HEAL*Net:* *Searching for Canadian Healthcare Solutions*

Regional Health Planning

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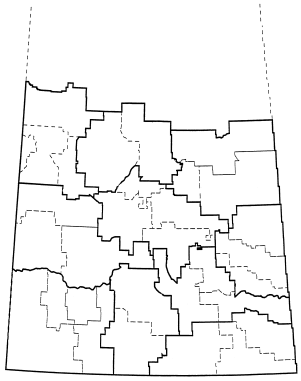
Regionalization at Age Five

Views of Saskatchewan Health Care Decision-Makers



Denise Kouri, Jackie Dutchak, Steven Lewis

December, 1997

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Networks of Centres of Excellence Program

Regionalization at Age Five: Views of Saskatchewan Health Care Decision-Makers
HEALNet Regional Health Planning
December, 1997
Second Printing

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Foreword

HEALNet Regional Health Planning is pleased to present *Regionalization at Age Five: Views of Saskatchewan Health Care Decision-Makers*, a report on the findings of our 1997 surveys.

HEALNet is a federally-funded national network of health services researchers, health policy decision makers, health care practitioners, and industry and labour representatives. Its slogan *Searching for Canadian Health Care Solutions* summarizes the network's goal of using the best available information to support health care decisions. Regional Health Planning is one of six themes that form the network. Headquartered in the Health Services Utilization and Research Commission in Saskatoon, Regional Health Planning focuses on decision-making by district health boards.

In early 1997, we surveyed all health district board members, district managers and Saskatchewan Health managers about decision-making in health care. This report presents some of the more significant findings from the surveys. It comes in two parts: the main body containing highlights and discussion, and a supplement containing frequency distributions for all coded fields.

Our purpose in carrying out the survey was two-fold: (1) to inform and assess our own project of creating information-based tools to assist decision-makers and (2) to study and contribute to the general knowledge of regionalization.

We hope you find the report informative and useful.

Steven Lewis

Theme Leader

Acknowledgments

This survey is the collective product of the authors, in collaboration with other investigators and staff of the HEALNet Regional Health Planning theme. Sandra Leggat, Harley Dickinson, Jeremiah Hurley, Cam Mustard, Jack Williams, Gerry Veenstra and Pamela Smith contributed to the questionnaire design. Renee Torgerson prepared the report appendix and supplement and Barbara Crockford contributed to the report processing and distribution.

We acknowledge with appreciation the Saskatchewan district health board members and managers and the provincial government employees who responded to our survey. We hope you find the results useful to your ongoing work.

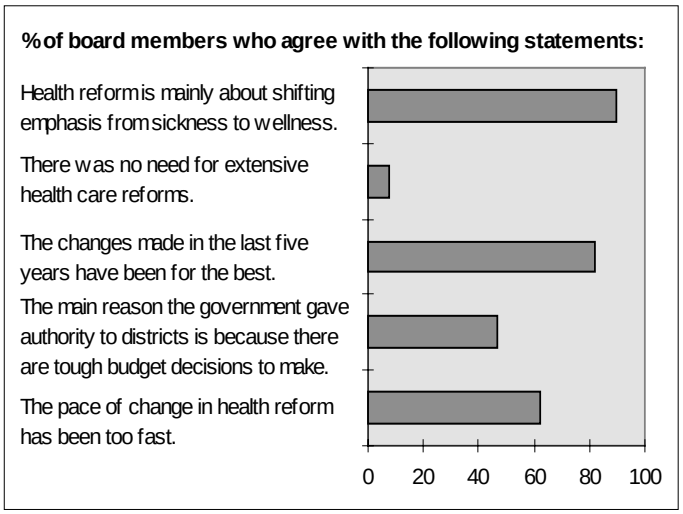
Highlights

In February and March of 1997 HEALNet Regional Health Planning (RHP) conducted a survey of health board members and managers in Saskatchewan about decision-making in health care. The survey included all district health board members in Saskatchewan (excluding the three boards in Northern Saskatchewan which were still in the process of formation), district senior managers, and Saskatchewan (SK) Health managers. In total, 275 (77%) health board members, 150 (71%) district managers and 100 (54%) SK Health managers responded to the survey. Respondents were asked about their views of regionalization and use of information.

Highlights of the survey findings are:

- Respondents support a broader definition of health and a needs-based system of health care. Over 90% agree high needs groups should be targeted for more health care resources.

- The large majority (90%) of board members agree that health reform is mainly about shifting emphasis from sickness care to wellness, and only 8% think there was no need for extensive health care reform. Managers' views are similar.



- Approximately half of responding board members and district managers think that offloading tough financial decisions was the main rationale behind the shift of authority from government to districts. SK Health managers are much less likely to agree (< 30%).

- There is strong board support for a publicly funded, comprehensive health care system. Few believe that a publicly funded system is no longer sustainable, or that individuals (rather than taxes) should pay directly for services if able to do so.

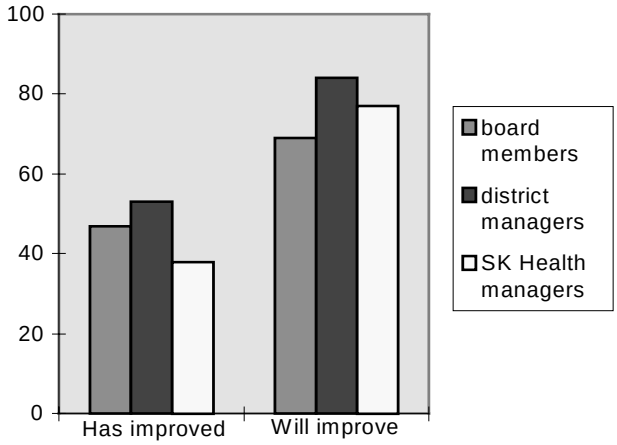
- In their evaluations of health reform to date, more than 4 in 5 board members and over 90% of others agree that the changes made in the last five years have been for the best, and 86% that the system is more needs-based than it was. Almost three-quarters of board members and district managers disagree that their district lost out because of health reform. There were no strong differences by size of district. These responses confirm widespread support for both the philosophy of health reform, and its perceived impact to date.

- In partial contrast, respondents are less satisfied with the implementation process. Over half of all respondents (nearly two-thirds of district managers) do not perceive a clear vision of what the reformed system should look like and 62% of board members, 72% of district managers, and 64% of SK Health managers think the pace of change has been too fast.

Highlights

- Respondents perceive that health reform has improved the quality of various aspects of the health system to date, but are even more optimistic about the future. Of board members, 62% think it has improved the quality of decisions (17% perceive a decrease), 46% the quality of services (28% perceive a decrease) and 47% the quality of the health system (28% perceive a decline). Much larger proportions (70% to 75%) anticipate improvements in the future, with only 10% to 15% expecting deterioration. SK Health managers express similar opinions—they are somewhat more optimistic about the future—while district managers are the most positive group both retrospectively and prospectively.

% of respondents who think health reform has improved and will improve the quality of the health care system.



- Devolution by definition is designed to increase local control over health care services. Over 90% of SK Health managers think reform has increased local control over services, compared to 63% of board members and 66% of district managers. This could reflect either that the Ministry's perception of its loss of control is greater than the districts' perception of their gain, or that some district respondents perceive a loss of *local* control to the now-centralized district level.

- The board is most accountable to *all* residents in their district, rather than special interest groups, electoral ward residents, or local health care providers, according to almost 80% of board members.

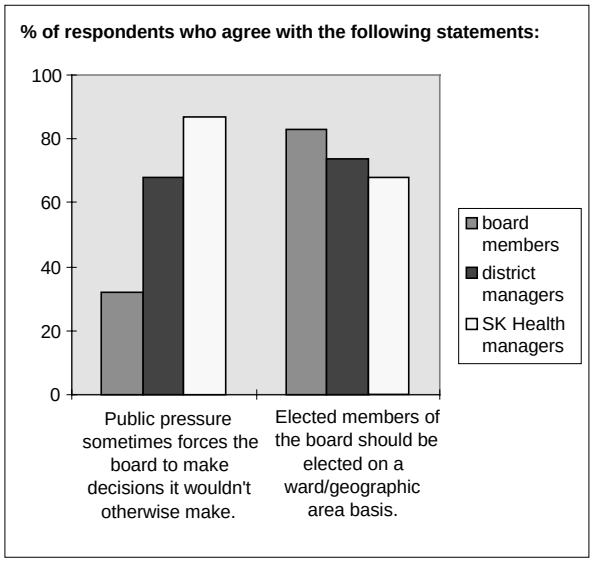
- Board members express discomfort with their level of authority versus that of the provincial government. More than three-quarters feel their boards are legally responsible for things over which they have no control, with almost two-thirds feeling too restricted by provincial government rules.

