HEALTH CARE REGIONALIZATION IN SASKATCHEWAN: AN EXERCISE IN DEMOCRACY

A Thesis

Submitted to the Faculty of Graduate Studies and Research

in Partial Fulfillment of the Requirements

for the Degree of

Master of Arts

in Social Studies

University of Regina

by

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Regina, Saskatchewan

April, 1999

Abstract

Health care regionalization in Saskatchewan has devolved authority from the provincial government to district health boards and altered the emphasis for health care delivery. One of the objectives of regionalization is to democratize health care. This thesis analyzes regionalization as an exercise in democracy.

The thesis uses literature on democracy and current analyses of health care in Saskatchewan to formulate implications for democracy in both a structural and a developmental sense. It presents the results of surveys of district health board members and Saskatchewan health care managers to show trends in board member participation and views, and in health care manager views.

The survey findings show that although there are some issues concerning the structural aspects of devolution, that is, a certain lack of clarity about roles and some contention about the extent of devolved control, health board members are mostly satisfied with the configuration. They see themselves as democratic and are committed to the notion that they are to represent their constituents fully. They believe their primary accountability is to all district residents and believe their constituents are entitled to make their views known to the board. There is some ambivalence in that not all are convinced that board decisions are understood and supported by residents, and there is some wariness about reconciling or representing competing interests within the district.

Survey findings are less clear about developmental democracy. Board members express a fairly strong commitment to reducing inequity in health, but are less explicit about increasing participation and interaction among citizens in a deliberative sense. Although health board members express a desire to be closer to their communities, their desired relationships and communication with residents are more in the direction of education than of political interchange. The survey findings do not show board members as explicitly considering issues of political efficacy or perceiving themselves as components of civil society.

The thesis draws out the implications of this for long term health status within the context of emerging population health arguments that equality in the ability to participate in society and to exercise autonomy over one's life is a determinant of health.

Acknowledgments

Several people played a vital role in seeing this Master's thesis through to completion. Thank you in particular to my supervisor Paul Gingrich for his guidance and support with my thesis and my whole Master's program. Without his contribution over the years, this work would not have been possible. I also thank Drs. John Conway and Phil Hanson for their time and effort as members of my thesis advisory committee, and for their previous support to my studies. I would also like to acknowledge Dr. Robert Stirling for his contribution over the years to my knowledge and thinking.

This work was supported by HEALNet (Health Evidence Application and Linkage Network), a member of the Networks of Centres of Excellence Program. HEALNet provided the survey data on which this thesis is based and infrastructural support for its completion. I would especially like to thank Steven Lewis, program leader responsible for HEALNet's research on regionalization, for providing formal support to my thesis in releasing the data to me, for reviewing my thesis draft, and for sharing his many helpful insights about regionalization.

Finally, I acknowledge with appreciation my partner, Don Kossick, for reviewing my thesis, for always sharing his ideas with me and for his longstanding support and contribution to my work.

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1. INTRODUCTION

1.1 Overview

Health care regionalization in Saskatchewan has devolved authority from the provincial central government to 32 district health boards and consolidated most health services under their management. Prior to regionalization in 1993, the provincial department of health controlled the funding and developed general policies governing most facilities and agencies, each of which had its own board (there were approximately 435 in the province). District boards now receive global budgets and have the flexibility, with some restrictions, to allocate funds according to their priorities.

This thesis addresses the following question: *In what way do district health boards represent an exercise in democracy?* In the thesis, I examine the relationship between district health boards and democracy. I argue that district health boards represent contributions to both structural democracy and developmental democracy.

I establish the framework using literature on democracy and current analyses of health care and health reform in Saskatchewan. I then examine the extent of the boards' contribution within the framework using the results of surveys of district health board members and Saskatchewan health care

managers carried out in 1997. I use the surveys to address the questions of who health board members are now and whom they represent, what is the democratic quality of their participation, what are their views about regionalization and democracy, and how health boards are viewed by managers in the system.

My discussion will develop the following line of argument. Structural democracy is concerned with the form of government, with the legal, fiscal and regulatory aspects of our society. It is a form of government in which the people rule, in contradistinction to monarchies, aristocracies, dictatorships, etc. It therefore entails some form of political equality among the people. Recently created district health boards are a devolved authority from a provincial government. Their structure is explicitly founded on democratic ideas about elections designed to foster political equality among the electors. Although there are limitations to their authority, they are a governmental component that is consistent with democratic political forms.

Developmental democracy, while requiring structural democracy as a foundation, extends the ideas beyond the structures of government to the experience of the members of society. The concept distinguishes itself both by its intention and its means. The intention is explicitly to increase human development, not simply to regulate the status quo. Human development refers to human dignity, and implies enhancing intellectual, emotional, and physical capacities. Its means include the practices of institutions and

individuals in society. Democratic practices refer to equality, openness and extent of participation in societal activities, particularly those that are about autonomy and self-governance. Although the concepts of developmental democracy are not new to our era, they have been reformulated somewhat over the last three decades, through the discourse created by the social and popular movements.

I use selections from the extensive literature on democracy to provide the background for and elaborate upon this distinction between the formal and substantive aspects of democracy, showing how the ideas have evolved and expressed themselves over time.

In elaborating the health care side of the argument, I describe the convergence that has occurred in the last decade, in Canada and similar nations, between the ideas about human development formulated in political communities and those in the health care communities. The set of concepts and hypotheses of what has come to be known as a "population health framework" draws links between human health and socio-political power in various ways, using arguments based on academic research. The persuasive power of this framework has helped it to become a major, although not the only, rationale for health reform.

The claim that socio-political power is a determinant of health, and more specifically that socio-political equality is a health enhancer, leads to the argument that societal democratic practice must therefore be a

determinant of health. However, the analysis has not yet been extended to this point in the population health discourse.

Although health boards are components of structural democracy, they may also be contributors to developmental democracy through their influence on health and its determinants. The surveys of health board members and other decision-makers in Saskatchewan's health care system provide some insights into this issue. In this thesis, I analyze the survey results to explore the perceptions of board members and others as they pertain to structural and developmental democracy. I conclude by drawing out the implications of these findings.

1.2 The emergence of regionalization

Regionalization in health care is a relatively new phenomenon in Canada. All provinces, except for Ontario, have in various ways regionalized health care delivery and decision-making. Health reform has come about in tandem with emerging concepts in health care theory emphasizing the longer term and societal determinants of health. In Saskatchewan, the health reform was officially launched in 1992, with two inter-related components: (1) devolution of authority to partially-elected district health boards and (2) an approach to health — termed the *Wellness Model* — based on population health concepts.

In Chapter Two, I describe the background and features of health reform in more detail. Here, I outline selected aspects to show why it is a significant change for health care and democracy.

According to Saskatchewan Health (1993), the roles and responsibilities of the districts include determining health needs, promoting and supporting the health of the people of the district, providing a range of health service in the district; shifting the balance of services from institutions to the community, ensuring the appropriate allocation of funds required to support health, and representing all segments of the community (p.2). 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" (Saskatchewan Health, 1996, p.1). With health reform, there is a new mandate: community involvement; population health; and an integrated client-centred system (Table 1.1).

Table 1.1 Principles of Saskatchewan health reform

- increasing community involvement in the health system;
- emphasizing disease and accident prevention, healthy lifestyles and population health;
- improving the balance between institutional services and home or community-based programs, to provide the right service at the right time in the right place -- as close to home as possible;
- coordinating and integrating health services for a more responsive, efficient, client-centred system; and
- ensuring a financially sustainable, publicly funded health system.

Source: Saskatchewan Health, 1996, p.1.

The implications for democracy are two-fold. (1) Regionalized health board structures are a new political formation, with responsibility for administering health care, an important social and economic activity. (2) In addition, the ideas about health itself are becoming increasingly politicized — population-based studies are increasingly documenting relationships between higher morbidity and mortality and social and economic class. These findings have significant implications for democratic practice within the health districts.

1.3 Debates about regionalization

Health care regionalization is both an administrative and a political phenomenon. The Canadian debate about its political significance is illustrated by the following remarks that introduced a conference held in Kingston, Ontario in June 1995 on the topic of *Regionalization and Decentralization in Health Care,* hosted by Queen's University and the Canadian Medical Association:

> Regionalization and decentralization are organizational devices to shift governance — by definition, to govern is to make choices — from the centre to the regional populations which are most directly affected by the outcome of setting priorities and making choices accordingly. The theory is very sound. Those primarily affected by decisions should be most closely involved in making them. In practice, however, there are some unanswered questions such as:
>
> - How are members of regional health authorities held accountable by the populations they are said to represent?

- What are the tolerable limits of variation in the outcomes of decisions on the availability of health-care services, region by region?
- What are the real limits available for decision-making by regional health authorities within the guidelines and management supervision imposed by central government?
- Where do we find people in our regions with the experience in governance, for membership on the boards of public sector institutions and agencies, and to take responsibility as directors/governors on regional health authorities?

(Sinclair, 1996, pp.xv-xvi.)

Addressing a different point at the same conference, Lomas used the metaphor *"the local mirror" versus "central enforcer" continuum* to make the following comments about whom regional heath authorities represent.

> Devolved authorities, are therefore, expected to not only flow *dollars* to providers and providing institutions, but also to impose some management on "the system." A key question is what will be the biggest influence on the management choices of a local or regional board — the input of dollars from its provincial government or the input of "needs and wants" from its community? If the dollar inputs predominate then the devolved board becomes little more than a central enforcer located in the community...; if the needs and wants of the community predominate then the board acts as a "local mirror" which may not reflect all that is congruent with central provincial government objectives. (Lomas, 1996, pp.29-31.)

Lomas also refers to a related prevalent concern about regional health authorities:

> ...either the potential for the boards to become captured by single-interest groups or the likely preponderance of ... "representational politics," i.e., that elected individuals will feel accountable to identifiable interest or geographic groups rather than to local citizens in general. (Lomas, 1996, p.33.)

Lewis makes similar points in a presentation to the Robarts Centre Symposium, his title *Regionalization and Devolution: Transforming Health, Reshaping Politics?* linking the issues of democratization and structural health care change:

> Among the political 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 inertia and parochialism inherent in excessively fragmented governance... There are no guarantees that these rechannelled loyalties will emerge at all, let alone overcome the problems of their narrower antecedents. (Lewis, 1997, p.2.)

The three analysts cited so far have discussed regionalization in terms of its structural aspects — the change in the formal structures of authority. Indeed much of the debate at the national level limits itself to this domain. This is linked to the fact that regionalization has taken place in Canada largely on the basis of fiscal imperatives of reducing government spending and downsizing the public sector. The major rationale for devolution has been on the basis of "efficiency," defined as reduced monetary expenditure of federal and provincial funds. For the most part, at the national level, issues of effectiveness or cost shifting have not been addressed in the claims of greater efficiency. The dominant view has been that there are currently gross inefficiencies in the health care delivery system, and rationalization and regionalization are steps in the direction of overcoming them.

1.4 Debates about equity and participation

Over the last decade, the debates in the health care field about equity and participation have taken place mainly in the domain of health promotion. One of the key reference documents in this vein is the Ottawa Charter on Health Promotion, adopted in 1986, which begins:

> Health promotion is the process of enabling people to increase control over and improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. (Saskatchewan Health, 1994, p.21.)

The extent to which these concepts of health as wellness and the relationship of health status to control, empowerment and participation are currently integrated into the system administered by Saskatchewan district health boards is arguable. Nevertheless, these ideas are part of the discourse around health, and have implications for the expectations and views of residents and members alike with respect to health care delivery and decision-making.

Lewis points to several aspects to politicizing health care that extend beyond formal democratization, to equitable health status. He notes that population health models lead to class questions inherent in resolving health

status inequities, and points out the challenge of addressing these issues in a regionalized context. He argues that the logical extension is more explicitly politicized regional health authorities (RHAs):

> One alternative is to hold the RHAs responsible for engaging in and altering the discourse about health, wealth and politics without (obviously) transforming political economy. The mandate would entail less action, and more speech: larger debates about politics and economic arrangements (employment policy, income distribution) refracted through the prism of health..... In the absence of a conscious and explicit decision to add a new political dimension to the culture of health, we can anticipate a wide range of approaches to how RHAs articulate and pursue their business.... Even assuming an entitlement and willingness to create and lead a new political discussion of health, success is far from assured. (Lewis, 1997, pp.10-11.)

Previous studies have documented the expressed need of the leadership of district health boards for ways to work democratically with their communities (Kouri, 1996) and have described some of their issues of representation and accountability (Kouri *et al.*, 1997). Political theory debates about politics, power, autonomy and participation — i.e., democracy — can inform the current dynamics of regionalization.

1.5 Terminology

Regionalization and health reform are used somewhat interchangeably in the literature. In theory, health reform, health promotion, wellness, are one cluster of interchangeable terms, while regionalization refers to the structural discussions. However, in practice the separation is not strict. In

fact, regionalization is used more in a national context and health reform more in Saskatchewan.

1.6 Thesis outline

The survey of district health board members will inform some, but not all of these questions. As indicated above, the thesis will use the survey to address the questions of who health board members are now and whom they represent, what is the democratic quality of their participation, and what are their views about regionalization and democracy.

Chapters Two and Three present the context. Chapter Two sets the context by describing the main aspects of health reform in Saskatchewan, particularly those of significance for our topic. Chapter Three reviews some of the major debates about democracy, again focusing on those of relevance to our topic.

Chapters Four and Five present the empirical aspect. Chapter Four describes the survey instruments and how these will be used to address the topic. Chapter Five presents and discusses the survey findings.

Chapter Six, the thesis paper's final chapter, closes by drawing out the main conclusions and implications of the work.

2. REGIONALIZATION AND HEALTH REFORM IN SASKATCHEWAN

2.1 Rationale

Health reform is not unique to Saskatchewan. In the 1980s most provincial governments in Canada conducted major reviews of their health care systems. Health Canada concludes that, "A number of common concerns have been raised through these reviews, including rising costs, inefficient organizational structures, inefficient use of human resources, technology and quality issues, and accessibility" (Health Canada, 1995, p.1).

Recommendations included:

- shifting the emphasis of the system from institutionally-focused service provision to prevention/promotion activities and non-institutional "alternative" delivery approaches;
- regional governance/management structures;
- funding of health services at sustainable levels;
- comprehensive management of health human resources;
- decision-making based on the needs of the population and the best available evidence;
- adoption of a determinants of health framework; and
- enhanced accountability.

(Health Canada, 1995, p.1.)

In Saskatchewan, two initiatives preceded the current health reform strategy. The Directions in Health Care Commission—often called the Murray Commission after its chairperson, Dr. Robert F. Murray, former chair

of the Saskatchewan Medical Care Commission and later Dean of Medicine at the University of Saskatchewan—was established in 1988. The Commission published its report, entitled *Future Directions for Health Care in Saskatchewan*, in 1990, proposing 46 directions for health services. Among these was the proposal of 15 divisions to "manage the total system and deliver the complete package of services, including community-based, home care, mental health care and acute and long-term institutional care" (Saskatchewan Commission on Directions in Health Care, 1990b, p.9). This was not the first time such a recommendation had been made — as far back as 1944 the Sigerist report had also recommended regionalization of health districts (Sigerist, 1944). This time, however, the call for regionalization was part of a larger chorus.

The problems in the health care system had been mounting over the previous three decades. One of the main features was its fragmentation. There were over 400 health care boards across the province and boundaries were a problem in co-ordinating care services. For example, the Saskatchewan Mental Health program maintained its own boundaries, and a local hospital and local special care home might each serve a different catchment area. The Saskatchewan Home Care program was divided into 45 districts based on municipal boundaries. Public Health services had 13 regions (Knoch, 1996). As well as geographic fragmentation, there was a lack

of a coordinated approach to planning and delivery of services within the provincial department of health. People in need of health care service were often subject to unnecessary confusions and duplications, leading to more ineffective and inadequate care.

> During its public hearings, the Commission repeatedly heard concerns about the way the health care system is managed, and the desirability of transferring some of the responsibility for its management from the provincial government to local authorities.
>
> Many reasons were given for these positions.
>
> Over and over, people referred to the way in which health care has been fragmented and divided into compartments, making it more complex and making people uncertain about who has responsibility for various programs.
>
> The Commission was told repeatedly that the system has been highly politicized over the decades, so that priorities and directions for the health of Saskatchewan people were often determined by the possibility of political gain. Because of this, honest suggestions for change often bring charges that those who make them are trying to dismantle the system. The fact is more and more people realize that a different way to make changes is needed. (Saskatchewan Commission on Directions in Health Care, 1990a, p.34.)

Despite being called a health care system, the system focused on medical care. As in the rest of North America, the Saskatchewan health care system had become increasingly focused on hospitals, doctors, drugs and technology. These developments were not balanced with attention to public health and to educating people about caring for their own health. It became

apparent that there were diminishing marginal returns from newer and more expensive technology.

> In an attempt to improve the health of its people, Saskatchewan has built a system that is increasingly dependent upon technology, buildings and highly trained professionals. People, the users of all these facilities and services, have become dependent on them, and the system has encouraged them to do so. They want the quick fix with the newest treatment or technology they have read about or seen on television; only in the last decade have some made the kind of lifestyle choices that might keep them from needing such a fix. Few people are prepared to suffer even a little pain, medicine must cure it. Going to bed with a hot water bottle and an aspirin is no longer an appropriate response to minor ailments, people believe; they want the doctor to fix it. The system encourages and reinforces this attitude. (Saskatchewan Commission on Directions in Health Care, 1990a, p.26.)

In addition, some illness problems, particularly those related to marginalized populations, were not being resolved through increased medicalization. There appeared to be an intractable gap in health status between classes. Different, non-medical, approaches were required to address these problems.

The dominant role of physicians in the system was also seen to be problematic. The compromise that ended the three-week doctors' strike that ushered in Medicare in 1962 granted physicians an autonomous role as fee for service independent agents. These concessions continued to plague the system with accountability and planning problems.

> The number of physicians licensed to practice in Saskatchewan has continued to rise, and is approximately 1500 in 1990.

> Statistics show a correlation between the number of physicians and the use of physicians, drugs and hospitals. A growing percentage of the population visits physicians, and the number of physician services used per 1,000 people has increased for every age group. (Saskatchewan Commission on Directions in Health Care, 1990b, p.7.)

Physicians were only partly accountable to the province for their activities, and there were no mechanisms to prevent them from clustering in urban areas and leave many rural areas without resident doctors.

> Rural hospitals are finding it increasingly difficult to recruit physicians into solo practices and basically impossible to recruit Canadian medical graduates into such practice settings. (Saskatchewan Commission on Directions in Health Care, 1990a, p.88.)

Physicians are the gatekeepers to the health care system. They decide who receives what medical treatment. Their unique role within the system also helps to maintain their implicit authority in the minds of the population. Through both legislation and in the minds of the public, their status eclipses that of both others who care for the sick (nurses, therapists, pharmacists, etc.), and of public health promoters and planners in the province.

Another feature of the health care system, consistent with those already described, was its focus on institutions as the location for treatment and services.

> Saskatchewan has more acute and long-term care institutions and beds in relationship to population than any place in Canada, and still more are planned. Because they exist, there is a tendency to use these institutions to accommodate people

> without examining their need for institutionalization. As a result, the dependence on hospitals and nursing homes, particularly in smaller communities, has not declined despite the growing use of alternatives to institutional care. (Saskatchewan Commission on Directions in Health Care, 1990b, p.12.)

Finally, the system was coming under increasing attack as being too expensive. Financing was based on historical patterns and existing facilities rather than identified need. Indeed the health department expenditures had increased. From $857 per capita in 1980, Saskatchewan's provincial health expenditures had increased to $1,515 in 1985 and to $2,268 by 1990. In real terms (constant 1986 dollars), this represented a 15 per cent increase from 1985 and a 35 per cent increase from 1980 (Health Canada, pp.13-14, 1997).

In 1989, Saskatchewan Health produced the *Study Into the Growth in the Use of Health Services*. The report documented increased health care costs in the period from 1977/78 to 1985/86 and demonstrated that the increases were not attributable to either population growth or increases in professional fees, but to increased utilization. The report raised questions regarding the allocation of scarce resources in health care.

2.2 The establishment of health reform

In 1992, the New Democratic Party (NDP) government initiated what became known as health reform in Saskatchewan. Health reform shifted much of what had previously been the authority of the department of health,

to regional authorities — called health districts. There were 30 formed at the time, in the southern half of the province containing 97% of the population. Districts in Northern Saskatchewan were not formed until 1998.

The new authorities were responsible for conducting needs assessments and developing district health plans; integrating, coordinating and managing health services at the district level; ensuring that services meet provincial guidelines and standards; and developing community health centres.

Saskatchewan Health continued to assume responsibility for negotiation of fees with and reimbursement of physicians as well as overall physician supply management, some highly specialized treatment programs and the provincial laboratory, the prescription drug plan and services in Northern Saskatchewan.

As indicated above, there were two related aspects to health reform: (1) regionalization — the formation of geographically defined authorities — which entailed both a decentralization of power from the provincial government, and a centralization of powers from more local and facility-based boards and (2) the wellness model with a broader conception of health.

The regional focus was considered essential to achieving more integration in health services. The regional authorities' mandate to improve health status was also intended to focus the health care agenda on a single,

more positively conceived and client-focused outcome, and therefore on a more integrated and determining program to achieve the outcome.

2.3 Structural changes

The mandate of the district health boards included increased public participation and community control. The structure and composition of the health boards were intended to aid this.

District health boards have 12 members (14 in Regina and Saskatoon) including eight elected members. Elections are based on a ward system. Rotational elections are held every two years to ensure boards always have experienced members.

> Throughout the process [of establishing health reform], the Government has remained committed to the eventual selection of health board members through an election...The advantages of elected boards include accountability to the electorate and enhanced responsiveness to district needs. Elected health boards will ensure that programs are tailored to the requirements of district residents. Elected representatives have the confidence of the community. (Saskatchewan Commission on District Health Board Elections, 1994, p.3.)

Up to four more board members may be nominated by district residents and appointed by the Minister to represent special skills or expertise, or to represent certain marginalized social groups.

> The appointed members will enhance the work of the board by bringing additional skills and abilities.
>
> In many cases, the appointed members will provide the perspective of a particular constituency like seniors, women and

> aboriginal people who might not otherwise be represented. The input of these communities of interest is important in a reformed health system seeking to deliver health services based on need. (Saskatchewan Commission on District Health Board Elections, 1994, p.21.)

