EVALUATING CHARACTERISTICS OF REGIONAL HEALTHCARE BOARDS IN MANITOBA AND SASKATCHEWAN

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FELLOWSHIP PROJECT

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EXECUTIVE SUMMARY

The later part of the 1990's saw many provinces across Canada embroiled in initiatives to reform the delivery of healthcare services. During this timeframe, the system experienced funding reductions, increasing demands for service, changing population demographics and a more knowledgeable public with higher expectations for more accountability. In response, some provincial governments have been "tinkering" with the regionalization model of healthcare delivery with the anticipation that they will find the optimum approach to ensure the most effective and efficient outcomes. With regionalization has come the expectation that Boards will be able to maximize the resources they receive to better address the needs of their communities.

Although the role and functions of these new regional health boards have been well articulated, there has not been a great deal of follow-up with the boards to see how this 'experiment' has been evolving. In the Prairie Provinces there have only been two studies to measure how well the regional board concept is progressing. In 1995 and 1997, McMaster University and HEAL*Net* Saskatchewan examined how well the boards saw themselves operating. Both of these studies used a different set of questions and approached the subject from slightly different perspectives. However both did look at some similar aspects of the board governance model, specifically communication, function and relationship to the funding agency.

In May 2001, a proposal to further the research in this area was submitted to the Canadian College of Health Service Executives to examine how regionalization was developing from the perspective of Board members in Manitoba and Saskatchewan.

The proposed Fellowship project developed a process for evaluating the exchange of information between the funding agency, the service providers and the clients, as well as defining specific responsibilities, which emphasize the roles of each group. A survey instrument was constructed to assess how well board members felt these relationships were working and to determine the effectiveness of the Boards in policy formulation, decision-making and accountability.

In summary, the objectives of the special Fellowship Project were as follows:

1. Preliminary discussions with board members indicated that a significant number of respondents felt the 'reform' process had not achieved its goals. This Project examined the reasons behind these preliminary statements.
2. This project not only sought feedback from existing board members, it also compared the results to the previous surveys to see what, if anything, had changed.
3. Although neither of the provincial Departments of Health had identified the characteristics that make for the effective functioning of healthcare boards, there had been a review of not-for-profit boards in Manitoba, which identified the principles that should be present in order to increase the potential for effective board function. This Fellowship Project assessed whether these characteristics were present in the functioning of the boards.
4. The Fellowship Project also determined if there were any relationships between the participant's responses and some demographic variables. The Saskatchewan survey included the collection of information regarding: length of service on the board, whether the respondent was appointed or elected and the

respondent's gender. The data was analyzed around these variables to see if there were any correlations.

The Fellowship Project acquired a great deal of data on the roles and function of the healthcare boards in both provinces. It also provided some insight into how the Boards have evolved over time and where they see an opportunity for the provincial government to shift its efforts in order to assist this process in the future. In summary, the Boards indicated the following:

- Board members participating in the survey indicated a high degree of satisfaction with the internal workings of their specific boards. Many members were fairly comfortable with their understanding of the roles and responsibilities, their information needs, who their clients were and their communication with the community.
- The perceived accountability to the provincial government was very low.
- There was still a high level of concern with the their perceived level of authority and the direction the healthcare reform process was headed.
- About three quarters of the subjects in both provincial jurisdictions indicated they thought there were barriers in the system, hindering them from meeting the needs of their constituents and almost two-thirds of these indicated government (policy, messages) as the main culprit.
- There was a great deal of variation on what subjects identified as being a desirable experience for a board member. It was interesting to note that there is a correlation in responses to the gender of the respondent.

- Board members felt they had a lot of opportunity to be involved in the decisions of the regional health board and individual board members made an effort to be part of the process.
- Although some subjects indicated an issue with the information they received, overall they felt they had an opportunity to consider options and that their Board decisions were based on the best thinking of Board members in relation to what they knew about their environment.
- Subjects indicated their strategic plans were built around their understanding of their specific communities, which was not always consistent with the messages coming from government.
- Subjects clearly indicated an understanding of whom the board was accountable to, their community.

One objective of this Project was to be able to take this information and determine if there are any lessons learned; i.e. are there any recommendations that might help improve on the effectiveness of the Regional Healthcare Boards. In general, there has been some progress on regionalization, albeit the communication amongst the stakeholders and the funding agency is still weak at best. Some immediate changes in the system that should improve upon the existing process include:

- The provincial governments and the Regional health Authority Boards must be clear on their individual responsibilities and shared accountabilities, if the Boards are to be held accountable for providing stewardship in the public healthcare system.

- Government has to set out the provincial goals for healthcare, and resource the regional health agencies according to their local needs, available resources and existing services. Boards should monitor how well they achieve their specific objectives.
- Formal board evaluations should be designed and then implemented on an annual basis. The outcomes should form part of the annual reporting processes.
- Recognize board decisions are influenced by demographic characteristics and in order to be more consistent, require local and provincial orientation programs to ensure a standardized approach to the information gathering, analysis and decision making process.
- As the relationship between the Board and its management can be misunderstood and/or strained, it is important that communication and evaluations of the Board and the CEO are conducted with transparency

INTRODUCTION

Background

During the early 1990's, many provinces across Canada were involved in reforming the delivery of their healthcare services. The impedance behind this change was the spiraling growth in healthcare spending in relation to government's taxation powers and growing deficits [Lomas (1)1996]. Although provincial governments needed to get a handle on their healthcare budgets they did not want to jeopardize access or the quality of service [Leatt 2000]. As discussions in the media began to present the government's concerns with the rising costs of healthcare, consumers began to become more articulate in this debate and questioned the level of accountability in the system [Shortt 2002]. Budgets alone were not the only issues needing to be addressed in the planning of health services in this era of renewal. There was the rapid growth of technology, an ever growing senior's population, the growing awareness of utilizing best practice in the delivery of health services and increased demands for more accountability in the healthcare system. By the late 1990's, with the exception of Ontario, most provinces had transferred the responsibility for allocating resources and cost control from provincial to regional health authorities [C.C.H.S.E. 2000].

Although there has not been a great deal of study surrounding the governance process, there have been a few reviews of regional health boards since reform. One of these studies indicated that even though provincial governments indicate other reasons for reform, devolution was largely embarked on as an instrumental means to achieve other ends, and not an end in itself [Lomas (1) 1996]. The study by McMaster University recognized the importance of establishing the relationship between the provider,

government and the community. Their survey examined the 'real' power of the board and critically looked at negotiation, communication and assessing the board's skills in determining the difference between needs and wants.

One of the goals of the provincial government's reform process has been to increase the involvement of the 'community' in the planning of their health services. [Saskatchewan Health,1992; Manitoba Health 1997] Although each province had its own document spelling out the merits of renewing its healthcare delivery system, most included statements addressing the need for containing costs, improving outcomes, increasing flexibility, being more responsive, and better coordination and integration. [Lomas (2) 1996] The internal and external functioning of the Regional Health Board in this new milieu can hinder or facilitate provincial governments being able to achieve these goals. It has been noted in past studies, as well as in some of the documents reporting on the status of health reform [C.C.H.S.E. 2000, 2001, 2002], that reforming the healthcare system may truly have had more to do with provincial governments attempting to balance their budgets and less to do with providing better healthcare.

Each province has approached reform differently in that program responsibility and authority exerted on regional health boards differs across the country. In some provinces the regional boards may be only planning boards with limited operational responsibility; while in other provinces they are responsible for the delivery of acute care, long term care and community based services within their defined region [C.C.H.S.E. 2000].

Saskatchewan was one of the initial leaders in reform in Western Canada in 1992, and was closely followed by policy announcements in Alberta, Manitoba and British Columbia. This report examines how well health board members in Saskatchewan and Manitoba feel this transition has evolved. Both provincial Health Departments recognized that in order to increase the opportunity for reform to succeed, the board's composition, and interaction with the staff that deliver the services and the community itself would have to be well defined.

Both provinces have advocated in their literature their support for 'policy governance' similar to that as developed by John Carver. [Carver, 1990, 1997] Policy Governance was developed for use in the non-profit sector and has been instrumental in boards being able to clearly define their role in relation to their owners, the organization's management and the 'customer'. In essence, the board's role can be visualized in its ability to formulate policy, make decisions and in overseeing its agenda [Pointer 1999; Provincial Auditor Saskatchewan 1999].

Traditionally, other service providers have viewed the physician as the gatekeeper to the healthcare system. That is, the resources that were needed by a community to provide services in a local hospital were in direct response to the specific services the physicians were able to provide. The focus of reform has been to shift towards assessing the needs of the community first, then depending on the level of provincial funding available, determine the programs and services the board will deliver. Regionalization is much broader than just looking at the needs of a hospital; it now includes health promotion, prevention and community services.

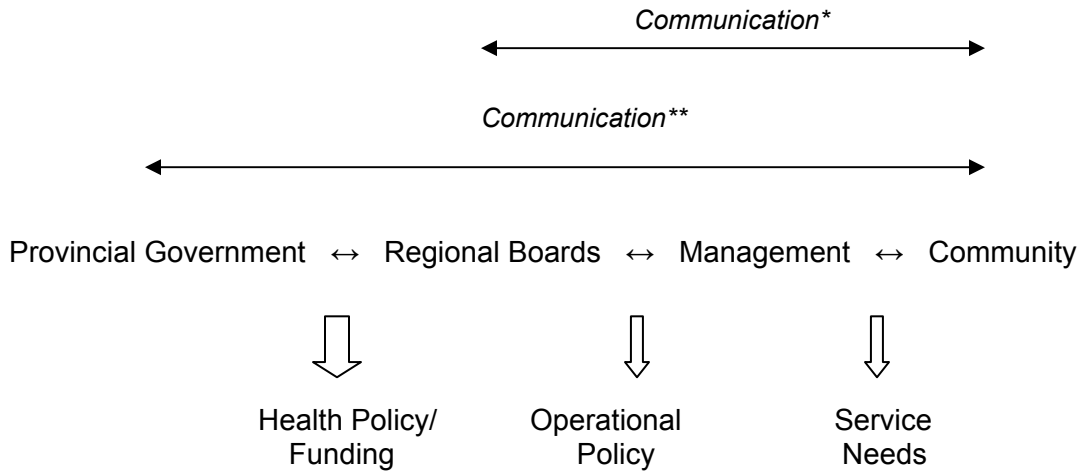
Along with the development and implementation of the health regions and their boards, governments introduced a 'wellness' approach to health. When examining the needs of communities, boards were also expected to ensure they addressed the determinants of health (Kahan 1999). This broader approach included examining employment, income, education, housing, the environment and individual lifestyle choices. Health reform policy makers saw regionalization as providing an opportunity for: decisions being made closer to the client; resources being maximized; local stakeholders being well informed; and expanded opportunities for public input [Rachlis 1994]. There is a public awareness across the country that public boards have become an important contributor to the healthcare community [Manitoba's Provincial Auditor, 2000]. With the introduction of regionalization, the '*new'* gatekeeper may now be the 'Board Trustee'.

In 1995 and 1997, two notable surveys of regional health authorities were conducted to determine how board members felt this reform experiment was evolving. There was a great deal of consensus between these studies in that respondents:

- recognized a need for change in the planning for healthcare services;
- funding needed to be tied to the needs of the community;
- they supported a publicly funded system; and
- most expressed a concern that there was no policy direction from government indicating where the reform process was headed [Kouri 1997, Lomas (3) 1996].

For this Fellowship Project, a survey instrument was used in order to assess where regional health board members in Manitoba saw themselves; as well a similar survey instrument was used in Saskatchewan to determine how other stakeholders (Affiliated Health Boards) view the workings of the regional boards. In essence, the Fellowship survey examined how well communications between the different groups was functioning. Figure 1 graphically depicts the communication model.

Figure1: Communication Network



*Notes: * communication between Board, management and the community.*

*** communication between government, the Board, management and the community*

Project Objectives

This Project utilized a process for evaluating the exchange of information between the funding agency, the service providers and the clients, as well as defining specific responsibilities, which emphasize the roles of each group. A survey instrument was constructed to assess how well board members felt these relationships were working and to determine the effectiveness of the boards in policy formulation, decision-making

and accountability. As boards function as the link between the 'funders' and the clients (patients), this survey examined how board members perceived how well this relationship was working in the reform milieu.

A review of the literature indicates there has not been a great deal of interest in examining the effectiveness of boards in the Canadian healthcare system. Since the beginning of regionalization by provincial governments, there have only been two concerted efforts by researchers, one national survey conducted by McMaster University in 1995 and one specific to Saskatchewan by HEAL*Net* in 1997. The survey in this project will compare some of the results from these earlier studies to determine if there were any changes in the experiences of board members over time in Saskatchewan.

McMaster University Survey

This survey was distributed to regional health boards in five provinces across Canada that had some form of regionalization in its healthcare delivery system. Three of the provinces had boards with about three years experience (included Saskatchewan). The objective of the survey was "to obtain socio-demographic backgrounds, training, prior experience, information use and activities of devolved health authority board members" [Lomas (1) 1996]. The conclusion of the study was that the respondents appeared to have the skills to position them to meet the expectations of their respective provincial governments, but fewer appeared to be structured to address the views of their providers and even less to incorporate the needs of their community [Lomas (3) 1996].

HEAL*Net*

The HEAL*Net* survey was specific to the experience in Saskatchewan. In early 1997, surveys were distributed to all District Health Board members, district senior managers and members of Saskatchewan Health's management team. The survey sought respondents' views on regionalization and the use of information. Overall, the respondents indicated they felt favourable towards the government's health reform initiative to date. However, they did indicate some confusion and concern about roles and accountability, about the pace of the change and the need for more evaluative information for decision-making.