- Unlike board members, most SK Health managers are less likely to agree that boards are unduly restricted by the provincial government (24%), are legally responsible for things over which they have insufficient control (36%), and that boards have less authority than expected (30%). While district managers' views are somewhat in line with those of board members, they are much less likely to agree the division of authority between boards and SK Health is clear (29% vs. 53%).

- The large majority of board members (95%) think that the work of the health district should be governed by the board's values and principles and 91% that the board's values reflect those of the district. Most board members think they represent the interests of their district residents. And 70% think that district residents are supportive of board choices.

- However, one-third agree that public pressure sometimes forces boards to make decisions they wouldn't otherwise make. And a significant minority (43%) report that being a board member has caused some resentment toward them by people in the community.

- Managers' views differ in some significant ways. Most dramatic is that 68% of district, and 87% of SK Health managers (vs. 32% of board members) think public pressure forces decisions the boards would not otherwise make. And 63% of district managers feel that carrying out their duties has provoked some resentment toward them by people in the community. Only 16% of SK Health managers think boards effectively communicate the rationale for their decisions to district residents, compared to over half of district managers and two-thirds of board members. Overall, board members have the most positive view of boards' relationships with their constituents, and SK Health managers the least positive view.



- Over 80% of board members agree that patients should have more say in how their health care needs are met. Somewhat fewer, although still a majority, envision a greater role in planning and providing services for providers other than physicians (67%) and about half (49%) think that physicians should have a greater say. Managers have similar views on physicians, but are more inclined to agree with increased patient input. Support for more input from nurses and other non-physician health care providers is greatest among SK Health managers.

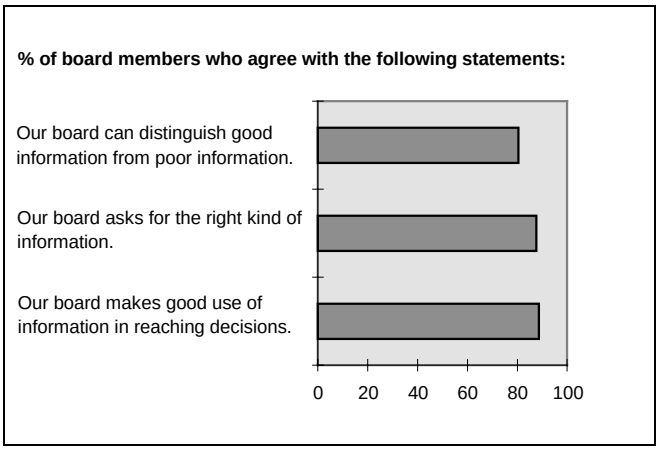
- The basis for electing district board members is a ward system. All respondent categories favour continuation of the ward system (83%, 74%, and 68% of board members, district managers, and SK health managers respectively). About 30% overall think boards have too many appointed members, while very few think there are too many elected members. A clear majority in all categories think the board mix is fine as is.

- A majority of board members and district managers think their districts are the right size in terms of population and area, while a significant minority think they are too small.

Highlights

- Most board members have a favourable view on boards' use of information. More than 80% of board members think their boards can distinguish good information from poor. They are near unanimous (~90%) about their ability to ask for the right kind of information and use it well.

- Of information board members receive, they rate as least adequate the evaluative data: satisfaction of providers, employees, patients and clients; quality of service indicators; program evaluation results; and citizen opinions and preferences. They express a need for information to be presented in a more meaningful and user-focused manner.



In summary, the results of the surveys are for the most part favourable toward health reform to date and optimistic about the future. There are some confusions and concerns about roles and accountability, and about the pace of change. The findings also reveal a need for more evaluative information for decision-making, presented in a more meaningful and user-focused manner.

The philosophy and achievements of reform receive almost uniformly high marks from respondents. The concepts of wellness and population health, though controversial in many quarters, are thoroughly ingrained in the senior non-clinical decision-makers of Saskatchewan.

Nevertheless, we caution that the results are very much insider views of health reform, and do not include two huge and powerful constituencies: health care providers and the general public.

Regionalization is a natural experiment with nine variants across the country. To understand it fully, it will be essential to gather data—preferably longitudinal—in a number of jurisdictions. It is predictable that some of the Saskatchewan findings will be mirrored elsewhere, and some will not. We hope to broaden our study sites in the future, both to test and expand the relevance of our initial work to other provinces, and to deepen our understanding of diverse and dynamic phenomena.

As a research group, we find the results of these surveys to be both encouraging and challenging. The overall support among Saskatchewan district decision-makers for the processes of regionalization provide us with some assurance that there will be a continuing set of interesting and provocative questions to address over the next few years. The support is not blanket, nor uncritical and we do not argue that it should be. We see the processes of regionalization, however, as an invitation to increase the participation of the province's residents in understanding their health and health care, and in governing the related services and policies that affect them.

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A. INTRODUCTION

HEALNet Regional Health Planning (RHP) is part of a Network of Centres of Excellence research project with sites across Canada. RHP is located at the Health Services Utilization and Research Commission (HSURC) in Saskatoon, and focuses on regionalization. RHP is developing information-based decision tools for district health boards and is studying regionalization itself in order to increase understanding about its various dimensions.

In February and March of 1997 the RHP theme surveyed health board members and managers in Saskatchewan about decision-making in health care. The survey series included all district health board members in Saskatchewan (excluding the three boards in Northern Saskatchewan which were still in the process of formation), district senior managers, and Saskatchewan (SK) Health managers. Respondents were asked to assess board decision-making processes and use of information; board and management roles; and aspects of health reform and regionalization such as structures, services and funding for health care.

This report provides results from these surveys. The main body of the report focuses on two topics: views of regionalization and use of information. The supplement provides frequency distributions for all questions for each survey.

The surveys cover many topics, and no single report of manageable size would do them justice. We have chosen to focus our discussion on regionalization and the use of information in decision-making because these correspond to the two major objectives of our project.

Health reform in Saskatchewan has devolved authority from central government to 30 district health boards and consolidated most health services under their management. Prior to regionalization, the provincial department of health controlled the funding and developed general policies governing all facilities and agencies. District boards now receive global budgets and have the flexibility, with some restrictions, to allocate funds according to their priorities.

In part the roles and responsibilities of the districts include determining health needs, shifting services from institutional based to community-based, ensuring the appropriate allocation of funds required to support health, and representing all segments of the community.[1] These obligations are to be carried out in accordance with the concept of *wellness*, the goal of which is "to improve the health, in its broadest context, of both individuals and society within a financially sustainable framework."[2]

These enhanced responsibilities require new and more complex processes for gathering, comparing, and analyzing information and evidence; making decisions; and justifying or explaining decisions to district residents. Exploring these issues and gaining a better understanding of how boards use information and perceive health reform will aid us in our goal of developing tools to assist boards in decision making.

The report focuses on the results of the board member survey; however, we also discuss results of the district and SK Health manager surveys to draw comparisons. In a section at the end of the report, we compare selected findings from our board member survey with those from a previous study carried out in 1995 by Lomas, Brown and Veenstra[3] at McMaster University. We also discuss the survey findings in light of our other research in RHP.[4] We consider this report to be an initial product and plan to produce further publications covering other issues and topics over the next year.

B. SURVEY METHOD

1. DEVELOPMENT AND DISTRIBUTION

The research team composed of RHP principal investigators, research associates and research staff developed, prioritized, and refined the survey topics and specific questions. We prepared three survey questionnaires: one for board members, another for district-level senior managers and a third for managers at the provincial level (in SK Health). The content areas were similar for all three respondent groups, with the wording of some questions modified to accommodate the perspective of the respondent.

We mailed the questionnaires to board members in early February 1997, district managers two weeks later, and SK Health managers in early March. We used slightly different procedures for each respondent group:

1. In February 1997, we sent questionnaires to the homes of all board members in the 30 districts, with a self-addressed, postage prepaid envelope for the return. A reminder card and follow-up letter were sent at approximately two-week intervals. Of the 357 board members, 275 (77%) responded.

2. We sent 10 questionnaires to the chief executive officer (CEO) of each of the 30 districts for distribution to senior managers (including the CEO), each with a self-addressed, postage prepaid envelope to be returned directly to RHP. We left it to the CEOs to define their senior management groups, which could number fewer than (and at their discretion in larger districts, more than) 10. We subsequently telephoned each CEO to remind him/her about the distribution, to inquire how many had been distributed, and whether more booklets were needed. This telephone survey was used as a basis for calculating the number of senior managers who received the survey. Of these 210 senior managers, 150 (71%) responded.