Regina and Saskatoon are permitted to have up to six appointed members. The Act prohibits remuneration except as set by Executive Council. Reasonable expenses may be reimbursed by the Health District.

Saskatchewan is the only province to have board members elected by universal suffrage. (Quebec regions have electoral colleges, made up of health care organizations and community groups, which elect board members from their ranks.) The first board elections were held in 1995 and the second in 1997.

District health boards are funded by the provincial government. They do not have the power of taxation. Global budgets are established for each district health board based on a *needs-based* formula implemented over five years, beginning in 1994-95. The needs-based funding approach followed by Saskatchewan Health directs funds to those populations with greatest need. Population size is adjusted for age and gender, health needs of the district[1], and broad variations in service delivery costs (Saskatchewan Health, 1993).

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[1] Indicators of health need include: acute medical and surgical services (standardized mortality rate); acute obstetrical services (standardized fertility rates, low birthweight rate); supportive services (living arrangements); and emergency services (standardized accident rate, cause-specific mortality rate).

The *one-way valve* is also part of the funding arrangements. Districts are provided funding in certain *envelopes*: acute, supportive or long term, and community care. By regulation they can transfer funds out of, but not into, acute care from the other sectors.

The number and size of health districts were based on location of communities, population distribution, geographic barriers, trading and commuting patterns, location of current health facilities and population health status. District populations range from 12,000 to 225,000. Community consultation was part of the process used in defining the boundaries. The guidelines were that no district would be less than 12,000 in population and the land mass should be contiguous. The end result of 30 districts was a much higher number than the 15 recommended by the Murray Commission. Some argue that this is a very high number, more than necessary, and hence the province will suffer from being "overgoverned." The tradeoff for the provincial government of this "voluntary" process of district formation was increased acceptance from participants — particularly in rural Saskatchewan.

Within these boundaries, the different institutions amalgamated with the district boards. The Union Hospital Districts and Boards and the Ambulance Districts and Boards were automatically amalgamated with the passage in 1993 of *The Health Districts Act* (Government of Saskatchewan,

1993). Others were voluntary affiliations as the Act does not require private health corporations to amalgamate with district health boards.

Other structural changes were at the provincial level. While Saskatchewan Health continued to administer provincial programs such as the Drug Plan, Medical Care Insurance, Vital Statistics, and medical and environmental laboratories, its restructured responsibilities included providing resources for health promotion and education, setting and monitoring standards, developing and implementing a funding formula, developing policy, developing a province-wide information system, and monitoring disease patterns (Saskatchewan Health, 1993, p16).

Three provincial associations representing hospitals, special care homes and home care were amalgamated to form the Saskatchewan Association of Health Organizations.

The Saskatchewan Provincial Health Council was created as an advisory body, composed of 16 members composed of a cross-section of citizens from a range of sectors and interest groups. Its purpose was to identify issues and trends that influence health through identifying health determinants in Saskatchewan, establishing population health goals and recommending and monitoring the implementation of healthy public policies (Saskatchewan Health, 1994, p.6).

A public consultation process was undertaken for the development of a framework and in 1996 the Council recommended a determinants of health

framework and population health goals. However, in 1997 the Council was dismantled and its functions reintegrated into Saskatchewan Health.

The Health Services Utilization and Research Commission was established as an arms-length body governed by a board appointed by the Ministry of Health. It is composed of health professionals and researchers, mandated to conduct research and provide scientific analysis to identify where and how health services can be provided or used more effectively in Saskatchewan. It also administers annual grant competitions to support health research in Saskatchewan (Saskatchewan Health, 1994, p.7).

2.4 Wellness

The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Saskatchewan Health (1992) uses this definition as its basis for the wellness component of health reform.

In its 1992 foundation document for health reform *A Saskatchewan Vision for Health: A Framework for Change*, Saskatchewan Health stated nine official *Wellness Goals*, listed in Table 2.1. More indicative of their overall strategy than the goals, however, are the components of the wellness approach.

The wellness approach will:

- Create a health system that is responsive to community needs by placing control and management responsibilities at local level.
- Balance the health system's current focus on treatment by emphasizing disease and accident prevention, consumer information, health education, health promotion and early intervention.
- Eliminate inequities in the health system by responding to the needs of women, families, the elderly, persons with low incomes, and other with special health needs.
- Make the health system more effective and efficient by integrating institutional, community-based and preventive programs, and by reducing waste and unnecessary duplication at all levels.

(Saskatchewan Health, 1992b, p.11.)

Table 2.1 Saskatchewan Health Wellness Goals

1. Ensure health is a priority and a responsibility of all sectors of our province.
2. Ensure effective and affordable service delivery.
3. Empower Saskatchewan people, communities and health professionals.
4. Strengthen family and community-based support and prevention approaches.
5. Enhance health promotion and disease prevention.
6. Maintain essential and appropriate services.
7. Develop alternative approaches.
8. Reduce health inequities.
9. Enhance health research and evaluation.

Source: Saskatchewan Health, 1992b, pp.12-13.

The wellness strategies are:

- Public policies that promote good health;
- Health promotion and disease prevention;
- Integration and co-ordination of health services;
- Community-based services; and
- Better use of health resources.

(Saskatchewan Health, 1992b, pp.14-20.)

The first two strategies from Saskatchewan Health's list are those which have most implications for democracy. The elements of *Public policies that promote good health* and *Health promotion and disease prevention* involve a shift in thinking about individual and population health — a thinking that includes power relationships within society. Linking health to poverty and other social and environmental factors is not a new idea. It is part of the tradition of public health. However, more recent formulations of these ideas, now termed population health, have taken on a wider scope and implications and gained new momentum. Related strategies are found in the *Strategies for Population Health: Investing in the Health of Canadians* that was approved in 1994 by the Federal, Provincial and Territorial Ministers of Health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). The analysis is based on research from several disciplines examining the factors which influence health. The most widely cited reference in this field in Canada is the book *Why Are Some People Healthy and Others Not?* (Evans *et al.*, 1994), which brings together a great deal of research evidence on key factors and conditions that determine health status. Hertzman *et al.*(1994), for example, use the results of various longitudinal research studies from different countries to conclude that:

> Socioeconomic factors, broadly defined, have an effect not only on the relative health of groups within a population, but on the health of "the same" population at different points in time. (Hertzman *et al.*, 1994, p.70.)

...

People now die of very different things. But whatever people die of, poor people continue to die sooner. (p.80.)

The Ministers of Health strategies are based on this kind of research evidence. Their document identifies health determinants as:

a) Income and social status: It is not the amount of wealth but its relative distribution that is the key factor that determines health status. Likewise, social status affects health by determining the degree of control people have over life circumstances and, hence, their capacity to take action.

b) Social support networks: Support from families, friends and communities is important in helping people deal with difficult situations and maintaining a sense of maturity over life circumstances.

c) Education: Education that is meaningful and relevant, equips people with knowledge and skills for daily living, enables them to participate in their community, and increases opportunities for employment.

d) Employment and working conditions: Meaningful employment, economic stability, and a healthy work environment are associated with good health.

e) Physical environment: Factors such as air and water quality, the type of housing and the safety of our community have a major impact on health.

f) Biology and genetic endowment: Recent research in the biological sciences has shed new light on "psychological make-up" as an important health determinant.

(Federal, Provincial and Territorial Advisory Committee on Population Health, 1994, pp.4-5.)

Although the language and focus are different, these determinants, in decreasing order, include factors that are part of democracy as human development, i.e., equity and participation. At a national policy level,

therefore, improvement in health status has been linked with improvements in equity and participation.

In Saskatchewan district health boards are accountable for health status. Subsection 35 (2) of *The Health Districts Act (1993)* requires the districts to submit to the Minister within three months of their year end, a report on the health status of the residents and the effectiveness of the districts' programs (Government of Saskatchewan, 1996).

In addition to the implications of structural reorganization, there are deeper implications from the linkages between democracy and health. Table 2.2 is from Saskatchewan Health's resource material provided to the health districts for public education purposes. It illustrates that the ideas about democracy and health are indeed a part of the agenda of health boards.

Table 2.2 Excerpts from Saskatchewan Health education materials

How does Social Status Affect Health?

- It affects health by determining the degree of control people have over life circumstances.
- It affects their capacity to act and make choices for themselves.
- Higher social position and income somehow act as a shield against disease.

Why Higher Income = Better Health?

- With higher income one has the ability to: purchase adequate housing, food and other basic needs; and make more choices and feel more in control over decisions in life.
- This feeling of being in control is basic to good health.

Men Work Stress and Health

- Studies have found that men with stressful jobs and little decision-making authority are more likely to develop high blood pressure and to die from heart attacks than those who have more freedom to make decisions.

Limited Options

- People who have limited options and lack the skills to cope with stress appear to be at greater risk of ill health.

Source: Saskatchewan Health, 1997, pp.C-1.29, C-1.16,C-4.26 and C-1.30.

2.5 Areas of Contention

The preceding sections outlined the history and formally defined intent and goals of regionalization in Saskatchewan. This section presents some of its more contentious aspects.

I have argued that the health determinants research indicates that district health boards cannot improve health status without attention to the issues of a "thick" democracy — one that attends to equity and participation. The research also indicates, however, that health status is not something that can be affected easily and in the short term, particularly by a single agency whose authority is limited to a specific sphere. Indeed this is one of the big debates in the new health paradigm — how can health boards on their own possibly be expected to effect improved health status?

It may be possible that the broader social and human developmental goals of health reform are not achievable in the current configuration. Immediate and acute health care needs might always trump the longer-term developmental agenda when the two are traded off directly as is the case when they come together under the administration of health boards.

Rasmussen (1997), for example, argues that the devolution of authority to smaller authorities makes the health care system more vulnerable to local interest groups, whether these be local citizens mobilizing to retain a particular facility or service, or local providers — physicians and

nurses. He claims that the provincial government, with its stronger electoral support base, would have more power to withstand this kind of lobbying. I would argue, however, that Rasmussen may be overestimating the provincial government's ability to withstand such lobbying. Before the reforms, the provincial government's control of health service delivery was very incomplete. As I pointed out above, the multitude of individual hospital boards, combined with fee-for-service physicians, and a series of disparate provincially-organized programs made the delivery system very difficult to manage. In addition to initial capitulation to physicians about fee-for-service in the introduction of Medicare in 1962, successive provincial governments have curtailed proposed advances to comprehensive coverage, including retreating from the Dental Plan and the Prescription Drug Plan. More recent examples of direct concessions to interest groups include the reversal of the formulary committee's decision in 1997 not to include Betaseron as part of the Drug Plan or its ad-hoc decision in 1998 to provide targeted additional funds for nurses across the province. Whatever the merits of these decisions, they were made as a result of public pressure by specific groups. The image of the apolitical and evidence-based body to which the health boards have been compared did not have a counterpart in reality. In fact, much of the rationale for region-based health reform is based on the provincial government's past inability to change the system for the better.

Nevertheless, Rasmussen's arguments about the vulnerability of health boards may be sound. District health boards face difficult problems in sorting out the competing claims of local interest groups, and in evaluating their combined claims against their own, and provincial and other priorities.

One of the arguments against health reform is that the provincial government introduced it mainly to deflect criticism when reducing health care budgets. This argument also applies to other provinces. Although the Saskatchewan health care budget was reduced (Table 2.3) in the early 1990s, largely as a response to the province's poor fiscal situation (partly caused by reductions in federal-provincial transfers for health care) the reductions were more cushioned here relative to other provinces.

Table 2.3 Saskatchewan Health expenditures, 1990-1997

Year	Total Health Expenditures ($'000s)	Per Cent Annual Change
1990	1,401	
1991	1,531	9.3
1992	1,581	3.3
1993	1,548	-2.1
1994	1,464	-5.4
1995	1,534	4.8
1996	1,555	1.4
1997	1,608	3.4

Source: Saskatchewan Finance, 1990-1997.

Bed reductions through hospital closures, although high profile when instituted, were limited in number compared to other provinces and for the most part the hospitals were converted to care centres. Increases for non-

institutional services were provided when institutional care was reduced — e.g., the home care budget doubled from 1992 to 1998.

However, there continues to be significant contention about the effectiveness of the health care system in Saskatchewan. Fiscal influences on health reform exist. There is no doubt that there is a relationship between the perceived motives for regionalization and its legitimacy in the population. The dismantling of the Saskatchewan Population Health Council in 1997, for example, fueled cynicism about the provincial government's intentions concerning health reform. The main agency to develop and monitor the new agenda for health had always operated only on an Order-in-Council, and eventually it was no longer supported. In contrast, the Health Services Utilization and Research Commission has been more firmly established, with its own Act, board and budget. The objective of studying utilization is to introduce efficiencies in the system. This may be a laudable goal, but when at the same time, the agency which was to have developed and promoted a new vision of health is abolished, it sends a message that the provincial government sets a higher priority on the fiscal aspects of health reform than on the health status one.

The concepts of health being more than the absence of disease and of health status being strongly influenced by the social and economic conditions under which people live are not new. Issues of poverty, housing, crime and social justice have been the discourse of social activists over decades. The

mainstreaming of the discourse, however, has only occurred in the last decade, concurrent with pressure to reduce public sector spending.

There has also been a parallel but less public debate within the health care system, about the need to integrate services around a client-centered system. The need for eliminating within-department rigidities and for integrating services has long been evident. Action on the problem did not occur, however, until there was pressure to reduce spending. And even so, major structural features, such as fee-for-service compensation to physicians, continue to create problems in managing the public system.

It would appear that the pressures to reduce expenditures have merged with arguments about a new vision of health and health care in such a way as to produce the current health reform package — with its combination of devolution of authority, the integration of health care services and the more encompassing concept of health. Increased democracy in a structural sense has been an explicit aspect of its justification. Not as evident are the implications of health reform for democracy in a developmental sense.

3. STRUCTURAL AND DEVELOPMENTAL DEMOCRACY: CONCEPTS IN THE LITERATURE

Addressing the relationship of district health boards to democracy requires a review of different conceptions of democracy and democracy's perceived benefits for society generally and for health care specifically. At one end of a continuum, democracy is, and only is, a system for choosing governments and is conceived at a formal or legalistic level. Toward the other end are perspectives in which democracy includes participation by the population at large at many other levels and many other arenas of socio-political decisions, with participation seen as necessary to empowerment. These perspectives are reflected in the different approaches to the potential scope and structure of district health boards.

In this chapter, I review classical and contemporary sources in the literature with the objective of formulating issues of relevance to regionalization in health care. I present the review within the framework of the two main components of the thesis, structural democracy and developmental democracy. I draw out the issues and implications for health reform and regionalization for each component.

The writings of MacPherson, Held, and Keane provide an overview of debates on democracy from the perspective of political science. In addition to their own perspective, MacPherson and Held provide overviews of classical

political thought about democracy. Keane also provides an analysis of the concept of civil society. These writers provide the basis for the discussion of authority and forms of representation within the democratic framework.

These same theorists also provide a bridge to the discussion of developmental democracy. All three conclude their analyses with the need to recognize, identify and develop ways for the structural and institutional mechanisms in our society to be more democratic, and with ideas about an increase in participatory democracy and about the need for democracy to extend to people's lived realities beyond the ballot box.

In the discussion of developmental democracy, I examine the feminist literature, which provides its own set of critiques of power relationships — an elaboration of the personal/political and public/private debates and of views about participation and forms of social action. I also include the work of Paulo Freire, Brazilian popular educator and theorist in political consciousness. Freirean concepts and methodology, like feminist approaches, are grounded in a vision of social change, with a focus upon liberation and humanization. They emphasize experience and consciousness in historically situated social movements. These approaches thereby contribute to the perspective of developmental democracy.

I conclude the chapter with a brief discussion of the concept of civil society, based on the work of Keane and Held. The emerging propositions

focusing on improving civil society bring together the issues about structure and process that are reviewed in the first two topic areas.

3.1 Structural democracy

Held's definition of democracy is straightforward. He defines democracy as a form of government in which, in contradistinction to monarchies and aristocracies, the people rule. Held adds that democracy entails a political community in which there is some form of *political equality* among the people (Held, 1996, p.1).

MacPherson discusses the idea that one definition of democracy limits it to a political system — that democracy is merely a mechanism for choosing and authorizing governments, or in some other way getting laws and decisions made. However he points out that democracy more often has been and is thought of as much more than that.

> From Mill through L.T. Hobhouse, A.D. Lindsay, Woodrow Wilson and John Dewey, to the current proponents of participatory democracy, it has been seen as a quality pervading the whole life and operation of a national or smaller community, or if you like as a kind of *society*, a whole set of reciprocal relations between the people who make up the nation or other unit. (MacPherson, 1977, p.5.)

Although health boards are not governments, they are authorities that have power delegated to them from government. The principles of

regionalization in Saskatchewan accept the desirability of democracy as a form of selecting these authorities — two-thirds of each board is elected by the people. The features that Held and MacPherson describe in their definitions of democracy are also those that are the focus for the discussion in this thesis, that is, on the one hand, the structure of health boards as representative institutions in a formal sense, and on the other hand, the questions of political equality, participation and reciprocal relations within the societies they represent.

Held points out that democracy is currently in vogue — that nearly everyone today professes to be a democrat and that although there is disagreement about how to effect it, there is general agreement that it is desirable. He also points out, however, that democracy has not always been considered so. Among the ancient Greeks, for example, both Plato and Aristotle were critical of democracy. Plato had negative experiences in Athens with the city's demise, and with deteriorating standards of leadership, morality and law. Plato referred to the "ignorance" of the masses. Held says that he came ever more to the view that political control must be placed in the hands of a minority. In fact Held states that Plato was scathing about democracy.

> He defined it as a form of society which "treats all men[1] as equal whether they are equal or not" and ensures that "every individual is free to do as he likes." This commitment to "political equality" and "liberty" is, according to Plato, the hallmark of democracy, and the basis of its most regrettable characteristics. (Held, 1996, p.27.)

Aristotle, as well, used the term democracy in a pejorative sense. For him, it meant the politics of the rabble, for the poor rather than in the public interest. He saw it as a form of power in which the common people can become tyrannical, threatening to level all social distinctions and earned privileges.

Such questions about democracy continue to be contentious today. The problem of lay people governing the health system is one that is identified by policymakers and board members alike. This is one of the reasons why other provinces have chosen only to appoint boards, and why in Saskatchewan, one third of members continue to be appointed.

In Chapter Two, I referred to current criticisms of health boards as not being able to withstand the pressure from the many local interest groups each wanting particular services and facilities. The problems of dealing with such "vested interests" are among the more difficult in governing the health care system and allocating resources within it.

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[1] The literature, at least until the present decade, uses the masculine pronouns only and I reluctantly cite it in that form. In some cases, the masculine pronoun is meant to refer to men and women, but in some cases, it actually refers only to men.

Many of our society's beliefs and norms about democracy are based on idealized notions of democracy based on classical Greek models (Table 3.1). However, as Held points out, these models were developed in small homogeneous populations, in which women, slaves, and other non-citizens were excluded. It is easier for some citizens to be "democratic" when populations are small and homogeneous and when they have more free time for deliberation because of the labour of others.

Table 3.1 Classical democracy

Principle(s) of Justification

- Citizens should enjoy political equality in order that they be free to rule and be ruled in turn

Key Features

- Direct participation of citizens in legislative and judicial functions
- Assembly of citizens has sovereign power
- The scope of sovereign power to include all the common affairs of the city
- Multiple methods of selection of candidates for public office (direct election, lot, rotation)
- No distinctions of privilege to differentiate ordinary citizens and public officials
- With the exception of positions connected to warfare, the same office not to be held more than twice by the same individual
- Short terms of office for all
- Payment for public services

General Conditions

- Small city-state with agricultural hinterland
- Slave economy creating 'free' time for citizens
- Domestic service, that is, the labour of women, freeing men for public duties
- Restriction of citizenship to relatively small numbers

Source: Held, 1996, p.33.

The size of a society dictates the need for representative forms. In larger, more complex societies such as ours, direct democracy at the government level is impossible in the classical sense of having all citizens

participate in the parliament. Participation in this sense is not always feasible. Some form of representational scheme is necessary. If the nation-state is going to be the organizational form of choice, "distant" representation is unavoidable. The question then becomes, how does representation become sufficiently open and responsive to the citizenry to confer a sense of participation and meaning? There are issues of both structure and process.

The electoral/representational system has been criticized as an instrument of maintaining the status quo in society. One of the more strenuous contemporary critiques of representational democracy was provided by feminists in the1960s and 1970s. This critique emerges from the linked perceptions of the need to make profound societal change and of the way such change occurs. Some feminists claim that the kind of structural change that is necessary can come about only with the mass consent and active support of the majority; and those who will be affected by the change must be involved in the process of actually making it. Such participation provides the numbers and power necessary to confront the state. It is also essential to the forging of new solutions and values. Feminists stress the need for the struggle to be controlled by those who are part of the struggle — in other words, to be *participatory* (Adamson *et al.*, 1988, p.173).

In this view, the practice of self-organizing for social change is contrasted to being governed by elected representatives. Representative

government is essentially non-participatory: it distances people from the act of making change and tends to foster feelings of ineffectiveness and disinterest.

Recently, advocacy from various quarters, including the Reform Party, has increased for forms of *direct democracy*, such as referenda, against what is seen as the slow tedious grind of representative democracy. Keane argues, however, that such methods introduce false simplicities and are relatively more open to manipulation (Keane, 1988, p.112). People who are unhappy with the outcome of a decision very often criticize the process as "undemocratic" rather than dealing with the substance of the decision. More democratic is often taken to mean "the more the better," defined in quantitative terms, such as more consultation or more frequent recall provisions, rather than in the quality of the participation or the discourse.

This is a problem for health boards, whose members are encouraged to engage in open and consultative processes with district residents, but with little guidance about principled ways to reconcile conflicting points of view among them.

When democracy is limited to the formal political level, the issue is less difficult. Our health system is legally and constitutionally the domain of the provincial government. The province has legally delegated authority to health boards. Duly elected and appointed board members have the authority

to make decisions on behalf of their constituents. The extent to which their constituents participate in the decisions or even agree with them is not the major issue.

Reimer (1967) describes four modes of operation for "representatives" of constituents: (1) the *trustee* follows his or her own judgment about what is in the best interest of the community (2) the *delegate* votes as his or her constituents, or at least a majority of them, would vote if consulted (3) the *partisan* adheres to his or her party (or group) platform and interpretations and (4) the *politico* balances the three preceding roles.