Fellowship Project

In summary, the approved objectives of the Canadian College of Health Service Executive's Special Fellowship Project are as follows:

1. To assess how well health reform has progressed and to compare the results of this project's survey to previous surveys to determine if any progress had been made over time.
2. To determine if there are any guiding principles or prescribed characteristics that can be used by Boards to assess how well they are operating.
3. To determine if the provincial government's reform policies have assisted or inhibited the Boards from carrying out their responsibilities.
4. To examine other demographic variables to determine if variables are correlated to specific responses such as the: length of service on the board; whether the respondent was appointed or elected; and the respondent's gender.

Note: For this paper the following definitions and abbreviations are being used:

- *SK, denotes the province of Saskatchewan.*
- *MB, denotes the province of Manitoba.*
- *DHB, denotes District Health Boards in SK.*
- *RHA, denotes Regional Health Authorities in MB.*
- *Devolution is the transfer of authority of defined decision making for specific healthcare services by central government to a DHB or RHA.*

METHODOLOGY

Overview

Data was collected from a survey completed by RHA board members in MB and DHB board members in SK, for which the author was the principal investigator in both provinces. (Appendix A Sample Saskatchewan Health District Board Survey). Regional health board members in MB and SK were asked to provide their opinion based on their experiences on the regional board. The surveys were conducted in MB in March 2000 and in SK in January 2001. All board members were requested to participate in the survey, as the number of board members in both provinces was relatively small.

A stratified random sample of affiliate health boards in SK was sought using a comparable survey format. An affiliate board is responsible for providing health services under contract to the DHB. A number of boards were selected, to reflect the diverse size in the affiliate organizations, as well as regional geographic variations (i.e. not all boards located in one district/region).

Survey Instrument

The survey instrument used in this Fellowship project was developed based on previous research conducted by HEAL*Net* (Saskatchewan) and McMaster University. Input on the survey's statements for this project was sought from HEAL*Net,* Manitoba's Provincial Auditor's Office, the Regional Health Authorities of Manitoba (RHAM) and the Saskatchewan Association of Health Organizations (SAHO). A modified 'Delphi' technique was used with the consulting organizations to construct the survey for this project. The instrument was distributed to MB's RHAs by the researcher in March 2000.

Preliminary findings from the survey in MB were presented at the Canadian College of Health Service Executive's National Conference and Exhibition in June 2000.

The survey instrument underwent minimal revisions to reflect the differences in terminology between MB and SK. As well, the SK survey added some board member demographic information. The response rate for the Fellowship project was comparable to the HEAL*Net* and McMaster surveys (60-75%). This Fellowship Project's surveys were coded to monitor participation rates, and provide demographic information for analyzing results. Results are presented in a manner to ensure participant and Board confidentiality.

The survey was designed to examine some specific functions of the Board. The survey instrument used a Likert five level-scaling indicator (strongly disagree → strongly agree). In the project's report, some responses are collapsed to show the percent variance between the 'agree' and 'disagree' responses, as the level of 'partially agree' or 'partially disagree' was not that significant. The assessment of how boards see themselves was measured as follows:

Chart 1: Boards Self Assessment Survey Process

FACTOR	STATEMENTS DESIGNED TO MEASURE
Governance	Was the function, role, accountability and authority well defined and understood by Board members?
Barriers	Were there any perceived barriers to the Board achieving its goals and what are they?
Experience	What kind of experience would be an asset to the functioning of a Board?
Contribution	How did each Board member assess their contribution to conducting Board business?

Effectiveness	In assessing the Board's internal decision-making process: • Was information readily available? • Were there options for consideration? • How were decisions made? • Were the decisions acted on?
Decision-making	Where there any external forces afoot: • Were there factors that constrained the Board? • Was the provincial government perceived as giving mixed messages? • Was the direction of the Board aligned with their understanding of health reform? • Did Board members feel they were rubber stamping management's recommendations?
Owners	Did Board members have a clear understanding of who their owners were?

A board's decisions should be based on a collective response, representing the accumulated decision and/or opinion of each board member [Carver 1990]. The individual perspectives may be a function of their duration on the board, how they became a member (elected or appointed), or their gender. This information was collected in SK so that correlations could be identified, to see if any of these factors had an impact on their individual survey responses.

Survey Distribution

Although the surveys were conducted during two different time frames in the two provinces, MB being March 2000 and SK January 2001, the process followed in distributing and returning the survey was similar. Given the relatively small sample size (MB, n=100; SK n=330) the survey was distributed to all board members to maximize the number of possible respondents.

Manitoba

In MB, the surveys were circulated to each of the RHA offices. A list of the RHA offices was received from the Regional Health Authorities of Manitoba. Contact was made with the Board chairs of each Authority to introduce the project and seek their support. The surveys were distributed to each office along with a self-addressed return envelope. The return address label was coded so that the sending RHA could be recorded. The codes do not pertain to individual respondents, just to the specific region, as anonymity was guaranteed.

During the distribution of the survey in MB some board members were replaced as part of the annual appointment process. This number was more than in past years due to a change in government. Only previously appointed board members were asked to complete the survey, as the survey was designed around a respondent's expectations and experience.

Saskatchewan

In SK there was a slight variation to the process. The surveys were distributed by SAHO staff to each DHB office. The researcher made contact with each district Board Chair to seek their support. Each health district office distributed a survey along with a return envelope and requested the survey be returned in the sealed envelope to the specific DHB office, from there they were sent directly to the researcher. Follow up phone calls were made by SAHO staff to only two districts, which did not comply with the request.

As with MB, board members completed the survey and placed them in a self-addressed envelope before returning them directly to the researcher. As with MB, the return address labels were coded to identify the responding area. On receipt, the assigned code tracked the document through its receipt, data entry and analysis. Follow-up phone calls were made to remind health districts with a low, to no participation rate. Due to some of the small "p" political circumstances facing specific boards, no further contact was made.

In SK, the survey was distributed three months before the release of a consultant's report (Fyke 2000) was to be released to the Saskatchewan government. Fyke's review was commissioned to address specifically the number and distribution of health districts. Although there were no specific statements in the Fellowship survey that addressed any proposed political interventions in both provinces, there were some open questions, which some respondents used to express their views on how they thought the political 'whims' had hampered or supported their efforts. (see Appendix B: Summary of Comments)

Exclusions

At the time of the survey, the Winnipeg Regional Health Authority Board in MB had just been named and was excluded from the survey. As well, there were a few anomalies in a couple of regions in SK. The provincial government had replaced one Board with a

public administrator and two other health districts had been experiencing internal strife so board members decided not to return their surveys.[2]

It is recognized that this is not a random survey, but a survey of a total defined population. The fact that these surveys are not a sample means that any bias would not be a result of a sampling error, but could be due to some of the individual respondent's personal views and/or principles. For example, subjects who responded may represent a special interest group or have a political affiliation, which made them more likely to respond in a specific manner.

Response Rate

The participation rate in MB was about 60% (n=61) and in SK 68% (n=207). Mail-out surveys tend to get a low response rate, as it requires participants to complete the survey without some sort of incentive. Researchers rely on the support of respondents for a research initiative. The response rates for this Fellowship survey are similar to those experienced in previous board surveys. For MB, individual regional participation went from a high of 100% to a low of 20%. Excluding the two districts in SK that did not respond, the participation rates experienced were comparable to MB. Overall, both provinces displayed a fairly consistent distribution of responses throughout their geography.

[2] Note: Compounding the healthcare environment is the fact that from the time that health reform initiatives began in each province, to the time of this project, only 6 of the original 30 CEOs remained in their first DHB in SK, and only 3 out of the then 13 RHA CEOs in MB.

Data Analysis

General patterns in 'agree/disagree' rates with the survey statements have been examined. Any correlations with other survey statements give some insight as to the effects one perspective may have to another. For example, the statement "The board has less authority than I expected when I was elected/appointed to the Board", was compared with the response to the level of agreement to the statement "The Board is constrained by legislation and regulations." Did the Board perceive they had their hands tied?

In the SK survey, trends have been assessed in relation to other captured demographic information such as: the individual's duration on the board; whether or not the board members were elected or appointed; and the gender of the respondent. An attempt was made to have regional summaries compared to the financial position of the organization, i.e. was there a correlation on the level of satisfaction and/or dissatisfaction of the Board in relation to the Board's financial position (surplus/deficit). A further analysis focused on providing a longitudinal perspective, as some of the survey statements were drawn up to provide comparability to previous surveys. In the earlier surveys, the research examined how well board members assessed their overall effectiveness. How has this attitude changed over time and what, if any barriers still exist in boards being able to meet their responsibilities?

Assumptions and Limitations

An assumption in this report is that only the requested board members completed the survey, and that the subject's responses reflect their individual opinions at the time the surveys were completed. Survey responses present the understanding, opinions and attitudes of individual board members as of March 2000 in MB and January 2001 in SK.

There is a clear recognition that these opinions reflect a point in time and may have changed since the Fellowship survey was conducted, as some of the board members may have gained new knowledge and experience. During the distribution of the survey in MB, new board members were being appointed and some of the respondents would have been advised that they were no longer on the board. In SK, there was a Commission poised to release their report recommending changes to the number and size of health districts in the province

.

Statements in the survey were drafted to ensure they provided clarity in their interpretation and were not leading the reader in any specific direction. (i.e. encouraging a certain response.) Open-ended questions provide a vehicle for respondents to provide additional information on their opinions or suggestions for change to improve the functioning of the boards. (Appendix B: Summary of Comments)

Results

Board Member Profiles

Board profiles provide some interesting comparisons in the mix of male and female members, as well as the years of experience on the Board. In both MB and the affiliate Boards, all members were appointed (MB-government, SK affiliates-organization). The percent distribution of the respondents to the survey in SK is comparable to the actual composition of the boards, which is four members appointed (33%), eight elected (66%). The distribution of experience in SK between the regional and affiliate members is also similar with the largest representation being from individuals who had served greater than 3 years composing 63% of the sample. A further breakdown of the SK board members by elected/appointed and examining their gender showed the appointed members to be 57% male and 43% female. The elected members were the opposite with 43% males and 57% females.

Chart 2: Board Profile Comparisons

Characteristic	SK %	Affiliate %	MB %[3]
Appointed	33	100	100
Elected	66		
<1yr	5	10	
1-3 yrs	32	27	
>3yrs	62	63	
Male	47	56	
Female	52	43	

Manitoba data (referred to as MB)

Number of subjects: 60 (no demographics)

See Map Appendix C

[3] No demographic information was collected for Manitoba subjects.

Frequencies

Board Governance: Open-ended questions

76.7% of respondents felt that there are barriers/challenges to better decision-making by the Board. Of those that saw barriers within the Board, almost half of them (50%) reported that the government was a potential challenge to effective decision-making.

Board Governance: Close-ended questions

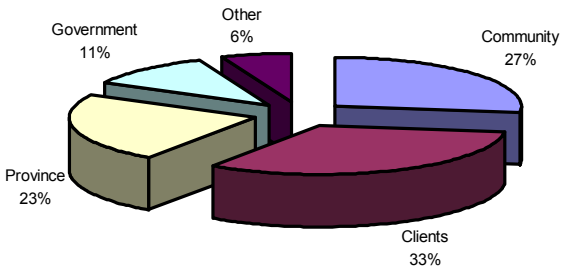
Table 1MB: Percent who "agree" with the following statements

Statement	Percent who "agree"
Board clearly understands its goals	59.3
Agreement by Board members on the Board's priorities	61.7
Board is accountable for the overall effectiveness of the organization	38.3
Consensus on whom the Board is responsible for	46.7
Board understands its legislated mandate	55.9
Board members are committed to the organization	49.2
Board members have common goals and values in relation to healthcare	70
Once the Board has made a decision, all members speak with a common voice on the issue	48.3
Board has developed linkages with other organizations, agencies and stakeholders	52.5
Board's relationship with the CEO and the staff is well defined	44.8
Board focuses its decisions on policy issues (not day-to-day business of the health district)	53.3
Board has less authority than I expected when I was elected/appointed	35
Board's goals have been developed based on the needs of the community and within resources available	52.5
Board and the CEO share a common view of the Board's priorities	44.1
Public pressure sometimes directs the Board to make decisions that may not be consistent with local needs	22
The Board's vision, mission and values are regularly discussed and understood by all Board members	56.7
Board is accountable to the residents in the District	44.1
Regular reporting to the community and stakeholders on what the Board is doing	37.3
Board has developed reporting guidelines on the information to be provided to the community	49.2
Information conveyed to the public and to government provides an update on how the Board is performing	55
Board ensures that external information is understood by the target audience	62.7
Published information is audited and/or reviewed by the Board	52.6

Board Member Interests

Subjects were asked to rank the top three interests (out of seven possible choices: community, clients/customers, provincial citizens, provincial government, Minister of Health, particular interest group, and other) that they represent on their respective Board. Figure 2 indicates the top three selected interest groups.

Figure 2: Top Three Interest Groups - MB



Of the subjects who chose the community as an interest group they represent, close to half (47.1%) reported it was a **secondary** interest. Almost all of the subjects reported that they represent clients/customers of the district at some level (66.1% chose this as their **primary** representative interest on the Board). Of those choosing the citizens of the province, 80.5% agreed that this was a **tertiary** interest. Only 8 subjects indicated they see themselves representing the government on the Board on some level (62.5% of the 8 subjects indicated this was a tertiary interest). Only 12 reported they represent the Minister of Health, and 6 of these subjects suggested that this was a secondary interest. Only 5 chose a particular interest group and 3 reported to represent another type of group (recorded as “other”) at some interest level. Therefore, the majority of subjects chose clients/customers, community and provincial citizens as interests they represent on their board, in that respective order (from primary to tertiary interest).