3. We defined the SK Health managers group from the list of management and out-of scope employees maintained in the SK Health human resources branch. On the day the surveys were distributed, a letter from the associate deputy minister expressing support for the survey was sent electronically to each employee. An electronic reminder was sent to the employees approximately three weeks later. Because the response rate for this group was lower than for the other two, in May we polled those employees who could be contacted by telephone about whether they had filled out the questionnaire and if not, why not. This poll served as another reminder. It also revealed that some persons were no longer employed at SK Health or were away, and therefore had not received the questionnaire. Of the total 184 who received the questionnaire, 100 (54%) responded.

2. RESPONSE

Survey response rates are summarized in Table B.1. The response rates are high for mail out surveys. Even the SK Health employees' rate of 54%, while lower than the other two respondent groups, is still higher than expected for a mail-out survey of a random sample of the general population.

However, these were not sample surveys, but surveys of total, defined populations. Indeed in the SK Health case, those receiving the survey likely included persons outside the targeted "population" (i.e. managers or policy-makers familiar with both health reform and devolution processes, activities, and performance). The telephone poll

Table B.1: Survey Response Rates

Survey	# Distributed	# Valid	# Returned	Response Rate
Board Members	360	357	275	77%
District Managers	300	210	150	71%
SK Health	199	184	100	54%

conducted subsequent to the survey revealed that several employees had "disqualified themselves" from the survey, on the basis that their job involved little contact with or knowledge of the districts. The fact that these are total defined population surveys and not samples means that any response bias is not due to sampling error, but to potentially different characteristics among respondents and non-respondents. For example, previous research has shown that those who have an intense interest in a given topic are also more likely to respond.

Board member response is well-distributed over all 30 districts. Nowhere did fewer than half the board members in a district respond. Of the board respondents, 66% were elected and 34% appointed, which almost exactly corresponds to the distribution in the overall board population. Over half (53%) the respondents are female. This is only a slight over-representation of the 50% female board members.

The district managers' response was relatively well-distributed among districts and represents a cross-section of the types of senior managers in the district (Table B.2). One shortcoming, however, is that only 16 of a possible 30 chief executive officers responded. There are no data available to compare the job descriptions and other characteristics of non-CEO district managers who responded to those who did not.

SK Health respondents also include a good range of managers (Table B.3). In SK Health at the time, there were 19 deputy/associate/assistant deputy ministers and branch heads, of whom 11 (58%) responded. There were 19 district directors and health consultants, and 14 (73%) responded. Just over a quarter (27%) of respondents report they have a great deal of contact with district boards and/or managers, and an additional 37% report they have some contact.

Table B.2: District Managers

Position in District	Respondents	
	#	%
Chief Executive Officer (CEO)	16	11
Assistant CEO, Director, Vice-President, or Medical Health Officer	18	12
Finance	14	9
Human Resources	10	7
Managers of Health Care Programs & Services	79	53
Not stated	13	9
Total	150	100

Table B.3: SK Health Managers

Position in District	Respondents	
	#	%
Deputy/associate/assistant deputy minister or branch head	11	11
District director or health consultant	14	14
Other management position	32	32
Other professional position	41	41
Not stated	2	2
Total	100	100

3. NOTES REGARDING INTERPRETATION OF THE FINDINGS

We wish to remind the reader in interpreting the findings, that this survey is subject to the same limitations inherent in all cross-sectional opinion surveys. The responses represent the understandings, opinions and attitudes of the individual respondents as of early 1997. Much has happened in the province and in health districts in the eight or nine months prior to the publication of this report. People may have changed their opinions and have almost certainly obtained new knowledge and experience. The second health board elections took place in October 1997, and new appointed and elected members have replaced outgoing ones. We can reasonably assume that some opinions have changed, but we do not know to what extent or in what direction.

In the analyses presented in this report, we have made no attempt to compare any of the responses provided in the surveys to ostensibly "objective" data on actual circumstances. For example, when respondents say they agree that their board decisions are effective, or that their district has lost out because of health reform, that is their opinion of the matter and we have reported it as such.

Notwithstanding these issues, and bearing in mind the nature and intent of the surveys and their high response rates, we are confident that the data fairly represent the views of the three respondent groups in February and March of 1997.

Notes to the Tables

The number of respondents reported as being *in agreement with* a particular statement includes those who responded *moderately agree* and *strongly agree*.

When calculating percentages, we omitted from the denominator respondents who did not answer the question and those who chose the "No Opinion/Don't Know" option.

The percentages have been rounded to the nearest whole number. Therefore their totals may not always equal 100%.

For those tables in which only percentages are reported, the number of respondents for each cell is provided in the appendix.

C. FINDINGS

1. REGIONALIZATION

1.1 VIEWS ON HEALTH, WELLNESS, AND REASONS FOR HEALTH REFORM

Regionalization has come about in tandem with two major emerging thrusts in health and health care theory: emphasis on the determinants of health and on the health of populations rather than individuals. We asked respondents several questions to identify the extent of agreement with these emphases. Board members support a broader definition of health and a needs-based system of health care. Specifically, 99% feel health is more than the absence of disease, with almost as many agreeing health is primarily affected by non-medical factors (Table C1.1). Over 90% agree on high needs groups being targeted for more health care resources. Managers express almost identical views.

It has been argued that the legitimacy of health reform among the population will depend upon issues such as the quality of and motives behind its implementation, in particular the suspicions that the government was devolving problems rather than genuine authority. We asked respondents about their understanding of the reasons for health reform. The large majority (90%) of board members agree that health reform is mainly about shifting emphasis from sickness care to wellness, and only 8% feel there was no need for extensive health care reform. These views are shared by managers. However, approximately half of responding board members also feel that offloading tough financial decisions was the main rationale behind the shift of authority from government to districts. And while approximately half of district managers agree fiscal issues were the reason behind the shift of authority, SK Health managers are much less likely to agree (< 30%).

There is strong board support for a publicly funded, comprehensive health care system. Only 15% of board members think those who can afford it should be made to pay directly for their health care and about one-fifth agree that we can no longer afford a comprehensive, publicly funded health care system. Managers are even more strongly supportive of a publicly funded system.

Table C1.1: Views of Health, Wellness and Reasons for Health Reform for Board Members (BM), District Managers (DM) and SK Health Managers (SK)

Per cent of respondents in agreement with the following:	BM	DM	SK
Health is more than the absence of disease.	99	100	99
Health is primarily affected by non-medical factors, including social and economic conditions.	95	98	93
More health care resources should be targeted towards groups with high needs that may not have been well-serviced in the past.	94	92	90
There was no need for extensive health care reforms.	8	8	5
Health reform is mainly about shifting emphasis from sickness care to wellness.	90	85	92
Health reform has more to do with reducing government spending than improving health.	41	42	27
The main reason that the government gave authority to health districts is because there are tough budget decisions to make.	47	52	28
Those who can afford it should be made to pay directly for their health care.	15	12	8
We can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services.	22	19	14

1.2 OPINIONS OF HEALTH REFORM TO DATE

We asked respondents for their opinions on a number of aspects of health reform to date. Health reform was officially launched in Saskatchewan in 1992. Therefore, at the time respondents completed this survey, health reform had been in effect provincially for about 5 years. However, because the districts formed at different times in that period (the last by September 1993), the years of experience of each district board member and manager with health reform would typically be fewer. For example, just over a third (37%) of board members had served as a health board member before October 1995, the first set of health board elections in the province.

There are some interesting, and perhaps predictable variations in the assessment of health reform concepts and results compared to processes. As we reported in the preceding section, almost all respondents (over 90% in all categories) agree extensive health reforms were needed and there is near-unanimity in favour of targeting more services toward previously under-served high needs groups—an explicit goal of a needs-based reform. In their evaluations of health reform to date, more than 4 in 5 board members and over 90% of others agree that the changes made in the last five years have been for the best, and 86% that the system is more needs-based than it was (Table C1.2). These responses confirm widespread support for both the philosophy of health reform, and its perceived impact to date.

In partial contrast, respondents are less satisfied about the implementation process. Over half of all respondents (nearly two-thirds of district managers) do not perceive a clear vision of what the reformed system should look like, which in the context of the otherwise very positive responses may reflect some discomfort with the notion that reform never ends, and the system is never static. While 90% of board members agree that health reform is about shifting emphasis from sickness to wellness (reported in the previous section), a third remain unconvinced that the process has made it easier for social, emotional and spiritual needs to be addressed. On the other hand, that two-thirds perceive that it has made a difference in these realms could be interpreted as remarkable given the tenacity of traditional patterns of care and public expectations.