The formulations can be used to describe the dilemma faced by health board members. Legally, the Health Act gives them the authority to act as *trustees* in the sense of Category (1) above. Mitigating this, however, is health boards' mandate to increase community involvement. The role of delegate in Category (2) would also be somewhat inconsistent with their role, because, notwithstanding the ward system for elected members, there is pressure against board members acting as singly-focused advocates for their geographical community or their institution. The same holds for health board members acting as partisans, either in a political party sense, or in the sense of adherence to an advocacy group, such as the Mental Health Association or the Health Coalition.

Although there would be variation by individual, the fourth option seeking to balance the other three may therefore be the only option in practice. This begs the question, however, of what *balancing* means, and how to achieve it.

3.2 Developmental democracy

One's opinion about whether, how much, and what kind of democracy is ultimately a good thing depends upon one's view of humankind. Different models of democracy are congruent with and require different kinds of society. MacPherson advises the following:

> In looking at models of democracy — past, present, and prospective — we should keep a sharp look-out for two things: [people's] assumptions about the whole society in which the democratic system is to operate, and their assumptions about the essential nature of the people who are to make the system work. (MacPherson, 1977, p.5.)

In discussing democracy and participation, MacPherson describes two versions of the human being: consumer or actor (i.e., participant). He argues that underlying one's view of democracy is one's view of human beings — as either essentially passive consumers who select among already formed choices or as actors who create and influence their lives. In the classical democracy (Table 3.1) of ancient Greece, for example, human beings are

considered to be political animals who can only find fulfillment within the *polis*[2] (Held, 1996, p.20).

One's view of humanity also shapes the extent to which one sees democracy in strictly formal terms or in more developmental terms. MacPherson and Held's descriptions of the different views of democracy as it developed in Western Europe over the last several hundred years show the terrain on which this debate was played out.

Held describes Hobbes as the theorist who departed systematically from the assumptions of the classical *polis*. In Hobbes' view, human beings are profoundly self-interested. Therefore, only a strong protective state can adequately reduce the dangers citizens face when left to their own devices. "Hobbes' position stands at the beginning of modern liberal preoccupations with the need to establish both the liberty of the individual and sufficient power for the state to guarantee social and political order" (Held, 1996, p.77).

For the utilitarians, such as Bentham, the only rationally defensible definition of social good was the greatest happiness of the greatest number, happiness being defined as the amount of individual pleasure minus pain. Bentham postulated that every individual seeks to maximize his/her own pleasure without limit, mainly through possession of material goods. Since money is the instrument of measuring the quantity of pain or pleasure, each

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[2] In ancient Greece, human beings in the full sense meant males or male citizens.

individual therefore seeks to maximize his/her own wealth without limit. One way is to get power over others. Therefore, as MacPherson describes it, the law of human nature is that society is a collection of individuals incessantly seeking power over and at the expense of each other (MacPherson, 1977, pp.33-34).

The response to this was in the developmental democracy perspective, as advocated by J.S. Mill. He did not equate the greatest aggregate happiness with maximum material goods, but rather with the permission and encouragement of individuals to develop themselves. MacPherson explains that the difference between Bentham and J.S. Mill is in what democracy could contribute to human development. He describes Mill's model of democracy as a moral model.

> The improvement that is expected is an increase in the amount of personal self-development of all the members of the society... "the advancement of community... in intellect, in virtue and in practical activity and efficiency." The democratic system makes the best use of the amount of moral, intellectual and active worth already existing, so as to operate with the greatest effect on public affairs... the worth of an individual is judged by the extent to which he develops his human capacities: the end of man... is the highest and most harmonious development of his powers to a complete and consistent whole. (MacPherson, 1977, p.47-48.)

In Held's summary of the model *Developmental Democracy* (Table 3.2), the principle of justification is that participation in political life is necessary

not only for the protection of individual interests, but also for the creation of an informed, committed and developing citizenry.

Table 3.2 Developmental democracy

Principle(s) of Justification

- Participation in political life is necessary not only for the protection of individual interests, but also for the creation of an informed, committed and developing citizenry. Political involvement is essential to the "highest and harmonious" expression of individual capacities

Key Features

- Popular sovereignty with a universal franchise (along with a "proportional" system of vote allocation)
- Representative government (elected leadership, regular elections, secret ballot, etc.)
- Constitutional checks to secure limitations on, and divisions in, state power and to ensure the promotion of individual rights, above all those connected with freedom of thought, feeling, taste, discussion, publication, combination and the pursuit of individually chosen "life plans"
- Clear demarcation of parliamentary assembly from public bureaucracy, i.e. the separation of the functions of the elected from those of the specialist (expert) administrator
- Citizen involvement in the different branches of government through the vote, extensive participation in local government, public debates and jury service

General Conditions

- Independent civil society with minimum state interference
- Competitive market economy
- Private possession and control of the means of production alongside experiments with "community" or cooperative forms of ownership
- Political emancipation of women, but preservation in general of traditional domestic division of labour
- System of nation-states with developed relations among states

Source: Held, 1996, p.116.

Held's argument that political involvement is essential to the expression of individual capacities echoes the holistic conceptions of health. Health board efforts to inform and obtain input from their communities can be seen as attempts to create and interact with an informed, committed and developed citizenry. The nature of the strategies boards employ can be seen

as a function of their views about the effect of participation on human development.

One's perspective on the essence of a human being also has implications for one's views about equality. Held's view is that for a democrat, liberty and equality are inextricably linked. Human beings in positions of less than full equality are not as free or able to develop themselves, act in the world, and govern their affairs.

MacPherson traces the linkages between equality and democracy in the political history of Western Europe. He argues that the utopian versions of democracy advocated in the sixteenth and seventeenth centuries should not be counted as models of liberal democracy, because they advocated classless or one-class societies. The watershed between utopian democracy and liberal democracy came in the early nineteenth century.

MacPherson argues that liberal democracy accepts, and even is founded on, class inequality.

> The difficulty is that liberal democracy during most of its life so far (a life which, I shall argue, began only about a hundred and fifty years ago even as a concept, and later as an actual institution) has tried to combine two meanings. Its life began in capitalist market societies, and from the beginning it accepted a basic unconscious assumption, which might be paraphrased "Market maketh man." Yet quite early on, as early as John Stuart Mill in the mid-nineteenth century, it pressed the claim of equal individual rights to self-development, and justified itself largely by that claim. (MacPherson, 1977, p.1.)

He argues that the most serious, and least examined, problems of the present and future of liberal democracy arise from the fact that liberal democracy has typically been designed to fit a scheme of democratic government to a *class-divided* society. MacPherson states that although Mill accepted class difference, he sought to mitigate its effects. However, MacPherson notes that the theorists of the first half of the twentieth century increasingly lost sight of class and exploitation.

Held points out that some views advocate the selection of a skilled and imaginative political elite capable of making necessary legislative and administrative decisions. It sets constitutional and practical limits on the "effective range of political decisions." This view also considers "average persons" as on the whole incapable of governing themselves.

Issues of egalitarianism are related to the health board situation in several ways. (1) First, there is the question of "elitism," in the sense of the Held model, within the board itself. As indicated earlier, this view is hinted at in the structure of health boards, in which every health board has four appointed members. One of the reasons for having these appointed members is to supply the expertise that may be absent from the elected members. (2) There is also the question of the board as an "elite" in relation to the community. There have been criticisms that health board members do not

represent their communities. (3) Within the district, all members or groupings do not have equal access to the board. Class and culture affect access. (4) In relation to the protection and enhancement of health, class and injustice affect the risk of ill health as well as access to health care.

MacPherson argues that the inequality inherent in a class-based society contradicts the developmental goals of democracy. He claims that the equilibrium produced is an equilibrium in inequality. The consumer sovereignty it claims to provide is largely an illusion, and to the extent it is real, it is a contradiction of the central democratic tenet — of equality of individual entitlement to the use and enjoyment of one's capacities. He argues that one needs money and/or skills to be political, yet these are correlated with class — the political market is far from being fully competitive. MacPherson argues further that democracy has served as a means of legitimizing class inequality. The perspective of democracy as a goal in itself rather than as an instrument to reaching other goals is related to the view of democracy as developmental. Held points out that, in the broadest sense, developmental theorists stress the *intrinsic* value of political participation for the development of citizens as human beings, while protective theorists stress its *instrumental* importance of the protection of citizens' aims and objectives.

In the early utilitarian views of democracy in Europe, the human being was viewed as a consumer and appropriator, but in the later views of liberal democracy which emerged, the view of the human being was as being capable of developing his/her powers or capacities, and the human essence was to exert and develop them.

The more contemporary critical theory of Paulo Freire is founded on his view of human beings as *actors* or *agents* who must be able to "perceive critically the themes of their time." Otherwise, he argues, they will not be able to intervene actively in reality, and will be carried along in the wake of change. Freire states that "choice" is illusory to the degree it represents the expectations of others (Freire, 1985, p.7).

This issue is central to current debates about health and health policy and their relationship to the public. Because of the points I have made above about the general desirability of democracy, there is currently a wide discussion about patients exercising their consumer choices about health services and about public participation in health care decisions. However, there is a wide range of strategies and approaches, and most strategies are adopted without reference to humans' ability to develop their critical capacities or shape their choices.

The means and ends issue is very relevant to health. The outcome of health programs and structures should presumably be high health status for

people. One might ask how democracy matters for this or why there should be democratic decision-making in this area. Can the "end" not just be good health care and high health status without the "means" of democracy? What difference does democracy make? People have argued that health care may be like purchasing a new automobile – in such a situation we likely do not care that much about democracy, we just want one that does the job well, lasts, and does not cost too much.

These distinctions fall away when the research on the determinants of health is brought to bear on the argument. This research indicates that the ability to control life choices assists in creating good health. Egalitarianism and democracy are not luxurious add-ons burdening health care administration — they are intrinsically related to the achievement of the goal of maximizing health. However, for this argument to be valid, democracy must be interpreted as being different than consumer choice, as in the new car example, and must extend to deeper issues regarding overall autonomy and sense of control over one's life — in other words, a developmental view of democracy.

A developmental view of democracy also has implications for the reach of democracy. It extends the application of democracy beyond the system of government. The feminist perspective on democracy extends the application

even further, from the publicly political to the social and private aspects of life.

In *Feminist Organizing for Change,* Adamson *et al.* state that in contemporary terms, the feminist assertion that the "the personal is political" was an argument that the shape of women's personal lives is *not* the result of individual choices, or even "laws of nature." In fact, the reverse is true they argue: the overall direction of women's lives is primarily shaped by the particular way in which society is structured.

> After more than twenty years of struggle by the grass-roots women's movement, this idea of a socially-structured oppression sounds less revolutionary that it did in the late 1960s — although it is still far from universally accepted. At the time, however, "the personal is political" was nothing less than an ideological watershed. Prevailing theories about the role of women, and of political economy in general were almost exclusively based on the dominant liberalism that is in the separation between the public and private spheres, the rights and role of the individual, and the concept of governing "natural laws." (Adamson *et al.*, 1988, p.200.)

The authors point out that issues related to family structure, domestic labour, sexuality and psychology were generally considered to be "private" or individual areas of concern, and therefore outside the framework of theories that examined political and economic structures and issues. To the extent that these areas were analyzed as social institutions at all, they were seen as essentially autonomous institutions and customs whose development was

primarily related to the human or natural condition and to individual choices, rather than to the nature of the social structures.

This history led to the development of the reliance on one's own experience as a source of information — related to concepts of power and autonomy at the individual level. The focus on examining women's own experience came from a profound distrust of accepted authority and truth. Conventional claims about what was valuable and true relied on existing assumptions about women's inherent nature and proper place. In order to call those truths into question, women had nowhere to turn except to their own experienced lives (Weiler, 1994, p.19). The implications of this approach have included a redefinition of the "economy," including a redefinition of the Gross Domestic Product, and new conceptualizations about the value of the informal economy and the home and family. Such economic measures and associated methodologies have implications for the health field, where much of the "benefit" and some of the cost are expressed in humanistic, qualitative terms, and not in terms of monetary value.

The feminist critique is not the only one to point out the limits of a "macro" focus on democracy. Social movements have also focused on the alienation of the oppressed individual from the institutions of power. Freire's methods are based on the connection with one's experience as a wellspring of autonomy.

> Paulo Freire's central message is that one can know only to the extent that one "problematizes" the natural, cultural and historical reality in which s/he is immersed. ... to problematize in his sense is to associate an entire populace to the task of codifying total reality into symbols which can generate critical consciousness and empower them to alter their relations with nature and social forces. This reflective group exercise is rescued from narcissism or psychologism only if it thrusts all participants into dialogue with others whose historical "vocation" is to become transforming agents of their social reality. Only thus do people become subjects, instead of objects of their own history. (Goulet, 1973, p.ix.)

Freire is explicitly political, believing that sharing of experiences should not be understood in psychological terms only, but invariably requires a political and ideological analysis as well. The sharing of experiences would entail both reflection and political action, with the objective of dismantling oppressive structures and mechanisms.

Conceptualization and integration of the "affective" domain, i.e., emotion and experience, are relevant to health care. (1) One of the values that health boards commonly include in their mission statement is compassion. Compassion is an emotion — allowing emotions to enter into "rational" decision-making processes is problematic. (2) Psychological health and the mind-body interaction are increasingly being recognized as legitimate areas of concern for the conventional medical system, let alone the wellness model. (3) Experiential and emancipatory methodologies are

increasingly being advocated in health promotion and community health work.

Held also critiques the classical models of democracy — developmental republicanism, liberalism and Marxism — along the narrow conception of the political.

> The narrow conception of the "political" in these traditions has meant that key conditions for the realization of the principle of autonomy have been eclipsed from view: conditions concerning, for example, the necessary limits on private control of productive resources if democratic outcomes are now to be skewed systematically to the advantage of the economically powerful (insufficiently examined by liberalism); and the necessary changes in the organization of household and childrearing, among other things, if women are to enjoy a common structure of political action (insufficiently examined by republicanism, liberalism and Marxism). (Held, 1996, p.309.)

In Held's view, politics is about power — as he defines it the *capacity* of social agents, agencies and institutions to maintain or transform their environment, social or physical. He agrees with the feminist perspective that politics cuts across public and private life and is involved in all the relations, institutions and structures which are implicated in the activities of production and reproduction in the life of societies. He believes that politics creates and conditions all aspects of our lives and it is at the core of the development of problems in society and the collective modes of their

resolution. In this way he sets the stage for a discussion of civil society (see Section 3.3).

> If politics is conceived in this way, then the specification of the conditions of enactment of the principle of autonomy amounts to the specification of the conditions for the participation of citizens in all those decisions concerning issues which impinge upon and are important to them (i.e., us). Thus it is necessary to strive towards a state of affairs in which political life — democratically organized — is in principle, a central part of all people's lives. (Held, 1996, p.310.)

Held's model of Participatory Democracy (not presented in detail in this thesis) contains proposals for promoting political efficacy in constituents and a concern for collective problems and the formation of a knowledgeable citizenry.

> An equal right to liberty and self-development can only be achieved in a participatory society, a society which fosters a sense of political efficacy, nurtures a concern for collective problems and contributes to the formation of a knowledgeable citizenry capable of taking a sustained interest in the governing process. (Held, 1996, p.271.)

These ideas are very pertinent for health boards in resolving over time some of the conflicts among or within communities (both of geography and of interest) in the health districts. The suggestions proposed in Held's model would be helpful to promoting democratic process for health boards: open information for informed decisions; reduction of bureaucracy; direct

participation and experimentation with political forms. Interestingly the first key feature he lists — direct participation of citizens in the regulation of the key institutions of society, including the workplace and local community — is what the formation of regional health boards is about.

3.3 Civil society

Some resolution in the long term to the problems of representation and accountability lies in expanding the venues and forms of democratic participation in society generally, while keeping an improved version of representational democracy. Development of civil society provides a way of deepening and extending democracy.

Keane argues that freedom and equality among individuals and groups depend upon preserving types of organizations that nurture local freedoms and provide for the active expression of particular interests. He argues that a pluralist and self-organizing civil society independent of the state is an indispensable condition of democracy. He points out that:

> There has never been a political regime which simultaneously nurtured democratic civil liberties and abolished parliament. Nor has there ever existed a political regime which simultaneously maintained a democratic parliament and abolished civil liberties. (Keane, 1988, p.182.)

He recommends two broad types of transformation. He first talks about a far-reaching transformation of the internal structures and parliamentary tactics of existing political parties; the replacement of electoral systems which disenfranchise minority parties and would-be parties by alternative systems (such as the single transferable vote form of proportional representation which more accurately reflects the voting preferences of civil society); and what he calls more active parliamentarism. He also encourages the development and maintenance of a creative tension between movements and voters, on the one side, and the party and the state on the other.

Keane argues that exposing the inadequacy of limited representative democracy challenges it to be both more democratic and more representative, and exposing its limits helps to legitimize, in the public consciousness, other structural routes to change, in particular that of mass-based social movements. Legitimizing social movements breaks the link between the *form* of liberal democracy (representative/parliamentary structures) and the *substance* of liberal democracy (individual rights and freedoms, justice and equality).

He argues that the democratic parties should abandon the false assumption that social development is always decided by parties and states.

> [Such a view] would instead acknowledge that further democratization of civil society ... depends ultimately on the way people live, love, work and socialize, and social initiatives and movements, and not parties or governments, are more capable of effecting these changes democratically. (p.144.)

He ends with references to multiple realities, and the tolerance of ambiguity implicit in fully democratic systems.

> Fully democratic systems...would recognize the necessity of relying always on judgment, for they would know of their ignorance, which is to say that they do not or cannot know or control everything. (p.240.)

Held's definitions of and conditions for democracy, developed as a prescription synthesized from his reviews and analysis are consistent with this view. This prescription focuses on the principle of autonomy and the pluralism of a civil society.

> ... the realization of the principle of autonomy would require the creation of a system of collective decision-making which allows extensive involvement of citizens in the diverse forms of political affairs that significantly affect them. A powerful case can be made ...that for such a system to be fully democratic it would have to meet the following criteria:
>
> - effective participation — citizens must have adequate and equal opportunities to form their preferences, to place questions on the public agenda, and to express reasons for affirming one outcome rather than another;
> - enlightened understanding — citizens must enjoy ample and equal opportunities for discovering and affirming what choice in a matter before them would best serve their interests.

- voting equality at the decisive stage — each citizen must be assured that his or her judgment will be counted as equal in weight to the judgments of other citizens at the decisive stage of collective decision-making.
- control of the agenda — the *demos* must have the opportunity to make decisions as to what matters are and are not to be decided by processes that meet the first three criteria.
- inclusiveness — the provision of the powers of citizenship to all mature persons with a legitimate stake in the polity (i.e., transients and visitors can be exempted).

(Held, 1996, pp.310-311.)

Held's model of democratic autonomy provides proposals about the state and civil society in such a perspective. Held would likely argue that the features of this model, while not all applicable to a health board, should be maximized as appropriate to the health board framework and mandate. Some of his "general conditions" seem particularly pertinent, that is, open availability of information; new democratic mechanisms from "citizen juries" to "voter feedback" to enhance the processes of enlightened participation; minimization of unaccountable power centers in public and private life; and maintenance of institutional frameworks receptive to experiments with organizational forms.

3.4 Summary

In this chapter, I reviewed the literature putting the historical and contemporary ideas about democracy on a continuum with structural

democracy clustered at one end and developmental democracy at the other. The review I presented shows that the ideas about democracy have in general moved over time from structural views to more developmental ones. Over the last century, social movements have pushed the ideas of democracy to encompass the ability and right to participate in society by a larger number of people in wider arenas of social life.

The correlation with time is not strict. In fact the early classical theorists can be seen as implicitly developmental in the sense that they saw participation in political life as part of human fulfilment and took for granted the rights and responsibilities of participation, albeit only among a narrower definition of citizens than prevails today. Conversely, in contemporary society, there are many who subscribe to the idea of a limited democracy — they see the right of each person to elect their representative to Parliament or its equivalent in other countries, as a necessary and sufficient precondition for the good society. In this view, going further to ensure equality of participation in other spheres would be encroaching on the rights of some citizens at the expense of others.

I have used the term developmental, as used by Held, to describe the cluster of features representing a "thick" view of democracy as compared to a "thin" view, limited to structure only. To recapitulate, structural democracy is about the concept of all citizens having the right to participate in choosing

their representatives to the state's highest, governing, authority. It includes the principle of equality among the citizenry, but only to the degree of equality in the right to elect. This is not a right or process to be thought of lightly. It has been established and legitimated in our societies over centuries. Its existence, however, has provided a basis for the evolution of ideas about the benefits of democracy to human development. Developmental democracy applies the criterion of citizen equality to participation in a wider range of sectors and at deeper levels of human experience.

Note that the differences between structural and developmental democracy should not be confused with the distinction between representative and direct democracy. Because the size of contemporary societies makes direct participation in the governing of the state impossible, it would be too easy to conclude that developmental democracy is therefore also not possible. However, ideas and strategies about developmental democracy, while emphasizing the significance of participation, do not require direct democracy at the state level. In fact, they address the question of how to maximize the ability to participate and exercise autonomy over one's life, and therefore maximize human development, within the framework of representative democracy. The mechanisms and processes to do this are part of the emerging strategies for civil society — of which health boards and similar devolved authorities are a part.

4. SURVEYS OF HEALTH BOARD MEMBERS AND OTHER DECISION-MAKERS

The conceptual discussion of democracy in the preceding chapter will serve as the basis for structuring my empirical analysis, which will be based on a series of surveys carried out in 1997 by HEALNet Regional Health Planning (RHP) in Saskatoon. RHP is part of a Network of Centres of Excellence research project with sites across Canada. It is located at the Health Services Utilization and Research Commission (HSURC) in Saskatoon, and focuses on regionalization. The objectives of RHP are to develop information-based decision tools for district health boards and to study regionalization itself in order to increase understanding about its various dimensions.

In February, 1997, RHP surveyed health board members in Saskatchewan, and managers in the health districts and Saskatchewan Health, about decision-making in health care. The survey included all health districts in Saskatchewan excluding the three boards in Northern Saskatchewan that were still in the process of formation. 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. A

summary report was published in December, 1997 focusing on decision-maker views of health reform and of information use (Kouri *et al.*, 1997).