Board Experience

Subjects were asked to rate a series of statements in terms of how important they believe each experience is in achieving an effective Board. Table 2MB indicates how many agreed the experience was "very important".

Table 2MB: Percent who feel the experience is "very important" in achieving an effective Board

Statement	Experience is "very important"
Knowledge of government activities	46.4
Prior Board experience	53.4
Healthcare experience	22.4
Political affiliation	1.7
Professional experience	36.2
General business knowledge	49.2
Understanding of local community issues	77.6
Representation by special interest groups	0
Understanding of strategic planning processes	86
Knowledge on monitoring program development and evaluation	62.1

Subjects were also asked how important they felt that their personal experience has been to their Board's deliberations. Table 3MB shows the results.

Table 3MB: Percent who feel their personal experience in certain activities is of high importance in terms of achieving an effective Board

Statement	Personal experience is of "high importance"
Knowledge of government activities	27.8
Prior Board experience	61.8
Healthcare experience	27.3
Political affiliation	9.1
Professional experience	44.4
General business knowledge	47.3
Understanding of local community issues	72.7
Representation by special interest groups	5.7
Understanding of strategic planning processes	62.5
Knowledge on monitoring program development and evaluation	45.5

Therefore, political affiliation and special interest group representation does not appear to be very important; however, understanding local community issues, having prior board experience, and a good understanding of strategic planning processes seemed to play a much larger role in achieving an effective board.

Board Function

Subjects were also asked to indicate what level they agreed with certain statements on the functioning of their Board. Table 4MB shows the percent of subjects who chose to "agree" with such statements.

Table 4MB: Percent who "agree" with statements on the functioning of their Board

Statement	Personal who "agree"
Board meetings are run effectively	58.3
During discussion all members are encouraged to provide input	50
Members provide constructive appraisals of Board activities	65
Board is usually provided with sufficient information to make decisions	45
Expectations at the time you were elected/appointed to the Board are consistent with your experiences to date	48.3
Too much material to review before meetings	10.2
Board is provided with sufficient alternative courses of action before making a decision	54.2
Overall, the Board receives less information than required to get a good understanding of an issue	11.7
Information currently provided to the Board:	
• Allows monitoring of performance against plans	74.6
• Is a complete and fair representation of the facts	66.7
• Is received in a timely manner for effective decision-making	63.8
• Gives a historical perspective	59.3
• Gives a future-oriented perspective	70.2
• Explains significant issues, changes, or problem affecting the DHB	70.2
There is a team approach when addressing issues	63.8
Members are unable to resolve conflicting positions	10.3
Members have an equal opportunity to express their views at meetings	55.2
Members feel comfortable expressing opposing views at meetings	53.4
Board has established the necessary committees	63.2
Board committees have defined roles	57.1

Board Decision-making

Based on their experience as Board members, subjects were asked to indicate to what extent they agreed with statements regarding Board decision-making. Table 5MB shows the percent of subjects who "agreed" with statements on decision-making.

Table 5MB: Percent who "agree" with statements on Board decision-making

Statement	Personal who "agree"
The Board is constrained by legislation and regulations	37.3
Government provides a consistent message about health reform expectations	10.3
Board's strategic plan, vision, mission, and values are aligned with those of the government	63.2
Government has articulated specific performance targets that it expects the Board to achieve	32.7
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets	55.6
Board has been criticized for decisions made by other government bodies	45.6
Decisions made by this Board are reconsidered too often	5.3
Decision-making is difficult because some Board members represent special interests rather than corporate interests	21.1
Decision-making is difficult because some Board members do not understand the issues facing the Board	23.6
Debates on matters before the Board may result in changes to the original proposal	73.2
The Board makes major changes to the policy recommendations of staff	15.8
The Board often acts as a "rubber-stamp" for conclusions reached by management	20.7
This Board clearly articulates its desired outcomes for the organization	60.3

Saskatchewan Data (referred to as SK)

Number of subjects: 207

See Map Appendix D.

Demographics:

- Length of time being a member: 22.4% have been a Board member for over 6 years, 39.5% for 4-6 years, 33% for 1-3 years, and only 5.4% reported being a Board member for less than one year.
- How were they appointed: 66% were elected, 33.7% were appointed
- Gender: More females (52.7% vs. 47.3%)

Frequencies

Board Governance: Open-ended questions

76.4 of respondents felt that there are barriers/challenges to better decision-making by the Board. Of those that saw barriers within the Board, almost two-thirds (66%) of them reported that the government was a potential challenge to effective decision-making. Almost 80% felt that the blended board approach provided their Board with an effective membership.

Board Governance: Close-ended questions

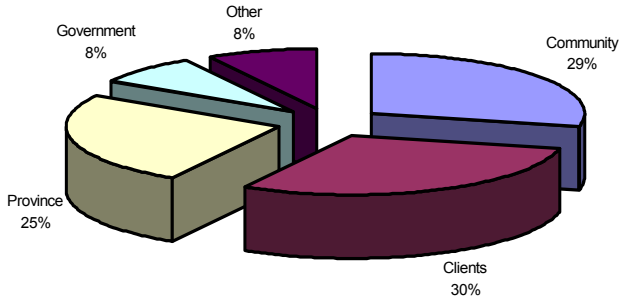
Table 1SK: Percent who "agree" with the following statements

Statement	Percent who "agree"
Board clearly understands its goals	66
Agreement by Board members on the Board's priorities	68.5
Board is accountable for the overall effectiveness of the organization	53.6
Consensus on whom the Board is responsible for	51.9
Board understands its legislated mandate	63.1
Board members are committed to the organization	49.3
Board members have common goals and values in relation to healthcare	61.2
Once the Board has made a decision, all members speak with a common voice on the issue	54.6
Board has developed linkages with other organizations, agencies and stakeholders	62
Board's relationship with the CEO and the staff is well defined	50.2
Board focuses its decisions on policy issues (not day-to-day business of the health district)	48.3
Board has less authority than I expected when I was elected/appointed	31.6
Board's goals have been developed based on the needs of the community and within resources available	64.5
Board and the CEO share a common view of the Board's priorities	57.8
Public pressure sometimes directs the Board to make decisions that may not be consistent with local needs	22.4
The Board's vision, mission and values are regularly discussed and understood by all Board members	54.9
Board is accountable to the residents in the District	54.1
Regular reporting to the community and stakeholders on what the Board is doing	55.1
Board has developed reporting guidelines on the information to be provided to the community	55.5
Information conveyed to the public and to government provides an update on how the Board is performing	60.9
Board ensures that external information is understood by the target audience	56.5
Published information is audited and/or reviewed by the Board	57.4

Board Member Interests

Subjects were asked to rank the top three interests (out of seven possible choices: community, clients/customers, provincial citizens, provincial government, Minister of Health, particular interest group, and other) that they represent on their respective Board. Figure 3 indicates the top three selected interest groups.

Figure 3: Top Three Interest Groups - SK



Of the subjects who chose the community as an interest group they represent, over half (57.1%) reported it was a **primary** interest. Almost all of the subjects reported that they represent clients/customers of the district at some level (40.4% chose this as their **primary** representative interest on the Board, while 56.1 chose this as their **secondary** representative interest). Of those choosing the citizens of the province, 85% agreed that this was a **tertiary** interest. Only 12 subjects indicated to represent the government on the Board on some level (75% of the 12 subjects indicated this was a tertiary interest). Only 15 reported they saw themselves representing the Minister of Health, and 12 of these subjects suggested that this was a tertiary interest. Only 5 chose a particular interest group and 13 reported to represent another type of group (recorded as "other") at some interest level. Therefore, the majority of subjects chose community, clients/customers, and provincial citizens as interests they represent on their board, in that respective order (from primary to tertiary interest).

Board Experience

Subjects were asked to rate a series of statements in terms of how important they believe each experience is in achieving an effective Board. Table 2SK indicates how many agreed the experience was "very important".

Table 2SK: Percent who feel the experience is "very important" in achieving an effective Board

Statement	Experience is "very important"
Knowledge of government activities	67
Prior Board experience	18.2
Healthcare experience	13.9
Political affiliation	1.5
Professional experience	22.1
General business knowledge	31.4
Understanding of local community issues	83.9
Representation by special interest groups	11.3
Understanding of strategic planning processes	64.2
Knowledge on monitoring program development and evaluation	54.9

Subjects were also asked how important they felt that their personal experience has been to their Board's deliberations. Table 3SK shows the results.

Table 3SK: Percent who feel their personal experience in certain activities is of high importance in terms of achieving an effective Board

Statement	Personal experience is of "high importance"
Knowledge of government activities	29.3
Prior Board experience	38.2
Healthcare experience	33.3
Political affiliation	5.4
Professional experience	19.6
General business knowledge	27.8
Understanding of local community issues	65.4
Representation by special interest groups	7.5
Understanding of strategic planning processes	34.6
Knowledge on monitoring program development and evaluation	31.2

Therefore, political affiliation and special interest group representation does not appear to be very important; however, understanding local community issues, having prior board experience, and a good understanding of strategic planning processes seemed to play a much larger role in achieving an effective Board.

Board Function

Subjects were also asked to indicate what level they agreed with certain statements on the functioning of their Board. Table 4SK shows the percent of subjects who chose to "agree" with such statements.

Table 4SK: Percent who "agree" with statements on the functioning of their Board

Statement	Personal who "agree"
Board meetings are run effectively	61.2
During discussion all members are encouraged to provide input	53.4
Members provide constructive appraisals of Board activities	64.4
Board is usually provided with sufficient information to make decisions	58.7
Expectations at the time you were elected/appointed to the Board are consistent with your experiences to date	41.3
Too much material to review before meetings	16.6
Board is provided with sufficient alternative courses of action before making a decision	51.2
Overall, the Board receives less information than required to get a good understanding of an issue	9.4
Information currently provided to the Board:	
• Allows monitoring of performance against plans	65.6
• Is a complete and fair representation of the facts	66.7
• Is received in a timely manner for effective decision-making	65
• Gives a historical perspective	51.7
• Gives a future-oriented perspective	57
• Explains significant issues, changes, or problem affecting the DHB	61.9
There is a team approach when addressing issues	64.9
Members are unable to resolve conflicting positions	9
Members have an equal opportunity to express their views at meetings	55.8
Members feel comfortable expressing opposing views at meetings	55.8
Board has established the necessary committees	65
Board committees have defined roles	67

Board Decision-making

Based on their experience as Board members, subjects were asked to indicate to what extent they agreed with statements regarding Board decision-making. Table 5SK shows the percent of subjects who "agreed" with statements on decision-making.

Table 5SK: Percent who "agree" with statements on Board decision-making

Statement	Personal who "agree"
The Board is constrained by legislation and regulations	48
Government provides a consistent message about health reform expectations	19.5
Board's strategic plan, vision, mission, and values are aligned with those of the government	43.2
Government has articulated specific performance targets that it expects the Board to achieve	43.6
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets	42.7
Board has been criticized for decisions made by other government bodies	51.7
Decisions made by this Board are reconsidered too often	15.2
Decision-making is difficult because some Board members represent special interests rather than corporate interests	18.7
Decision-making is difficult because some Board members do not understand the issues facing the Board	16.6
Debates on matters before the Board may result in changes to the original proposal	72.1
The Board makes major changes to the policy recommendations of staff	9.5
The Board often acts as a "rubber-stamp" for conclusions reached by management	26.8
This Board clearly articulates its desired outcomes for the organization	54.5

Combined Manitoba and Saskatchewan data

Frequencies

Board Governance: Open-ended questions

76.5% of respondents felt that there are barriers/challenges to better decision-making by the Board. Of those that saw barriers within the Board, 60.9% of them reported that the government was a potential challenge to effective decision-making.

Board Governance: Close-ended questions

Table 1CB: Percent who "agree" with the following statements

Statement	Percent who "agree"
Board clearly understands its goals	64.5
Agreement by Board members on the Board's priorities	66.9
Board is accountable for the overall effectiveness of the organization	50.2
Consensus on whom the Board is responsible for	50.8
Board understands its legislated mandate	61.5
Board members are committed to the organization	49.2
Board members have common goals and values in relation to healthcare	63.2
Once the Board has made a decision, all members speak with a common voice on the issue	53.2
Board has developed linkages with other organizations, agencies and stakeholders	59.8
Board's relationship with the CEO and the staff is well defined	49.1
Board focuses its decisions on policy issues (not day-to-day business of the health district)	49.4
Board has less authority than I expected when I was elected/appointed	32.3
Board's goals have been developed based on the needs of the community and within resources available	61.8
Board and the CEO share a common view of the Board's priorities	54.8
Public pressure sometimes directs the Board to make decisions that may not be consistent with local needs	22.3
The Board's vision, mission and values are regularly discussed and understood by all Board members	55.3
Board is accountable to the residents in the District	51.9
Regular reporting to the community and stakeholders on what the Board is doing	51.1
Board has developed reporting guidelines on the information to be provided to the community	54.1
Information conveyed to the public and to government provides an update on how the Board is performing	59.5
Board ensures that external information is understood by the target audience	57.9
Published information is audited and/or reviewed by the Board	56.4

Board Member Interests

Subjects were asked to rank the top three interests. Of the subjects who chose the community as an interest group they represent, over half (53.1%) reported it was a **primary** interest. Almost all of the subjects reported that they represent clients/customers of the district at some level (50.6% chose this as their **secondary** representative interest on the Board). Of those choosing the citizens of the province, 84.1% agreed that this was a **tertiary** interest. Only 20 subjects indicated to represent the government on the Board on some level (70% of the 20 subjects indicated this was a tertiary interest). Only 27 reported to represent the Minister of Health, and 17 of these subjects suggested that this was a tertiary interest. Only 10 chose a particular interest group and 16 reported to represent another type of group (recorded as "other") at some interest level. As with the individual provincial responses, the majority of subjects chose community, clients/customers, and provincial citizens as interests they represent on their board, in that respective order (from primary to tertiary interest).