Perhaps most significantly, 62% of board members, 72% of district managers, and 63% of SK Health managers think the pace of change has been too fast. That this sentiment is so powerful among district managers suggests the complexity inherent in implementation. Those "at the coalface" bear the brunt of the dislocations associated with rapid and widespread change. The capacity of any large and complex system to sustain change is invariably limited; the challenge is to find the right speed. It is interesting to note, however, that "exceeding the speed limit" seems not to have diminished confidence in the validity of the goals or the value of the results. Almost three-quarters of board members and district

Table C1.2: Opinions about Health Reform to Date

Per cent of respondents in agreement with the following:	BM	DM	SK
The changes made in the last five years have been for the best.	82	91	90
Health reform has created a system based on needs rather than traditional patterns of utilization.	86	78	77
There is no clear vision of what our reformed health care system should look like.	57	65	46
Health reform has made it easier for social, emotional and spiritual needs to be addressed.	66	66	68
The pace of change in health reform has been too fast.	62	72	63
Our district has lost out because of health reform.	27	21	n/a[5]

managers disagree that their district lost out because of health reform.

Respondents perceive that health reform has improved the quality of various aspects of the health system to date, but are even more optimistic about the future (Table C1.3). Of board members, 62% think it has improved the quality of decisions (17% perceive a decrease); 46% the quality of services (28% perceive a decrease); and 47% the quality of the health system (28% perceive a decline). Much larger proportions (70% to 75%) anticipate improvements in the future, with only 10% to 15% expecting deterioration. SK Health managers express similar opinions—they are somewhat more optimistic about the future—while district managers are the most positive group both retrospectively and prospectively.

Devolution by definition is designed to increase local control over health care services. Over 90% of SK Health managers think reform has increased local control over services, compared to 63% of board members and 66% of district managers. This could reflect either that the Ministry's perception of its loss of control is greater than the districts' perception of their gain, or that some district respondents perceive a loss of *local* control to the now-centralized district level.

1.3 REPRESENTATION AND RELATIONSHIPS

Among the goals of regionalization is to create greater citizen awareness of and participation in health and health care issues and decisions. Regional boards are supposed to respect and nurture a sense of community and participation while at the same time transcending the problems inherent in excessively fragmented governance. We asked respondents for their views on roles, accountability and community representation.

THE ROLE OF BOARD MEMBERS

Board members are divided on what other office-holding role is most similar to their own. The role is, perhaps, difficult to define, with 14% of board members not answering this question, with several commenting that they do not have enough experience to be able to compare. Of those responding, the most frequent choice is *member of a school board*, with 25% of responses, followed by *member of a hospital board* with 23%. Member of the legislature, of a Crown corporation board and of a non-governmental organization board receive 14%, 12% and 11% of responses, respectively. A small number of respondents (2%) state that their role is most like a member of a municipal council. Nine percent of the respondents say the role of district

Table C1.3: The Effects of Health Reform

Per cent of respondents who agree that health reform has increased or will increase:	**Over the past few years**			**During the next few years**		
	BM	**DM**	**SK**	**BM**	**DM**	**SK**
local control over health care services	63	66	93	68	75	88
quality of health care decisions	62	67	55	75	83	83
quality of health care services	46	53	38	68	84	80
quality of the health care system	47	53	49	69	84	77
the health of the population	31	24	24	70	80	78

Table C1.4: Board Accountability

Per cent of respondents in agreement with the following:	BM	DM	SK
The board is most accountable to all residents of their district.	79	61	67
The board is most accountable to residents from the ward a board member represents.	12	6	3
The board is most accountable to the Minister of Health.	10	23	17

health board members is a new role, unlike any of the other roles. An additional 4%, also not choosing among the roles provided, describe their role as "powerless", a "puppet" or a "go-between" between government and district.

In contrast, 61% and 33% of SK Health and district managers, respectively, liken the role to that of a school board member. Almost a quarter of district managers see the board member role as analogous to that of a member of the legislature. These data are interesting from the perspective of health reform as a political phenomenon and innovation. Member of the legislature, school board member, and hospital board member are, in descending order, political-democratic offices. Board members—two-thirds of whom are elected—define themselves in less political terms than the other respondent groups, and district managers in particular perceive strongly political dimensions to their boards

ACCOUNTABILITY OF BOARD MEMBERS

Almost 80% of board members consider the board most accountable to *all* residents in their district, as opposed to special interest groups, ward residents, or local health care providers (Table C1.4).

Managers (both categories) agree, although to a lesser extent, and are somewhat more inclined to see boards as being most accountable to the Minister of Health.

BOARD RELATIONSHIP WITH SK HEALTH

Board members express discomfort with their level of authority versus that of the provincial government. More than three-quarters feel their boards are legally responsible for things over which they have no control, with almost two-thirds feeling too restricted by provincial government rules (Table C1.5). Opinions are split almost down the middle on other issues — namely, whether the division of authority between district health boards and SK Health is clear and whether the board has less authority than expected.

SK Health managers are much less likely to agree that boards are unduly restricted by the provincial government (24%), are legally responsible for things over which they have insufficient control (36%), and that boards have less authority than expected (30%). While district managers' views are somewhat in line with those of board members, they are much less likely to agree that division of authority between boards and SK Health is clear (29% vs. 53%).

Table C1.5: The Relationship Between Boards and SK Health

Per cent of respondents in agreement with the following:	BM	DM	SK
The division of authority between district health boards and SK Health is clear.	53	29	47
Health boards are legally responsible for things over which they have insufficient control.	76	84	36
We're (the boards) too restricted by rules laid down by the provincial government.	63	81	24
The board has less authority than I expected when districts were formed.	57	68	30

Table C1.6: SK Health Manager Views of SK Health's Role Under Regionalization

Per cent of respondents in agreement with the following (SK Health Managers only):	SK
SK Health's role is to set standards for the districts.	95
SK Health's goal is to set policy objectives and goals.	87
SK Health has less direct control over services than before districts were formed.	85
I learn a lot from the district personnel I am in contact with.	85
The reformed health care system is more democratic than before.	84
The reformed health care system is more effective than before.	76
Because we have to share authority with the districts, it's harder to get things done.	50
SK Health has developed an effective management strategy for the reformed health care system.	46
Regionalization has made my job more difficult.	42
The reformed health care system is more bureaucratic than before.	36
I would prefer to have more influence over district activities.	28
The establishment of districts has meant more control of services for SK Health.	1

We asked SK Health managers a series of questions about their work experience and their views of SK Health's role under regionalization. Not surprisingly, almost half (47%) report that their work experience has changed substantially since health reform, with an additional 24% reporting that it has changed somewhat. Just under half (42%) feel that regionalization has made their job more difficult (Table C1.6), with half (50%) agreeing that sharing authority makes it more difficult to get things done. However, only a minority (28%) state they would like to have more influence over district activities, and a large majority (85%) report that they learn a lot from district personnel. Three quarters (76%) feel the system is more effective than before and 84% feel it is more democratic. There is strong agreement about SK Health's role in setting standards and policy objectives and goals.

BOARD REPRESENTATION OF AND RELATIONSHIP WITH DISTRICT RESIDENTS

The large majority of board members (95%) feel that the work of the health district should be governed by the board's values and principles and 91% feel that the board's values reflect those of the district. Most board members feel they represent the interests of their district residents: 80% agree that the board is responsive to wishes of district residents, and 99% that district residents are entitled to make representation to the board when they have an issue (Table C1.7). In addition, 84% think they have an accurate understanding of what district residents want for the health care system and more than 70% feel that district residents are supportive of board choices. However, this sense of accountability and democratic responsiveness comes with a price tag: one-third agree that public pressure sometimes forces boards to make decisions they wouldn't otherwise make. And a significant minority (43%) report that being a board member has caused some resentment toward them by people in the community.

Managers' views differ in some significant ways. Most dramatic is that 68% of district, and 87% of SK Health managers (vs. 32% of board members) think public pressure forces decisions the boards would not otherwise make. And 63% of district managers feel that carrying out their duties as manager has provoked some resentment toward them by people in the community. Only 16% of SK Health managers think boards effectively communicate the rationale for their decisions to district residents, compared to over half the district managers and two-thirds of board members. Overall, board members have the most positive view

Table C1.7: Board Relationship With District Residents

Per cent of respondents in agreement with the following:	BM	DM	SK
Our board's values and principles should govern the work of the health district.	95	96	90
Our board's values reflect the values of the district.	91	83	79
Our board is responsive to wishes of district residents.	80	80	67
District residents are entitled to make representation to the board when they have an issue.	99	97	92
Our board has an accurate understanding of what district residents want for the health care system.	84	75	62
Most district residents are supportive of our board choices.	71	65	54
Even if they don't agree, most district residents generally understand and respect our board choices.	70	56	49
Public pressure sometimes forces our board to make decisions we would not otherwise make.	32	68	87
Being a board member/Carrying out my duties as a manager has provoked some resentment toward me by people in the community.	43	63	n/a[6]
Our board effectively communicates the rationale for our decisions to district residents.	66	56	16

of boards' relationships with their constituents, and SK Health managers the least positive view.