The survey was designed by the RHP research team, composed of RHP principal investigators, research associates and research staff. Questionnaires were similar for the three respondent groups, with adjustments being made to account for their different roles in the system. Copies of each of the questionnaire booklets and their accompanying letters are provided in the Appendix.

Questionnaires were mailed in stages. Board members were mailed the questionnaires to their homes in early February, 1997. The list with addresses of all board members was obtained from Saskatchewan Health. A self-addressed, postage prepaid envelope for the return was included in their mailing. A reminder postcard was mailed three weeks later.

Questionnaires to district managers were also mailed in February, 1997, two weeks after the board member mailing. Ten questionnaires were sent to the Chief Executive Officer (CEO) of each of the 30 health districts. The CEOs were asked to distribute the survey to colleagues they would define as senior managers. Each questionnaire was accompanied by a prepaid self-addressed envelope so that each manager could return his or her questionnaire individually. The CEO was encouraged to request more questionnaires if needed. After two weeks, RHP staff called each CEO to

follow up on whether more questionnaires were needed, and how many indeed had been distributed, so that an appropriate response rate could be calculated.

The Saskatchewan Health managers, defined as all out-of-scope employees, were mailed a questionnaire in March 1997. A self-addressed, postage prepaid envelope for the return was included. A follow-up telephone call two weeks later by RHP staff served as a reminder and also established an appropriate denominator for the response rate. For example, some employees were away on leave, and others had disqualified themselves from the survey, on the basis that their job involved little contact with or knowledge of the districts.

Of the 357 board members, 275 (77%) responded. Of the 210 district managers, 150 (71%) responded. Of the 184 Saskatchewan Health managers, 100 (54%) responded (Table 4.1).

Table 4.1 Survey Response Rates

Survey	Number Distributed	Number Returned	Response Rate
Board Members	357	275	77%
District Managers	210	150	71%
SK Health	184	100	54%

Board member response was 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.

District managers' responses were also relatively well distributed among districts and represented a cross-section of the types of senior managers in the district. However, only 16 of a possible 30 CEOs responded. There were no data available to compare the job descriptions and other characteristics of non-CEO district managers who responded to those who did not.

Saskatchewan Health respondents also included a good range of managers. In Saskatchewan 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 reported they have a great deal of contact with district boards and/or managers, and an additional 37% report they have some contact.

These were not sample surveys, but surveys of total, defined populations. 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.

The surveys are subject to the same limitations inherent in all cross-sectional opinion surveys. The responses represent the views of the respondents at the time of the survey, that is, early 1997. Much has happened in the time since the surveys were carried out.

For the purposes of this thesis, however, the most significant limitation is that the surveys were not designed to explore in an explicit way the questions of democracy as I have discussed them so far. The data address only a subset of the questions raised.

Nevertheless, because many of the concepts of health reform are based on implicit notions of democracy, the surveys provide much that is relevant to the topic. Under the topic of structural democracy, I will first examine the extent to which the democratic intentions of the structural aspects of health reform have been realized. The surveys can indicate how well health board members as a group compare to the Saskatchewan population, along several sociodemographic characteristics.

Also under the topic of structural democracy, I will examine how board members perceive their role as authorities. The boards' relationship with Saskatchewan Health shapes their perception of their own autonomy. Do board members see themselves primarily as transmitters and administrators

of decisions made elsewhere? How do health board members perceive their own role, the role of health boards in general and health reform? How do other decision-makers in the system see them? In addition to the specific questions about regionalization in health care, these survey questions will indicate the extent to which boards might be considered elements of civil society — as agents semi-detached from the state with a societal role of their own.

I will next examine board member perceptions of themselves as representatives of their constituents. I will also consider what the other decision-makers in the system think about this. Regionalization has been rationalized by the desirability of democracy, i.e., as communities having more control over their health services. In general, do board members see themselves as representing their communities, and in what way? What are their views about how and to whom they are accountable? What do other health care decision-makers think about this? These results will inform the discussion of representation, and the modes of operation board members use as representatives.

In the discussion of structural democracy in Chapter Three, I noted that, even in its limited form as a system for choosing governments, democracy assumes and implies some form of equality in the society. However, although political equality is generally recognized as a precondition

for democracy, distributive justice has been a more contentious goal. I will therefore examine the issues of relationships with and within constituencies. Districts are examples of heterogeneous populations — different interests are at stake. How do board members deal with these differences? The challenge is how competing interests are resolved in a democracy — how interests are defined and how they are defended and promoted. As a subset of district residents, health care providers are a specific, controversial, local constituency for health board members. How do board members view the issues surrounding providers? How do other health care decision-makers view these decisions? Along with other competing community interests, those arising from health care providers are cases that embody the difficulties and also the test of democracy.

I will then explore the topic of developmental democracy. First, I will look at board members' own processes for arriving at decisions. If democracy is seen as a quality pervading the whole society, boards will be expected to use democratic processes in their own operations. What are board processes like? What is the quality of the participation of board members? What is their self-evaluation of the experience and of their own contribution with respect to the quality of discussions and their own participation? To what extent do board members see their own processes as important? Do they see themselves as democratic? In what way? Is participation important for them?

In the discussion of this topic in Chapter Three, I noted that human development is considered both a goal of and a precondition for democracy. There has been an extension of the idea of political equality to that of equality of participation as a precondition for human development and democracy, and in turn an extension of the idea of equality of participation to a wider range of forms of human experience as legitimate terrain for preconditions and goals of democracy — an expansion of boundaries. Finally there has been an extension to conscientization — fully participatory, autonomous, reflective and compassionate citizenship as a precondition for human development and democracy. I will therefore examine the board members' attitudes along this continuum. What are their views about citizen participation and consciousness?

The literature from Adamson, Held and Keane advocates a series of strategies designed to improve the organic relationships between the people and their authority: fostering pluralism, social movements for the generation of ideas, political efficacy, concern for collective problems and solutions; formation of a knowledgeable citizenry — about both the substantive content of issues and about collective solutions and democracy itself. What are health board views toward the development of such political efficacy? What are others' views?

In Chapter Two, I pointed out the relationship between equity and participation and health status. I therefore ask: What are board members' views of health enhancement in general? What are their views about population health, health determinants, and the wellness model? What do they see as the successes and failures of health reform for health? I compare these to other decision-makers' views.

5. DEMOCRACY AND HEALTH BOARDS

5.1 Structural democracy

5.1.1 Extent of representation

In representative democracy, the way in which authorities are elected and the way in which they function as representatives of their electors is a key issue. However, the word *represent* has two meanings. In its political meaning, it refers to a delegate with the authority to make decisions and act on behalf of others. However, it can also mean to reflect a larger population, as in how a sample may represent a population. To what extent do current health board members *reflect* their electorate?

In February 1997, there were 357 board members in the 30 southern health districts. A first point is that the HEALNet survey response rate of 77 per cent provides us with some confidence that the respondents' characteristics "represent" (e.g., reflect) those of the whole population of board members. Of the 357, exactly half were male and half were female. Two-thirds were elected and one-third appointed.

A second point is that it can be expected that the distribution of many of the characteristics of the population of board members as a whole will not be the same as that of the Saskatchewan adult population. This is partly because of the composition of the boards. That there are 12 board members in

each of the 30 districts means there will be an over-representation, in the board member population, of persons living in smaller and rural communities, compared to the Saskatchewan population as a whole. This structural over-representation implies that the board member population will more likely be older and have a higher proportion of farming and retired populations. Furthermore, in North America, electoral patterns are that elected populations tend to be older, better educated, have higher than average incomes, and have a higher proportion of men than the population as a whole.

Survey findings reveal that indeed Saskatchewan board members are older than the average Saskatchewan population, over half being in the 45 to 64 year old age group, a large over-representation compared to the Saskatchewan population (Table 5.1).

Table 5.1 Health board members (1997) and Saskatchewan population (1996) by age: 25 to 74 years

Age	Board Members (Per cent)	Saskatchewan Population (Per cent)
25-44 years	27	52
45-64 years	59	34
65-74 years	14	14
N	*268*	*550,665*

Note: There were 3 board members who did not provide their age, and four who were older than 74.
Source for Saskatchewan Population: Statistics Canada, 1996a.

To make an appropriate comparison of the board member age distribution with that of the Saskatchewan population, Table 5.1 is restricted

to persons between 25 years and 74 years inclusive. Widening the comparison to all those 18 years and over (eligible voters) would make the difference even more pronounced.

Health board members are more highly educated than the Saskatchewan population (Table 5.2). Because formal education is related to age in the population at large, I present the comparisons separately for the two major age groups of board members. However, both age groups reveal a similar pattern. The proportion of board members with a university degree is about twice that of the population as a whole. The proportion with other postsecondary education is about one and a half times that of the population. Virtually no board members have less than a high school education.

Table 5.2 Health board members (1997) and Saskatchewan population (1996) by education and age: 20-64 years

Education Level	Age 20-44 years		Age 45-64 years	
	Board Members (Per cent)	Sask. Popn. (Per cent)	Board Members (Per cent)	Sask. Popn. (Per cent)
University degree	30	16	45	16
Other post-secondary	47	29	41	26
High school	22	26	11	14
Less than high school	1	29	3	44
N	*70*	*349,135*	160	*187,075*

Source for Saskatchewan Population: Statistics Canada, 1996b

Board members are also more likely to be employed. Of those under 45 years of age, 94 per cent (66 of 70) reported they were full-time, part-time or self-employed, compared to 79 per cent of the 20 to 44 year old Saskatchewan

population. Of board members 45 to 64 years of age, 83 per cent (132 of 160) were employed compared to 72 per cent of the population. (Statistics Canada, 1996b.)

Almost half the board members are or were at one time health care providers, that is, employed in the health field. Twenty-eight percent (77 persons) of board members are currently employed in the health field: mostly nurses, several physicians and pharmacists, and therapists, technicians, and administrators. An additional 19 per cent (52 persons) have been employed in the health field in the past.

Consistent with their higher age, education and employment levels, board members have a somewhat higher than average annual household income: approximately $60,000[1] (n=244) compared to the $42,685 for Saskatchewan households in 1995. (Statistics Canada, 1996c.)

Appointed and elected members have more similarities than differences. Appointed members are 50 per cent male while elected members are 46 per cent male. Appointed members tend to be a bit younger, although over half of both groups are between 45 and 64 years of age. And all four persons over age 74 are appointed. Appointed members have a somewhat higher proportion of persons with a university degree (38 per cent of

[1] Average income was calculated from the income categories by assigning each respondent the mid-point of the range that he or she indicated. Those responding in the top category of $100,000 and over were assigned the income of $110,000. This is a conservative figure. Using a higher value would make the difference from the population even larger.

appointed compared to 34 per cent of elected) and conversely elected members have a somewhat higher proportion of persons with high school only (18 per cent of elected compared to 13 per cent of appointed). Appointed members have somewhat higher annual average household incomes ($63,000 for appointed compared to $58,000 for elected.) The most surprising difference is that the proportion of appointed members who currently are health care providers is lower than for elected members: 20 per cent compared to 32 per cent.

The number of children in the home is also an important factor, especially for women. In Saskatchewan, the proportion of husband-wife families without (never-married) children at home was 43 per cent in 1996 (Statistics Canada, 1996d.) By comparison, the proportion of married board members with no persons under 18 years at home was much higher at 65 per cent. The lower proportion of children at home and the higher than average age of board members would, of course, be related. Two-thirds of all board members had no persons under 18 years of age living in their home. The proportion was exactly the same for both elected and appointed board members and very similar for males (68 per cent) and females (65 per cent).

The survey asked board members to explain what factors make it easier for them to function as board members, and what factors make it more difficult (Table 5.3). This was an open-ended question.

Table 5.3 Factors making it easier or more difficult to be a board member

What made it easier? (Principal reasons; can be duplicate)	Per cent of board members
Personal resources/time/income/energy	50
Previous experience with organizations, the community	22
Knowledge of and interest in health care	20
Supportive family/colleagues	15
N	*275*

What made it more difficult? (Principal reasons; can be duplicate)	Per cent of board members
Other commitments (work, family, community)	76
Family, friends and neighbours as health providers	28
Time demand	16
Travel requirements	10
N	*275*

As might be expected, the main factors that make it more difficult are time factors and other commitments. Conversely, among the factors that made it easier were time and other resources, and the support of family, friends and colleagues. Previous experience was another facilitator. These factors are among those one would expect to affect the level of voluntary participation in organizations. One unexpected finding is the strength of the other major factor causing difficulty — having family, neighbours and friends who work for the health district.

Only 31 per cent of board members reside in the town or city where the district health board office is located. For the 71 per cent who have to travel to meetings, the average distance is 68 kilometers. Appointed members have

a somewhat higher proportion who reside in the head office community (36 per cent compared to 29 per cent) and their average distance to the district office for those who travel is 60 kilometers compared to 72.

Board members are in general community leaders. Most of them have experience on some other board or agency. Fully 94 per cent report having served as a volunteer in community organizations. Over two-thirds (68 per cent) have served on other boards in the past. For 10 per cent of board members, however, this other service was restricted to a hospital board. (Altogether, one quarter of health district board members had been members of hospital boards.)

On the other hand, close to half (48 per cent) of health board members have served at some point on the board of a non-governmental organization and one fifth (20 per cent) have served on a school board. Eleven persons were board members of a Crown corporation and 2 board members have been MLAs.

The survey did not inquire about the ethnic origin of board members. One of the important questions in Saskatchewan is the representation of the Aboriginal population. Because of the jurisdictional questions around First Nations governments, the question of what proportion of the health board constituents are of Aboriginal ancestry is not easily answered. However, as discussed in Chapter 2, the appointment process was designed on the assumption that persons of Aboriginal ancestry would be underrepresented

in the electoral component, and in districts with high Aboriginal populations, at least one board member was appointed from the Aboriginal communities specifically so that boards would better "reflect" this population.

In summary, board members as a whole are older, better educated, and have higher incomes on average than do the population from which they are drawn. This is true for elected board members as well as for appointed ones. These findings confirm what would be expected. Indeed, resources for running for election, and particularly for serving after being elected are factors in why more established and better educated persons have a higher chance of being members of elected bodies. Social status serves to screen people out of campaigns before it has a chance of having an effect in the actual choice by constituents.

The one feature that is unexpected compared to other elected groups is that district health board members have an equal distribution of males and females. This is true of the elected as well as the appointed. Two trends about women's participation in public life could partially explain this. In general, the more local the structure, the more likely women will participate. In addition, health care is a field that has received a relatively high degree of women's concern and involvement.

Finally, as might be expected, survey findings show that health board members are part of the network of local leadership in Saskatchewan.

5.1.2 Health board authority

The distribution of power, authority and accountability are the main questions of democracy as a political enterprise. In Chapter Two, I pointed out that the extent of authority that has been devolved to health boards from the provincial government is a contentious issue. To what extent are health boards able to be governing bodies? Indeed, the relationship with Saskatchewan Health is problematic for board members. Only 53 per cent agree that the division of authority between district health boards and Saskatchewan Health is clear (Table 5.4). Fully three-quarters (76 per cent) feel that health boards are legally responsible for things over which they have insufficient control and 63 per cent feel that boards are too restricted by rules laid down by the provincial government.

Table 5.4 Health board authority: views of elected and appointed board members

Respondents in agreement with the following:	Elected (per cent)	Appointed (per cent)	All (per cent)
The division of authority between district health boards and Saskatchewan Health is clear.	47	62	53
Health boards are legally responsible for things over which they have insufficient control.	79	59	76
We're (the boards) too restricted by rules laid down by the provincial government.	66	57	63
N	*173-175*	*83-89*	*256-520*

The relationship is more problematic for elected than appointed members. Fewer than half of elected members feel the relationship is clear, compared to 62 per cent of appointed members, and 79 per cent of elected members feel they are legally responsible for things over which they have insufficient control compared to 59 per cent of appointed members.

A related issue is that of local control over health services. Board members were asked what they thought were the effects of health reform in Saskatchewan over the last five years on local control over health services: 63 per cent report that local control has increased; another 24 per cent, however, report that it has decreased. The view that it has decreased is more prevalent among elected (30 per cent) than appointed members (12 per cent).

These results about the delegation of authority from the province to the boards speak to the issues around the dual nature of health boards — they are partly governmental and partly non-governmental. Health boards have much in common with Crown corporations, commissions, school boards, municipal councils and other forms of quasi-governmental formations that exist in Saskatchewan and Canada. They are restricted by their mandate, their regulations, and their resources. On the other hand, they exert a degree of autonomy and create societal relations in their own sphere. To an extent, they are organizations which nurture local freedoms and provide for the active expression of particular interests, to use the Keane formulation described in Chapter 3, and part of what is broadly called the civil society.

Many non-governmental organizations that are nominally independent are in practice dependent on the state for funding. However, although this might impede their role in practice, it does not impede it in a legal or formal way.

Other decision-makers have different views on the question of authority than do board members, and indeed from each other (Table 5.5). District managers are on the whole more dissatisfied with the role of health boards than are board members. Perhaps this is because structurally district managers have the least authority and the most responsibility to deliver. Conversely, Saskatchewan Health managers show the least discomfort with the differentiation of roles.

Table 5.5 Health board authority: views of board members (BM), district managers (DM) and Saskatchewan Health managers (SK)

Respondents in agreement with the following:	BM (per cent)	DM (per cent)	SK (per cent)
The division of authority between district health boards and Saskatchewan Health is clear.	52	26	43
Health boards are legally responsible for things over which they have insufficient control.	72	78	31
We're (the boards) too restricted by rules laid down by the provincial government.	61	72	19
N	*271*	*148*	*97*

The survey of Saskatchewan Health managers included a series of questions designed to elicit their views about health reform changes on their own situation. Results reveal that on the whole, Saskatchewan Health

managers are not negative about district abilities or about regionalization. In fact 61 per cent feel the system is more effective than before and 72 per cent feel it is more democratic.

5.1.3 Accountability and representation

Although the relationship with Saskatchewan Health may require clarification, there appears to be less ambiguity on the part of health board members with respect to the relationship with their electorate. When asked the question *To whom do you feel most accountable for your decisions?*, the large majority of board members (76 per cent) respond they feel primarily accountable to all district residents. Only 8 per cent report feeling most accountable to all residents of their ward or to the group they represent, and fewer still (4 per cent) to the Minister of Health (Table 5.6). Proportions are similar for elected and appointed members, and for health care providers.

Table 5.6 Board accountability: views of board members*

To whom do you feel most accountable for your decisions?	Per cent selecting the item
All residents of my district	76
All residents of Saskatchewan	10
Residents from the ward or group I represent	8
The Minister of Health	4
Local interest groups I identify with	1
Other	1
N	*229*

* Those who selected more than one option were excluded from this table.

The formal relationship of board members to their district residents is one of representation in a political sense. In terms of the Reimer categories I described in Chapter 3, i.e., trustee, delegate, partisan and politico, these findings indicate that the majority of board members operate mainly in the trustee mode — 87 per cent believe that even if a decision is opposed by the majority of citizens in the community, they will support it if they believe it is the right decision (last row of Table 5.7).

Nevertheless, the large majority (91 per cent) of board members feel their board values reflect those of the district. They also feel that they represent their constituents' interests: they believe they have an accurate understanding of what district residents want (84 per cent) and have their support, understanding and respect (70 per cent), even when they do not agree. However, 43 per cent state that being a board member has provoked some resentment toward them by people in the community.

Board members are committed to resident input into their decisions. Board members are virtually unanimous (99 per cent) in agreeing that district residents are entitled to make representation to the board when they have an issue. And 82 per cent of members feel that patients should have a greater say in how their health needs are met.

Table 5.7 Board relationship with district residents: views of board members

Respondents in agreement with the following:	Per cent
Our board's values reflect the values of the district.	91
Our board is responsive to wishes of district residents.	80
My input to board decisions is strongly affected by the people in my community.	69
Our board has an accurate understanding of what district residents want for the health care system.	84
Most district residents are supportive of our board choices.	71
Even if they don't agree, most district residents generally understand and respect our board choices.	70
Being a board member/Carrying out my duties as a manager has provoked some resentment toward me by people in the community.	43
Public pressure sometimes forces our board to make decisions we would not otherwise make.	32
Our board effectively communicates the rationale for our decisions to district residents.	66
District residents are entitled to make representation to the board when they have an issue.	99
Patients should have a greater say in how their health needs are met.	82
Even if a decision is opposed by the majority of citizens in my community I will support it if I believe it is the right decision.	87
N	*272-275*

The majority (80 per cent) of members state that they are responsive to the wishes of district residents and 69 per cent say their input to board decisions is strongly affected by the people in their community. In fact, one third (32 per cent) feel that public pressure sometimes forces the board to make decisions they would not otherwise make.

Among the different types of information they receive, information about citizen opinions and preferences and patient/client satisfaction is rated as less adequate. However, in their opinion, the need to make decisions

quickly does not prevent adequate consultation with interested parties — 88 per cent report this happens rarely or only on occasion.

Although on the whole, board members appear to be comfortable with the idea that they represent their districts adequately, there were some differences between appointed and elected members about their perception of the relationship between the board and the district residents. Appointed members are more complacent about the relationship: for example, 75 per cent of appointed members feel that even if they do not agree, most district residents generally understand and respect board choices, compared to 62 per cent of elected members. Similarly, 72 per cent of appointed members feel the board effectively communicates the rationale for decisions to district residents, compared to 62 per cent of elected members. Although 87 per cent of appointed members feel the board is responsive to residents, only 77 per cent of elected members agree. On the other hand, a higher proportion of appointed members (48 per cent) feel resentment in the community compared to elected members (41 per cent). However, these differences between appointed and elected members are small compared to the overall trend in the data.

The large majority (83 per cent) of board members are in favor of continuing the ward system of elections rather than a district-wide basis. The elected members feel this more strongly (89 per cent) than appointed members (71 per cent). However, only 28 per cent feel that elected members

should primarily represent the interests of their wards — 34 per cent of elected members and 19 per cent of appointed members. One-fifth (20 per cent) of board members believe that candidates in future board elections should run as members of slates presenting platforms — with the elected members (22 per cent) being more in favor than appointed ones (16 per cent).

