Devolution to democratic health authorities in Saskatchewan: an interim report

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Abstract

Background: In 1995 Saskatchewan adopted a district health board structure in which two-thirds of members are elected and the rest are appointed. This study examines the opinions of board members about health care reform and devolution of authority from the province to the health districts.

Methods: All 357 members of Saskatchewan district health boards were surveyed in 1997; 275 (77%) responded. Analyses included comparisons between elected and appointed members and between members with experience as health care providers and those without such experience, as well as comparisons with hypotheses about how devolution would develop, which were advanced in a 1997 report by another group.

Results: Most respondents felt that devolution had resulted in increased local control and better quality of decisions. Ninety-two percent of respondents believed extensive reforms were necessary and 83% that changes made in the previous 5 years had been for the best. However, 56% agreed that there was no clear vision of the reformed system. A small majority (59%) perceived health care reform as having been designed to improve health rather than reduce spending, contrary to a previous hypothesis. Many respondents (76%) thought that boards were legally responsible for things over which they had insufficient control, and 63% perceived that they were too restricted by rules laid down by the provincial government, findings that confirm the expectation of tensions surrounding the division of authority. Respondents with current or former experience as health care providers were less likely than nonprovider respondents to believe that nonphysician health care providers support decisions made by the regional health boards (45% v. 63%, $p = 0.02$), a result that confirmed the contention that the role of health care providers on the boards would be a source of tension.

Interpretation: Members of Saskatchewan district health boards supported the general goals of health care reform and believed that changes already undertaken had been positive. There were few major differences in views between appointed and elected members and between provider and nonprovider members. However, tensions related to authority and representation will require resolution.

All Canadian provinces except Ontario have regionalized substantial parts of their health care systems. Contemporary (post-medicare) regionalization began in Quebec in 1971 and became the central feature of health services restructuring in the 1990s. It is not a new idea — the Sigerist Report[1] in Saskatchewan recommended full-scale regionalization in 1944, but it was implemented very selectively (essentially for public health services) and was not a major force in the development of the province's health care system. The 1990 report of the Murray Commission[2] also recommended a fuller regionalization model in Saskatchewan to address the fragmentation of the existing system. The model was implemented beginning in 1992, in modified form (e.g., 30 instead of the proposed 15 districts). At that time, the newly elected New Democratic Party (NDP) govern-

Research

Recherche

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This article has been peer reviewed.

CMAJ 2001;164(3):343-7

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ment faced the worst financial crisis in the province since the Depression, inheriting a huge debt and deficit and a reduced credit rating. The restructuring of health care, apart from the merits anticipated by the Murray Commission, was but one of many efforts to restore fiscal health to public administration.

Even though they exhibit a number of features common to health boards in many jurisdictions, Saskatchewan's regional health authorities are unique in several important ways. Since October 1995, two-thirds of members have been elected by universal suffrage on a ward system basis; the remaining one-third of members are appointed. To date, these are the only publicly elected regional health authorities in Canada. Unlike some other jurisdictions, the province has neither prohibited nor discouraged health care providers from serving on boards. In 1995 nearly half the board members had a background in health care. Finally, the boards were allowed to define their own geographic boundaries rather than following those dictated by government. Population density is low — commonly 12 000 to 20 000 people spread out over 25 000 km^2 or more — which presents particular organizational challenges.

Although there has been considerable discussion of the structure and functions of regional health authorities,[3–6] only one other major survey of health board members has been published to date. In 1995 Lomas and associates surveyed 791 members of regional health boards (of whom 514 responded) in 5 provinces: British Columbia, Alberta, Saskatchewan, Nova Scotia and Prince Edward Island.[7–10] Their perspectives and empirical work generated a number of hypotheses about devolution, including the following:

- Regional health authorities are expected to develop and implement more locally sensitive and effective mechanisms for achieving greater effectiveness and efficiency.[10]
- Provincial governments established regional health authorities to deflect criticism for the consequences of spending cuts.[10]
- The success of regional health authorities depends on their perception as legitimate by the local community.[7]
- Regional health authorities will have to deal with tensions surrounding the role of health care providers on boards, and success will depend on the degree of support for reforms among health care providers.[7]
- There may be tensions between the regional bodies and the provincial government concerning the division of authority.[7]

All respondents to the survey of Lomas and associates were board appointees, but those authors did discuss the potential impact on the development of regional health authorities of introducing the democratic process. The present paper reports on a 1997 survey of members of Saskatchewan health boards, which explored the province's unique democratic variant of regionalization. Our survey addressed a wide range of themes, many of which are reported elsewhere.[11] Here, we present data that relate primarily to the hypotheses of Lomas and associates, as listed above. In addition, we report on how board members generally experienced health care democratization in its early manifestation. Our questions included the following: Do elected and appointed members, and providers and nonproviders, view themselves and their worlds differently? Do formally democratic boards hold parochial views of their obligations and loyalties? Do they support or oppose the goals of health care reform?