INPUT IN THE PLANNING OF HEALTH CARE SERVICES

District boards have the responsibility of "planning, managing, delivering and integrating the provision of health services."[7] However, "there must be opportunities for broad-based community involvement."[8] We reported above that 80% of board members agree that the board is responsive to wishes of district residents, and 99% agree that district residents are entitled to make representation to the board when they have an issue. With respect to health care services specifically, over 80% of board members agree that patients should have more say in how their health care needs are met (Table C1.8). Somewhat fewer, although still a majority, envision a greater role in planning and providing services for providers other than physicians (67%) and about half (49%) feel that physicians should have a greater say. Managers have similar views on physicians, but are more inclined to agree with increased patient input. Support for more input from nurses and other non-physician health care providers is greatest among SK Health managers.

1.4 BOARD AND DISTRICT STRUCTURE

Saskatchewan's districts were essentially allowed to define themselves, with two main criteria: they had to cover a contiguous land mass, and the population had to be at least 12,000. There is as a result considerable variety in the population, geographic size, and shape of districts, as well as the range of services and institutions available within district boundaries. In 1990, the Saskatchewan Commission on Directions in

Table C1.8: Planning Health Care Services

Per cent of respondents in agreement with the following:	BM	DM	SK
Patients should have a greater say in how their health care needs are met.	84	93	95
Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	67	69	80
Physicians should have a greater say in planning and providing health care services.	49	46	52

Health Care[9] recommended no more than about 15 regions with a minimum population of about 30,000. The actual district structure attempts to balance efficiency (critical mass essential to the provision of certain services, economies of scale) and the desire for local control and involvement, especially in light of the province's vast stretches of low-density rural areas.

There are some interesting contrasts in the responses by category. A majority of board members and district managers think their districts are the right size in terms of population and area, while a significant minority think they are too small. About 20% (combined) think the geographic areas are too large, illustrating the trade-off between population size and distance in creating boundaries. Among SK Health managers, 83% think the typical district population is too small. The results suggest that the Ministry managers assign greater importance to efficiency and comprehensiveness, while the district respondents are more content with current configurations in spite of the acknowledged constraints imposed by small population bases.

The basis for electing district board members is a ward system. All respondent categories favour continuation of the ward system (83%, 74%, and 68% of board members, district managers, and SK Health managers respectively). Interestingly, only 20% of board members think candidates in future elections should run as members of slates compared to 32% of district managers and 24% of SK Health managers. About 30% overall think boards have too many appointed members, while very few think there are too many elected members. A clear majority in all categories think the board mix is fine as is.

1.5 ELECTED AND APPOINTED MEMBERS

The boards are a deliberate hybrid of elected (2/3) and appointed (1/3) members. Although board members perceive little difference between elected and appointed members, many agree that the community does. Only 12% think the latter are more knowledgeable on health issues than the former (compared to 22% of district managers and 29% of SK Health managers), and only 8% think the views of elected members carry more weight within the board itself. However, almost half feel that elected members have more legitimacy and credibility in the community, increasing to 58% among district managers and 64% of SK Health managers.

In general, SK Health managers perceive a greater difference between appointed and elected members, with more than one-third disagreeing that the distinction between the two becomes unimportant over time. Views of district managers tend to fall in between those of the other respondents groups.

Elected and appointed members share the same views on most regionalization issues.

Table C1.9: Views of Health Reform, Selected Comparisons, Elected and Appointed Board Members

Per cent of respondents in agreement with the following:	Elected	Appointed
Health is primarily affected by non-medical factors, including social and economic conditions.	96	94
There was no need for extensive health care reforms.	8	7
Health reform is mainly about shifting emphasis from sickness care to wellness.	87	89
The main reason that the government gave authority to health districts is because there are tough budget decisions to make.	51	35
The pace of change in health reform has been too fast.	65	53
Our district has lost out because of health reform.	31	17
The changes made in the last five years have been for the best.	75	87

With respect to health as wellness, and the need for health reform, their views are virtually identical (Table C1.9). However, elected members tend to be more in agreement than appointed members about the fiscal basis for health reform and about the pace of change having been too fast. And while both groups have positive views on the whole, appointed members are more upbeat about the past and anticipated future effects of health reform.

An equally strong majority of both elected and appointed feel board members are most accountable to all residents of their district (Table C1.10). However, appointed members perceive somewhat more agreement between the board and district residents.

The most pronounced differences between elected and appointed members emerge in their views about the authority of health districts. Although fewer than half of elected members feel the division of authority between SK Health and the districts is clear, the majority (62%) of appointed members feel it is. And a larger majority of elected members (79%) compared to appointed members (59%) feel that health boards are legally responsible for things over which they have no control. Perhaps these views are related to expectations: whereas 61% of elected members feel that their board has less authority than they expected when districts were formed, only 39% of appointed members agree.

With respect to structural questions about regionalization, we found that although for both groups, the majority favour the ward system for board member elections, the elected members are more strongly in favour. A larger minority of elected members also support the idea that elected members of the board should primarily represent the interests of their wards.

Almost half (43%) of elected members feel that boards have too many appointed members, while, not surprisingly, virtually no appointed members agree. The converse is not true — neither elected nor appointed members feel there are too many elected members. Over half (54%) of elected members feel that they have more legitimacy and credibility in the community than appointed members, while only 22% of appointed members agree. However, neither elected nor appointed members feel that within the board itself, the views of elected members carry more weight. The large majority of both elected and appointed members feel that over time the distinction between elected and appointed members becomes unimportant, although appointed members are a little more likely to agree with this than are elected ones.

1.6 DISTRICT SIZE

In Saskatchewan, urban-rural issues are dominant. Establishing a new set of geographic entities supported by a new, needs-based funding formula among other

Table C1.10: Views of Representation and Accountability, Selected Comparisons Elected and Appointed Board Members

Per cent of respondents in agreement with the following:	Elected	Appointed
The board is most accountable to all residents of their district.	79	79
Even if they don't agree, most district residents generally understand and respect our board choices.	62	75
Our board effectively communicates the rationale for our decisions to district residents.	62	72
The division of authority between district health boards and SK Health is clear.	47	62
Health boards are legally responsible for things over which they have insufficient control.	79	59
The board has less authority than I expected when districts were formed.	61	39

things rearranges traditional funding patterns. This in turn creates impressions of "winning" or "losing" as a result of reform. We analyzed board member responses according to the "size" of their district in order to identify any patterns. We categorized districts on the basis of a combined variable which includes the related measures of population and type of hospital(s) within the district, i.e., base, regional, large community hospital and small community hospital. Table C1.11 provides the number of board member respondents for the districts falling into each category.

By and large we did not find any consistent differences by size of district. Most differences are minor, and more significantly, there is no consistent pattern in the relationship between respondent views and size of district. For example, a large majority within all district groupings agree that the changes made in the last five years have been for the best (Table C1.12). And although there are apparent differences among district groupings about whether the district lost out because of health reform, these differences do not appear related to size. The pace of change may be somewhat more of an issue in smaller districts, but the pattern is not consistent.

Table C1.11: District Groupings and Number of Board Member Respondents

District Grouping	Districts	#[10]
Regina-Saskatoon	Saskatoon, Regina	18
Other Urban	Prince Albert, Battlefords, East Central, Swift Current, Moose Jaw/Thunder Creek	44
Medium-Sized	Central Plains, Lloydminster, South Central, North Central, South East, North-East, North Valley	61
All Other Districts	All Other Districts	148

There is one issue, however, which does reveal a consistent pattern by district. Smaller districts feel more strongly that health reform represents a decrease in local control. A significant minority of board members in these districts perceive this about the last few years, and anticipate it to persist in the future. As we discussed above, this finding is consistent with regionalization as both centralizing and devolving authority.

Table C1.12: Views of Health Reform, Selected Comparisons, Board Members by District Groupings

Per cent of respondents in agreement with the following:	Regina Saskatoon	Other Urban	Medium-sized	All Other Districts
The changes made in the last five years have been for the best.	88	84	77	84
Our district has lost out because of health reform.	29	24	33	24
The pace of change in health reform has been too fast.	33	57	75	61
Per cent of respondents choosing each response:				
Past effects of health reform on local control over health services:				
decrease	11	17	18	30
increase	78	69	70	57
Future effects of health reform on local control over health services:				
decrease	6	10	16	23
increase	78	78	71	62

We reported earlier that a majority of board members and district managers think their districts are the right size in terms of population and area, while a significant minority think they are too small. It is worth noting that over 30% of board members in all district groupings other than Saskatoon and Regina consider their district too small in population.