With reference again to the Reimer categories, these results indicate that board members, while not subscribing to the delegate approach, in which they would tie themselves to the wishes of their ward constituents, are also not largely in favour of a partisan approach, in which board members would be tied to particular groups' positions. Indeed I pointed out above that most say they would support a decision they felt was right even if they knew a majority of their constituents were opposed. On the other hand, they report being responsive to the wishes of district residents, and that their input to board decisions is strongly affected by people in the community. These opinions are not necessarily contradictory — they could represent the fourth Reimer category — which he describes as balancing the three roles of trustee, delegate and partisan.

District managers and Saskatchewan Health managers are not as positive as board members about board relationships with residents (Table 5.8).

Table 5.8 Board relationship with district residents: views of board members (BM), district managers (DM) and Saskatchewan Health managers (SK)

Respondents in agreement with the following:	BM (Per cent)	DM (Per cent)	SK (Per cent)
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*
Our board effectively communicates the rationale for our decisions to district residents.	66	56	16
N	*272-275*	*145-150*	*98-100*

* Saskatchewan Health managers were not asked this question.

Saskatchewan Health managers in particular have markedly lower confidence about board members being responsive to, understanding and communicating well with their district residents, and about district residents supporting board choices. A large majority (87 per cent) feel that public pressure sometimes forces the board to make decisions they would not otherwise make.

Putting these views together with those reported previously about Saskatchewan Health managers feeling on the whole that the regionalized health system is more democratic than before indicates that these managers

subscribe to the view that democracy makes local authorities more vulnerable to public pressure.

5.1.4 Health care providers

One special constituency among the residents of the district is the providers of health care, whether these be employees of the health district or independent practitioners. As I indicated earlier, close half of board members themselves are or have been health care providers.

Respondents were asked whether they see health care providers as being more influential than other district residents. A minority (42 per cent) of board members agree physicians are more influential and a smaller minority (37 per cent) agree that nurses and other health care providers are. This opinion was equally shared among elected and appointed members.

Two-thirds of board members (67 per cent) feel that nurses and other (non-physician) providers should have more say in planning and providing health services. Just under half (47 per cent) feel that physicians should have more say. The proportions are higher for current providers on the board (85 per cent compared to 59 per cent for nurses having more say and 57 per cent compared to 47 per cent for physicians having more say).

It is interesting, however, that Saskatchewan Health managers are relatively more supportive than board members about providers having a greater say in planning and providing health care services (Table 5.9).

Table 5.9 Providers' role in planning health care services: views of board members (BM), district managers (DM) and Saskatchewan Health managers (SK)

Respondents in agreement with the following:	BM (Per cent)	DM (Per cent)	SK (Per cent)
Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	64	67	79
Physicians should have a greater say in planning and providing health care services.	47	45	51
N	*275*	*148*	*100*

Close to two-thirds (64 per cent) feel that most district physicians are supportive of their board choices and 57 per cent feel that other providers are. This is less than the 71 per cent agreement with the analogous item about district residents being supportive. Again, elected members show less agreement on this item than do appointed members. Although providers on the board share the opinion of other board members about physicians' support, they show far less agreement about the board having the support of nurses and other health care providers (44 per cent compared to 62 per cent).

These findings indicate an ambivalence among board members about the role of the health care providers as participants in the processes of decision-making. Their role in the planning aspects appears to be supported

— however, whether or how their role should be extended as a special constituency in the shaping of policy is not clear from the survey.

5.1.5 Democratic process

When Held provided his definition of democracy, he indicated that contemporary societies are increasingly taking democracy to include democratic relationships pervading the whole society. Democratic governments must not only be selected democratically, they must operate democratically. What this means in practice is not fully defined. As a minimum, however, it includes equal access to participation in discussion, equal access to information and open processes for debate.

There are five items in the questionnaire that ask respondents about their role within the board (Table 5.10). There is a high level of agreement among the board member respondents on all of these items. So to the extent these features constitute democratic process, the members' experience of the board is that it is democratic.

Over 90 per cent of respondents agree that they have a clear understanding of their role in the decision-making process; they are respected by other board members, they are comfortable in asking for more information if they feel it is needed, and they feel comfortable in proposing new items for the agenda. These are all typical process criteria for democratic group

behaviour. Because of the near unanimity on these items, I did not explore the issue further to identify any relationships with the characteristics of the respondents.

Table 5.10 Board role: views of board members

Respondents in agreement with the following:	Per cent
I have a clear understanding of my role in the decision making process.	97
I am respected by other board members.	92
I am comfortable in asking for more information if I feel it is needed.	97
I feel comfortable in proposing new items for the agenda.	90
I influence the decisions made by my board.	78
N	*272*

The only item in Table 5.10 where the agreement is substantially lower is the item about whether the board member influences the decisions made by the board. There was still strong agreement about this at 78 per cent, but because it was lower than the others, and because it is in a sense a more outcomes-based test of democratic process — that is, whether the criteria of respect, understanding, etc. actually translate into more influence — I investigated whether the lack of influence is felt more by some respondents than others. I compared elected to appointed, education, residence, age, and labour force status of full-time homemaker, retired, and self-employed, and health care provider. For only two of these variables was the difference notable — education and age. Proportionately more of those aged 55 years and over feel they do not influence decisions, compared to those

who are younger (26 per cent compared to 13 per cent). A somewhat higher proportion of providers feel they do not have influence on board decisions (22 per cent compared to 17 per cent).

The large majority (89 per cent) of board members report they are usually or always influenced by knowledge gained from their own experience when making board decisions. And two-thirds (66 per cent) state that their personal experiences with the health care system strongly influence their work as board member.

Board members were asked about the mix of appointed and elected members. Most (63 per cent) board members feel that the mix is satisfactory; however 31 per cent feel there are too many appointed members. These latter are almost all elected members (96 per cent). Elected members and appointed members differ in their opinions of each other. Just over half (55 per cent) of elected members feel that they have more legitimacy and credibility in the community than do appointed members, but only a quarter (24 per cent) of appointed members agree. And although the same proportional discrepancy exists for the analogous item about appointed members, the level of agreement is much lower. Only 17 per cent of appointed members feel they are more knowledgeable about health issues than elected members, and 9 per cent of elected members agree.

The above discussion refers to the experience of board members as individuals. I now turn to an examination of board process as reflected in the

reports of members about their board. The quality of board discussions was rated highly — 36 per cent believe that their board discussions are always helpful to making decisions and an additional 56 per cent that they are usually helpful, and only 9 per cent feel that decisions are usually or always made before adequate discussion.

I also examined several other items describing board process which reflect first, openness and respect for different views, and second, the seeking of diversity in a more proactive way. I also looked at board mechanisms for identifying and considering moral and ethical values in decision-making and for resolving conflicts among members.

The large majority of members agree that their board respects all views (83 per cent), including between elected and appointed members (88 per cent) and men and women (83 per cent) (Table 5.11).

Table 5.11 Board members' opinions of their board's process

Respondents in agreement (a) or disagreement (d) with the following:	Per cent
Within the board itself, the views of elected members carry more weight than those of appointed members (d)	88
All board members' views are respected. (a)	83
Men's views tend to be heard more than women's in board decision-making. (d)	83
Our board can be described as valuing diverse points of view (a)	75
Discussion of different points of view rarely causes anyone to change his or her mind. (d)	67
Vested interests have too big a say in board decisions. (d)	61
Our board has satisfactory mechanisms to consider moral and ethical values in its decisions. (a)	78
Our board has adequate procedures to resolve conflicts among members. (a)	68
Our board can be described as seeking out assumptions underlying members' points of view. (a)	53
N	*272-274*

The size of the majority decreases, but remains substantial, on the item asking whether the board values diverse points of view (75 per cent). Consistent with this are the 67 per cent who disagree that discussion of various points of view rarely causes anyone to change his or her mind — in other words, discussion has an effect. A similar proportion (61 per cent) disagree that vested interests have too much of a say in board decisions. This latter item, however, could either express comfort with vested interests, or the absence of vested interests.

The last three items in Table 5.11 are perhaps more revealing. Although 78 per cent agree are satisfied with their board mechanisms for considering ethical and moral values in decisions, only 68 per cent feel their processes for resolving conflict among members are adequate, and just over half (53 per cent) agree that their board seeks out assumptions underlying different members point of view.

5.2 Developmental democracy

The literature reviewed in Chapter Three provided the background for the way in which equality, distributive justice, and democracy as human development are related to each other. In Chapters One, Two and Three, I indicated that equity and distributive justice are part of the wellness model through the arguments about the determinants of health and the health of

populations. In this section, I examine board member views of population health — in particular those having to do with equity and human development. The questionnaire was not designed specifically to examine this question. However, some indications are provided by board member responses to items about health and board goals.

The survey reveals a high degree of agreement among board members about the wellness-related concepts of health (Table 5.12). There is almost universal agreement (99 per cent) that health is more than the absence of disease. As little as a decade ago, this idea would not have been so widely accepted.

Table 5.12 Health and wellness: views of elected and appointed board members

Respondents in agreement with the following:	Elected (per cent)	Appointed (per cent)	All (per cent)
Health is more than the absence of disease	99	99	99
Health is primarily affected by non-medical factors, including social and economic conditions.	96	94	95
More health care resources should be targeted towards groups with high needs that may not have been well-served in the past.	94	95	94
There was no need for extensive health care reforms.	8	7	8
Health reform is mainly about shifting emphasis from sickness care to wellness.	87	89	90
The main reason that the government gave authority to health districts is because there are tough budget decisions to make.	51	35	47
The pace of change in health reform has been too fast.	65	53	62
Our district has lost out because of health reform.	31	17	27
The changes made in the last five years have been for the best.	75	87	82
N	*177-180*	*92-93*	*269-273*

Even more surprising is that almost as many (95 per cent) agree with the determinants of health argument that "health is primarily affected by non-medical factors, including social and economic conditions" and (94 per cent) with the needs-based argument that more health care resources should be targeted towards groups with high needs that may not have been well-served in the past. Indeed only 8 per cent believe that extensive health reform was unnecessary.

To explore the issue of egalitarianism among board members further, I examined the items that were more specific about the distribution of health services. First I examined the questions of commitment to universal medical care. Only 15 per cent of board members agree that those who can afford to should be made to pay directly for their health care, and 22 per cent agree that we can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services. There is some overlap in these two items, but altogether 28 per cent agree with one or the other. For the purpose of the discussion that follows I term this the *user-pay* characteristic.

The proportion of men who agree with *user-pay* is somewhat higher than of women (34 per cent compared to 23 per cent). Current providers on the board are somewhat less likely to be *user-pay* advocates than others (23% compared to 30%). Elected and appointed members hold similar views on this

issue, with elected members being only slightly more likely to agree with *user-pay* than appointed members (29 per cent compared to 26 per cent). One interesting finding is that 38 per cent of those with bachelor's degrees agree with *user-pay* compared to 23 per cent of those with higher degrees. In fact, the proportion of *user-pay* board members is higher for those with bachelor's degrees than for all other educational categories. There were no discernible trends in views of board members on this issue by income.

Another indicator of egalitarianism is the idea that more health services should be targeted to residents living in poverty. Altogether 78 per cent of the 260 respondents who provided an opinion on this question feel that their district should increase their services to residents living in poverty — 21 per cent saying the services should increase a great deal. A deeper look into respondent characteristics reveals that two respondent characteristics showed a difference in whether board members feel that their district should increase services to the poor — whether the respondents are female and whether they are relatively poorer themselves. About 28 per cent of female board members state that these services should increase a great deal, compared to 15 per cent of male board members. The trend for income is displayed in Table 5.13. In general lower income board members are more supportive of increasing services to the poor.

Table 5.13 Board members who agree that services to people living in poverty should *increase a great deal* in their district by income of board member

Annual Household Income of Board Member	Per cent in Agreement
Under $20,000	33
$20,000-39,999	28
$40,000-59,999	30
$60,000-79,999	11
$80,000-99,999	17
$100,000 plus	18
N	*244*

A question related to that of poverty is whether the district should greatly increase its services to residents of Aboriginal ancestry. The proportion of all board members feeling this is 15 per cent. However, the districts of East Central, Assiniboine Valley, Saskatoon, Northwest, and Gabriel Springs have especially high agreement with this — all districts with a high First Nations population. And as I indicate below in Table 5.14, for four per cent of board members, improving relations with First Nations is one of their hoped-for successes over the next few years. Assessing this response is difficult, however, for two reasons. First, not all districts have a substantial First Nations or other Aboriginal population. Second, health services for First Nations members fall under federal, not provincial, jurisdiction. Therefore saying the health district should not increase its services to First Nations members would not necessarily mean they should not get more services.

Board members were asked to list three successes or accomplishments they would like their board to achieve over the next two years (Table 5.14). Of the 230 board members who responded to the question, 98 (43 per cent) provided relationship-oriented responses, that is, referring to relationships with the public, affiliates, or providers, and to reducing inequities among groups of residents.

Table 5.14 Desired board successes, selected for relationship-oriented attributes: views of board members

Success Category	Per cent of responses
Increased communication with the public to increase confidence of the public in the board, or to educate or persuade the public	10
Improved communication with the public to have more input from and better relationships with the public	9
Improved relationships with providers	10
Improved relationships with affiliates	8
Improving relationships and equity with First Nations residents	4
N	*230*

Altogether 19 per cent of board members mentioned improved communication with the community as a sign of success in the future. Half of these (10 per cent of respondents) spoke of communicating with the public to increase confidence of the public in the board, or to educate or persuade the public. The other half (9 per cent of respondents) described it as a desire for input from or partnership with the community. Other preoccupations were relationships with providers and affiliates. Only four per cent of board members explicitly mentioned improving equity as a goal — all of these

responses in reference to First Nations. In summary, when asked about their anticipated successes in an open-ended format, only a minority of board members describe their success as having to do with changing power relationships between themselves and others in the community or with improving equity in society.

5.3 Summary

The survey findings show that for board members, the devolution of authority as an issue remains contentious. There is a substantial number of board members for whom the relationship with Saskatchewan Health is not clear, and there is also a difference in views among the various groups of health care decision-makers about how resolved the issue is — Saskatchewan Health managers are more satisfied on this issue. In addition to the lack of clarity, there is contention about the extent of control that has been devolved.

Health board members are committed to the notion that they are to represent their constituents as much as possible. They see themselves as primarily accountable to district residents. They also feel their constituents are entitled to make their views known to the board. This opinion corresponds to other items in the questionnaire that indicate that board members see their boards as democratic structures. This opinion about the boards is shared by the managers in the system.

The survey results indicate that board members, while not subscribing to a delegate approach, in Reimer's terms, in which they would tie themselves to what their ward constituents want, are also not largely in favour of a partisan approach, in which board members would be tied to particular groups' positions. Most say they would support a decision they felt was right even if they knew a majority of their constituents were opposed. On the other hand, they report being responsive to the wishes of district residents, and that their input to board decisions is strongly affected by people in the community.

There is ambivalence, however, among respondents about the strength and nature of relationships with district residents — not all are convinced that board decisions are understood and supported by residents. District and Saskatchewan Health managers are not as positive about board relationships with residents. This ambivalence is an indication of the difficulty inherent in health reform's goal to "increase citizen ownership of the health system." From the boards' commitment to democracy in the sense of allowing constituents a voice and being open to their input inevitably emerges the problem of how best to actually represent their constituents amid different points of view.

Board members appear to be satisfied with the democracy in their own processes. They report being open and process-oriented in their group decision-making. Where they are slightly less satisfied is in mechanisms to

resolve conflict, and not unrelated, in understanding each others' underlying views.

Survey findings are not as clear with respect to the board members' understanding of, or commitment to, developmental democracy. Board members express a commitment to population health ideas in general and to health reform. They also express commitment to targeting groups with special needs and to increasing services to those living in poverty. On the other hand, only a minority of board members perceive changing power relationships or improving equity as health board goals. Although the limitations of the survey have to be taken into account in assessing their views — the questions were not asked directly — the responses to the questions about goals and anticipated successes for health district show limited acknowledgment of the significance of participation, a key tenet of developmental democracy. Although health board members express a desire to be closer to their communities, their desired relationships and communication with residents are more in the direction of education than of political interchange. They do not exhibit a strong commitment to communication in dialogic or deliberative forms. Nor do they see the ability of citizens to act and interact with each other as an issue for their mandate. In short, the survey findings do not show board members as explicitly considering issues of political efficacy or perceiving themselves as components of civil society.

6. CONCLUSION

In the examination of the relationship between district health boards and democracy in this thesis, I looked at district health boards as instruments of both structural democracy and of developmental democracy. I reviewed the background and policies underlying regionalization and health reform to show the explicit linkage made between democratic intentions and the creation of district health boards. I provided current research evidence that shows, in more detailed ways than before, the connection between long term health status and equitable social relationships in society and, by extension, to developmental democracy.

I used democratic theorists to elaborate the historical and contemporary ideas surrounding the concept of democracy, and its different interpretations. In reviewing these ideas, I emphasized the distinction between structural democracy and developmental democracy. Structural democracy is about the concept of all citizens having the right to participate in choosing their representatives to the state's highest governing authority. It includes the principle of equality among the citizenry, but only to the degree of equality in the right to elect. Developmental democracy applies the criterion of citizen equality to participation in a wider range of sectors and at

deeper levels of human experience. It represents a "thick" view of democracy as compared to a "thin" view, limited to structure only.

I then used the findings from the surveys of health board members and other decision-makers to identify to what extent the ideas about democracy form part of the current perspective of these decision-makers. How do board members see themselves with respect to these issues? How do they see themselves as authorities? To whom are they accountable?

Do they see democracy in structural terms only, or do they also have a developmental perspective in terms of a commitment to equity, social participation, and political efficacy?

The survey findings show that for board members, the devolution of authority as an issue remains contentious. In addition to the lack of clarity about roles, there is contention about the extent of control that has been devolved. However, health board members see themselves as democratic structures and are committed to the notion that they are to represent their constituents as fully as possible. They see themselves as primarily accountable to district residents and feel their constituents are entitled to make their views known to the board. There is ambivalence, however, among respondents about the strength and nature of relationships with district residents — not all are convinced that board decisions are understood and supported by residents. There is also some uncertainty about how best to

represent or reconcile different points of view in their district or within the board.

Survey findings are not clear with respect to the board members' understanding of, or commitment to, developmental democracy. Board members certainly express a commitment to population health ideas in general and to health reform. They also show commitment to targeting groups with special needs, and to increasing services to poorer residents. However, there is less evidence about board members' understanding of the significance of democratic practice with respect to health. Although the limitations of the survey have to be taken into account in assessing their views — these issues were not put to them directly — the responses to the questions about goals and anticipated successes for the health district reveal limited acknowledgment of the importance of participation or interaction. Although health board members express a desire to be closer to their communities, their desired relationships and communication with residents are more in the direction of education than of political interchange. Nor do they see the ability of citizens to act and interact with each other as an issue for their mandate. In short, the survey findings do not show board members as explicitly considering issues of political efficacy or perceiving themselves as components of civil society.

I am not arguing this is a surprising finding. In fact, the level of commitment there is among board members and decision-makers to the

democratic and equitable components of health reform is more surprising. Public media coverage about the health care system generally paints a picture of a cynical and dissatisfied public. Yet board members, the majority of whom are "members of the public," do not express the same cynicism.

However, they appear to be unaware of the limitations to structural democracy as they are experiencing it. An ambiguous and possibly incomplete devolution of authority combined with an increased standard of accountability and responsiveness to citizenry may be untenable in the longer term. Board members are likely to respond by seeking strategies to make their position more stable and less ambiguous. This may mean striving for more autonomy and establishing more formalized, less open, and more protected relationships with citizens.

However, a less participatory form of structural democracy, even were this to occur, would not necessarily be the most significant implication for democracy. Because there is a distinction between having structural forms of democracy and advancing substantive democracy, it is possible for a board to be developmental and sensitive to democratic forms and objectives without the citizenry being involved in their business in a structural sense. Whether one needs to be a true citizen to experience good health is quite a different contention than that one needs citizens to express their participation and citizenship by actively governing and interacting with the health system. People need to participate in society; their health will be better if they feel

connected; but health care may not necessarily be the area where they should be spending their civic resources.

From a population health perspective, therefore, the more problematic implication may be that the board members' relatively lower level of commitment to developmental democracy and their limited understanding of its relationship to better health will limit what they achieve in the long term. In fact, I would argue that without this understanding, they will not be able to achieve their mandate of improved health status. It is true that the effect of an absence of attention to developmental democracy may not be obvious in the short term. However, if the evidence from population health research is correct, in the long term the effects will be experienced in limited health gains.

The implications of these conclusions are that board members should bring more attention to bear on the issues of political efficacy and developmental democracy. Ideas and strategies about developmental democracy address the question of how to maximize the ability to participate and exercise autonomy over one's life, and therefore maximize human development, within the framework of representative democracy. Held's proposals for democratic autonomy, for example, call for promoting effective participation and enlightened understanding of the citizenry — with distributive justice as a foundation. The mechanisms and processes to do this are part of the emerging strategies for civil society — of which health boards

and similar devolved formations might play a part. Held talks about experimentation with organizational forms. As organizations of civil society, district health boards would contribute to both democracy and health by enacting such proposals.

There are implications of these findings for further research. The most evident need is for more information about what the population at large thinks about the issue of regionalization and health reform. What is the extent of support and understanding among the public about the relationships between long term health status and social equity and democracy? Research at the board level is also required. For example, there should be more in-depth study of board opinions to probe more fully their views on developmental democracy and its potential. There should also be more research focusing directly on the linkages among power, participation and health — what are the pathways involved?

Perhaps most importantly, there should be more research and analysis into formations and processes of social organization that enhance democratic autonomy and human development.

Such research would then have its own implications for how boards should function. As I indicated above, the survey results are limited, especially in providing insights about board members' views on developmental democracy. Findings are mixed. Although I could not find a strong, expressed commitment to developmental democracy as I have

formulated it here, it is also true that the survey identified many elements that are related to it. There is continuing support for universal medical care. Board members and other health care decision-makers are committed to the egalitarian ideas of population health and targeting health services to those with high needs that may not have been well served in the past. Such commitments are certainly prerequisites for developmental democracy and they hold promise for the future.

Afterword

Two years have passed since the surveys used in this thesis were carried out. Much has happened in the province since that time. At the time of writing, Canadians have just experienced a federal budget debate in which the most controversial issue was the restoration of federal-provincial transfer payments for health care. Saskatchewan is currently approaching a provincial election and health care has immediately emerged in a politically partisan way. The opposition is focusing on hospital closures as a symbol of current government reductions in health care. That there are no such announced closures and that the responsibility for this area is now in the hands of health boards are facts that so far have not entered the debate.