Board Experience

Table 2CB indicates how many agreed the experience was "very important".

Table 2CB: Percent who feel the experience is "very important" in achieving an effective Board

Statement	Experience is "very important"
Knowledge of government activities	62.5
Prior Board experience	26.1
Healthcare experience	15.8
Political affiliation	1.5
Professional experience	25.2
General business knowledge	35.4
Understanding of local community issues	82.5
Representation by special interest groups	8.9
Understanding of strategic planning processes	69
Knowledge on monitoring program development and evaluation	56.5

Subjects were also asked how important they felt that their personal experience has been to their Board's deliberations. Table 3CB shows the results.

Table 3CB: Percent who feel their personal experience in certain activities is of high importance in terms of achieving an effective Board

Statement	Personal experience is of "high importance"
Knowledge of government activities	29
Prior Board experience	43.2
Healthcare experience	32
Political affiliation	6.2
Professional experience	24.8
General business knowledge	31.9
Understanding of local community issues	66.9
Representation by special interest groups	7.1
Understanding of strategic planning processes	40.6
Knowledge on monitoring program development and evaluation	34.2

Therefore, political affiliation and special interest group representation does not appear to be very important; however, understanding local community issues, having prior board experience, and a good understanding of strategic planning processes seemed to play a much larger role in achieving an effective Board.

Board Function

Subjects were also asked to indicate what level they agreed with certain statements on the functioning of their Board. Table 4CB shows the percent of subjects who chose to "agree" with such statements.

Table 4CB: Percent who "agree" with statements on the functioning of their Board

Statement	Personal who "agree"
Board meetings are run effectively	60.5
During discussion all members are encouraged to provide input	52.7
Members provide constructive appraisals of Board activities	64.5
Board is usually provided with sufficient information to make decisions	55.6
Expectations at the time you were elected/appointed to the Board are consistent with your experiences to date	42.9
Too much material to review before meetings	15.2
Board is provided with sufficient alternative courses of action before making a decision	51.9
Overall, the Board receives less information than required to get a good understanding of an issue	9.9
Information currently provided to the Board:	
• Allows monitoring of performance against plans	67.7
• Is a complete and fair representation of the facts	66.7
• Is received in a timely manner for effective decision-making	64.8
• Gives a historical perspective	53.5
• Gives a future-oriented perspective	59.9
• Explains significant issues, changes, or problem affecting the DHB	63.7
There is a team approach when addressing issues	64.6
Members are unable to resolve conflicting positions	9.3
Members have an equal opportunity to express their views at meetings	55.7
Members feel comfortable expressing opposing views at meetings	55.3
Board has established the necessary committees	64.6
Board committees have defined roles	64.9

Board Decision-making

Based on their experience as Board members, subjects were asked to indicate to what extent they agreed with statements regarding Board decision-making. Table 5CB shows the percent of subjects who "agreed" with statements on decision-making.

Table 5CB: Percent who "agree" with statements on Board decision-making

Statement	Personal who "agree"
The Board is constrained by legislation and regulations	45.6
Government provides a consistent message about health reform expectations	17.4
Board's strategic plan, vision, mission, and values are aligned with those of the government	47.7
Government has articulated specific performance targets that it expects the Board to achieve	41.2
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets	45.5
Board has been criticized for decisions made by other government bodies	50.4
Decisions made by this Board are reconsidered too often	13
Decision-making is difficult because some Board members represent special interests rather than corporate interests	19.2
Decision-making is difficult because some Board members do not understand the issues facing the Board	18.1
Debates on matters before the Board may result in changes to the original proposal	72.4
The Board makes major changes to the policy recommendations of staff	10.9
The Board often acts as a "rubber-stamp" for conclusions reached by management	25.5
This Board clearly articulates its desired outcomes for the organization	55.8

Affiliate Data: Saskatchewan

Number of subjects: 93

Demographics

- Length of time as an affiliate board member: 35.9% over 6 years, 54.4% between 1 and 6 years
- Gender: More males (56.5% vs. 43.5%)

Frequencies

Board Governance: Open-ended questions

36.4% of respondents felt that there are barriers/challenges to better decision-making by the Board. Of those that saw barriers within the Board, 88.9% reported that other interest groups posed a potential challenge to effective decision-making.

Board Governance: Close-ended questions

Table 1AF: Percent who "agree" with the following statements

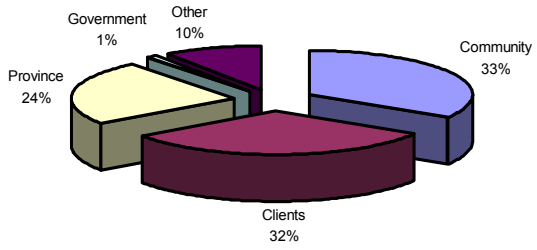
Statement	Percent who "agree"
Board clearly understands its goals	58.7
Agreement by Board members on the Board's priorities	48.4
Board is accountable for the overall effectiveness of the organization	57.3
Consensus on whom the Board is responsible for	N/A
Board understands its legislated mandate	N/A
Board members are committed to the organization	35.9
Board members have common goals and values in relation to healthcare	58.9
Once the Board has made a decision, all members speak with a common voice on the issue	53.8
Board has developed linkages with other organizations, agencies and stakeholders	58.6
Board's relationship with the CEO and the staff is well defined	45.1
Board focuses its decisions on policy issues (not day-to-day business of the health district)	52.3
Board has less authority than I expected when I was elected/appointed	25.3
Board's goals have been developed based on the needs of the community and within resources available	68.2
Board and the CEO share a common view of the Board's priorities	53.4
Public pressure sometimes directs the Board to make decisions that may not be consistent with local needs	38.8
The Board's vision, mission and values are regularly discussed and understood by all Board members	56.7
Board is accountable to the residents in the District	56.5
Regular reporting to the community and stakeholders on what the Board is doing	48.8
Board has developed reporting guidelines on the information to be provided to the community	28.4
Information conveyed to the public and to government provides an update on how the Board is performing	49.4
Board ensures that external information is understood by the target audience	61.9
Published information is audited and/or reviewed by the Board	48.3

Board Member Interests

Subjects were asked to rank the top three interests (out of seven possible choices: community, clients/customers, provincial citizens, provincial government, Minister of Health, particular interest group, and other) that they represent on their respective Board. Figure 4 depicts the top three interest groups selected by the Affiliate board members.

Of the subjects who chose the community as an interest group they represent, 64.8% reported it was a **primary** interest. Almost all of the subjects reported that they represent clients/customers of the district at some level (63.4% chose this as their **secondary** representative interest on the Board). Of those choosing the citizens of the province, 80.6% agreed that this was a **tertiary** interest. Only 2 subjects indicated to represent the government on the Board on some level (100% of the 2 subjects indicated this was a tertiary interest). Only 1 reported to represent the Minister of Health, 18 chose a particular interest group and 17 reported to represent another type of group (recorded as "other") at some interest level. Therefore, the majority of subjects chose community, clients/customers, and provincial citizens as interests they represent on their Board, in that respective order (from primary to tertiary interest).

Figure 4: Top Three Interest Groups - SK Affiliates



Board Experience

Subjects were asked to rate a series of statements in terms of how important they believe each experience is in achieving an effective board. Table 2AF indicates how many agreed the experience was "very important".

Table 2AF: Percent who feel the experience is "very important" in achieving an effective Board

Statement	Experience is "very important"
Knowledge of government activities	41.8
Prior Board experience	20.9
Healthcare experience	18.9
Political affiliation	3.3
Professional experience	29.3
General business knowledge	31.9
Understanding of local community issues	62
Representation by special interest groups	3.4
Understanding of strategic planning processes	46.1
Knowledge on monitoring program development and evaluation	35.6

Subjects were also asked how important they felt that their personal experience has been to their Board's deliberations. Table 3AF shows the results.

Table 3AF: Percent who feel their personal experience in certain activities is of high importance in terms of achieving an effective Board

Statement	Personal experience is of "high importance"
Knowledge of government activities	19.8
Prior Board experience	36.4
Healthcare experience	27.8
Political affiliation	3.3
Professional experience	28.9
General business knowledge	22
Understanding of local community issues	43.5
Representation by special interest groups	8.1
Understanding of strategic planning processes	35.2
Knowledge on monitoring program development and evaluation	25

Therefore, political affiliation and special interest group representation does not appear to be very important; however, understanding local community issues, prior board experience, and having a good understanding of strategic planning processes play a much larger role in achieving an effective Board.

Board Function

Subjects were also asked to indicate what level they agreed with certain statements on the functioning of their Board. Table 4AF shows the percent of subjects who chose to "agree" with such statements.

Table 4AF: Percent who "agree" with statements on the functioning of their Board

Statement	Personal who "agree"
Board meetings are run effectively	51.6
During discussion all members are encouraged to provide input	55.9
Members provide constructive appraisals of Board activities	60.9
Board is usually provided with sufficient information to make decisions	46.7
Expectations at the time you were elected/appointed to the Board are consistent with your experiences to date	57.6
Too much material to review before meetings	13.3
Board is provided with sufficient alternative courses of action before making a decision	71
Overall, the Board receives less information than required to get a good understanding of an issue	6.7
Information currently provided to the Board:	
• Allows monitoring of performance against plans	63.8
• Is a complete and fair representation of the facts	65.9
• Is received in a timely manner for effective decision-making	60.4
• Gives a historical perspective	50
• Gives a future-oriented perspective	55.7
• Explains significant issues, changes, or problem affecting the DHB	60
There is a team approach when addressing issues	59.3
Members are unable to resolve conflicting positions	2.3
Members have an equal opportunity to express their views at meetings	52.7
Members feel comfortable expressing opposing views at meetings	59.8
Board has established the necessary committees	50.6
Board committees have defined roles	59.1

Board Decision-making

Based on their experience as Board members, subjects were asked to indicate to what extent they agreed with statements regarding Board decision-making. Table 5AF shows the percent of subjects who "agreed" with statements on decision-making.

Table 5AF: Percent who "agree" with statements on Board decision-making

Statement	Personal who "agree"
The Board is constrained by legislation and regulations	N/A
Government provides a consistent message about health reform expectations	23.3
Board's strategic plan, vision, mission, and values are aligned with those of the government	50.6
Government has articulated specific performance targets that it expects the Board to achieve	N/A
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets	50.6
Board has been criticized for decisions made by other government bodies	9.8
Decisions made by this Board are reconsidered too often	1.1
Decision-making is difficult because some Board members represent special interests rather than corporate interests	2.3
Decision-making is difficult because some Board members do not understand the issues facing the Board	10.3
Debates on matters before the Board may result in changes to the original proposal	64.7
The Board makes major changes to the policy recommendations of staff	15.3
The Board often acts as a "rubber-stamp" for conclusions reached by management	9.4
This Board clearly articulates its desired outcomes for the organization	58.6

DATA ANALYSIS

Summary of Combined Provincial Data

In order for a board to be effective, there has to be well-defined lines of communication between the government, the board, the organization's management, the healthcare providers, and the community [Carver 1990]. The Minister of Health for each Province has the ultimate authority for the provision of healthcare services, usually prescribed through legislation. The minister of health has the discretion to delegate this authority to his department's staff and/or to healthcare boards in their jurisdiction. Health reform attempts to streamline this process by reducing the number of boards that previously had this responsibility for delivering services. In SK for example, the government reduced the number of healthcare boards responsible for services from some 400 boards pre-reform to a post-reform 32 district health boards. This number has since been further reduced in 2002 to 14 regional health boards. One objective of this Fellowship Project's survey was to assess how much authority board members felt they actually experienced, by comparison to what the government had publicly prescribed.

Real authority in the healthcare system depends on the isolated importance of the negotiated compromises between the expectations of government, the interests of the providers and the local needs, wants and preferences of the community the board serves (Lomas (1) 1996). This survey examined each of these relationships, however the limit was on the impressions of the board members as to how well they saw these expectations being met. A more comprehensive picture would have examined this relationship from each participant's vantage point (i.e. board member, community, management and government).

In order to determine the degree of authority, the survey examined if the Board member saw government policy as a hindrance or as an aid. What level of authority did the Board use in its decision making process, was it visionary or reactionary? Did the Board seek community input and how were the results incorporated into its planning initiatives? Overall the Boards in both MB and SK had some comparable responses, which indicates there may be some similarities in how these boards function, even though their composition is unique to the selection process in each province.

