making, funding levels, and board composition. Most questions were asked in a closed-ended format, with respondents circling a number to indicate their opinions.

Survey I - RHA Boards:
Surveys were mailed out to all RHA board members between late September and early October of 2001, and respondents were given approximately three weeks to reply. Reminder post cards were sent out approximately two weeks after the initial survey was mailed out. A second, duplicate survey was then sent to any non-responding board members after the initial due date.

One exception to this protocol was the administration of the survey with Alberta RHA boards. At the time we initiated our survey, Alberta was only three weeks away from holding its first RHA board member elections. Because we were interested in hearing the opinions of experienced board members, we decided to solicit survey responses only from people who were members of Alberta RHA boards prior to the October elections. We therefore mailed surveys to these individuals in late September, and made reminder telephone calls to their RHA offices one week later. Because we could not have delivered duplicate surveys to non-responding board members before their elections, this follow up step did not occur with Alberta RHA boards.

In all cases, whenever possible, mailings were sent directly to RHA board members at their home addresses. In some cases, however, these addresses were not available to us, and we therefore mailed surveys to their respective RHA offices, and asked staff there to forward the mailing on to board members. In all cases, regardless of distribution method, a self-addressed, postage paid, return envelope accompanied each survey, so that respondents could return their completed surveys directly to us, and need not have returned them through their RHA office.

Survey II - CEOs and Senior Managers:
The following is a list of the regional agencies to whom we delivered the RHA CEO and Senior Manager surveys:

- 17 RHAs in Alberta,
- 11 Regional Health Boards in British Columbia (we did not survey their Community Health Councils or Community Health Service Societies),
- 12 RHAs in Manitoba,
- 8 Regional Hospital Corporations in New Brunswick,
- 12 Newfoundland Boards (6 institutional, 4 community and 2 integrated boards – we did not surveys their provincial nursing home or cancer center boards)

- 9 District Health Authorities in Nova Scotia,
- 9 Health and Social Service Boards in the Northwest Territories,
- 5 RHAs in Prince Edward Island,
- 18 régies régionales de la santé et des services sociaux in Quebec, and
- 33 District Health Boards (including its 1 Northern Health Authority) in Saskatchewan.

Ten surveys were mailed out to each CEO of the above listed agencies. Each CEO was asked to complete one and distribute the remaining 9 among those who were in their senior management team, with the definition of this being up to him or her. They were instructed to contact the CCARH office (at our toll free number) to request additional copies of the surveys if more than 9 were needed (although none did so). Surveys were mailed out in late October 2001. Respondents were given approximately three weeks to reply. Reminder post cards were sent out approximately two weeks after the initial survey was mailed out, and a second, duplicate survey was sent to all CEOs after the initial due date. Using the job title question on the survey, CEO survey respondents were identified, and a third duplicate survey was then sent to all non-responding CEOs approximately one month after the initial due date. A self-addressed, postage paid, return envelope accompanied each survey, so that respondents could return their completed surveys directly to us, and need not have returned them through their CEO or RHA office.

Upon analyzing the survey results, it became evident that the distribution of the surveys to senior managers had not been consistent across the provinces. This problem, in addition to the relatively low response rates for this group (35%), indicated more follow up work would be required. An initial comparison of the CEO and senior manager responses revealed that the responses of senior managers were similar to those of the CEO group. Therefore the senior manager results were not been included in the analysis for the initial report.

<u>Survey III - Ministries of Health</u>:
In order to contact senior management teams within the provincial and territorial Ministries of Health, we first solicited the permission and support of the respective Ministers. With the exception of Alberta, all ministries agreed to participate. According to their preferences, we then either mailed the requested number of surveys to a specified ministry contact person, who would then distribute them among their self-defined senior management team, or ministries provided us the names and addresses of their senior management team, and we sent surveys directly to these individuals. In either case, a self-addressed, postage paid, return envelope accompanied each survey, so that respondents could return their completed surveys directly to us, and need not do so through their ministries office.

Surveys were mailed out to the ministries between December 2001 and January 2002, with the exception of Quebec who agreed to participate in February and were surveyed in March. Respondents were given approximately three weeks to reply. Reminder post cards were sent out approximately two weeks after the initial survey was mailed out, and a second duplicate survey was then sent out after the initial due date.

Appendix B. Number of Respondents by Reported Item by Province

This appendix provides the number of respondents for each cell in the report tables where only percentages were reported.