Opposition to the provincial government is focusing on hospital facilities as a symbol of rural life. In this context, the problems that first led to the emergence of health reform are eclipsed. Arguments about increasing preventive programs, community-based services, and client-centered health care delivery, and reducing the control of physicians are not heard. Research and experiences showing that small rural hospitals are not the best way to provide acute care services nor to ensure that rural Saskatchewan retains primary care services are not acknowledged.

As a researcher on a HEALNet project in Saskatchewan designed to assist health care decision-makers, I have spent the last two years working with district health board members. My major activity has been delivering workshops about decision-making. It is my opinion, based on this experience, that there is indeed a deep commitment among the majority of board members at this time to the ideas of health reform. There is also a substantial minority in opposition to it, not so much I believe, because of the ideas themselves, but because of the implications for the survival of individual rural communities. With Saskatchewan facing a shrinking rural population, there is competition among rural communities for survival. Not surprisingly, most rural leaders believe that any provincially-subsidized facility will assist in such survival and must be fought for.

It may not appear to be the best time to be discussing such lofty topics as developmental democracy. However, provincial elections do not last forever. After this is over, there will continue to be a need for effective health care strategies in urban and rural Saskatchewan. Such strategies, as I have argued in this thesis, in addition to providing effective medical and other health care services to the population, should attend to the longer term needs of the population for equity, autonomy, participation and interaction. Regionalization in both its structural and substantive aspects, while bringing its own issues for resolution, can and should contribute to this effort.

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Appendix

Survey Instruments

Letter of Permission from HEALNet Regional Health Planning to Use the Survey Data

Letters Accompanying Each Questionnaire
- District health board member
- District health board manager
- Saskatchewan Health manager

Questionnaires
- Saskatchewan District Health Board Survey (for district health board members)
- Saskatchewan Health District CEO/Management Survey (for district health board managers)
- Saskatchewan Health Management and Professional Employees Survey (for Saskatchewan health managers)

HEALNet: *Searching for Canadian Healthcare Solutions*

Regional Health Planning

Health Services Utilization and Research Commission
Box 90 • 103 Hospital Drive • Saskatoon Saskatchewan • S7N 0W8
Fax (306) 655-6879 • E-mail kourid@sdh.sk.ca
Phone (306) 655-6877 • Toll-free 1-800-804-6814

June 17, 1998

Paul Gingrich
Department of Sociology and Social Studies
University of Regina
Regina, Saskatchewan

Dear Mr. Gingrich:

I am writing to inform you that Denise Kouri has permission to use the data base from the HEALNet Regional Health Planning 1997 survey of district health boards for her thesis research. If you have further questions or concerns please do not hesitate to call me at (306) 655-1504.

Sincerely,

Steven Lewis
Theme Leader

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February 3, 1997

[Individual letter, mailed directly
to district health board members
in Saskatchewan]

Dear . . . . . ,

Saskatchewan is in the forefront of regionalization in Canada. There is great interest within and outside the province about how the restructuring has affected decision-making and health care. The enclosed survey presents an opportunity for you to describe your experiences and provide your opinions on these important topics. We are surveying every district health board member in the province. The responses should contribute greatly to our understanding and suggest areas where the system could be improved.

The survey is vital to the work of a national research project called HEALNet. The project is university-based and non-profit. Saskatchewan is the site for the Regional Health Planning theme, housed at the Health Services Utilization and Research Commission in Saskatoon. The overall goal of HEALNet is to develop tools and processes to assist decision-making in health and health care. The survey will produce the first comprehensive overview of what the decision-makers think of regionalization to date. In addition to district health board members, we will survey CEOs and managers, and Saskatchewan Health officials to obtain views from a number of key perspectives. We plan to repeat these surveys in 1999 to identify any changes.

Your opinions and experience are important. We appreciate your time and effort in completing this survey. We also hope that **completing the survey will be interesting and worthwhile for you as a board member.** Several board members who pre-tested the survey told us that completing the survey was a rewarding experience. It helped them reflect on the issues Saskatchewan boards face today.

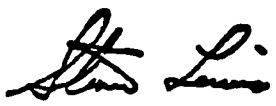
We will provide the survey results to your board and other Saskatchewan boards. These results will be a unique resource for future board decision-making.

Your response to the survey will be kept in strict confidence. We want you to be aware, however, that there is an anonymous numerical identifier on your survey form. This identifier is necessary because we are using this survey as a baseline to identify change over time. However, we will use the identifiers only to link to the 1999 survey and to save the cost of a reminder once the survey has been returned. We will delete the identifiers once the computerized data are linked. No names will be used in any analyses or in reporting any results.

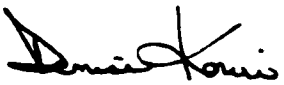
When you have completed the survey, please return it in the **stamped self-addressed envelope**, by **February 28, 1997**.

We appreciate your assistance. Please do not hesitate to contact either one of us at the number listed above if you have any questions or concerns.

Sincerely,



Steven Lewis
Project Leader



Denise Kouri
Project Coordinator

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February 18, 1997

[Generic letter to all District Health Board Senior Managers, distributed through district offices by CEO]

Dear District Health Board Senior Manager,

Saskatchewan is in the forefront of regionalization in Canada. There is great interest within and outside the province about how the restructuring has affected decision-making and health care. The enclosed survey presents an opportunity for you to describe your experiences and provide your opinions on these important topics. We are surveying every district health board member in the province. The responses should contribute greatly to our understanding and suggest areas where the system could be improved.

The survey is vital to the work of a national research project called HEALNet. The project is university-based and non-profit. Saskatchewan is the site for the Regional Health Planning theme, housed at the Health Services Utilization and Research Commission in Saskatoon. The overall goal of HEALNet is to develop tools and processes to assist decision-making in health and health care. (District CEOs have a copy of a brochure which describes the project in more detail.)

The survey will produce the first comprehensive overview of what decision-makers think of regionalization to date. In addition to district CEOs and senior managers, we are surveying district board members, and Saskatchewan Health officials to obtain views from a number of key perspectives. We plan to repeat these surveys in 1999 to chart the evolution of the system over time.

Your opinions and experience are important. We appreciate your time and effort in completing this survey. We also hope that **completing the survey will be interesting and worthwhile for you as manager,** as well as providing an important complementary perspective to those of the boards and Saskatchewan Health. (Colleagues who pre-tested the survey told us that completing it was a rewarding experience. It helped them reflect on the issues districts face today.)

We will provide the survey results to all respondent groups. These results will be a unique resource for future board and departmental decision-making.

Your response to the survey will be kept in strict confidence. We want you to be aware, however, that there is a district identifier on your survey form. This identifier is necessary because some of the results will be reported by district, and because we are using this survey as a baseline to identify change over time.

Similarly, you will note that we have asked for your job title. Our reason for requesting the title and other job-related information is that, taken over all districts in the province, there may be interesting trends in opinions about regionalization among persons with different years of experience or with different spheres of responsibility (between program managers and finance officers, for example). Wherever we report results by district, we will aggregate the managers' data. If there appears to be any chance of identifying individuals, we will not report those data.

When you have completed the survey, please return it directly to us in the **stamped self-addressed envelope**, by **March 21, 1997**.

We appreciate your assistance. Please do not hesitate to contact either one of us at the number listed above if you have any questions or concerns.

Sincerely,

Steven Lewis
Project Leader

Denise Kouri
Project Coordinator

HEALNet: *Searching for Canadian Healthcare Solutions*

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Toll-free 1-800-804-6814

March 11, 1997

[Individual letter, mailed directly to each
of the Management and Professional
Employees of Saskatchewan Health]

Dear . . . . . ,

Saskatchewan is in the forefront of regionalization in Canada. There is great interest within and outside the province about how the restructuring has affected decision-making and health care. The enclosed survey presents an opportunity for Saskatchewan Health management and professional employees to describe your experiences and provide your opinions on these important topics. The responses should contribute greatly to our understanding and suggest areas where the system could be improved.

The survey has the full support of Saskatchewan Health. The survey is vital to the work of a national research project called HEALNet, which is university-based and non-profit. The overall goal of HEALNet is to develop tools and processes to assist decision-making in health and health care. Saskatchewan is the site for the Regional Health Planning theme, housed at the Health Services Utilization and Research Commission in Saskatoon. Our theme has an Operations Committee on which Lois Borden and Georgina MacDonald are Saskatchewan Health representatives.

The survey will produce the first comprehensive overview of what decision-makers think of regionalization to date. In addition to Saskatchewan Health management and professional employees, we are surveying district board members, CEOs and senior managers to obtain views from a number of key perspectives. We plan to repeat these surveys in 1999 to chart the evolution of the system over time. Comparative information will indicate areas of both convergence and disagreement, and help to identify issues to be resolved as regionalization evolves.

We will provide the survey results to all respondent groups. These results will be a unique resource for future board and departmental decision-making.

Your opinions and experience are important. We appreciate your time and effort in completing this survey. We also hope that **completing the survey will be interesting and worthwhile for you and your colleagues,** as well as providing an important complementary perspective to those of the boards and their CEOs/senior managers. (Colleagues who pre-tested the survey told us that completing it was a rewarding experience. It helped them reflect on the issues the department and the districts face today.)

As you read the questions, you may feel that in some cases you do not feel close enough to "the system", or perhaps to district boards, to provide a response. Please remember that your opinions are important, and that no one has definitive knowledge of how the system works in all quarters. Perception often guides reality, and how regionalization develops will certainly be influenced by how Saskatchewan Health officials both think and feel about it. While you certainly have the "no opinion" or "don't know" option, all that we ask is that you be as forthcoming as possible on as many questions as possible.

Responses to the survey will be kept in strict confidence. We have asked for some basic demographic and work experience information. Our reason for requesting the information is because, for instance, there may be different and interesting responses on some questions between, say, district consultants and policy and planning officials. We will not disaggregate or report on group responses if there appears to be any chance of identifying individuals.

Please return the survey form in the stamped self-addressed envelope by April 9, 1997.

We appreciate your assistance. Please do not hesitate to contact either one of us at the number listed above if you have any questions or concerns.

Sincerely,

Steven Lewis
Project Leader

Denise Kouri
Project Coordinator

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Regional Health Planning

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Saskatchewan District Health Board Survey

February 1997

This survey is being conducted by the HEALNet Regional Health Planning research project to explore decision-making in health care. This survey booklet has been sent to all district health board members in Saskatchewan.

The survey has been designed to be as easy to complete as possible. Most questions ask you to circle your choice. This should allow you to complete the survey quickly. However, please feel free to express yourself further in your own words, if you so choose. There is space at the back of the booklet for your comments. In order to preserve confidentiality, please do not place your name on this booklet.

When you have completed the survey,
please return it in the stamped self-addressed envelope.
We would appreciate receiving your response
by February 28, 1997.

Additional information about the survey is provided in the cover letter accompanying this booklet. If you have any questions or concerns please do not hesitate to call Denise Kouri, Project Coordinator, at the number listed above.

Your opinions and experience are important.
We appreciate your time and effort in completing this survey.
We hope that completing the survey will be interesting and rewarding.

Thank you!

SECTION A: HISTORY WITH THE DISTRICT HEALTH BOARD

The first section of the survey inquires about your history with the district health board.

A1. Are you an elected or appointed member? *(Please circle one.)*

1 Elected member
2 Appointed member

A2. Were you a health board member before October 1995?

1 Yes
2 No

A3. Why were you interested in serving on the district health board?

A4. How many hours per week on average do you spend on board work? _____

A5a. *For elected members only:*

Do you plan to run for re-election?

1 Yes
2 No

☞ **Why or why not?**

A5b. *For appointed members only:*

Would you accept a reappointment?

1 Yes
2 No

☞ **Why or why not?**

Would you run for election?

1 Yes
2 No

☞ **Why or why not?**

SECTION B: USING INFORMATION

The following questions refer to the use of information by district health boards - one of the main topics of the study. We are interested in the information boards use in making decisions.

B1. In thinking about your board, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Our board makes good use of information in reaching decisions.	1	2	3	4	5
b. Our board asks for the right kind of information to assist decision-making.	1	2	3	4	5
c. Management is responsive to board requests for information.	1	2	3	4	5
d. Our board can distinguish good information from poor information.	1	2	3	4	5
e. We need more information from research findings in making board decisions.	1	2	3	4	5

B2. In thinking about *yourself as an individual board member*, please circle the number from 1 to 5 that best describes *how often* the following applies to you.

	Rarely or Never	On Occasion	Usually	Always	Doesn't Apply
With respect to the information I receive at the board:					
a. I use it.	1	2	3	4	5
b. I understand it.	1	2	3	4	5
c. I understand its purpose.	1	2	3	4	5
d. I know how it was produced.	1	2	3	4	5
e. I am comfortable using numerical data.	1	2	3	4	5
f. I am comfortable using anecdotes and stories.	1	2	3	4	5
When making board decisions, I am influenced by:					
g. Statistical data from financial and scientific reports.	1	2	3	4	5
h. My knowledge of community expectations.	1	2	3	4	5
i. Knowledge gained from my own experience.	1	2	3	4	5

B3. Please rate the *adequacy* of the following types of information provided to *your board*. Circle the number from 1 to 5 that best reflects your opinion. If you have not received the information, circle 6.

	Very Poor	Poor	Average	Good	Excellent	Have not Received
a. Needs assessments	1	2	3	4	5	6
b. Population health status indicators	1	2	3	4	5	6
c. Program evaluation results	1	2	3	4	5	6
d. Quality of service indicators	1	2	3	4	5	6
e. Service utilization data	1	2	3	4	5	6
f. Citizen opinions and preferences	1	2	3	4	5	6
g. Patient/client satisfaction	1	2	3	4	5	6
h. Provider/employee satisfaction	1	2	3	4	5	6
i. Financial information	1	2	3	4	5	6
j. Relevant research/scientific literature	1	2	3	4	5	6
k. Saskatchewan Health policy directions	1	2	3	4	5	6

B4. In which of the above categories (or other areas) does the board especially need to increase or improve its information?

B5. In which of the above categories (or other areas) does the board receive information that is not relevant to its work?

B6. What do you consider to be good information for the board?

SECTION C: BOARD DECISION-MAKING

District health boards make decisions about many issues and use a variety of methods. These questions ask you to describe the way your board makes decisions.

C1. In thinking about *your board*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Our board has adequate mechanisms to identify emerging issues.	1	2	3	4	5
b. Board decisions are consistent with our objectives.	1	2	3	4	5
c. Board decisions are too often based on budget considerations, not health needs.	1	2	3	4	5
d. Because our main activity is trying to deal with the impact of a reduced budget, we can't focus on long term plans.	1	2	3	4	5
e. Most of our board's time is spent reacting to issues raised by others.	1	2	3	4	5
f. Our board has satisfactory mechanisms to consider moral and ethical values in its decisions.	1	2	3	4	5
g. In general, members of our board have common goals and values when it comes to health care.	1	2	3	4	5
h. Our board has adequate procedures to resolve conflicts among members.	1	2	3	4	5
i. All board members' views are respected.	1	2	3	4	5
j. Men and women members of our board participate equally in discussions.	1	2	3	4	5
k. Our board decision-making results from a process of mutual learning, rather than negotiating among competing points of view.	1	2	3	4	5
l. Vested interests have too big a say in board decisions.	1	2	3	4	5
m. Men's views tend to be heard more than women's in board decision-making.	1	2	3	4	5
n. In our board, discussion of different points of view rarely causes anyone to change his or her mind.	1	2	3	4	5
o. Members accept and support a decision they have disagreed with, once the majority of board members has agreed to it.	1	2	3	4	5

C2. In thinking about *your board*, please circle the number from 1 to 5 that best describes *how often* the following applies to your board.

	Rarely or Never	On Occasion	Usually	Always	No Opinion Don't Know
a. Our board discussions are helpful to making decisions.	1	2	3	4	5
b. We have adequate options in making decisions.	1	2	3	4	5
c. Our board reopens decisions for further discussion.	1	2	3	4	5
d. Urgent issues drive more important issues off our agenda.	1	2	3	4	5
e. The need to make decisions quickly prevents adequate consultation with interested parties.	1	2	3	4	5
f. Decisions are made before the board has adequately discussed the issue.	1	2	3	4	5
g. Compromise, rather than seeking the optimal solution, drives board decisions.	1	2	3	4	5
h. The reasons for making a particular decision are clear to members.	1	2	3	4	5
i. Decisions are based on good criteria.	1	2	3	4	5
j. On important issues our board is able to reach consensus.	1	2	3	4	5

C3. Do you perceive any barriers or challenges to better decision-making by the board? ***(Please circle one.)***

1 Yes
2 No

☞ **If yes, what are these barriers or challenges?**

☞ **If yes, what factors might help the board (or management on behalf of the board) overcome these barriers or challenges?**

SECTION D: YOUR BOARD EXPERIENCE

These questions ask you to describe your own experience on the board, as an individual board member.

D1. In thinking about *yourself as an individual board member*, please circle the number from 1 to 5 that best reflects what you think about each statement.

As a board member,	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. I have a clear understanding of my role in the decision making process.	1	2	3	4	5
b. I influence the decisions made by my board.	1	2	3	4	5
c. I am respected by other board members.	1	2	3	4	5
d. I am comfortable in asking for more information if I feel it is needed.	1	2	3	4	5
e. I feel comfortable in proposing new items for the agenda.	1	2	3	4	5
f. I don't mind delaying a decision until I am sure about where I stand.	1	2	3	4	5
g. I have more confidence in my personal opinion than I have in my board's consensus opinion.	1	2	3	4	5
h. My personal experiences with the health care system strongly influence my work as a board member.	1	2	3	4	5
i. I am comfortable with speaking and expressing my point of view in public.	1	2	3	4	5
j. My input to board decisions is strongly affected by the people in my community.	1	2	3	4	5
k. Even if a decision is opposed by the majority of citizens in my community, I will support it if I believe it is the right decision.	1	2	3	4	5
l. I have a good grasp of the issues our board has to deal with.	1	2	3	4	5
m. Being a board member has provoked some resentment toward me by people in the community.	1	2	3	4	5
n. My personal values are important to my board decision-making.	1	2	3	4	5
o. Being a board member is a rewarding experience.	1	2	3	4	5
p. The workload of board members is excessive.	1	2	3	4	5

SECTION E: THE BOARD'S ROLE

The following questions ask about the activities and role of your board in relation to others in the district.

E1. In thinking about *your board*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
District residents:					
a. Most district residents are supportive of our board choices.	1	2	3	4	5
b. Even if they don't agree, most district residents generally understand and respect our board choices.	1	2	3	4	5
c. Our board effectively communicates the rationale for our decisions to district residents.	1	2	3	4	5
d. Our board has an accurate understanding of what district residents want for the health care system.	1	2	3	4	5
e. Our board is responsive to wishes of district residents.	1	2	3	4	5
f. District residents are entitled to make representation to the board when they have an issue.	1	2	3	4	5
g. Public pressure sometimes forces our board to make decisions we would not otherwise make.	1	2	3	4	5
h. Our board's values reflect the values of the district.	1	2	3	4	5
Management:					
i. Our board's main role is policy development, not management.	1	2	3	4	5
j. In order to function effectively, boards have to be involved in operational management of the health district.	1	2	3	4	5
k. The policy governance model (the Carver model) results in a board less informed than it should be to make good decisions.	1	2	3	4	5
l. Our board essentially rubber-stamps what management proposes.	1	2	3	4	5
m. Our board's values and principles should govern the work of the health district.	1	2	3	4	5
Health care providers:					
n. Most district physicians are supportive of our board choices.	1	2	3	4	5
o. Most district nurses and health care providers aside from physicians are supportive of our board choices.	1	2	3	4	5
p. Physicians are more influential than other district residents in influencing board decisions.	1	2	3	4	5
q. Nurses and health care providers aside from physicians, are more influential than other district residents in influencing board decisions.	1	2	3	4	5

SECTION F: SERVICES AND FUNDING

This section asks about services and funding to the health district.

F1. Please indicate the degree to which you feel your board should increase or decrease its involvement in the following activities:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Raising revenue	1	2	3	4	5	6
b. Assessing community needs	1	2	3	4	5	6
c. Setting priorities	1	2	3	4	5	6
d. Allocating funds	1	2	3	4	5	6
e. Planning programs and services	1	2	3	4	5	6
f. Ensuring service effectiveness & efficiency	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

F2. Please indicate the degree to which you feel your district should increase or decrease its services to the following population groups:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Youth	1	2	3	4	5	6
b. Elderly	1	2	3	4	5	6
c. Males	1	2	3	4	5	6
d. Females	1	2	3	4	5	6
e. Residents living in poverty	1	2	3	4	5	6
f. Residents of Aboriginal ancestry	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

F3. ASSUMING A FIXED TOTAL BUDGET, please indicate the degree to which, in your view, the proportion of the district's funds should increase or decrease for each type of service.
Remember we are assuming a fixed budget; if you believe some areas should get more funding, you must indicate that at least one other area should get less.

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Acute (hospital based services)	1	2	3	4	5	6
b. Supportive (long-term) services	1	2	3	4	5	6
c. Home-based services	1	2	3	4	5	6
d. Rehabilitation services	1	2	3	4	5	6
e. Mental health services	1	2	3	4	5	6
f. Health promotion	1	2	3	4	5	6
g. Public health	1	2	3	4	5	6
h. Other (*Please specify.*) _____	1	2	3	4	5	6

SECTION G: YOUR BOARD

This section asks for your opinion about your board in general.

G1. In thinking about *your board*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Board meetings are run efficiently and effectively.	1	2	3	4	5
b. I am confident that our board generally makes good decisions.	1	2	3	4	5
c. Our board decisions generally reflect the values we profess.	1	2	3	4	5
d. Our board has made budget allocations to advance our goals.	1	2	3	4	5
e. It appears to me that most other health boards in Saskatchewan are doing a better job than our board is.	1	2	3	4	5
Our board can be described as:					
f. Creative in addressing problems.	1	2	3	4	5
g. Making premature judgements or decisions.	1	2	3	4	5
h. Valuing diverse points of view.	1	2	3	4	5
i. Seeking out assumptions underlying members' points of view.	1	2	3	4	5
j. Reacting positively to new ideas.	1	2	3	4	5
k. Trying to meet multiple goals.	1	2	3	4	5
l. Comfortable with addressing many issues at one time.	1	2	3	4	5
m. Comfortable with deviating from established procedures when the situation requires it.	1	2	3	4	5
Our board:	1	2	3	4	5
n. Manages its money well.	1	2	3	4	5
o. Is good at long range planning.	1	2	3	4	5
p. Has adequate mechanisms for board member development and education.	1	2	3	4	5
q. Has adequate mechanisms for board evaluation.	1	2	3	4	5

G2. List three successes or accomplishments you would like your board to achieve over the next two years.