Methods

We developed a comprehensive survey to assess the decision-making processes of boards and their use of information; board and management roles; and aspects of health care reform and regionalization, such as structures, services and funding for health care. We mailed the surveys in February and March 1997 to all 357 members of Saskatchewan district health boards and used either written or telephone reminders to contact the entire study population. The response rate was 77% (275/357).

We grouped the relevant items from our questionnaire into topic areas corresponding as closely as possible to the hypotheses of Lomas and associates.[7–10] For selected topic areas, we also used bivariate analysis (χ^2 tests) to identify the effects of the independent variables of member status (elected or appointed, experience as a health care provider or not).

Neither sex, age nor education explained a significant proportion of the differences in responses between elected and appointed members and between health care providers and nonproviders. Therefore, the logistic regression analyses are not reported here.

Results

Table 1 presents the significant characteristics of the respondents. There were no objective measures or survey items to verify whether the regional health authorities have in fact developed locally sensitive mechanisms for improving effectiveness and efficiency. Respondents generally reported success: 63% believed that health care reform had increased local control over health care services (whereas 24% perceived a decrease in such control); 62% believed that the quality of health care decisions had improved (whereas 28% perceived a decline in quality); and 46% believed that the quality of health care services had improved (whereas 28% perceived a decline in this measure). Respondents were not complacent about achievements to date: 75% believed that their boards should become more involved in improving effectiveness and efficiency, and 72% advocated more involvement in assessing community needs.

Respondents were divided on their perceptions of the motives for devolution. Fewer than half (41%) of respondents (47% of those elected and 29% of those appointed, $p < 0.01$) agreed that health care reform has more to do with reducing government spending than with improving health, whereas the remaining 59% disagreed with this statement. Similarly, only 47% of respondents (53% of those elected and 37% of those appointed, $p < 0.01$) agreed that government gave the districts the authority to make tough decisions, whereas 53% disagreed with this statement.

About 70% of respondents perceived that district resi-

dents supported their decisions and understood and respected board choices (Table 2). A significantly higher proportion of appointed members than of elected members perceived community respect and support.

Large minorities of respondents thought that physicians and other health care providers influenced board decisions more than did the public. Board members with experience as health care providers — 96% of whom were nonphysicians — were significantly less likely to consider their practising counterparts as supportive of board decisions (Table 3). Interestingly, a higher proportion of providers than of nonproviders thought that patients should have a greater say in how their health care needs are met (Table 3).

Table 1: Selected characteristics of respondents to a survey of members of Saskatchewan's district health boards

Characteristic	No. (and %) of respondents
Board status	
Elected	181 (66)
Appointed	94 (34)
Health care provider†	
Current	77 (28)
Former	52 (19)
Never	145 (53)
Sex	
Male	129 (47)
Female	143 (53)
Age, yr	
25–34	10 (4)
35–44	61 (22)
45–54	86 (32)
55–64	73 (27)
65–74	38 (14)
≥ 75	4 (1)
Education	
At least university master's degree	26 (10)
University bachelor's degree	71 (26)
Some postsecondary	121 (44)
High school	45 (16)
Less than high school	10 (4)

*Total numbers of respondents for categories other than board status were less than 275.
†Current or former experience as a health care provider.

As a rule, respondents expressed concerns about the degree of boards' autonomy from government in making decisions. Perceived problems included legal responsibility for things over which the board had insufficient control (expressed by 76% of all respondents — 82% of elected members and 64% of appointed members, $p < 0.01$); restrictive rules laid down by the government (expressed by 63% of respondents); less authority than expected when the districts were formed (according to 64% of elected members and 42% of appointed members, $p < 0.01$); and lack of clarity in the division of authority between boards and Saskatchewan Health.