Table 3. The Provincial-Regional Division of Authority

	Number of Respondents		
	Boards	**CEOs**	**Ministries**
Clarity:			
The division of authority between RHAs and the Ministry of Health is clear.	804	71	79
If residents of a region do not support a board decision they take their complaints to the provincial ministry or government.	736	69	79
Extent of devolution:			
Boards are legally responsible for things over which they have insufficient control.	782	70	75
Boards are too restricted by rules laid down by the provincial government.	813	70	77
Boards have less authority than I expected.	809	69	76

Table 4: Authority Issues over Time (Saskatchewan)[23]

	Number of Respondents	
	1997	**2001**
The division of authority between RHAs and the Ministry of Health is clear.		
Board Members	265	219
CEOs/ Senior Managers	133	21
Ministry of Health	89	10
Boards are legally responsible for things over which they have insufficient control.		
Board Members	262	217
CEOs /Senior Managers	137	20
Ministry of Health	81	10
Boards have less authority than I expected.		
Board Members	254	222
CEOs / Senior Managers	133	21
Ministry of Health	80	10
Boards are too restricted by rules laid down by the provincial government.		
Board Members	260	226
CEOs/ Senior Managers	132	21
Ministry of Health	77	10
Board members BC, AB, SK, NS, PE (1995)	*	*

23 See footnotes 3 and 5 for sources. Note that 1997 Saskatchewan results include both CEOs and senior managers.

Table 5. Effect on Local Control

	Number of Respondents		
	Boards	**CEOs**	**Ministries**
Thinking back over the last few years, what do you think have been the effects of health reform in your province/territory on local control over health care services?	786	67	73

Table 6. Citizen and Stakeholder Influence on Board Decisions

	Number of Respondents		
	Boards	**CEOs**	**Ministries**
Citizens, interest groups and vested interests:			
Even if a decision is opposed by the majority of citizens, board members support it if they believe it is the right decision.	809	67	65
Interest groups sometimes force boards to make decisions they would not otherwise make.	810	69	73
Vested interests have too big a say in board decisions.	809	70	72
Provider influence:			
Physicians are more influential than other residents in influencing board decisions.	810	68	71
Nurses and other health care providers are more influential than other residents in influencing board decisions.	801	70	69

Table 7: Beliefs about Health Reform

	Number of Respondents		
	Boards	**CEOs**	**Ministries**
There was no need for the extensive health reform of the 1990s.	785	70	76
Health reform has more to do with controlling or reducing government spending than improving health.	809	71	78
If new money were to be made available to regional health authorities, the majority of it should be allocated to health promotion and illness prevention activities as opposed to those aimed at treating disease and illness.	802	66	79

Table 8. Assessment of the Impact of Health Reform

	Number of Respondents		
	Boards	**CEOs**	**Ministries**
In general, the changes made over the last decade with health reform have been for the best.	796	70	77
Our region/the regions served by RHAs lost out with the health reform of the 1990's.	754	64	64
Thinking back over the last few years, what do you think have been the effects health reform in your province/territory on the quality of the health care system?	785	67	68

Table 9: Assessment of Health Reform Impact over Time (Saskatchewan)[24]

	Number of Respondents	
	1997	**2001**
In general, the changes made over the last decade with health reform have been for the best.		
Board Members	260	218
CEOs/Senior Managers	139	21
Ministry of Health	97	10
Our region/the regions served by RHAs lost out with the health reform of the 1990s.		
Board Members	267	219
CEOs /Senior Managers	142	17
Ministry of Health	-	9
Health reform has resulted in an increase in the quality of the health care system.		
Board Members	249	219
CEOs/Senior Managers	142	21
Ministry of Health	85	8

24 See footnotes 3 and 5 for sources. Note that 1997 Saskatchewan results include both CEOs and senior managers.

Table 10: Number of respondents by province in reference to Figures 1 to 6

Item	BC	AB	SK	MB	QC	NS	NB	PE	NF
The division of authority between RHAs and the ministry of health is clear.									
Board Members	84	54	219	91	93	71	58	26	84
CEOs	6	8	21	5	7	7	5	4	6
Ministry of Health	17	-	10	-	8	12	-	6	8
If residents of a region do not support a board decision they take their complaints to the provincial ministry or government.									
Board Members	80	50	208	73	83	59	54	27	80
CEOs	6	8	20	5	7	7	4	4	6
Ministry of Health	17	-	10	-	8	12	-	6	7
Vested interests have too big a say in board decisions									
Board Members	85	54	222	89	93	72	60	27	82
CEOs	6	8	21	5	7	7	4	4	6
Ministry of Health	12	-	10	-	7	12	-	5	8
Boards are too restricted by rules laid down by the provincial government.									
Board Members	82	52	226	93	91	71	62	27	84
CEOs	6	8	21	5	7	7	4	4	6
Ministry of Health	16	-	10	-	8	12	-	6	8
The changes made over the last decade with health reform have been for the best.									
Board Members	84	54	218	89	92	70	57	27	82
CEOs	6	8	21	5	7	7	4	4	6
Ministry of Health	15	-	10	-	8	12	-	6	8
Health reform has resulted in an increase in quality of the health care system.									
Board Members	81	50	219	90	91	69	61	22	79
CEOs	6	7	21	4	7	7	4	3	6
Ministry of Health	16	-	8	-	6	12	-	5	4

(Column group header: Number of Respondents)

Table 11: Number of board respondents by province in reference to Figure 7

Item	Number of Board Respondents			
	Less than 1yr	1 to 3 yrs	Less than 3 yrs	Total
Health reform has resulted in an increase in quality of the health care system.	93	272	419	784