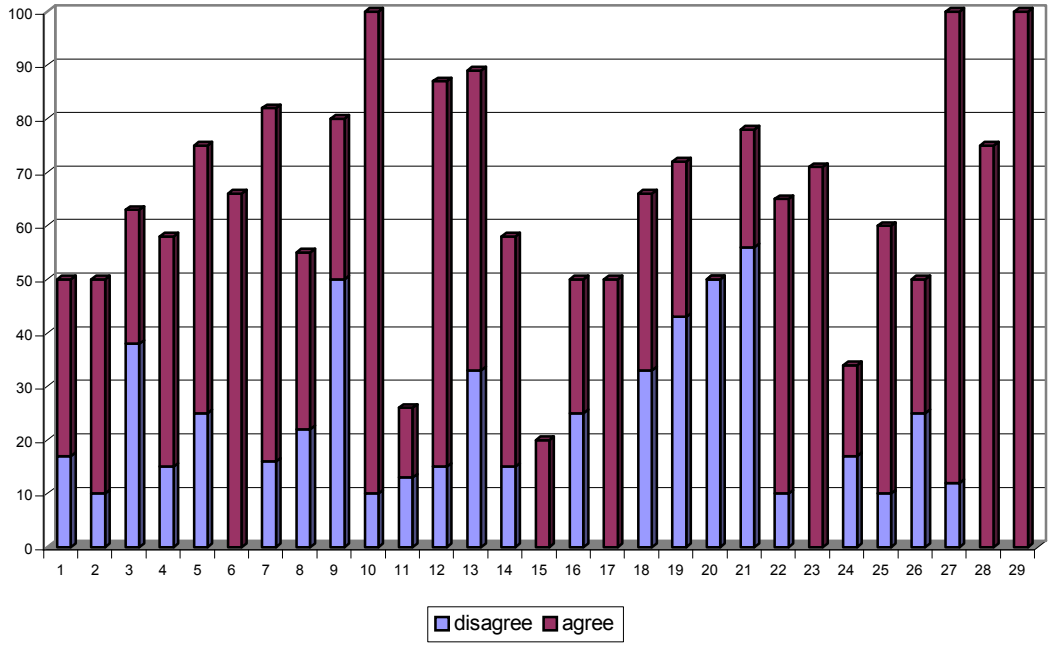
Board Governance

Table 1CB shows that between 55-65% of subjects felt their Board had a clear understanding of their goals, priorities and mandate. The individual responses depicted in Table 1MB and 1SK show little variance between the two provinces. There was also some consistency in how members assessed public pressure. Both provinces showed that only 22% of subjects felt outside pressure. Surprisingly, there was not a strong regional influence between respondents in specific areas. When the survey was being conducted in SK, there were specific DHBs that were experiencing some financial difficulties, and they were making efforts to modify or close local healthcare facilities in their community. In examining the issue of consistency with the board's strategic plan and government, and the question of perceived authority, one might have expected some variations in subject responses by region. An examination of the SK data[4] did not show this; in fact the regional response was fairly well distributed with just over 30% of respondents indicating they actually had less authority than when they were first

[4] A similar analysis was conducted on the MB data but the number of respondents was too small to draw any conclusions.

elected/appointed to the board. As well, the distribution of negative responses regarding government's understanding of the board's plan was fairly consistent provincially. Figure 5 indicates the "agree" and "disagree" responses, subjects indicating "neutral" responses were excluded (i.e. sum of percentages may not equal zero). There were only four DHB's that had a 100% agreement. The rest of the districts had a wide difference of opinion as to whether or not the Board was in line with the direction of the government, as well there does not appear to be any regional influence as the distribution of responses appears to vary throughout the province.

Figure 5: Board's strategies align with those of government.



From whom does the board get its 'marching orders'? Does the board see itself accountable to the government or to the owners, its constituents? Boards tend to be perceived by some critics of reform as responding to the whims of the government, and ill prepared to address the specific views of their providers and fewer to incorporate the perspectives of their community. 50% of the total respondents saw themselves as being

accountable to their residents, SK was a little higher at 54% and MB was at 44%. This variance may be due to the fact that 60% of the board members in SK are elected and may feel more ownership to those that put them on the board.

In examining the Board/CEO relationship, about half (50%) of board members felt the relationship was unclear or problematic. This was slightly higher in SK at 55% and 45% in MB. Reporting to the community was seen as being only 50% successful, with a higher level of comfort in SK and lower in MB. This might be a result of the boards in SK having more experience as they have been in operation longer. There were a lot of similarities in the responses and it shows that in the area of governance, members see their comfort with this function of the Board at between 50-60%.

Board Member Expertise

One section of the survey where board members indicated a variation in their responses was in the importance of expertise on the board.

Chart 3: Comparison MB and SK on importance of experience

Statement: Experience/knowledge is "very important"	MB (%)		SK (%)	
	desirable	actual	desirable	actual
Government activities	46	28	67	29
Prior board	53	62	18	38
Healthcare	22	27	14	33
Political affiliation	2	9	2	5
Professional	36	44	22	20
General business	49	47	31	28
Local community issues	78	73	84	65
Special interest groups	0	6	11	8
Strategic planning processes	86	63	64	35
Monitoring program development and evaluation	62	46	55	31

The expressed variances in the importance of experience and knowledge may be attributable to how the board members were selected, as in MB they were are appointed

and in SK there was an 8 elected to 4 appointed split. This part of the survey examined the importance of background information (i.e. government, prior board) and information about process (i.e. planning, monitoring). As Board's begin to determine how their environment affects them and what they assess to be important influences, these factors will shape how they approach their decision-making processes. A summary of the responses in Chart 3 shows the following:

- Boards in both provinces indicate that having an understanding of their local issues is of high importance and both expressed that they actually felt they did. SK members indicated a larger variation between desirable/actual.
- Understanding government was of medium importance with their actual experience in both sectors being low. SK members rated the importance of this area higher, which may be due to the influence of elected members.
- Prior board experience was seen as being of more importance in MB than in SK.
- Both MB and SK rated knowledge of the healthcare system and their actual experience low.
- Although both provinces have government appointed members, both sectors rated political affiliation of very low importance; similarly a low importance for special interest groups.
- In the areas of both professional and business, knowledge/experience was weighted low although the levels of importance were slightly higher in MB. This may be due in part to a higher representation of the business sector on MB boards.[5]

[5] Anecdotally, in my role as a consultant in both SK and MB I observed more members in MB from a business background.

- Both MB and SK board members indicated a high importance for planning and monitoring, and both indicated a lower level of experience (about 50% less than desired).

As many of these board members were appointed by the provincial government, there might be an expectation that there would be a higher influence of government policy on the board, than was expressed. It was also interesting to note the low importance of professional and business experience. Although members identified a high importance for planning, monitoring and evaluation; they felt they had a much lower capability to actually carry out the activity.

Board Functioning

Overall boards in both provinces (Table 4CB) rated their functioning (50 - 65%) fairly consistently and relatively they appeared to be satisfied with: how the meetings are conducted (60 – 65%); the information they were provided with (90%); the discussion that ensued (50 – 55%); and the openness of the meetings (60%).

There were some slight differences between provincial responses in the quantity of information; MB members indicated that they felt they did not get enough information to discuss contentious issues, SK members felt the information did not provide any futuristic perspective and their was a discrepancy in the use of board committees. The latter may be a result of more SK boards subscribing to the Carver model of board governance.

In summary, both MB and SK board members appear to feel some level of satisfaction with the internal functioning of the board and there is a degree of consistency in the subject's responses between the two jurisdictions.

Decision Making

In general there was a great deal of consistency between respondents in SK and MB (Table 5CB). About 50% of respondents thought that government policy hindered their ability to address community needs and a large percentage (83%) stated that over time the message from government fluctuated. Members from MB did not feel as constrained by the reform policy, but they did indicate they felt more pressure to move in directions that were contrary to the feelings of their respective boards. Both provinces indicate it is unclear what government expectations are (67%), with MB indicating a slightly higher level of satisfaction (56%).

Board members in both provinces, consistently indicated they felt comfortable with their internal decision making and that decisions were not influenced by local environmental factors. As well, both SK and MB members see that proposals from staff are usually accepted (70%); as well they indicated they feel there is opportunity for debate, as they did not feel that they just accepted (20-26%) the recommendations of management.

Another area were the boards were consistent in their response was that members felt they were not able to articulate outcomes for the organization, which is consistent with responses in the section that examined board skill set.

A Test of Significance (Chi-square)

Data of any level of measurement can be used in the chi-square test, but it is most often used for nominal and ordinal data. For higher-level data (interval and ratio level data), parametric tests such as t-tests are used. The chi-square test is commonly used to determine whether or not the observed difference between sub-groups is due to sampling error or whether it is due to a real difference in the population. Normally, a significance level of the chi-square test is .05 (or lower). This significance levels means that there is only a 5 percent probability (or less) that the difference is due to a sampling error (5 percent of the time our results will be wrong). In other words, there is a 95 percent chance that the observed difference is due to a real difference between the groups. For this report the significance level was chosen to be at .10, allowing for a broader inspection of the associations within the data. In cases where 20% or more of the expected cells have a value of less than 5, the chi-square statistic is not considered accurate. Footnotes are added to notify where this occurred during the data analysis.

For this section of the report data was collapsed by specific categories to make the statistical tests more (accurate) meaningful (i.e. to have a 2 X 2 chi-square test versus a 6 X 4 or in the case of DHBs a 11 X 4). For example, “Disagree” became "1" (collapsed strongly disagree and disagree categories); “Agree” became "2" (collapsed strongly agree and agree categories);” Neutral” was deleted from the analysis.

Important became "1" (collapsed somewhat important and very important).

Not important "2" remained the same. Low importance "1" remained the same as did high importance "2", “Average” was deleted from the analysis, as it was similar to “Neutral”.

Length of time as a board member was collapsed into two categories: up to 3 years (combining 2 categories), and four years or more (combining 2 categories).

Saskatchewan Data

The SK Data had three variables of interest: gender (GEN), length of time as a board member (LEN), and if they were elected or appointed as a board member (EOA). Cross tabulations and chi-square tests were performed with the data by GEN, LEN, and EOA.

Statistical Significant Results: “All variables” by “GEN”

Chart 4 shows the results for the chi-square test of independence between various questions on the survey and gender.

Of key importance (from the significant results) is the following:

- Gender and how the member was given their position (elected or appointed) was significant. More females than males are elected (72.2% vs. 59.8%), while more males than females are appointed (40.2% vs. 27.8%).
- More females compared to males were likely to disagree with the statement that, “The Board has developed appropriate linkages with other organizations, agencies and stakeholders” (11.7% vs. 2.4%)

- More females compared to males were likely to disagree with the statement that, "The information conveyed to the public and to government provides an update on how the Board is performing" (13.5% vs. 2.7%)
- Males were more likely to count prior Board experience as of high importance in relation to their Board's deliberations (78% vs. 53.3%)
- Whereas more females were likely to view healthcare experience as of high importance in relation to the Board's deliberations (62.5% vs. 46%), more males were likely to view professional expertise as of high importance (63.2% vs. 30.8%)
- More males than females (97.8% vs. 44.4%) were likely to view general business knowledge as of high importance in relation to the Board's deliberations

Chart 4: "Variables" by "GEN": Significant Results

VARIABLE	Test Results	
	X^2	p value
How was the member elected? Appointed or elected?	3.5	.06
The Board clearly understands its goals[6]	3.6	.06
The Board has developed appropriate linkages with other organizations, agencies and stakeholders	5.5	.02
The Board's goals have been developed based on the needs of the community and within available resources	4.1	.04
There is regular reporting to the community and stakeholders on what the Board is doing	5.0	.03
The information conveyed to the public and to government provides an update on how the Board is performing	6.1	.01
Government has articulated specific performance targets that it expects the Board to achieve	4.8	.03
How important experiences such as representation by special interest groups is in achieving an effective board	2.8	.09
How important personal experience as a Board member has been to the Board's deliberations	8.0	.01
How important personal experience with healthcare has been to the Board's deliberations	3.3	.07
How important personal experience with political affiliations has been to the Board's deliberations	3.2	.07
How important personal experience with professional expertise has been to the Board's deliberations	9.3	.00
How important personal experience with general business knowledge has been to the Board's deliberations	28.3	.00
How important personal experience with understanding the process of strategic planning has been to the Board's deliberations	5.8	.02

Statistical Significant Results: "All variables" by "EOA"(elected or appointed)

Chart 5 shows the results for the chi-square test of independence between various questions on the survey and how they became Board members.

Of key importance (from the significant results) is the following:

- Members who have been appointed versus those who have been elected were more likely to believe the blended approach provides the Board with an effective membership (90.9% vs. 73.2%). (Note: There was a movement in SK to have all

[6] 2 cells (50%) had expected counts less than 5.

members elected. Municipal governments were lobbying the provincial government, as they saw this, as the only way board representatives would be concerned with local issues. This point seems to confirm this viewpoint.)

- Elected members were more likely to agree that "Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets" (84.6% vs. 59.5%). Elected members were sometimes politically motivated and ran on platforms consistent with their affiliations.
- Although the majority felt Board experience was important, elected members were less likely to report that prior Board experience is important in relation to achieving an effective Board (73.9% vs. 91%)
- Appointed members were more likely to report that prior Board experience is of high importance in relation to the Board's deliberations (82.1% vs. 57.5%)
- Elected members reported more often that prior healthcare experience is of high importance in relation to the Board's deliberations (64.8% vs. 32.4%). As the government was leery in appointing staff, due to a perceived conflict of interest, elections saw nurses and physicians running for board positions. As an example, in one DHB, three physicians were elected to the board.

Chart 5: "Variables" by "EOA": Significant Results

VARIABLE	Test Results	
	X^2	p value
Do you believe that the election/appointment approach (blended approach) provides your Board with an effective membership?	7.1	.01
Are you male or female?	3.5	.06
There is general agreement by Board members on the Board's priorities[7]	3.9	.05
The Board has developed appropriate linkages with other organizations, agencies and stakeholders[8]	4.1	.04
The Board's relationship with the CEO and the staff is well defined	2.9	.09
The Board focuses its decisions on policy issues and not on the day-to-day business of the health district	3.7	.06
The Board's vision, mission and values are regularly discussed and understood by all the Board members	3.0	.08
Members feel comfortable expressing opposing views at meetings	3.7	.05
The Board has established the necessary committees[9]	3.8	.05
The Board is constrained by legislation and regulations	5.9	.02
Our Board's strategic plan, vision, mission and values are aligned with those of government	4.9	.03
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets	9.5	.00
This Board has been criticized for decisions made by other government bodies	4.2	.04
Information currently provided to the Board is received in a timely manner for effective decision-making	2.8	.09
How important is prior Board experience in achieving an effective Board	8.1	.00
How important is experience with professional expertise in achieving an effective Board	5.6	.02
How important is understanding strategic planning in achieving an effective Board[10]	4.0	.05
How important personal experience with healthcare has been to the Board's deliberations	10.5	.00
How important personal experience with prior Board experience has been to the Board's deliberations	7.0	.01

Statistical Significant Results: "All variables" by "LEN" (up to three years, or four year +)

Chart 6 shows the results for the chi-square test of independence between various questions on the survey and how long they have been a Board member. For ease of explanation, those members who have been in their position for three years or less were

[7] 1 cell (25%) had an expected count less than 5
[8] 1 cell (25%) had an expected count less than 5
[9] 2 cells (50%) had expected counts less than 5
[10] 2 cells (50%) had expected counts less than 5

called “newer members”, while those who have been Board members for four years or more were called “older members”.