SECTION H: HEALTH REFORM AND REGIONALIZATION

As an experienced board member, your opinions about health reform and regionalization in Saskatchewan are valuable.

H1. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Health is more than the absence of disease.	1	2	3	4	5
b. Health is primarily affected by non-medical factors, including social and economic conditions.	1	2	3	4	5
c. More health care resources should be targeted towards groups with high needs that may not have been well-served in the past.	1	2	3	4	5
d. Health reform is mainly about shifting emphasis from sickness care to wellness.	1	2	3	4	5
e. Health reform has more to do with reducing government spending than improving health.	1	2	3	4	5
f. Health reform has created a health care system based on needs rather than traditional patterns of utilization.	1	2	3	4	5
g. Health reform has made it easier for social, emotional and spiritual needs to be addressed.	1	2	3	4	5
h. There is no clear vision of what our reformed health care system should be like.	1	2	3	4	5
i. There was no need for extensive health care reforms.	1	2	3	4	5
j. The main reason that the government gave authority to districts is because there are tough budget decisions to make.	1	2	3	4	5
k. Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	1	2	3	4	5
l. Patients should have a greater say in how their health care needs are met.	1	2	3	4	5
m. Physicians should have a greater say in planning and providing health care services.	1	2	3	4	5
n. Those who can afford it should be made to pay directly for their health care.	1	2	3	4	5
o. We can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services.	1	2	3	4	5
p. The pace of change in health reform has been too fast.	1	2	3	4	5
q. Our district has lost out because of health reform.	1	2	3	4	5
r. The changes made in the last five years have been for the best	1	2	3	4	5

H2. Thinking *back* over the last few years, what do you think *have been* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

H3. Thinking *forward* to the next few years, what do you think *will be* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

H4. My role on the district health board is most like: ***(Please circle one.)***

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board
6 Other (*Please specify.*)

_____

H5. To whom do you feel most accountable for your decisions?

1 The Minister of Health
2 All residents of Saskatchewan
3 All residents of my district
4 Residents from the ward or group I represent
5 Local interest groups I identify with
6 Local health care providers and institutions
7 Other (*Please specify.*)

_____

H6. All things considered, our district *population* is:

1 Too large
2 The right size
3 Too small

H7. All things considered, our district *area* is:

1 Too large
2 The right size
3 Too small

H8. The number of board members:

1 Is fine as is
2 Is too high
3 Is too low

H9. The mix of elected and appointed members:

1 Is fine as is
2 Has too many elected members
3 Has too many appointed members

H10. The elected members of the district health board should be elected on a:

1 Ward/geographic area basis (current situation)
2 A district-wide, at-large basis

H11. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Candidates in future board elections should run as members of slates presenting platforms.	1	2	3	4	5
b. Elected members of the board should primarily represent the interests of their wards.	1	2	3	4	5
c. Elected members have more legitimacy and credibility in the community than appointed members.	1	2	3	4	5
d. Appointed members are more knowledgeable about health issues than elected members.	1	2	3	4	5
e. Within the board itself, the views of elected members carry more weight than those of appointed members.	1	2	3	4	5
f. Over time the distinction between elected and appointed members becomes unimportant.	1	2	3	4	5
g. The division of authority between district health boards and Saskatchewan Health is clear.	1	2	3	4	5
h. Health boards are legally responsible for things over which they have insufficient control.	1	2	3	4	5
i. We're too restricted by rules laid down by the provincial government.	1	2	3	4	5
j. The board has less authority than I expected when districts were formed.	1	2	3	4	5

SECTION I: BASIC INFORMATION

This last group of questions inquires about your own experiences and circumstances in addition to your health board activity. Some of these questions are to learn about the experience and resources members bring to the board and about the constraints they may have on their time. Other questions will help determine how board members compare to the rest of the population.

I1. Have you ever served as one of the following? (*Please circle all that apply.*)

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board

I2. Have you been a volunteer in other community organizations?

1 Yes
2 No

☞ **If yes, please describe your activities briefly.**

I3 Are you:

1 Male
2 Female

I4. What is your age?

1 under 25
2 25-34
3 35-44
4 45-54
5 55-64
6 65-74
7 75+

I5. What is your marital status?

1 Single
2 Married
3 Separated or divorced
4 Widowed

I6. How many persons under 18 years of age live in your home?

_____

I7. How many persons 18 years of age or older, including yourself, live in your home?

_____

I8. Do you reside in the town or city where the district health board head office is located?

1 Yes
2 No

☞ **If No, how many kilometres is it to that city or town from your place of residence?**

_____ km.

I9. What is the highest level of education you have completed?

1 Post graduate (Master's degree or higher)
2 University degree (Bachelor's level)
3 Technical/vocational programme
4 Community college diploma
5 High school
6 None of the above
7 Other *(Please specify.)*

_____

I10. Are you presently: (*Circle all that apply.*)

1 Full-time employed
2 Part-time employed
3 Self-employed
4 Retired
5 Unemployed
6 Full-time homemaker
7 Part-time homemaker
8 Student (full or part-time)
9 Other

I11. What is your current occupation, job or profession?

_____

I12. Have you been in the past, or are you now, working in the health care field?

1 Yes, currently
2 Yes, in the past
3 No

I13. Do you use a computer? (*Circle all that apply.*)

1 Yes, at home
2 Yes, at work
3 No

I14. Do you have access to e-mail? (*Circle all that apply.*)

1 Yes, at home
2 Yes, at work
3 No

I15. What is your household income before taxes?

1 Under $10,000
2 $10,000 to $19,999
3 $20,000 to $39,999
4 $40,000 to $59,999
5 $60,000 to $79,999
6 $80,000 to $99,999
7 $100,000 plus

I16. What factors in your personal circumstances make it easier to serve as a board member?

I17. What factors in your personal circumstances make it more difficult to serve as a board member?

☞ **Please feel free to elaborate or comment on any questions in this survey, or on any other aspects of your experience as a district health board member.**

THANK YOU FOR YOUR TIME.

HEALNet: *Searching for Canadian Healthcare Solutions*

Regional Health Planning

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Saskatchewan Health District
CEO/Senior Management Survey

February 1997

This survey is being conducted by the HEALNet Regional Health Planning research project to explore decision-making in health care. This survey booklet has been sent to all health district senior managers in Saskatchewan.

The survey has been designed to be as easy to complete as possible. Most questions ask you to circle your choice. This should allow you to complete the survey quickly. However, please feel free to express yourself further in your own words, if you so choose. There is space at the back of the booklet for your comments. In order to preserve confidentiality, please do not place your name on this booklet.

When you have completed the survey,
please return it directly to us in the stamped self-addressed envelope.
We would appreciate receiving your response
by March 21, 1997.

Additional information about the survey is provided in the cover letter accompanying this booklet. If you have any questions or concerns please do not hesitate to call Denise Kouri, Project Coordinator, at the number listed above.

Your opinions and experience are important.
We appreciate your time and effort in completing this survey.
We hope that completing the survey will be interesting and rewarding.

Thank you!

SECTION A: USING INFORMATION

The following questions refer to the use of information - one of the main topics of the study. We are interested in the information senior managers and board members use in making decisions.

A1. In thinking first about *senior management*, then about *your board*, please circle the number from 1 to 5 that best reflects what you think about each statement.

		Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
	Senior management:					
a.	Senior management makes good use of information in reaching decisions.	1	2	3	4	5
b.	Our managers ask for the right kind of information to assist decision-making.	1	2	3	4	5
c.	Senior management can distinguish good information from poor information.	1	2	3	4	5
d.	We need more information from research findings in making management decisions.	1	2	3	4	5
	The Board:					
e.	The board makes good use of information in reaching decisions.	1	2	3	4	5
f.	The board asks for the right kind of information to assist decision-making.	1	2	3	4	5
g.	Management is responsive to board requests for information.	1	2	3	4	5
h.	The board can distinguish good information from poor information.	1	2	3	4	5
i.	The board needs more information from research findings in making decisions.	1	2	3	4	5

A2. In thinking about *yourself as an individual manager*, please circle the number from 1 to 5 that best describes *how often* the following applies to you.

		Rarely or Never	On Occasion	Usually	Always	Doesn't Apply
	With respect to the information I receive:					
a.	I use it.	1	2	3	4	5
b.	I understand it.	1	2	3	4	5
c.	I understand its purpose.	1	2	3	4	5
d.	I know how it was produced.	1	2	3	4	5
e.	I am comfortable using numerical data.	1	2	3	4	5
f.	I am comfortable using anecdotes and stories.	1	2	3	4	5
	When making decisions, I am influenced by:					
g.	Statistical data from financial and scientific reports.	1	2	3	4	5
h.	My knowledge of community expectations.	1	2	3	4	5
i.	Knowledge gained from my own experience.	1	2	3	4	5

A3. Please rate the *adequacy* of the following types of information provided to *your board*. Circle the number from 1 to 5 that best reflects your opinion. If this information has not been provided to your board, circle 6.

	Very Poor	Poor	Average	Good	Excellent	Not Provided
a. Needs assessments	1	2	3	4	5	6
b. Population health status indicators	1	2	3	4	5	6
c. Program evaluation results	1	2	3	4	5	6
d. Quality of service indicators	1	2	3	4	5	6
e. Service utilization data	1	2	3	4	5	6
f. Citizen opinions and preferences	1	2	3	4	5	6
g. Patient/client satisfaction	1	2	3	4	5	6
h. Provider/employee satisfaction	1	2	3	4	5	6
i. Financial information	1	2	3	4	5	6
j. Relevant research/scientific literature	1	2	3	4	5	6
k. Saskatchewan Health policy directions	1	2	3	4	5	6

A4. In which of the above categories (or other areas) does senior management especially need to increase or improve its information?

A5. In which of the above categories (or other areas) does senior management receive information that is not relevant to its work?

A6. As a senior manager what do you consider to be good information for the board?

SECTION B: MANAGEMENT-BOARD DECISION-MAKING

District health boards and their senior management make decisions about many issues and use a variety of methods. These questions ask you to describe the way decisions are made in your district.

B1. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Our board has adequate mechanisms to identify emerging issues.					
b. Senior management has adequate mechanisms to identify emerging issues.	1	2	3	4	5
c. Management decisions are consistent with Board objectives.	1	2	3	4	5
d. Board decisions are too often based on budget considerations, not health needs.	1	2	3	4	5
e. Because the board's main activity is trying to deal with the impact of a reduced budget, they can't focus on long term plans.	1	2	3	4	5
f. Most of our board's time is spent reacting to issues raised by others.	1	2	3	4	5
g. Our board has satisfactory mechanisms to consider moral and ethical values in its decisions.					
h. Senior management has satisfactory mechanisms to consider moral and ethical values in its decisions.	1	2	3	4	5
i. Board members and senior management have common goals and values when it comes to health care.	1	2	3	4	5
j. We have adequate procedures to resolve conflicts among senior management.	1	2	3	4	5
k. We have adequate procedures to resolve differences between senior management and the board.	1	2	3	4	5
l. Board members respect management's views.	1	2	3	4	5
m. In our district, decision-making results from a process of mutual learning, rather than negotiating among competing points of view.	1	2	3	4	5
n. Vested interests have too big a say in board decisions.	1	2	3	4	5
o. In our board, discussion of different points of view rarely causes anyone to change his or her mind.	1	2	3	4	5
p. In senior management, discussion of different points of view rarely causes anyone to change his or her mind.	1	2	3	4	5
q. Men's views tend to be heard more than women's in senior management's decision-making.	1	2	3	4	5

B2. In thinking about *your board*, please circle the number from 1 to 5 that best describes *how often* the following applies to your board.

	Rarely or Never	On Occasion	Usually	Always	No Opinion Don't Know
a. Discussions between management and our board are helpful to making decisions.	1	2	3	4	5
b. Our board has adequate options in making decisions.	1	2	3	4	5
c. Our board reopens decisions for further discussion.	1	2	3	4	5
d. Urgent issues drive more important issues off the board's agenda.	1	2	3	4	5
e. Our board's need to make decisions quickly prevents adequate consultation with interested parties.	1	2	3	4	5
f. Decisions are made before the board has adequately discussed the issue.	1	2	3	4	5
g. Compromise, rather than seeking the optimal solution, drives board decision-making.	1	2	3	4	5
h. The reasons underlying board decisions are clear to senior managers.	1	2	3	4	5
i. Board decisions are based on good criteria.	1	2	3	4	5
j. On important issues our board is able to reach consensus.	1	2	3	4	5

B3. Do you perceive any barriers or challenges to better decision-making by the board? ***(Please circle one.)***

1 Yes
2 No

☞ **If yes, what are these barriers or challenges?**

☞ **If yes, what factors might help the board (or management on behalf of the board) overcome these barriers or challenges?**

SECTION C: YOUR EXPERIENCE

These questions ask you to describe your own experience as an individual member of senior management.

C1. In thinking about *yourself as an individual member of senior management*, please circle the number from 1 to 5 that best reflects what you think about each statement.

As a member of senior management,	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. I have a clear understanding of my role in the decision making process.	1	2	3	4	5
b. I influence the decisions made by my board.	1	2	3	4	5
c. I am respected by board members.	1	2	3	4	5
d. I am comfortable in asking for more information if I feel it is needed.	1	2	3	4	5
e. I feel comfortable in proposing new items for the agenda.	1	2	3	4	5
f. I don't mind delaying a decision until I am sure about where I stand.	1	2	3	4	5
g. My personal experiences with the health care system strongly influence my work as a senior manager.	1	2	3	4	5
h. I am comfortable with speaking and expressing my point of view in public.	1	2	3	4	5
i. My input to board decisions is strongly affected by the people in my community.	1	2	3	4	5
j. I have a good grasp of the issues our board has to deal with.	1	2	3	4	5
k. Carrying out my duties as a manager has provoked some resentment toward me by people in the community.	1	2	3	4	5
l. My personal values are important to my decision-making.	1	2	3	4	5
m. Being a senior manager is a rewarding experience.	1	2	3	4	5
n. The workload of senior management is excessive.	1	2	3	4	5

SECTION D: THE BOARD'S ROLE

The following questions ask about the activities and role of the board in relation to others in the district.

D1. In thinking about *the board in your health district*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
District residents:					
a. Most district residents are supportive of the board's choices.	1	2	3	4	5
b. Even if they don't agree, most district residents generally understand and respect the board's choices.	1	2	3	4	5
c. The board effectively communicates the rationale for its decisions to district residents.	1	2	3	4	5
d. The board has an accurate understanding of what district residents want for the health care system.	1	2	3	4	5
e. The board is responsive to wishes of district residents.	1	2	3	4	5
f. Even if a decision is opposed by the majority of citizens in the community, board members should support it if they believe it is the right decision.	1	2	3	4	5
g. District residents are entitled to make representation to the board when they have an issue.	1	2	3	4	5
h: Public pressure sometimes forces the board to make decisions they would not otherwise make.	1	2	3	4	5
i. The board's values reflect the values of the district.	1	2	3	4	5
Management:					
j. The board's main role is policy development, not management.	1	2	3	4	5
k. In order to function effectively, boards have to be involved in operational management of the health district.	1	2	3	4	5
l. The policy governance model (the Carver model) results in a board less informed than it should be to make good decisions.	1	2	3	4	5
m. The board essentially rubber-stamps what management proposes.	1	2	3	4	5
n. The board's values and principles should govern the work of the health district.	1	2	3	4	5
Health care providers:					
o. Most district physicians are supportive of the board's choices.	1	2	3	4	5
p. Most district nurses and health care providers aside from physicians are supportive of the board's choices.	1	2	3	4	5
q. Physicians are more influential than other district residents in influencing board decisions.	1	2	3	4	5
r. Nurses and health care providers aside from physicians, are more influential than other district residents in influencing board decisions.	1	2	3	4	5

SECTION E: SERVICES AND FUNDING

This section asks about services and funding to the health district.

E1. Please indicate the degree to which you feel the board in your health district should increase or decrease its involvement in the following activities:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Raising revenue	1	2	3	4	5	6
b. Assessing community needs	1	2	3	4	5	6
c. Setting priorities	1	2	3	4	5	6
d. Allocating funds	1	2	3	4	5	6
e. Planning programs and services	1	2	3	4	5	6
f. Ensuring service effectiveness & efficiency	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

E2. Please indicate the degree to which you feel the board in your health district should increase or decrease its services to the following population groups:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Youth	1	2	3	4	5	6
b. Elderly	1	2	3	4	5	6
c. Males	1	2	3	4	5	6
d. Females	1	2	3	4	5	6
e. Residents living in poverty	1	2	3	4	5	6
f. Residents of Aboriginal ancestry	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

E3. ASSUMING A FIXED TOTAL BUDGET, please indicate the degree to which, in your view, the proportion of the district's funds should increase or decrease for each type of service.
Remember we are assuming a fixed budget; if you believe some areas should get more funding, you must indicate that at least one other area should get less.

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Acute (hospital based services)	1	2	3	4	5	6
b. Supportive (long-term) services	1	2	3	4	5	6
c. Home-based services	1	2	3	4	5	6
d. Rehabilitation services	1	2	3	4	5	6
e. Mental health services	1	2	3	4	5	6
f. Health promotion	1	2	3	4	5	6
g. Public health	1	2	3	4	5	6
h. Other (*Please specify.*) _____	1	2	3	4	5	6

SECTION F: YOUR BOARD

This section asks for your opinion about the board in your health district.

F1. In thinking about *the board in your health district*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Board meetings are run efficiently and effectively.	1	2	3	4	5
b. I am confident that the board generally makes good decisions.	1	2	3	4	5
c. Board decisions generally reflect the values they profess.	1	2	3	4	5
d. The board has made budget allocations that advance their goals.	1	2	3	4	5
e. It appears to me that most other health boards in Saskatchewan are doing a better job than our board is.	1	2	3	4	5
The board in our health district can be described as:					
f. Creative in addressing problems.	1	2	3	4	5
g. Making premature judgements or decisions.	1	2	3	4	5
h. Valuing diverse points of view.	1	2	3	4	5
i. Seeking out assumptions underlying members' points of view.	1	2	3	4	5
j. Reacting positively to new ideas.	1	2	3	4	5
k. Trying to meet multiple goals.	1	2	3	4	5
l. Comfortable with addressing many issues at one time.	1	2	3	4	5
m. Comfortable with deviating from established procedures when the situation requires it.	1	2	3	4	5
The board:	1	2	3	4	5
n. Manages its money well.	1	2	3	4	5
o. Is good at long range planning.	1	2	3	4	5
p. Has adequate mechanisms for board member development and education.	1	2	3	4	5
q. Has adequate mechanisms for board evaluation.	1	2	3	4	5

F2. List three successes or accomplishments you would like the board in your health district to achieve over the next two years.

SECTION G: HEALTH REFORM AND REGIONALIZATION

As an experienced member of senior management your opinions about health reform and regionalization in Saskatchewan are valuable.

G1. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Health is more than the absence of disease.	1	2	3	4	5
b. Health is primarily affected by non-medical factors, including social and economic conditions.	1	2	3	4	5
c. More health care resources should be targeted towards groups with high needs that may not have been well-served in the past.	1	2	3	4	5
d. Health reform is mainly about shifting emphasis from sickness care to wellness.	1	2	3	4	5
e. Health reform has more to do with reducing government spending than improving health.	1	2	3	4	5
f. Health reform has created a health care system based on needs rather than traditional patterns of utilization.	1	2	3	4	5
g. Health reform has made it easier for social, emotional and spiritual needs to be addressed.	1	2	3	4	5
h. There is no clear vision of what our reformed health care system should be like.	1	2	3	4	5
i. There was no need for extensive health care reforms.	1	2	3	4	5
j. The main reason that the government gave authority to districts is because there are tough budget decisions to make.	1	2	3	4	5
k. Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	1	2	3	4	5
l. Patients should have a greater say in how their health care needs are met.	1	2	3	4	5
m. Physicians should have a greater say in planning and providing health care services.	1	2	3	4	5
n. Those who can afford it should be made to pay directly for their health care.	1	2	3	4	5
o. We can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services.	1	2	3	4	5
p. The pace of change in health reform has been too fast.	1	2	3	4	5
q. Our district has lost out because of health reform.	1	2	3	4	5
r. The changes made in the last five years have been for the best.	1	2	3	4	5

G2. Thinking *back* over the last few years, what do you think *have been* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

G3. Thinking *forward* to the next few years, what do you think *will be* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

G4. A district health board member's role is most like: ***(Please circle one.)***

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board
6 Other (*Please specify.*)

_____

G5. To whom do you feel the board is most accountable for its decisions?

1 The Minister of Health
2 All residents of Saskatchewan
3 All residents of the district
4 Residents from the ward or group a board member represents
5 Local interest groups a board member identifies with
6 Local health care providers and institutions
7 Other (*Please specify.*)

_____

G4. All things considered, our district *population* is:

1 Too large
2 The right size
3 Too small

G5. All things considered, our district *area* is:

1 Too large
2 The right size
3 Too small

G6. The number of board members:

1 Is fine as is
2 Is too high
3 Is too low

G7. The mix of elected and appointed members:

1 Is fine as is
2 Has too many elected members
3 Has too many appointed members

G8. The elected members of the district health board should be elected on a:

1 Ward/geographic area basis (current situation)
2 A district-wide, at-large basis

G9. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Candidates in future board elections should run as members of slates presenting platforms.	1	2	3	4	5
b. Elected members of the board should primarily represent the interests of their wards.	1	2	3	4	5
c. Elected members have more legitimacy and credibility in the community than appointed members.	1	2	3	4	5
d. Appointed members are more knowledgeable about health issues than elected members.	1	2	3	4	5
e. Within the board itself, the views of elected members carry more weight than those of appointed members.	1	2	3	4	5
f. Over time the distinction between elected and appointed members becomes unimportant.	1	2	3	4	5
g. The division of authority between district health boards and Saskatchewan Health is clear.	1	2	3	4	5
h. Health boards are legally responsible for things over which they have insufficient control.	1	2	3	4	5
i. We're too restricted by rules laid down by the provincial government.	1	2	3	4	5
j. The board has less authority than I expected when districts were formed.	1	2	3	4	5

SECTION H: BASIC INFORMATION AND HISTORY IN HEALTH CARE

This last group of questions asks for some basic information as well as inquiring about your employment history in health care in general and with your district in particular. Please be assured that the responses to these questions will be kept confidential. We will only report aggregate responses.