Consistent with the findings of Lomas and associates,[7–10] 76% of respondents considered themselves most accountable to *all* residents in their district, rather than to special interest groups, ward residents, the provincial minister of health or local health care providers. There was one key difference in responses: elected members were much more likely to feel most accountable to their ward residents (17% v. 3%, $p < 0.01$).

We were also interested in the degree to which board members were "politicized" and their perceptions of their representative roles. Twenty-five percent thought their role was most like that of a school board member, 23% likened their role to that of a hospital board member, 14% to that of a member of a legislature, 12% to that of a board member for a Crown corporation, and 11% to that of a board member for a nongovernmental organization. Fully 91% maintained that they would support a decision they believed to be right, even if it was opposed by a majority of the community, 36% had more confidence in their personal opinions than in their boards' consensus opinions, and 30% did not feel that their input to board decisions was strongly affected by people in their communities. Nonetheless, 80% thought that their boards were responsive to the wishes of district residents, 91% felt that their boards' values reflected those of their districts, and 32% admitted that public pressure sometimes forced their boards to make decisions they would not otherwise have made.

Only 20% agreed that slates of candidates (i.e., groupings resembling political parties) should run in future elections. Interestingly, only 38% of the appointed respondents indi-

Table 2: Board members' perceptions of board credibility within the community

Statement	Percentage of respondents agreeing with statement			
	All board members $n = 275$	Elected members $n = 181$	Appointed members $n = 94$	p value*
Even if they don't agree, most district residents generally understand and respect our board choices	70	66	79	0.028
Most district residents are supportive of our board choices	71	65	83	0.002
Being a board member has provoked some resentment toward me on the part of people in the community	43	41	48	NS

Note: NS = not significant.
*χ^2 test with 1 degree of freedom.

cated that they would consider running in a board election, and barely half (53%) of the elected members said they would run again — a considerably lower proportion than among first-term incumbents in legislatures or school boards. In fact, 72% of elected members did run again in 1999.

Most respondents (84%) believed that differences between elected and appointed members disappeared over time. Nonetheless, 45% of respondents (55% of elected members v. 23% of appointed members, $p < 0.01$) continued to believe that elected members had more legitimacy and credibility in the community than their appointed colleagues. It would seem, then, that respondents thought their constituents would differentiate members on the basis of board status, whereas they themselves did not.

There was a marked contrast in board members' views on the meaning of and necessity for health care reform and the motivations behind it, as described above. Ninety percent agreed that health care reform is about shifting the emphasis from sickness care to wellness, and 92% believed that there had been a need for extensive reforms. Eighty-six percent agreed that health care reform had created a system based on needs rather than on traditional patterns of utilization. However, 56% agreed that there was no clear vision of what the reformed health care system should be like. These findings suggest views highly congruent with the official and implicit goals of government, along with uncertainty about precisely how to achieve them.

Saskatchewan board members were generally positive about achievements to date and were even more uniformly optimistic about the future. About half the members thought that the changes over the past few years had improved the system, whereas only 22% perceived a decline in performance. Fully 83% perceived that the changes made in the previous 5 years had been for the best, even though 26% thought that their districts had lost out because of health care reform. From two-thirds to three-quarters expected that over the next few years health care reform would increase local control over health services, the quality of decisions, services and the overall system, and the health of the population. Only about 1 in 7 expected the opposite trends.

Interpretation

How does Saskatchewan's uniquely democratic devolution compare with experiences elsewhere in Canada? A striking feature is that there was little that could be attributed exclusively to the electoral process. Regionalization and health care reform have generated a variety of issues and responses across the country. Cost containment created stress on the system, much of which was inherited by the developing regional authorities. Public confidence in the system plummeted during the 1990s. The environment has been volatile, and failures have received far more attention than successes. Informed only by media accounts of health care, Canadians might be shocked to learn that health status in the general population has improved markedly in the past 10 years.[12]

It is conceivable that the perceived legitimacy and function of the (still very young) regional health boards have less to do with formal structures and more to do with the timing of their formation. In Saskatchewan and New Brunswick, for example, the provincial governments made major and controversial restructuring decisions (such as decisions to close hospitals) before they formed the regional authorities. By contrast, shortly after their formation, Alberta's regional health authorities were required to plan for an 18% reduction in expenditures over 3 years (albeit a reduction that ultimately was never realized). Not surprisingly, 67% of Alberta respondents to the survey by Lomas and associates[9] but only 49% of their Saskatchewan counterparts attributed devolution to the government's desire to offload tough budgetary decisions.