Of key importance (from the significant results) is the following:

- Newer members were more likely to be elected (79.5% vs. 58.3%). Although this is an expected result, as the election process was fairly new, it does also show that newer members were also appointed which sometimes did not provide a high degree of consistency in membership in some regions. Board orientation may have become a way of life for some boards.
- Older members were more likely to agree that the blended approach made for an effective membership (85.7% vs. 67.1%)
- Older members were more likely to agree that, “my expectations, at the time I was appointed/elected to the Board, are consistent with my experience to date” (74.5% vs. 50.9%)
- Newer members were more likely to agree that “there is too much material to review before Board meetings” (38.6% vs. 18.6%) and that “decisions made by the Board are reconsidered too often” (33.3% vs. 16.8%)
- Newer members were more likely to feel that representation by special interest groups is important in achieving an effective Board (57.3% vs. 37.3%)
- Older members were more likely to report that knowledge of government activities is of high importance in relation to the Board’s deliberations (76.7% vs. 45.2%)
- Older members were more likely to report that prior Board experience is of high importance in relation to the Board’s deliberations (74.6% vs. 52.1%)

The length of time on a Board appears to be reflective of experience and/or "maturity". Older members were more aware of their individual expectations, more cognitive of the importance of knowing government policy and the importance of prior board experience.

Chart 6: "Variables" by "LEN": Significant Results

VARIABLE	Test Results	
	X^2	p value
Do you believe that the election/appointment approach (blended approach) provides your Board with an effective membership?	8.8	.00
Were you appointed or elected?	9.7	.00
There is general agreement by Board members on the Board's priorities	3.0	.08
The Board has developed appropriate linkages with other organizations, agencies and stakeholders	3.1	.08
In general, Board members have common goals and values in relation to healthcare[11]	5.6	.02
My expectations, at the time I was appointed/elected to the Board, are consistent with my experience to date	8.9	.00
There is too much material to review before Board meetings	7.5	.01
There is a team approach when addressing issues[12]	2.9	.09
Decisions made by this Board are reconsidered too often	6.1	.01
The Board is constrained by legislation and regulations	4.2	.04
The Board often acts as a "rubber-stamp" for conclusions reached by management	2.9	.09
How important Board member feels representation by special interest groups is in achieving an effective Board	7.6	.01
How important personal experience with knowledge of government activities has been to the Board's deliberations	9.0	.00
How important personal experience with prior Board experience has been to the Board's deliberations	6.5	.01
How important personal experience with understanding local community issues has been to the Board's deliberations[13]	5.8	.02
How important is experience with professional expertise in achieving an effective Board	5.6	.02

Manitoba Data

The MB survey given to Board members did not ask the respondents any demographic questions. However, the survey was given out to different RHAs in the province and

[11] 2 cells (50%) had expected counts less than 5
[12] 1 cell (25%) had an expected count less than 5
[13] 2 cells (50%) had expected counts less than 5

these RHAs were combined into three regions for analysis to see if there were any variations due to geography. This was more in response to anecdotal perceptions of differences in attitudes between the east and west. The three regions selected for the analysis were the North, West, and East.

Statistical Significant Results: "All variables" by "REGION" (North, West, or East)

There were very few statistical findings when the data was compared by region. Lack of statistical significance may be related to the small sample size. Of key importance (from the significant results) is the following:

- The East was more likely to agree that "public pressure sometimes directs the Board to make decisions that may not be consistent with local needs" (64.3% vs. 25.9% from the West and 22.2% from the North). X^2 (2) = 6.8, p = .03.
- The East was more likely to agree that "decision-making is difficult because some members represent special interests rather than corporate interest" (53.3% vs. 18.5% from the West and 25% from the North). This finding must be interpreted with caution as 33.3% of the cells had expected counts of less than 5. X^2 (2) =5.7, p=.06.

What this appears to indicate is that there are very few characteristics that can be attributed to geography.

Therefore, because there were so many similarities in the responses between SK and MB subjects, along with the results of this specific test, it appears to indicate that one

could expect to have some application of the Fellowship survey results to other provincial jurisdictions.

Affiliated Data

Surveys were also sent out to affiliate board members in SK. The affiliates were asked demographic questions such as their gender and their length of time being a board member. Statistical tests were performed on the data by these two demographics.

Statistical Significant Results: "All variables" by "GEN" and "LEN"

Again, due to the small sample size many of the associations that reached significance ($p<.10$) can not be considered accurate as 50% of the cells had expected counts less than 5. However, of key importance (from the significant results) is the following:

- Older members, when compared to the newer members, were more likely to agree that, "decision-making is difficult because some Board members do not understand the issues facing the District Health Board" (21.1% vs. 3.8%).
  (X^2 (1) = 3.8, p = .05, 25% of cells had expected counts less than 5)
- Older members were also more likely to agree that, "the Board makes major changes to policy recommendations of staff" (30.6% vs. 10%).
  (X^2 (1) = 3.1, p = .08, 25% of cells had expected counts less than 5)
- More females than males rated personal experience with healthcare as of high importance in relation to the Board's deliberations (80% vs. 28.1%).
  (X^2 (1) = 13.3, p = .00)

- More males than females rated professional expertise as of high importance in relation to the Board's deliberations (83.3% vs. 55%).

  (X^2 (1) = 3.5, p = .06)

- More males were also more likely to rate experience with general business knowledge as of high importance in relation to the Board's deliberations (87.5% vs. 50%).

  (X^2 (1) = 4.7, p = .03, 50% of cells had expected counts less than 5)

It is interesting to note that the characteristics of the affiliate members are consistent with the findings of the regional health board subjects in SK.

DISCUSSION

General

As the healthcare system has been going through reform, there have been numerous indicators that the reform "experiment" has not been without its challenges. The main focus of reform has been to establish a system, which is more efficient, while maintaining a high degree of effectiveness. Documents prescribing the reform process dealt with issues such as improved accountability, conducting needs assessments based on the determinants of health and improved communications between the regional health boards and the community they served. Although there was a great deal of promotional material on the "what and how's" of regionalization, boards felt they lacked specifics regarding the outcomes and/or expectations from government on what the reformed system should look like (82.6%).

Before looking at strictly the healthcare system, are there any lessons that can be learnt from the private sector that may be of assistance? There has been a great deal of public interest in board responsibilities recently with the scandals with companies such as ENRON, Bre-X Minerals Ltd. and the financial perils of Nortel. What we are experiencing now in North America, is not new for some other countries. As an example, there was a great deal of concern with how well non-profit boards were functioning in Australia in the early 1990's. One study examined thirteen of these boards to determine what the skills were for boards in their economic environment. If these boards were to be responsible for public funds, the public wanted to be assured that they were accountable and that they had the tools to do so [Radbourne 1993]. What they

found is that boards need to ensure they have the skills to be good stewards and fill gaps with formal training activities.

In 1995, an article examining the changing role of corporate boards cited two observations that lead one to think that the dilemma facing the healthcare sector is also shared by other industries as well [Weidenbaum 1995]. In healthcare and in private corporations, the main concern is how does the investor and/or taxpayer ensure they are getting the most out of their dollars. What Weidenbaum found was the most frequently made criticism of Directors is that they only rubber-stamp the views of management. The second criticism was that CEOs dominate the direction of the board and lastly, boards are plagued with conflicts of interest. In the case of the regional health boards, 74.5% do not see themselves 'rubber stamping' managements proposals, while 45.2% of subjects think their views and the CEOs are not consistent. As well only 50% indicated the CEO/Board relationship was well defined. The Fellowship survey results indicate some consistency with the perceptions of public boards.

Another aspect of the literature worth noting is the discussion about who has the power in an organization to make the decision. Traditional corporate and public boards were established on a managed-corporation model. In looking at why corporations are getting into trouble, it's not an issue of having the authority, it is about the process of how boards and managers make decisions and monitor corporate progress. The organization has to be structured such that there is an effective decision making process and the role of the board is to ensure the proper information is used, a formalized process is in place to ensure a wide spectrum of appropriate input and the board follows up on the desired outcomes. This process called "governed corporation" reconnects two

critical parts, the community and the board members into the decision making process [Pound 1995]. In essence, a board's responsibility can be defined as ensuring the organization's strategic plan undergoes rigorous scrutiny, evaluates management's ability to or results in attaining the desired outcomes within prescribed parameters [Byrne 1997]. From the survey, 32% of subjects indicated they felt the boards had less authority than when they started, 40% did not understand their mandate, only 50% appeared to know whom they were responsible to and 41.2% thought government had articulated specific performance targets.

In SK, a recent consultant's report examining the state of healthcare in the province reviewed: everyday services; specialized care; making things fair; getting results and paying the bills [Fyke 2000]. Its focus was on trying to identify the future healthcare needs of the province in relation to the available services. It is interesting to note that the initial thrust of reform was the restructuring of the management and governance; this study did not appear to examine its progress to date. One of the recommendations of the report was to reduce the number of health districts to further reduce administrative costs, but there was no real examination of what is working in the governance process and what was not. It did not seem to address the important reform goal, which was to ensure an efficient delivery system.

A review of the documents established during the initial stages of Reform did not clearly define what the specific functions and roles of the regional board were to be, however later documentation did provide a guideline to assist boards in their development (Provincial Auditor of Saskatchewan 1999). The government is responsible for ensuring

boards are in place, and these boards were expected to take over the responsibility for the operations of devolved agencies. In 1998, the Provincial Auditor of MB conducted a review of public sector boards (Provincial Auditor 1998). Even though this review did not include regional health boards, because they were newly established, there are some lessons that should be noted, as they can be transferred over to the healthcare sector.

A Generic Model of Governance

During the initial phase of their analysis, the Auditor's Office developed four pillars of effective governance, which were based on their review of best practice and the work in other jurisdictions. Through discussions with the provincial crown agency board members, the Office was assured that their proposed model would not only work for this group, but could easily be applied to any board, as the principals seen as being generic to the functioning of a board. These attributes were utilized in this Fellowship Project to determine how well regional health boards measured up to what the Auditor's expectations of a board would be. The model is built on four pillars with the following attributes:

Chart 7: Generic Governance Model

Model of Governance MB Provincial Auditor's Study	
Pillar	Attributes of an Effective Board
Stewardship	• Understanding of goals • Set priorities • Defined clients • Linkages with stakeholders
Leadership	• Defined responsibilities • Effective organization • Defined CEO job description
Responsibility	• Committed membership • Policy focused • Board directed, not staff
Accountability	• Accountable for effectiveness • Decisions based on information

The model developed by the Auditor's Office was perceived to be valid and there was a common understanding between board members and the CEOs, as the model was endorsed by over 90% of the respondents. Their survey was sent out to 29 Boards, represented by about 350 members, 28 CEOs and over $10 billion in assets. They experienced a 73% response rate. It is not the intention of this Fellowship Project to present the findings of the Auditor's survey, however, there was one notable observation. Given that these are Crown organizations (government appointed), it was interesting to note that only 11% of respondents ranked the government or the Minister as the prime interest represented (Manitoba Provincial Auditor 1998), a similar percentage was reported by the regional health board members in this Fellowship Project.

How well do the regional health board members feel they are meeting the requirements of this model? By comparison, how did the affiliate subjects see themselves given that they do not have any direct ties to the government's board selection process?

Chart 8: Comparison to Generic Model

Pillar	Attribute	Combined Regional %	Affiliate %
Stewardship	Goal setting	65	59
	Priorities	67	49
	Defined clients	51	n/a
	Stakeholder linkages	60	59
Leadership	Defined roles	55	51
	Effective	61	52
	CEO/Board relationship	50	46
Responsibility	Committed	55	57
	Policy focused	49	52
	Board directed	56	59
Accountability	Effective decisions	65-70	60-65

It is interesting to note that there is a great deal of similarity as to how well the two broad groups of Boards rate themselves in relation to the pillars of governance. This may be an indication of a cascading effect. The affiliates have a contractual obligation in the provision of services and if there are certain perceptions held by the regional boards, then perhaps these are passed onto the organizations that have contracts with them. For example, the affiliate Boards will have as much comfort with their role, as their associated regional Board expresses it.

The Provincial Auditor's office in Saskatchewan also went through a similar exercise to Manitoba's experience. They developed a document, which set out some principles and key responsibilities for DHBs. The process they used was to develop the best practices for board development. These practices were based on consultations with organizations responsible for board development in the province including academia, SAHO, the government and some Crown corporations. They then tested these against an existing DHB that had shown leadership in this area. From their deliberations they established the following best practice statements [Provincial Auditor Saskatchewan 1999]:

- Promote understanding of the board's purpose. Boards should consider areas of responsibility; examine any implications; and link planning to their roles.
- Foster board commitment to govern in all key responsibility areas. This should include accountability relationships; endorsing a vision and mission; and adopting values.
- Increase board capability to govern in all key responsibly areas. This would include fostering a learning culture; the allocation of resources;

identification of gaps in capability; and the development of strategies to fill the gaps.