2. INFORMATION

One of the goals of regionalization is to involve the public more fully in defining health, establishing acceptable thresholds of risk and benefit, shifting emphasis toward promotion and prevention and choosing governance. Regional health boards are conscious of community-specific and group-specific issues and at the same time of the expectation that they will take the high road in service of a greater good. Resolving such a dilemma requires visionary and informed thinking. The use of information in decision-making is a focus for the entire HEALNet research program. We asked respondents about their current patterns of use and for their opinions about the information they currently receive.

2.1 USING INFORMATION

Most board members have a favourable view on boards' use of information; they are near unanimous (~90%)[11] about their ability to ask for the right kind of information and use it well. They also report district management is responsive to their requests for it. District and SK Health managers are somewhat less positive on the first two issues (with the majority still having a favourable view), but share board views on management responsiveness.

More than 80% of board members think their boards can distinguish good information from poor (compared to 56% of their managers and 45% of SK Health managers). At least 90% of board members and SK Health managers, and 83% of district managers, think boards need more research-based findings to inform decisions. Over 90% of district managers think they ask for, assess, and use information well.

Board members tend to be more comfortable using numerical data (83% state *Usually* or *Always*) rather than anecdotes or stories (64%), but are influenced more often by their own experiences and knowledge than by statistical data when making decisions (Table C2.1). The views of both sets of managers correspond to those on the comfort level with using anecdotes and stories, but SK Health managers are much more likely to view board members as having a lower comfort level using numerical data. Only 27% think board members are *Usually* or *Always* comfortable using this type of information.

Finally, all managers agree with board members' views on the influence of different types of information on their decision making, with one exception. More than half of SK Health managers think board members' are at most occasionally influenced by statistical data.

2.2 INFORMATION AND PERFORMANCE

Another area of interest to the RHP theme is district health board performance. We asked several questions to learn board members *opinions* about the performance of

Table C2.1: Influence of Information on Decision Making According to Board Members

When making board decisions, I am influenced by:	**Rarely or Never**	**On Occasion**	**Usually**	**Always**
statistical data from financial & scientific reports	1	19	54	26
my knowledge of community expectations	1	10	48	41
knowledge gained from my own experience	0	10	41	49

Table C2.2: Relationship Between Views on Board Use of Information and Performance, Board Members Only

Views on Board Use of Information		Views on Board Performance, Board Members Only *Per cent of each category in agreement with the following:*			
Category:	*Per cent in category*	I am confident that our board generally makes good decisions	Our board decisions generally reflect the values we profess.	Our board has made budget allocations to advance our goals.	Board decisions are consistent with our objectives.
Our board makes good use of information in reaching decisions:					
Agree	*89*	97	98	92	93
Disagree	*11*	48	62	52	33
Our board can distinguish good information from poor:					
Agree	*82*	97	99	92	93
Disagree	*18*	69	73	65	63

their board, with the goal of establishing a baseline for future evaluation. The survey referred to boards' meetings, decisions, and decision making processes, with some items reflecting process (e.g., *Board meetings are run efficiently and effectively.*) and others, outcome (e.g., *I am confident our board generally makes good decisions.*). This self-assessment was quite positive with most (~ 90% or more) board members agreeing their board makes good decisions, tries to meet multiple goals, makes budget allocations that advance its goals, manages its money well, and makes decisions that reflect board values. Fewer consider their boards good at long range planning (74%), as having adequate mechanisms for board member development and education (73%) and board evaluation (64%).

We further analyzed how the perceived use of information relates to perceived performance levels. Over 90% of board members who agree they make good use of information or are able to distinguish good from poor, have favourable views of their boards' performance related to budget allocations to advance their goals, making decisions consistent with their objectives and values, and decision-making in general (Table C2.2).

Although their numbers are far fewer, board members who disagree their boards are able to make good use of information or distinguish between good and poor are often split on their opinions of board performance. Only about half to two-thirds give their performance a high rating in the decision-making performance areas described above. Among those who feel their board does not make good use of information in reaching decisions, about half assign negative ratings to the performance measures.

2.3 ADEQUACY OF INFORMATION

Information quality is a serious concern for board members. Only financial, needs assessment, population health status indicators and service utilization information rate as *Good* or *Excellent* according to more than half the respondents (Table C2.3). They rate as least adequate the evaluative data: satisfaction of providers, employees, patients and clients; quality of service indicators; program evaluation results; and citizen opinions and preferences. SK Health managers generally give lower ratings to most of the information received by boards, while district managers' views are more in line with those of board members. Notable is the fact that SK Health managers assign the lowest

Table C2.3: How Board Members (BM), District Managers and CEOs (DM) and SK Health (SK) Managers[12] Rate the Information They Receive

Type of Information	BM		DM		SK	
	G/E*	P/VP**	G/E	VP/P	G/E	VP/P
financial information	79	7	79	7	61	9
needs assessments	64	15	52	15	20	33
population health status indicators	55	14	34	29	25	51
service utilization data	55	11	52	13	43	16
SK Health policy directions	49	16	54	14	29	22
relevant research/scientific literature	42	16	26	31	14	53
patient/client satisfaction	40	20	41	27	16	33
program evaluation results	40	20	28	28	8	57
quality of service indicators	35	20	19	41	13	56
citizen opinions & preferences	30	23	38	17	27	27
provider/employee satisfaction	26	26	23	33	9	44

ratings of the three groups to information on their own departmental policy directions.

We asked board members to indicate, in their own words, where improvements were needed most among the categories listed in Table C2.3, and also to suggest other areas that might need improvement. Two hundred fifty-three (92%) board members answered this question. Not surprisingly, the categories currently rated least adequate are cited most frequently as needing to be increased or improved: program evaluation results lead the way, cited by 32% of those responding (Table C2.4). Provider/employee satisfaction, citizens' opinions and preferences, patient/client satisfaction, quality of service indicators and needs assessments are all cited by over 20% of those answering this question. Conversely, financial information is least cited (8% of those responding to the question), followed by relevant research/scientific literature (9%).

Table C2.4: Categories in which board members suggest information could be improved or increased (percentages are of the 253 responding to the question)

Number and per cent choosing each response:	#	%
Program evaluation results	80	32
Provider/employee satisfaction	73	29
Citizen opinions and preferences	60	24
Patient/client satisfaction	57	23
Needs assessments	55	22
Quality of service indicators	55	22
Population health status indicators	46	18
Saskatchewan Health policy directions	39	15
Service utilization data	28	11
Relevant research/scientific literature	23	9
Financial information	19	8

* G/E = good or excellent.

** P/VP = poor or very poor.

We also asked respondents to tell us about information received that is *not* relevant to the board's work. Just over half — 153 (56%) — of board members responded to this question, and of these half again state that "all information received by the board is relevant" (Table 2.5).

"The board information received is all relevant to some degree. The individual board member must prioritize and use appropriately."
Survey respondent

It is interesting that of all the categories of information in the list provided to them, the one board members cite most frequently as not relevant is "relevant research and scientific literature," cited by 22 respondents.

[Not relevant is] research/scientific literature - interesting but better utilized by the service providers. *Survey respondent*

Some research and scientific literature does not work very well for rural health boards. It is as if nothing can be done in rural districts, it must be all urban. *Survey respondent*

Another frequently cited response (19 respondents) refers to general information, that may be "good to know" but not obviously relevant to decisions.

Some board members ask for information that is not relevant to board decisions but is "something good to know" - it is taking precious time away from our management staff and we do have good management. *Survey respondent*

Crazy making information. Piles of information describing what senior managers are doing but no real outcome based reporting. Information is given after the decisions have been planned and it makes you feel reactive rather than active in planning any real strategic direction.
Survey respondent

We receive a lot of information in sorry form which goes on for ever. Busy reading it's called, far too much of this as a result our meetings start at 10 a.m. and go till 9 p.m. *Survey respondent*

The third most frequently-cited item considered not relevant is advertising or lobbying material.

Table C2.5: Categories in which board members indicate information they receive is not relevant (percentages are of the 153 responding to this question)

Number and per cent providing each response:	#	%
They are all relevant	80	52
Relevant research/scientific literature	22	14
Too much undifferentiated information	19	12
Flyers and lobbying	13	8
Saskatchewan Health policy directions	8	5
Financial information	7	5
Service utilization data	6	4
Citizen opinions and preferences	6	4
Provider/employee satisfaction	4	3
Needs assessments	3	2
Quality of service indicators	3	2
Population health status indicators	1	1
Program evaluation results	1	1
Patient/client satisfaction	0	0

Notices and pamphlets of useless reading material. *Survey respondent*

A lot of medical input/opinion, that amounts to lobbying by one stakeholder group.
Survey respondent

There were 122 (81%) district managers who identified information that could be increased or improved. The most frequently cited categories are program evaluation results and population health status indicators.