There were surprisingly few differences in perception between elected and appointed members in Saskatchewan. Furthermore, few respondents perceived

Table 3: Board members' perceptions of degree to which health care providers support the health board and perceptions of the planning and provision of services*

Statement	Percentage of respondents agreeing with statement: All board members	Members with current or former experience as health care providers	Members with no experience as health care providers	*p* value†
Most district physicians are supportive of our board choices	64	65	62	NS
Most district nurses and health care providers, aside from physicians, are supportive of our board choices	57	45	63	0.020
Nurses and other health care providers, such as physiotherapists and chiropractors, should have a greater say in planning and providing health care services	67	86	51	0.000
Physicians should have a greater say in planning and providing health care services	49	57	45	NS
Patients should have a greater say in how their health care needs are met	84	91	79	0.018

*Some members did not provide a response for some statements.
†χ^2 tests with 1 degree of freedom.

their role to be analogous to that of a member of a legislature, whereas more felt the boards' role was similar to that of less overtly political bodies. There is thus far little perception that health board elections should involve the political parties and formal partisanship of general elections. These findings should allay the fears of those who anticipated that the electoral process would overtly politicize boards, resulting in institutionalized conflict and parochial position-taking.

Anecdotally, it does not appear that Saskatchewan citizens are more inclined to mobilize around health care issues than those in other provinces, which implies that formal democratization in itself does not guarantee interest. Voter turnouts have thus far been low, as in many municipal elections. On the other hand, recent changes in Canadian health care have tended to evoke more protest against unpopular actions than advocacy in favour of new initiatives. In this context, the absence of observable mobilization may be an endorsement of board actions rather than evidence of public indifference. The data do appear to reject the notion that electing rather than appointing boards creates a high level of discontent with overall provincial goals or division into factions. There were no startling differences of opinion between the exclusively appointed Saskatchewan board members surveyed in 1995 and the mainly elected cohort surveyed in 1997. The elected members did not consider themselves tethered reflexively to the views of their constituencies nor hostage to majority opinion on every issue. Perhaps more important, they were not a monolithic group, but rather encompassed a diversity of views inherent in a functioning democracy. In Saskatchewan at least, board members appeared united in their understanding of and commitment to the philosophy of health care reform and more divided about motive and performance to date.

That so few citizens have voted in elections of board members and that elected members view the world through the same lens as appointed members raises the question of why the government should bother with elected boards. Elections are cumbersome, and many capable people are disinclined to present as candidates, particularly where rewards are modest, as is the case for regional health authorities. One obvious rationale for democratization is to confer locally generated legitimacy on decision-makers. When and if the confusion surrounding board authority and autonomy abates and the citizenry becomes more inclined to participate in health care issues, the democratic elements may mature. In a sense the timing could not have been worse: born in an era of fiscally driven turbulence and declining voter turnout in governmental elections, the electoral process for health boards is caught in a downdraft. At this stage perhaps all that can be firmly concluded is that neither the worst fears nor the highest hopes have been realized. If we as a society continue to believe that democracy is intrinsically valuable, these realities alone may be a sufficient warrant to extend the process for at least a few more iterations.

Addendum

The third round of Saskatchewan health board elections took place in October 1999. Voter turnout was a mere 10%. With several boards, notably that in Regina, running up huge deficits, there has been renewed discussion of the viability of the districts and the wisdom of the electoral process. In August 2000 the government appointed a one-person commission to review all aspects of the system, including its organizational features (though not the democratic process per se). It appears that democratic devolution is still viewed as an experiment rather than a permanent feature of the Saskatchewan health care landscape.

Competing interests: None declared.

Contributors: Mr. Lewis participated in designing the research project and was the lead writer of the manuscript. Ms. Kouri participated in designing the research project, directed the collection of the data and the compilation of the results and participated in writing and revising the manuscript. Ms. Dutchak participated in collecting the data, compiling the results, and writing and revising the manuscript. Dr. Dickinson and Dr. Estabrooks participated in designing the research project and in writing the manuscript. Drs. Williams, Hurley and Mustard participated in designing the research project and commented on the various versions of the manuscript.

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

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