- Monitor board development. Boards need to set objectives; evaluate progress; and modify development to achieve objectives.

In general, the combined regional board members indicated that about 65% felt they understood their goals and had set appropriate priorities. Relationship with their stakeholders was well defined (60%) and a clear sense of where they were going in relation to their perception (65%). There is a concern though with how well the board's direction matched that of government's (48%). Clearly boards expressed a higher level of comfort with their own internal operations, and a high level of uncertainty with where they were going with their decisions in relation to the directions of government. In both MB and SK, 76% of members indicated they had barriers in the system to making decisions consistent with their identified needs and more than half of these stated (50% - MB; 66% - SK) that government was the route cause.

Longitudinal Analysis: Related Research

McMaster's University Regional Health Board Survey

In the mid 1990's, McMaster University conducted a review of regionalization, which included a critical examination of the "raison d'être" for regional boards, along with the results of a survey that presented the current board members and CEO's perspective on the process. Their survey was circulated to 62 Boards in five provinces (n=514, response rate= 65%). The data broke out the survey responses by province. In

summary, the survey examined the board's socio-economic status, previous experience, motivation, accountability, training, activities, views and attitudes.

For the purpose of this paper, SK's data has been extracted. For SK, 30 Boards were sent surveys with 27 participating (N=314, response rate=63.5%). Some of the board demographics include: the average length of their appointment was 21 months; 49% of respondents were female; only 9% had a minimum of high school education; about 60% had an income over $50,000; and 25% were employed in the health or social sector. The survey for this Fellowship Project did not request info on income and/or education for comparability. 90% of respondents had board experience with 70% being on other health related boards. 32% indicated they had been on other government appointed boards.

Early in the SK reform initiative, training and orientation of board members was weak at best. A quarter, to a third of board members felt they had received inadequate training in setting priorities, needs assessment and healthcare legislation. They felt comfortable with running effective board meetings and implementing actions relative to what was presented by the staff. They expressed a concern that decisions were made mainly as a result of responding to the budget, with little or no regard for the identified needs of the community. As part of the transition, the McMaster study found that as the boards gained more experience, they began to modify their approach to making decisions. Boards initially started by focusing on priority setting and needs assessment activities, later shifting to ensuring more effectiveness and efficiency by reallocating funds. Overall respondents expressed a sense of frustration with the fact that when they came on the

Board they believed that health reform was to focus on prevention and community based services; the reality was in a different direction, reallocating resources to stay ahead of shrinking budgets.

One of the observations in the McMaster study worth noting regarding the history of regionalization, is that a federal task force examining healthcare had stated in the early 70's: "*The concept of area-wide or regional planning for health facilities and services has been accepted as a viable, effective approach, and is required if integrated and balanced healthcare systems are to be achieved*." [Lomas (1) 1996] The difference in the 1990's is two fold: firstly, the system has passed the discussion phase to one of implementation; secondly, paradoxically, nationally there is less agreement on whether or not this is a good thing.

Each province has approached the devolution of services differently, as the resulting regional boards have a different range of services and responsibilities. Even within provinces, they experienced different perspectives on how effectively individual boards were assessing the needs and wants of their community based on their perceptions of what government wanted. J. Lomas interpreted this to the development of democratic representation. That is, there will be a movement along a continuum of initially seeking the wishes of a constituent before making a decision, towards a situation where an expert decides on a strategy's direction by taking care of the perceived ignorant masses similar to how a parent responds to the needs of a child.

HEAL*Net*

In February 1997, questionnaires were sent out to senior managers in SK health, senior managers in the 30 Health Districts and their Board members. Respondents were asked to assess board decision-making processes, use of information, board and management roles, aspects of health reform, regionalization with respect to structure and funding. The main part of the report focused on two topics, views of regionalization and use of information. The HEAL*Net* report examined the views of the boards, and government and Health District management on how well the reform process had developed.

Responses by board members participating in the HEAL*Net* project (n= 275, response rate = 77%) are compared to the McMaster study, and some specific questions in this Fellowship Project's survey.

Between the times of the two surveys, the SK government had implemented the elected board process and many of the boards experienced a change in their board representation. The Ministry of Health attempted to maintain some form of consistency by ensuring that as many members as possible from the first board were appointed to the new board. The HEAL*Net* survey took a different approach than the McMaster study as the researchers tried to get the perspectives of three partners, being the Ministry, district boards and their management. As to be expected there was a shift in how the boards perceived themselves, as with elected members, they expressed a closer relationship to their public.

Study Comparisons

The McMaster study examined how well the reform process was developing in different provinces. It presented the views of boards that were seen to be early in their development in comparison to some ' more' established entities recognizing that this process was fairly new in the Canadian scene. For this section of the report a few key comparative questions were identified to see what, if anything, had changed over time in the SK experience. Did boards exhibit any consistent thinking over time, recognizing that board membership had likely changed from the first study with the elections, and government and the boards would likely have grown in their thinking? Chart 7 presents the results:

Chart 9: Survey Comparisons

Statement	McMaster %	HEALNet %	Project %
Informed decision-making	73	80	64
System is more needs based	48	86	52
Board meetings are effective	81	90	61
Boards blamed for Government decisions	20	n/a	52
Board Makes good decisions	95	92	85
Accountable to local citizens	71	80	85
Accountable to Government	2	10	8
Boards restricted by rules/legislation	54	63	48
Consistent government vision	n/a	57	37
Board has less authority	n/a	57	32

In examining a longitudinal perspective on the development of regional health boards in SK, it is important to note that over the duration of the surveys there was a change in how their members were selected. The process went from one of being totally government appointed, to one of one-third appointed two-thirds elected. As was shown in the characteristics section of this report, gender and duration of experience can have a bearing on how a board operates. Given these variables, we note the following comparisons between the studies:

Board Function: There was a slight drop in the board members perception on how well they perceived their process of being able to collectively make decisions, however members did feel that the decisions that were made were good ones (average 90%). Again, there was a slight change in how effective they perceived themselves. This may be a reflection of a linkage between their decision making process and how effective they see themselves in conducting this process. Survey results indicated that respondents had varying perspectives on their stated beliefs about the determinants of health, as well as an understanding of what impact they could have in addressing them [Kahan 1999].

Accountability: Board members were consistent in who they see themselves accountable to. Although the first appointed board members expressed less of a connection with their communities (71%), later surveys showed an increased awareness (80%). It is interesting to note that whether or not the boards were appointed or elected, there is a consistent perspective in the three studies that the board is not specifically accountable to the government (2%, 10%, 8%). This finding is consistent with the results of the Provincial Auditors report on Crown Agencies in MB where only 11% ranked the government (Minister) as the primary interest [Provincial Auditor 1998].

Government Vision/Authority: Over time, board members did not feel that government had been giving much direction to the reform process. Although midway in the process the percentage had dropped from 57% to 37%. A similar experience was seen on the boards perception of their level of authority, 32% indicated they felt their level of responsibility was less than expected which was an improvement over the earlier 57%.

About half of the respondents expressed a concern that government's rules and legislation restricted their ability to meet the needs of their communities, which was a fairly constant response over the three studies. There was an increase over time in the number of board members (20% → 52%) that indicated that boards were being blamed for government decisions.

Cross Sectional Analysis

The longitudinal analysis provides some insight into how the boards have developed over time. The cross sectional analysis was completed to see if there are any patterns in the data between the different surveys that might be applicable to other provincial jurisdictions. Two different analyses are presented. Firstly, an examination of the differences and similarities between the SK and MB data might provide some insight into how plausible these observations might be applied to other provinces. Secondly, the test of significance looked at variations in response in gender, their process for getting on the board, their duration on the board and geography.

Combined SK and MB data

The results from this section of the report indicate there were far more agreement and disagreement with statements than variations. Any minor differences appeared to be in the comfort of the subjects carrying out and participating in the board's job. SK members indicated a slightly higher level with statements related to the conducting of the meetings and their decision-making. This perception may be attributed to the board members and the reform process simply being around longer in SK than MB.

Although overall the similarity in responses was very high, there were three distinct statements were the response were significantly different.

- In SK, subjects indicated that a prior knowledge of government was a priority in being able to make good decisions.
- In MB, subjects felt they did not get enough information, and SK members indicated the information provided a good historical perspective and not much substance in forecasting what might occur.
- Although both provinces overwhelming indicated they did not receive any strategic direction from government, SK indicated a higher agreement with the fact that the government policy actually constrained them in being able to meet community needs.

As stated earlier, clearly there were far more similarities in the subject's responses in both MB and SK, than not.

Board Member Characteristic Comparisons

One of the objectives of this report was to examine if there are demographic attributes that might have an influence on the responses of subjects. As the survey for MB did not gather this information, only SK data will be discussed. The test of significance showed a few relationships worth noting. The tests examined the statistical significance of the subject's gender, how they got onto the board and the duration of experience.

Gender: Females appear to approach the Board with 'softer' skills and males tend to focus on the business part of the Board's job.

Chart 8: Gender Variations

Female	Male
More likely elected	More Likely appointed
Healthcare experience important	Prior board, professional and general business experience important.
Boards do not provide an update to the community	
Board has not made appropriate linkages to the community	

The significant differences in attitude appear to be around the need for professional, business type experience in conducting the board's responsibilities. Males tend to view this experience as a priority on the board; whereas females saw having knowledge of healthcare, and ultimately being able to assess the implications on the system as being paramount. Females also indicated that the softer skill of communication between the DHB and community were not as much as they would like to see.

Board Membership: Elected members clearly expressed themselves as being more responsive to the community.

Chart 9: Member Selection Variations

Elected	Appointed
Government expects boards to undertake policy decisions not to be compatible with board's goals	Liked the blended approach
Prior experience on boards of low importance	Prior board experience important
Prior experience in healthcare of importance	

As elected members may not have had any past experience, it should not be surprising that they saw the importance of this as low. As reported earlier in the paper, anecdotally many of the elected members were involved in the delivery of healthcare services so that importance would likely be reported by subjects. As there may be no direct linkage

with the government, the elected members felt that there were occasions when government policy and local needs may not always be in sync.

Duration as a Member: The maturity of a Board member's experience might influence how they approached Board activities.

Chart 10: Length of Time Variations

Newer	Older
Elected member	Liked the blended boards
Felt there was too much material.	Their expectations were consistent with experience
Decisions are reconsidered too much.	Need knowledge of government activities
Need input of special interest groups	High need for board experience.

The fact that most new members were elected, may confirm what was anecdotally reported by SAHO as the first elections were being held, and that is that not many of the first appointed members were going to run in the process. New members want to see less information to make decisions and they do not want to revisit past directions. Older members appear to be indicating that as your experience on the board increase, your expectations and intuitive skills increase, which is how one matures in a position.

Regional Significance

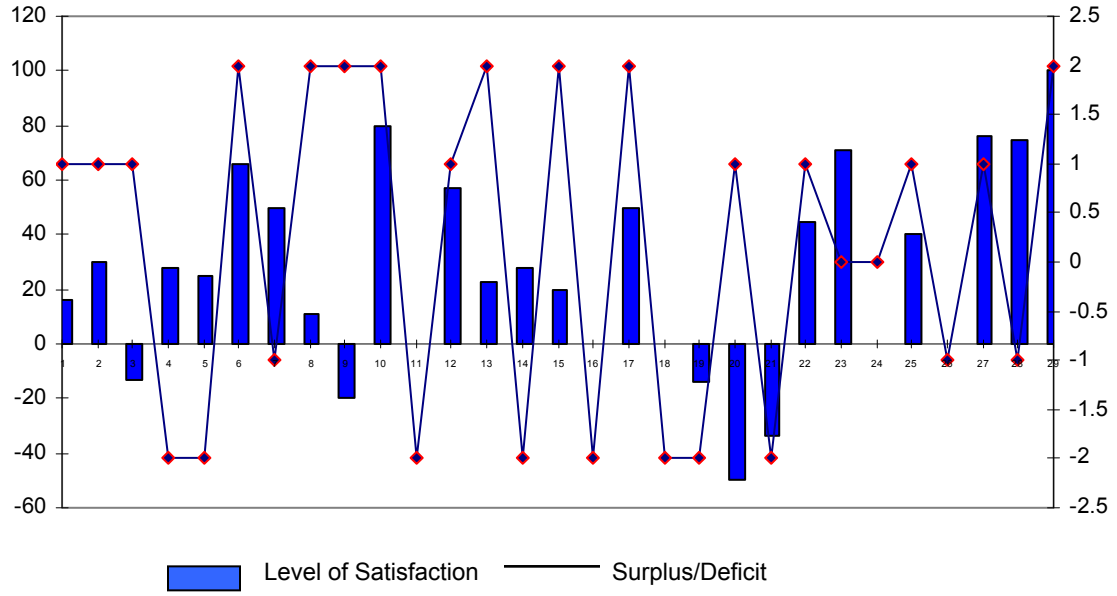
One question posed in this Fellowship project's proposal was; is there a way of determining how valid would these findings be in examining other regional health boards in other jurisdictions? One way to check the results for statistical significance was to break the data up regionally to see what, if any differences might appear.

A regional test of significance in MB indicated that the only variable of statistical significance was 'public pressure' in the board's decision-making. It is expected that as boards were dealing with shortfalls in budgets and examining options that may include the changing or closing of local facilities, that a negative sentiment might be experienced by many boards over time. Excluding public pressure, there were no other statements that appeared to be regionally driven and the responses by subjects were a result of factors other than a regional influence.