H1. Are you:

1 Male
2 Female

H2. What is your age?

1 under 25
2 25-34
3 35-44
4 45-54
5 55-64
6 65-74
7 75+

H3. What is the highest level of education you have completed?

1 Post graduate (Master's degree or higher)
2 University degree (Bachelor's level)
3 Technical/vocational programme
4 Community college diploma
5 High school
6 None of the above
7 Other *(Please specify.)*

_____

H4. What is the title of your current position?

_____

H5. How long have you been in your present position?

____ Years ____ Months

H6. How long have you been employed by your health district?

____ Years ____ Months

H7. How long have you been employed in the health care sector?

____ Years ____ Months

H8. Have you ever been employed as a direct provider of health care services, i.e., physician, nurse, or other health care provider?

1 Yes
2 No

☞ **If yes, in what capacity?**

H9. Have you had previous employment in either of the following? ***(Please circle all that apply.)***

1 Other health district(s)
2 Saskatchewan Health

H10. Have you held other management positions in any of the following? ***(Please circle all that apply.)***

1 My health district
2 Other health district(s)
3 Saskatchewan Health
4 Sector other than health care

H11. Your main experience in the health care field has been in: ***(Please circle one.)***

1 Acute care
2 Long term institutional care
3 Community care/home care
4 Public health/promotion/prevention
5 Other *(Please specify)*

_____

H12. Do you use a computer? (*Circle all that apply.*)

1 Yes, at home
2 Yes, at work
3 No

H13. Do you have access to e-mail? (*Circle all that apply.*)

1 Yes, at home
2 Yes, at work
3 No

H14. Please circle the number from 1 to 5 that best describes how often the following applies to you.

	Rarely or Never	On Occasion	Usually	Always
a. I attend board meetings	1	2	3	4
b. I make regular reports to the board.	1	2	3	4
c. I participate in board discussions.	1	2	3	4

H15. Have you ever served as one of the following? *(Please circle all that apply.)*

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board

H16. Have you been a volunteer in other community organizations?

1 Yes
2 No

☞ **If yes, please describe your activities briefly.**

☞ **Please feel free to elaborate or comment on any questions in this survey, or on any other aspects of your experience as a member of senior management in your health district.**

THANK YOU FOR YOUR TIME.

HEALNet: *Searching for Canadian Healthcare Solutions*

Regional Health Planning

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Saskatchewan Health
Management and Professional Employees Survey

March 1997

This survey is being conducted by the HEALNet Regional Health Planning research project to explore decision-making in health care. This survey booklet has been sent to Saskatchewan Health management and professional employees, with the Department's full support.

The survey has been designed to be as easy to complete as possible. Most questions ask you to circle your choice. This should allow you to complete the survey quickly. However, please feel free to express yourself further in your own words, if you so choose. There is space at the back of the booklet for your comments. In order to preserve confidentiality, please do not place your name on this booklet.

When you have completed the survey,
please return it directly to us in the stamped self-addressed envelope.
We would appreciate receiving your response
by April 9, 1997.

Additional information about the survey is provided in the cover letter accompanying this booklet. If you have any questions or concerns please do not hesitate to call Denise Kouri, Project Coordinator, at the number listed above.

Your opinions and experience are important.
We appreciate your time and effort in completing this survey.
We hope that completing the survey will be interesting and rewarding.

Thank you!

HEALNet • ***RELAIS***
Health Evidence Application and Linkage Network
Le Réseau de liaison et d'application de l'information sur la santé

Networks of Centres of Excellence Program

✎ Please read before answering the questionnaire:

This questionnaire has been designed for a wide range of Saskatchewan Health officials. As you read the questions, you may feel that in some cases you do not feel close enough to district health boards or to other parts of the system to provide a response. If you feel unable to answer these questions, please use the "no opinion" or "don't know" option. However, please keep in mind that your opinions are important. Regionalization will certainly be influenced by how Saskatchewan Health officials both think and feel about it. We ask that you be as forthcoming as possible on as many questions as possible. Thank you.

SECTION A: FAMILIARITY WITH DISTRICTS

The first section of the survey inquires about your familiarity with district health boards.

A1. Your knowledge of district boards' mandates and activities is ***(Please circle one.)***:

1 Very good
2 Quite good
3 Not very good
4 Not at all good

A2. Your job requires what level of contact with district boards and/or managers ***(Please circle one.)***:

1 A great deal of contact
2 Some contact
3 Not much contact
4 No contact

A3. Which of the following best describes how often you have observed district boards in action?

1 Rarely or never
2 Occasionally
3 Frequently
4 Always

A4. Do you think the majority of elected board members will choose to run again?

1 Yes
2 No

☛ **Why or why not?**

A5. Do you think the majority of appointed board members will accept reappointment if offered?

1 Yes
2 No

☛ **Why or why not?**

A6. Assuming you were eligible and perceived no conflict of interest, would you consider running in a district health board election?

1 Yes
2 No

☛ **Why or why not?**

SECTION B: HEALTH REFORM AND REGIONALIZATION

As key participants in and observers of the system, your opinions about health reform and regionalization in Saskatchewan are valuable.

B1. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Health is more than the absence of disease.	1	2	3	4	5
b. Health is primarily affected by non-medical factors, including social and economic conditions.	1	2	3	4	5
c. More health care resources should be targeted towards groups with high needs that may not have been well-served in the past.	1	2	3	4	5
d. Health reform is mainly about shifting emphasis from sickness care to wellness.	1	2	3	4	5
e. Health reform has more to do with reducing government spending than improving health.	1	2	3	4	5
f. Health reform has created a health care system based on needs rather than traditional patterns of utilization.	1	2	3	4	5
g. Health reform has made it easier for social, emotional and spiritual needs to be addressed.	1	2	3	4	5
h. There is no clear vision of what our reformed health care system should be like.	1	2	3	4	5
i. There was no need for extensive health care reforms.	1	2	3	4	5
j. The main reason that the government gave authority to districts is because there are tough budget decisions to make.	1	2	3	4	5
k. Nurses, and other health care providers, such as physiotherapists, chiropractors, etc., should have a greater say in planning and providing health care services.	1	2	3	4	5
l. Patients should have a greater say in how their health care needs are met.	1	2	3	4	5
m. Physicians should have a greater say in planning and providing health care services.	1	2	3	4	5
n. Those who can afford it should be made to pay directly for their health care.	1	2	3	4	5
o. We can no longer afford a publicly funded health insurance system that provides a comprehensive range of health care services.	1	2	3	4	5
p. The pace of change in health reform has been too fast.	1	2	3	4	5
q. The changes made in the last five years have been for the best.	1	2	3	4	5

B2. Thinking *back* over the last few years, what do you think *have been* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

B3. Thinking *forward* to the next few years, what do you think *will be* the effects of health reform in Saskatchewan on:

	Decrease	No Effect	Increase	No Opinion Don't Know
a. Local control over health care services	1	2	3	4
b. Quality of health care decisions	1	2	3	4
c. Quality of health care services	1	2	3	4
d. Quality of the health care system	1	2	3	4
e. The health of the population	1	2	3	4

B4. The role of a district health board member is most like: ***(Please circle one.)***

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board
6 Other (*Please specify.*)

_____

B5. To whom do you feel boards are most accountable for their decisions?

1 The Minister of Health
2 All residents of Saskatchewan
3 All residents of their districts
4 Residents from the wards or groups they represent
5 Local interest groups they identify with
6 Local health care providers and institutions
7 Other (*Please specify.*)

_____

B6. All things considered, the typical district *population* is:

1 Too large
2 The right size
3 Too small

B7. All things considered, the typical district *area* is:

1 Too large
2 The right size
3 Too small

B8. The number of board members per district:

1 Is fine as is
2 Is too high
3 Is too low

B9. The mix of elected and appointed members:

1 Is fine as is
2 Has too many elected members
3 Has too many appointed members

B10. The elected members of the district health board should be elected on a:

1 Ward/geographic area basis (current situation)
2 A district-wide, at-large basis

B11. Please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Candidates in future board elections should run as members of slates presenting platforms.	1	2	3	4	5
b. Elected members of the board should primarily represent the interests of their wards.	1	2	3	4	5
c. Elected members have more legitimacy and credibility in the community than appointed members.	1	2	3	4	5
d. Appointed members are more knowledgeable about health issues than elected members.	1	2	3	4	5
e. Within the boards, the views of elected members carry more weight than those of appointed members.	1	2	3	4	5
f. Over time the distinction between elected and appointed members becomes unimportant.	1	2	3	4	5
g. The division of authority between district health boards and Saskatchewan Health is clear.	1	2	3	4	5
h. Health boards are legally responsible for things over which they have insufficient control.	1	2	3	4	5
i. Boards are too restricted by rules laid down by the provincial government.	1	2	3	4	5
j. The boards have less authority than I expected when districts were formed.	1	2	3	4	5

SECTION C: SERVICES AND FUNDING

This section asks about services in and funding to the health districts.

C1. Please indicate the degree to which you feel boards should increase or decrease their involvement in the following activities:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Raising revenue	1	2	3	4	5	6
b. Assessing community needs	1	2	3	4	5	6
c. Setting priorities	1	2	3	4	5	6
d. Allocating funds	1	2	3	4	5	6
e. Planning programs and services	1	2	3	4	5	6
f. Ensuring service effectiveness & efficiency	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

C2. Please indicate the degree to which you feel districts should increase or decrease their services to the following population groups:

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Youth	1	2	3	4	5	6
b. Elderly	1	2	3	4	5	6
c. Males	1	2	3	4	5	6
d. Females	1	2	3	4	5	6
e. Residents living in poverty	1	2	3	4	5	6
f. Residents of Aboriginal ancestry	1	2	3	4	5	6
g. Other (*Please specify.*) _____	1	2	3	4	5	6

C3. ASSUMING A FIXED TOTAL BUDGET, please indicate the degree to which, in your view, the proportion of the districts' funds should increase or decrease for each type of service.
Remember we are assuming a fixed budget; if you believe some areas should get more funding, you must indicate that at least one other area should get less.

	Decrease a great deal	Decrease	Stay the same	Increase	Increase a great deal	No Opinion Don't Know
a. Acute (hospital based services)	1	2	3	4	5	6
b. Supportive (long-term) services	1	2	3	4	5	6
c. Home-based services	1	2	3	4	5	6
d. Rehabilitation services	1	2	3	4	5	6
e. Mental health services	1	2	3	4	5	6
f. Health promotion	1	2	3	4	5	6
g. Public health	1	2	3	4	5	6
h. Other (*Please specify.*) _____	1	2	3	4	5	6

SECTION D: YOUR PERCEPTIONS AS A MANAGER IN THE SYSTEM

This section asks for your perspective on managing in a devolved authority environment.

D1. In thinking about *your role in Saskatchewan Health*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Regionalization has made my job more difficult.	1	2	3	4	5
b. I would prefer to have more influence over district activities.	1	2	3	4	5
c. The reformed health care system is more bureaucratic than before.	1	2	3	4	5
d. SK Health has less direct control over services than before districts were formed.	1	2	3	4	5
e. Because we have to share authority with the districts, it's harder to get things done.	1	2	3	4	5
f. I learn a lot from the district personnel I am in contact with.	1	2	3	4	5
g. The reformed health care system is more effective than before.	1	2	3	4	5
h. The reformed health care system is more democratic than before.	1	2	3	4	5
i. SK Health has developed an effective management strategy for the reformed health care system.	1	2	3	4	5
j. SK Health's role is to set standards for the districts.	1	2	3	4	5
k. SK Health's goal is to set policy objectives and goals.	1	2	3	4	5
l. The establishment of districts has meant more control of services for SK Health.	1	2	3	4	5

D2. Has your work experience in Saskatchewan Health changed since health reform?

1 Yes, substantially
2 Yes, somewhat
3 No
4 Not applicable

☞ **If yes, please describe how it has changed.**

SECTION E: HOW BOARDS FUNCTION

This section asks for your opinion about health boards in general.

E1. In thinking about *health boards in general*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Board meetings are run efficiently and effectively.	1	2	3	4	5
b. Boards generally make good decisions.	1	2	3	4	5
c. Board decisions generally reflect the values they profess.	1	2	3	4	5
d. Boards have made budget allocations to advance their goals.	1	2	3	4	5
Boards can be described as:					
e. Creative in addressing problems.	1	2	3	4	5
f. Making premature judgements or decisions.	1	2	3	4	5
g. Valuing diverse points of view.	1	2	3	4	5
h. Seeking out assumptions underlying members' points of view.	1	2	3	4	5
i. Reacting positively to new ideas.	1	2	3	4	5
j. Trying to meet multiple goals.	1	2	3	4	5
k. Comfortable with addressing many issues at one time.	1	2	3	4	5
l. Comfortable with deviating from established procedures when the situation requires it.	1	2	3	4	5
Boards generally:					
m. Manage their money well.	1	2	3	4	5
n. Are good at long range planning.	1	2	3	4	5
o. Have adequate mechanisms for board member development and education.	1	2	3	4	5
p. Have adequate mechanisms for board evaluation.	1	2	3	4	5

E2. List three successes or accomplishments you would like boards to achieve over the next two years.

SECTION F: THE BOARDS' ROLE

The following questions ask about the activities and role of health boards in relation to others in their districts.

F1. In thinking about *health boards in general*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
District residents:					
a. Most district residents are supportive of boards' choices.	1	2	3	4	5
b. Even if they don't agree, most district residents generally understand and respect their boards' choices.	1	2	3	4	5
c. Boards effectively communicate the rationale for their decisions to district residents.	1	2	3	4	5
d. Boards have an accurate understanding of what district residents want for the health care system.	1	2	3	4	5
e. Boards are responsive to the wishes of district residents.	1	2	3	4	5
f. District residents are entitled to make representation to the boards when they have an issue.	1	2	3	4	5
g. Public pressure sometimes forces boards to make decisions they would not otherwise make.	1	2	3	4	5
h. Boards' values reflect the values of their districts.	1	2	3	4	5
Management:					
i. Boards' main role is policy development, not management.	1	2	3	4	5
j. In order to function effectively, boards have to be involved in operational management of their districts.	1	2	3	4	5
k. The policy governance model (the Carver model) results in boards less informed than they should be to make good decisions.	1	2	3	4	5
l. Boards essentially rubber-stamp what management proposes.	1	2	3	4	5
m. Boards' values and principles should govern the work of their health districts.	1	2	3	4	5
Health care providers:					
n. Most district physicians are supportive of boards' choices.	1	2	3	4	5
o. Most district nurses and health care providers aside from physicians are supportive of boards' choices.	1	2	3	4	5
p. Physicians are more influential than other district residents in influencing boards' decisions.	1	2	3	4	5
q. Nurses and health care providers aside from physicians, are more influential than other district residents in influencing boards' decisions.	1	2	3	4	5

SECTION G: BOARD DECISION-MAKING

District health boards make decisions about many issues and use a variety of methods. These questions ask you about your perceptions of how boards make decisions.

G1. In thinking about *health boards in general*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Boards have adequate mechanisms to identify emerging issues.	1	2	3	4	5
b. Boards' decisions are consistent with their objectives.	1	2	3	4	5
c. Boards' decisions are too often based on budget considerations, not health needs.	1	2	3	4	5
d. Because their main activity is trying to deal with the impact of a reduced budget, boards can't focus on long term plans.	1	2	3	4	5
e. Most of boards' time is spent reacting to issues raised by others.	1	2	3	4	5
f. Boards have satisfactory mechanisms to consider moral and ethical values in their decisions.	1	2	3	4	5
g. In general, board members have common goals and values when it comes to health care.	1	2	3	4	5
h. Boards have adequate procedures to resolve conflicts among members.	1	2	3	4	5
i. All board members' views are respected.	1	2	3	4	5
j. Men and women members of boards participate equally in discussions.	1	2	3	4	5
k. Board decision-making results from a process of mutual learning, rather than negotiating among competing points of view.	1	2	3	4	5
l. Vested interests have too big a say in board decisions.	1	2	3	4	5
m. Men's views tend to be heard more than women's in board decision-making.	1	2	3	4	5
n. Discussion of different points of view rarely causes any board members to change their minds.	1	2	3	4	5
o. Members accept and support a decision they have disagreed with, once the majority of board members has agreed to it.	1	2	3	4	5

G2. In thinking about *health boards in general*, please circle the number from 1 to 5 that best describes *how often* the following applies.

	Rarely or Never	On Occasion	Usually	Always	No Opinion Don't Know
a. Board discussions are helpful to making decisions.	1	2	3	4	5
b. Boards have adequate options in making decisions.	1	2	3	4	5
c. Boards reopen decisions for further discussion.	1	2	3	4	5
d. Urgent issues drive more important issues off boards' agendas.	1	2	3	4	5
e. The need to make decisions quickly prevents adequate consultation with interested parties.	1	2	3	4	5
f. Decisions are made before the boards have adequately discussed the issues.	1	2	3	4	5
g. Compromise, rather than seeking the optimal solution, drives board decisions.	1	2	3	4	5
h. The reasons for making a particular decision are clear to members.	1	2	3	4	5
i. Decisions are based on good criteria.	1	2	3	4	5
j. On important issues boards are able to reach consensus.	1	2	3	4	5

G3. Do you perceive any barriers or challenges to better decision-making by the boards? ***(Please circle one)***

1 Yes
2 No

☛ **If yes, what are these barriers or challenges?**

☛ **If yes, what factors might help the boards (or management on behalf of the board) overcome these barriers or challenges?**

SECTION H: USING INFORMATION

The following questions refer to the use of information by district health boards - one of the main topics of the study. We are interested in your views about the information boards use in making decisions.

H1. In thinking about *health boards in general*, please circle the number from 1 to 5 that best reflects what you think about each statement.

	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree	No Opinion Don't Know
a. Boards make good use of information in reaching decisions.	1	2	3	4	5
b. Boards ask for the right kind of information to assist decision-making.	1	2	3	4	5
c. Management is responsive to board requests for information.	1	2	3	4	5
d. Boards can distinguish good information from poor information.	1	2	3	4	5
e. Boards need more information from research findings in making board decisions.	1	2	3	4	5

H2. In thinking about *health boards in general*, please circle the number from 1 to 5 that best describes *how often* the following applies.

	Rarely or Never	On Occasion	Usually	Always	Don't Know
With respect to the information boards receive:					
a. They use it.	1	2	3	4	5
b. They understand it.	1	2	3	4	5
c. They understand its purpose.	1	2	3	4	5
d. They know how it was produced.	1	2	3	4	5
e. They are comfortable using numerical data.	1	2	3	4	5
f. They are comfortable using anecdotes and stories.	1	2	3	4	5
When making decisions, boards are influenced by:					
g. Statistical data from financial and scientific reports.	1	2	3	4	5
h. Their knowledge of community expectations.	1	2	3	4	5
i. Knowledge gained from their members' experiences.	1	2	3	4	5

H3. Please rate the *adequacy* of the following types of information provided to health boards. Circle the number from 1 to 5 that best reflects your opinion. If you are unfamiliar with the information, circle 6.

	Very Poor	Poor	Average	Good	Excellent	Don't Know
a. Needs assessments	1	2	3	4	5	6
b. Population health status indicators	1	2	3	4	5	6
c. Program evaluation results	1	2	3	4	5	6
d. Quality of service indicators	1	2	3	4	5	6
e. Service utilization data	1	2	3	4	5	6
f. Citizen opinions and preferences	1	2	3	4	5	6
g. Patient/client satisfaction	1	2	3	4	5	6
h. Provider/employee satisfaction	1	2	3	4	5	6
i. Financial information	1	2	3	4	5	6
j. Relevant research/scientific literature	1	2	3	4	5	6
k. Saskatchewan Health policy directions	1	2	3	4	5	6

H4. In which of the above categories (or other areas) do boards especially need to increase or improve their information?

H5. In which of the above categories (or other areas) do the boards receive information that is not relevant to their work?

H6. What do you consider to be good information for the boards?

SECTION I: BASIC INFORMATION

This last group of questions inquires about your own experiences and circumstances in addition to your employment activity. Some of these questions are to learn about the experience and resources public servants bring to their work. Other questions will help determine how public servants compare to board members, district senior managers, and the rest of the population.

I1. Your position in the department is *(Please circle one)*:

1 Deputy/Associate/Assistant Deputy Minister or Branch Head
2 District Director or Health Consultant
3 Other management position
4 Other professional position
5 Other

I2. You began working in Saskatchewan Health *(Please circle one)*:

1 Before January 1, 1992
2 January 1, 1992 or later

I3. Your main responsibilities are in *(Please circle one)*:

1 Policy/planning/research/evaluation
2 Operations/finance/administration

I4. In what health sector do you have the most knowledge and experience *(Please circle one)*:

1 Acute care
2 Long term institutional care
3 Home care/community care
4 Mental health
5 Public health/health promotion
6 Other (*Please specify.*) _____

I5. Have you ever served as one of the following? *(Please circle all that apply.)*

1 A member of the legislature
2 A member of a school board
3 A member of the board of a non-governmental organization (NGO)
4 A member of the board of a Crown corporation
5 A member of a hospital board

I6. Have you been a volunteer in other community organizations?

1 Yes
2 No

☞ **If yes, please describe your activities briefly.**

I7. Are you:

1 Male
2 Female

I8. What is your age?

1 under 25
2 25-34
3 35-44
4 45-54
5 55-64
6 65-74
7 75+

I9. What is the highest level of education you have completed?

1 Post graduate (Master's degree or higher)
2 University degree (Bachelor's level)
3 Technical/vocational programme
4 Community college diploma
5 High school
6 None of the above
7 Other *(Please specify.)*

_____

☞ **Please feel free to elaborate or comment on any questions in this survey, or on any other aspects of your experience as a Saskatchewan Health official.**

THANK YOU FOR YOUR TIME.