Very few managers responded to the question about the forms of information they receive that they would not consider relevant. As is the case for board members, most managers report that all their information is relevant. Several managers refer to there being too much information at times to be helpful.

We also asked respondents one general question about information: *What do you consider to be good information for the board?*

Two hundred thirty-five (85%) board members answered this question. Many (28) state that all the categories of information listed in the questionnaire constitute good information. The single most frequently reported item is financial information, referred to by 34 board members, followed by public opinion, client satisfaction and needs assessments (often mentioned together). Other categories include information about utilization and evaluation — the need for progress and monitoring reports in particular — and comparative data with other districts. Several respondents mention Saskatchewan Health information and several express a need for information about board governance and staff issues.

Although most board members answered the question about good information by suggesting information *topics*, such as the financial information just cited, about 38% referred to the *form* of information. The most frequent responses in this latter group are that information should be relevant to the decision (29 respondents) and should be clear and understandable (21).[13] Respondents also feel that information should be concise (17), factual (16), accurate or reliable (15) and timely (15). Twelve respondents assert that information received by the board should discuss pros and cons of a decision, or provide alternatives. Twelve respondents mention that the information should be research-based.

Selected Board Member Comments

Information that the board can digest and make relevant and pertinent decisions.

Comprehensive executive reports that integrate finances with statistics given with time for discussion and with demonstrated staff input. Pros and cons of plan along with outcomes expected, break even point and time for elected members to speak with community.

Information that has been carefully thought out, with the rationale on the subject plus any data on how it was established being brought to the board and the total package comes over, not in bits and pieces.

Valid data collected by valid methods (not by department's designing their own method for their own vested purposes). Regular updates of changes in staffing, services, pertinent events, potential problems.

Information that reveals the pros and cons, so the board can make the decision and not have to rely on management's recommendations, because the board doesn't have the information to make the decision.

Information that gives hands on information not a jumble of figures that mean little to other than a professional analyst. Information that clearly shows 1) reason for consideration, 2) background/baseline, 3) choices and possible results of several options for action.

That which gives us a good understanding of any issues on which we make decisions. We need to know the potential outcomes of each decision and what new programs we might institute that would further improve the health of our residents.

Information that provides background, knowledge and options to assist in our decision making process.

Good information is information that all board members can understand.

D. RELATED RESEARCH

1. THE MCMASTER SURVEY

The RHP survey is, to our knowledge, only the second major survey of regional health board members. In July and August of 1995, researchers at McMaster University surveyed regional board members in five provinces across Canada: British Columbia, Alberta, Saskatchewan, Nova Scotia and Prince Edward Island. The McMaster survey included 179 Saskatchewan board members. In our survey, we included several questions that were also asked in the McMaster survey, in order to provide a basis for comparison. The results for our Saskatchewan board members are presented in Table D.1, alongside the McMaster survey results. We have included for comparison the McMaster results for Saskatchewan, as well as the results for all five provinces covered in that survey.

There is consistency among the surveys with respect to board members' confidence in their decision-making and their opinion that fiscal issues are a significant factor in health reform. However, a much higher proportion of our survey respondents agree that they can't focus on long term plans because their main activity is trying to deal with the impact of a reduced budget. And a somewhat higher proportion agree that that they are restricted by rules laid down by the provincial government.

In our survey, over a third state they are more confident of their own personal opinions than of their boards' consensus opinions—three times the proportion in the earlier survey. As a group, the Saskatchewan 1997 board members differ from the previously surveyed group in two key respects: two-thirds of them are elected, and they have more experience in a regionalized environment. The results may indicate that board members with experience and knowledge are more sure of themselves and less susceptible to "group-think." Alternatively, elected board members may perceive that they have a democratically won mandate to pursue their agendas regardless of where the consensus view lies.

Table D.1: Selected Comparisons, HEALNet RHP and McMaster Surveys

Per cent of respondents in agreement with the following:	**HEALNet RHP Saskatchewan 1997**	**McMaster Saskatchewan 1995**	**McMaster Five Provinces 1995**
I am confident that our board generally makes good decisions.	92	95	94
The main reason that the government has provided us with local authority is because there are budget decisions to be made.	47	49	57
Even if a decision is opposed by a majority of citizens in my community I will support it if I believe it is the right decision.	90	89	84
I have more confidence in my personal opinion than I have in my board's consensus opinion.	35	12	13
Because my main activity is trying to deal with the impact of a reduced budget, I can't focus on long term plans.	65	33	26
We're very restricted by rules laid down by the provincial government.	63	53	48

2. THE RHP NEEDS ASSESSMENT

In 1996, as part of the initial phase of its study, RHP conducted an assessment of the needs experienced by the six district health boards participating in our project of developing decision tools. Three key informants from each of the six districts were interviewed in a semi-structured personal interview. The findings were collected into a preliminary framework, which was reviewed by the boards, and subsequently prioritized by their representatives. The needs assessment was a more in-depth process with a narrower scope than the province-wide surveys we describe in this report. However, the similarities and differences are interesting.

Both the needs assessment (NA) and survey participants expressed strong agreement on the need for health reform and support for its concepts of population health and integrated services. The NA participants also expressed anxieties about the pace of reform. In fact, their preoccupations, perhaps expressed more strongly in the context of a needs assessment, were with methods to make the process function better.

In this regard, the NA participants revealed less satisfaction with current information than did survey respondents. Both groups expressed a need for evaluative and user-focused information. However, NA participants were more vocal about the need for locally-based data on health and its determinants in order to assess health status and to plan programs. They also highlighted the need for value-based approaches to allocating resources and for methods to assess costs and benefits across health sectors.

Both the NA and survey respondent groups perceived their primary accountability to be to district residents. NA participants expressed less satisfaction, however, with the relationships between the board and district residents, and expressed a need for methods to assist in working well with communities.

E. CONCLUSION

This report presents major findings from the HEALNet RHP surveys on regionalization and district health boards' use of information. The results of the surveys are for the most part favourable toward health reform to date and optimistic about the future. There are some confusions and concerns about roles and accountability, and about the pace of change. The findings also reveal a need for more evaluative information for decision-making, presented in a more meaningful and user-focused manner.

The philosophy and achievements of reform receive almost uniformly high marks from respondents. The concepts of wellness and population health, though controversial in many quarters, are thoroughly ingrained in the senior non-clinical decision-makers of Saskatchewan.

Nevertheless, we caution that the results are very much insider views of health reform, and do not include two huge and powerful constituencies: health care providers and the general public. In contrast to the optimism of our three respondent groups, over half (53%) of Saskatchewan residents indicated in a September 1997 public opinion poll that they expect health services to deteriorate over the next 10 years.[14] Yet levels of satisfaction with services actually received remain high. The vast majority of Saskatchewan residents using the province's health services in the previous 12 months rate the quality of the service they received as good or excellent (86%). The two most influential provider groups—doctors and nurses—have often been prominent critics of health reform, and particularly budgetary restraint. No doubt these expressed concerns have influenced public opinion to some extent.

Are the Saskatchewan findings generalizable to other provinces? The history of health care, health politics, and regionalization differs from province to province, as do political culture, public expectations, and the credibility of government in the health arena. There may be strongly held concerns about changes to the health system, but Saskatchewan is known for its commitment to Medicare principles and has strong civic traditions.

That Saskatchewan is still alone in implementing a full-fledged district board electoral system is perhaps the most powerful symbol of interprovincial variability. As of early 1998, British Columbia has abandoned intentions to hold elections, Alberta has more than once deferred its inaugural round, and no other province has elections on the horizon.

Regionalization is a natural experiment with nine variants across the country. To understand it fully, it will be essential to gather data—preferably longitudinal—in a number of jurisdictions. It is predictable that some of the Saskatchewan findings will be mirrored elsewhere, and some will not. We hope to broaden our study sites in the future, both to test and expand the relevance of our initial work to other provinces, and to deepen our understanding of diverse and dynamic phenomena.

As a research group, we find the results of these surveys to be both encouraging and challenging. The overall support among Saskatchewan district decision-makers for the processes of regionalization provide us with some assurance that there will be a continuing set of interesting and provocative questions to address and to assist with over the next few years. The support is not blanket, nor uncritical and we do not argue that it should be. We see the processes of regionalization, however, as an invitation to increase the participation of the province's residents in understanding their health and health care, and in governing the related services and policies that affect them.

[1] Saskatchewan Health. Health District Development Guide, 1992.

[2] Saskatchewan Health. Health Renewal is Working. Progress Report, October 1996.

[3] Lomas J, Woods J, Veenstra G. Devolving authority for health care in Canada'a provinces: 1. An introduction to the issues. *CMAJ* 1997; 156 (3): 371-7

Lomas J, Veenstra G, Woods J. Devolving authority for health care in Canada'a provinces: 2. Backgrounds, resources and activities of board members. *CMAJ* 1997; 156 (4): 513-20

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

[4] Kouri, D. Assessing Board Decision-Making Needs: Saskatchewan District Health Boards. HEALNet Regional Health Planning Occasional Paper No. 1, November 1996.

Lewis S. Regionalization and Devolution: Transforming Health, Reshaping Politics? HEALNet Regional Health Planning Occasional Paper No. 2, October 1997.

[5] SK Health managers were not asked this question.

[6] SK Health managers were not asked this question.

[7] Saskatchewan Health. A Framework of Accountability, 1995.

[8] Saskatchewan Health. Planning Guide for Saskatchewan Health Districts. Part I: Strategic Planning, 1993.

[9] Saskatchewan. Commission on Directions in Health Care. *Future Directions for Health Care in Saskatchewan.* Regina: Commission on Directions in Health Care, 1990.

[10] The district was unknown for four respondents.

[11] When calculating percentages, we omitted from the denominator respondents who did not answer the question and those who chose the "No Opinion/Don't Know" option.

[12] Percentages of G/E and VP/P responses do not total 100 since we excluded responses of "Average."

[13] The responses are not mutually exclusive.

[14] Government of Saskatchewan. Public Opinion Polling and Market Research from October 1, 1997 to December 31, 1997.

Appendix

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

Table C1.1: Views of Health, Wellness and Reasons for Health Reform for Board Members (BM), District Managers and CEOs (DM) and SK Health Managers (SK)

	BM	DM	SK
Health is more than the absence of disease.	273	148	100
Health is primarily affected by non-medical factors, including social and economic conditions.	274	148	100
More health care resources should be targeted towards groups with high needs that may not have been well-serviced in the past.	269	144	95
There was no need for extensive health care reforms.	273	149	98
Health reform is mainly about shifting emphasis from sickness care to wellness.	270	146	99
Health reform has more to do with reducing government spending than improving health.	264	146	96
The main reason that the government gave authority to health districts is because there are tough budget decisions to make.	264	143	99
Those who can afford it should be made to pay directly for their health care.	273	145	100
We can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services.	271	146	99

Table C1.2: Opinions about Health Reform to Date

	BM	DM	SK
The changes made in the last five years have been for the best.	260	139	97
Health reform has created a system based on needs rather than traditional patterns of utilization.	269	148	96
There is no clear vision of what our reformed health care system should look like.	271	149	96
Health reform has made it easier for social, emotional and spiritual needs to be addressed.	255	145	82
The pace of change in health reform has been too fast.	273	145	98

Table C1.3: The Effects of Health Reform.

	Over the past few years			During the next few years		
	BM	DM	SK	BM	DM	SK
local control over health care services	268	143	95	258	141	93
quality of health care decisions	242	142	81	253	142	86
quality of health care services	252	142	84	251	141	88
quality of the health care system	249	142	85	251	139	87
the health of the population	226	117	73	241	134	86

Table C1.4: Board Accountability

	BM	DM	SK
The board is most accountable to all residents of their district.	275	150	100
The board is most accountable to residents from the ward a board member represents.	275	150	100
The board is most accountable to the Minister of Health.	275	150	100

Table C1.5: The Relationship Between Boards and SK Health

	BM	DM	SK
The division of authority between district health boards and SK Health is clear.	265	133	89
Health boards are legally responsible for things over which they have insufficient control.	262	137	81
We're (the boards) too restricted by rules laid down by the provincial government.	260	132	77
The board has less authority than I expected when districts were formed.	254	133	80

Table C1.6: SK Health Manager Views of SK Health's Role Under Regionalization

	SK
SK Health's role is to set standards for the districts.	94
SK Health's goal is to set policy objectives and goals.	93
SK Health has less direct control over services than before districts were formed.	93
I learn a lot from the district personnel I am in contact with.	81
The reformed health care system is more democratic than before.	84
The reformed health care system is more effective than before.	80
Because we have to share authority with the districts, it's harder to get things done.	86
SK Health has developed an effective management strategy for the reformed health care system.	82
Regionalization has made my job more difficult.	89
The reformed health care system is more bureaucratic than before.	89
I would prefer to have more influence over district activities.	86
The establishment of districts has meant more control of services for SK Health.	90

Table C1.7: Board Relationship With District Residents

	BM	DM	SK
Our board's values and principles should govern the work of the health district.	265	147	92
Our board's values reflect the values of the district.	257	142	76
Our board is responsive to wishes of district residents.	263	144	76
District residents are entitled to make representation to the board when they have an issue.	271	148	83
Our board has an accurate understanding of what district residents want for the health care system.	267	145	81
Most district residents are supportive of our board choices.	252	142	78
Even if they don't agree, most district residents generally understand and respect our board choices.	257	139	79
Public pressure sometimes forces our board to make decisions we would not otherwise make.	267	142	85
Being a board member/Carrying out my duties as a manager has provoked some resentment toward me by people in the community.	257	145	n/a
Our board effectively communicates the rationale for our decisions to district residents.	269	147	76

Table C1.8: Planning Health Care Services

	BM	DM	SK
Patients should have a greater say in how their health care needs are met.	270	148	100
Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	264	143	99
Physicians should have a greater say in planning and providing health care services.	265	145	98

Table C1.9: Views of Health Reform, Selected Comparisons, Elected and Appointed Board Members

	Elected	Appointed
Health is primarily affected by non-medical factors, including social and economic conditions.	180	94
There was no need for extensive health care reforms.	180	94
Health reform is mainly about shifting emphasis from sickness care to wellness.	181	94
The main reason that the government gave authority to health districts is because there are tough budget decisions to make.	179	94
The pace of change in health reform has been too fast.	181	94
Our district has lost out because of health reform.	180	93
The changes made in the last five years have been for the best.	178	93

Table C1.10: Views of Representation and Accountability, Selected Comparisons Elected and Appointed Board Members

	Elected	Appointed
The board is most accountable to all residents of their district.	181	94
Even if they don't agree, most district residents generally understand and respect our board choices.	178	93
Our board effectively communicates the rationale for our decisions to district residents.	179	93
The division of authority between district health boards and SK Health is clear.	180	91
Health boards are legally responsible for things over which they have insufficient control.	180	90
The board has less authority than I expected when districts were formed.	180	91

Table C1.12: Views of Health Reform, Selected Comparisons, Board Members by District Groupings

	Regina Saskatoon	Other Urban	Medium-sized	All Other Districts
The changes made in the last five years have been for the best.	17	43	56	140
Our district has lost out because of health reform.	17	42	58	146
The pace of change in health reform has been too fast.	18	44	59	148

Table C1.13: Views of Past and Future Effects of Health Reform, Board Members by District Groupings

	Regina Saskatoon	Other Urban	Medium-sized	All Other Districts
Past effects of health reform on local control over health services:	18	42	61	143
Future effects of health reform on local control over health services:	18	41	58	137

Table C2.1: Influence of Information on Decision Making According to Board Members

When making board decisions, I am influenced by:	
statistical data from financial & scientific reports	275
my knowledge of community expectations	274
knowledge gained from my own experience	275

Table C2.2: Relationship Between Views on Board Use of Information and Performance, Board Members Only

Views on Board Use of Information	Views on Board Performance, Board Members Only :			
	I am confident that our board generally makes good decisions	Our board decisions generally reflect the values we profess.	Our board has made budget allocations to advance our goals.	Board decisions are consistent with our objectives.
Our board makes good use of information in reaching decisions:				
Agree	244	238	235	239
Disagree	29	29	27	27
Our board can distinguish good information from poor:				
Agree	221	218	213	216
Disagree	48	48	46	48

Table C2.3: How Board Members (BM), District Managers and CEOs (DM) and SK Health (SK) Managers Rate the Information They Receive

Type of Information	BM	DM	SK
financial information	270	143	70
needs assessments	263	142	77
population health status indicators	258	133	72
service utilization data	253	136	68
SK Health policy directions	271	139	72
relevant research/scientific literature	249	125	64
patient/client satisfaction	240	136	64
program evaluation results	248	136	62
quality of service indicators	240	126	63
citizen opinions & preferences	248	133	62
provider/employee satisfaction	226	118	64