Further analysis examined the level of the perceived subject's satisfaction (SK data), using how well the Board's strategic direction related to that of government, in comparison to how they were doing financially.[14] As in Figure 5, the proxy statement for satisfaction, was to see how the subjects felt their strategic plans matched government's. For this analysis, the level of satisfaction for the Board was calculated by subtracting the percentage of "agrees" from the "disagrees". The result was a positive or negative level of satisfaction. The question was how does this compare to their financial position? Were Boards, that were in a surplus position more satisfied with their strategic direction than a Board in a deficit? The degree of the surplus or deficit was arbitrarily weighted. (i.e. surplus "2" = > $500K; deficit "–2" = < ($500K)) Figure 6 provides a visual representation of the results.

[14] A similar analysis was difficult to conduct for MB as Manitoba Health does not include the financial status of the RHA's as part of its annual report, as does Saskatchewan Health.

Figure 6: Board satisfaction versus financial position



Although there are some consistencies with the level of satisfaction and their financial status, there are also a few anomalies [Saskatchewan Health 2001][15]. Excluding the DHBs (4) who had a zero degree of satisfaction (agrees cancelled out disagrees), seventeen (17) match their level of overall satisfaction with their financial position, and eight (8) are not comparable. The assumption used is that subjects who are satisfied are in a surplus position and those who are dissatisfied in a deficit position. Therefore, there may be other characteristics that might be applied to this analysis that might better predict the financial status and the operation of the board.

A similar test of significance was also conducted on the affiliated boards in SK and the results are comparable to those derived from the DHB data. This would appear to indicate that the variations experienced by older members and those represented by the gender analysis are fairly consistent.

[15] For the reporting year 47% of all the provincial Health Districts reported a deficit and 53% a surplus.

As the regional and affiliate analysis resulted in a high degree of comparability, there may also be a high degree of probability that the results of this survey could be fairly consistent in other jurisdictions. There is a good likelihood that the characteristics found as result of the election versus appointment process; a board members gender; and the length of their experience on the board would also be present.

SUMMARY

Observations

It is evident from the results of the Fellowship survey that board members feel there are still some strategic issues that need to be addressed in order to improve on the effectiveness and perhaps efficiency of regional health boards. The summary comments will be presented in the format specified in Chart 1: Boards Assessment Survey Process.

Governance

Overall, many Board members in the survey (SK, MB, Affiliates) indicated a high degree of satisfaction with the internal workings of their specific boards. More than half of the subjects were fairly comfortable with their understanding of the roles and responsibilities, their information needs, who their clients were and their communication with the community. There was also a high level of consistency with who they were responsible to, their local public. Not unlike other surveys on public sector boards, the perceived accountability to the provincial government was very low. There was still a high level of concern with their perceived level of authority, as well as to where healthcare reform process was headed. Some of the affiliate board members indicated their specific DHB did not provide information on government policy, however this may not be attributed to the DHB, but a sign that the regional board itself may not have had a clear picture to pass on.

Barriers

About three quarters of the subjects in both provincial jurisdictions indicated they thought there were barriers in the system, hindering them from being able to meet the needs of their constituents and almost two-thirds of these indicated government (policy, messages) as the main culprit.

Experience

There was a great deal of variation on what subjects identified as being desirable experience for a Board member. It was interesting to note that there is a correlation in responses to the gender of the respondent. Females indicated healthcare experience as being important, while males tend to lean more towards a business background. There was some consensus as well as in the importance of past board experience, elected members indicating the least, appointed and older members rating its importance higher.

Contribution

All subjects agreed with most of the statements in this section of the survey. Members felt they had a lot of opportunity to be involved in the decisions of the regional health board and individual board members made an effort to be part of the process.

Effectiveness

Although some subjects indicated an issue with the information they received, overall they felt they had an opportunity to consider options and that their board

decisions were based on the best thinking of Board members in relation to what they knew or perceived about their environment. Any reported issues were in relation to what the Board had identified through its community needs assessment process, as they were not always consistent with the direction prescribed by government. This sometimes made the implementation of their decisions impractical.

Decision-Making

Although there is a high level of support by the subjects for their internal decision making process, there is a concern with their decisions being consistent with health reform and/or the needs of the community. In essence, subjects indicated their strategic plans were built around an understanding of their specific communities, which was not always consistent with the provincial government's messages. Although subjects indicated they were not just rubber-stamping the recommendations coming from their management, half felt unclear about their defined relationship with their CEO.

Owners

Subjects clearly indicated an understanding of whom the board was responsible to, their community. This level of accountability was clear in the early stages of health reform activities and was still present at the time of this Fellowship Project survey.

Back in the early 1990's as health reform initiatives were taking place across the country, it was observed that even with the expanded scope these regional boards would be taking on; devolved authorities may still struggle to make reality from the widespread rhetoric about the broader determinants of health, especially given their need to maintain morale among their existing dominant providers as they absorb expenditure reductions.[Lomas (3) 1996] The determinants of health as defined by government are broad and the Boards indicated their application was confusing in relation to their perceived role and function.

Accountability is defined succinctly as an obligation to answer for a responsibility conferred and in the delivery of government programs it has become increasingly prominent in recent Canadian public discourse [Shortt 2002]. Although the boards indicated their internal decision-making and reporting processes were well defined, and they felt they could be held accountable to their specific communities, both SK and MB subjects felt there were government barriers that impeded their achieving their perceived legislative responsibilities effectively.

There has clearly been some progress on regionalization, albeit the communication between the regional health authorities and the funding agency is still weak at best. Chart 1 indicated that in order to have a system that is effective and efficient the linkages between all of the participating partners is needed. Both the McMaster and HEAL*Net* surveys examined how this relationship was developing and this special Fellowship Project indicates there is still a great deal of room for improvement. This Project

appears to indicate that the role and functions of the governing Board during this period of healthcare Reform may still not be clearly understood by its participants.

Lessons Learned

One of the objectives of this Project was; *to determine if there are any guiding principles or prescribed characteristics that can be used by Boards to assess how well they are operating*. That is, are there any lessons to be learned, which could be addressed to improve on the effectiveness of the Boards?

The Provincial Auditors in both Saskatchewan and Manitoba have both focused on conducting studies to measure the effectiveness of the governance process. As part of their work, they have defined templates to replicate the functions of the Boards. The templates indicate the importance of stewardship, leadership, responsibility and accountability. The Fellowship survey indicated some characteristics of Board composition and functioning that may bear some attention as the reform process continues. Some specific areas, which need to be addressed to improve on overall Board effectiveness, include the following:

- If the Board of Trustees have become the 'new gatekeeper' to the healthcare system, they can only be held accountable for ensuring the appropriate services at the right costs, if the provincial governments are clear in their expectations. Figure 1 depicted the communication network that exists in healthcare between the government, the Board, the regional organization's management and the community it serves. There appears to be an inherent

mistrust between the provincial funding agency and the Boards. This longitudinal perception appears to have been spawned in the early days of health reform, has been shown by other reports to be prevalent in other government appointed boards and was found to be a significant contributor in this Project's survey. Health Ministers and their staff, and the Regional Healthcare Boards and their staff require the same understanding of Reform policies and directions in order to move the 'reform experiment' forward. This can only be achieved by a commitment to an ongoing open dialogue.

- If Boards are to provide '*stewardship'* in the public healthcare system, the provincial government has to be clear and consistent in its messages. Clearly the survey subjects indicated confusion about their level of authority and where health reform was ultimately headed. Government needs to ensure regular, consistent communiqués with the Boards, as well as its public and the messages have to covey the same interpretations of policy. In the open comments section of the survey there are suggestions that this was not always the case. It is difficult for Boards to plan and implement strategies when the direction appears unclear, is inconsistently applied or the provincial priorities appear to be constantly shifting.
- Although Board members indicated in the survey a high degree of comfort for their internal functionality and for the importance of being able to plan, monitor and evaluate their efforts; they acknowledged a low level of ability for them to actually be held '*responsible'* for conducting these tasks. Compounding this was the government's expectation that each Board would carry out community needs assessments. What might be more appropriate is

for the government to determine the overall provincial healthcare direction and then divvy it's funding according to the defined local requirements and existing services. Therefore government would establish the goals. Boards would develop strategies to address these goals, and monitor their implementation and evaluate their success in achieving the outcomes as defined by the provincial government.

- In an environment of increased transparency and '*accountability'*, there is a definite need for Boards to evaluate how well they are functioning not only internally but also externally. As the public and funding agencies are demanding more accountability for healthcare organizations, boards are also being expected to be more action oriented. This is being seen in the context of governance, not with the expectation that they will become more involved with what management does. The Fellowship survey examined: how well subjects felt they participated in decisions; did they receive appropriate information; were they proactive in policy development or reactionary; how did they function in relation to their stakeholders; and did they involve their community? Board evaluations are being seen as a self-assessment. Part of this process needs to determine how well their external interactions has added value to what they are doing. A 360-degree review will provide the board with the necessary input from all of their stakeholders, government and the community. This should be included within the realms of the organization's annual reporting processes.
- A standardized orientation has to be developed and delivered on an on going basis, in recognition that there will be constant turnover in board membership.

As government priorities change as a result of other "P" politics, it may be more appropriate to have this initiative carried out by an arms length agency to minimize these outside influences. Orientation programs are only of value when they are maintained. An organization that is formally responsible for delivering the sessions should also be responsible for ensuring the material is kept up to date. Given the cost of travel and the remoteness for some of these board members, it may be cost effective to make use of technology as many of these board members indicated they had Internet access. It will be important to conduct evaluations of an orientation program to ensure board members are kept abreast of their responsibilities. Consistent Board orientations throughout the province may not necessarily result in the same outcomes provincially.

- There has to be recognition that the process used by Boards to make decisions is complex, and their individual outcomes may not be easily forecasted. (i.e. Two groups dealing with the same issue may not necessarily arrive at the same conclusion.) This Project shows that experience, length of board service and gender will impact on how information is processed by each member and could effect how decisions are derived. There needs to be a consistent approach to *'stewardship',* to ensure strategic directions are understood and supported when board membership changes. How government selects board members will determine how the board ultimately functions. Local orientation sessions may alleviate some of this, as new members may feel comfortable with the level of information being provided and how the Board has arrived at its past decisions.

- In the area of '*leadership'*, half of the board members indicated a high level of discomfort with their relationship to their CEO. In the survey, subjects expressed potential concerns with: their perceived lack of a shared vision; a quarter of them felt they just rubber stamped management's decisions; and in the open comments section of the survey some expressed outright frustration with how their CEO functioned. This is not only a perception expressed by Board members in the survey, it was also reinforced by the anecdotal information showing the number of regions who had changed CEO's over a short period of time. Board and CEO evaluations should be conducted in a manner that both parties comprehend their roles, identify where improvements are needed and in general terms be able to determine how well the relationship is evolving. Board and CEO assessments are tools that should be used to enhance the relationship between the board and their only employee, not as a vehicle to assist in the removal of an individual, unless of course the evaluation indicates the match of ideologies dictates that outcome.

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APPENDIX A

SASKATCHEWAN DISTRICT HEALTH BOARD SURVEY 2000

INDIVIDUAL RESPONSES WILL BE KEPT STRICTLY CONFIDENTIAL

To complete the survey, please place an "x" in the area ( ) that best reflects your level of agreement with each of the statements made. If you do not have an opinion or do not have a response, feel free to leave the response blank. There are some questions, which are more open ended where you can express your thoughts in specific areas.

SECTION 1.0 BOARD GOVERNANCE

BASED UPON YOUR EXPERIENCE AS A BOARD MEMBER, PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS REGARDING YOUR DISTRICT HEALTH BOARD (DHB).

SECTION 1.0 BOARD GOVERNANCE	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Board clearly understands its goals.	( )	( )	( )	( )	( )
There is general agreement by Board members on the Board's priorities.	( )	( )	( )	( )	( )
The Board is accountable for the overall effectiveness of the organization.	( )	( )	( )	( )	( )
There is consensus on whom the Board is responsible to.	( )	( )	( )	( )	( )
The Board understands its legislated mandate.	( )	( )	( )	( )	( )
Board members are committed to the organization.	( )	( )	( )	( )	( )
In general, Board members have common goals and values in relation to healthcare.	( )	( )	( )	( )	( )
Once a Board decision is made, all members speak with a common voice on the issue.	( )	( )	( )	( )	( )
The Board has developed appropriate linkages with other organizations, agencies and stakeholders.	( )	( )	( )	( )	( )
The Board's relationship with the CEO and the staff is well defined.	( )	( )	( )	( )	( )
The Board focuses its decisions on policy issues and not on the day-to-day business of the health district.	( )	( )	( )	( )	( )
The Board has less authority than I expected when I was elected/appointed to the Board.	( )	( )	( )	( )	( )

Table 1/1.1

SECTION 1.0 CONTINUED…	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Board's goals have been developed based on the needs of the community and within available resources.	( )	( )	( )	( )	( )
This Board and the CEO share a common view of the Board's priorities.	( )	( )	( )	( )	( )
Public pressure sometimes directs the Board to make decisions that may not be consistent with local needs.	( )	( )	( )	( )	( )
The Board's vision, mission and values are regularly discussed and understood by all the Board Members.	( )	( )	( )	( )	( )
The Board is accountable to the residents in the District.	( )	( )	( )	( )	( )
There is regular reporting to the community and stakeholders on what the Board is doing.	( )	( )	( )	( )	( )
The Board has developed reporting guidelines on the information to be provided to the community.	( )	( )	( )	( )	( )
The information conveyed to the public and to government provides an update on how the Board is performing.	( )	( )	( )	( )	( )
The Board ensures that external information is understood by the target audience.	( )	( )	( )	( )	( )
Published information is audited and/or reviewed by the Board (i.e. Annual Report, community newsletters).	( )	( )	( )	( )	( )

Table 2/1.2/Table 3/1.3

DO YOU SEE ANY BARRIERS OR CHALLENGES TO BETTER DECISION-MAKING BY THE BOARD? YES / NO
IF YES, PLEASE DESCRIBE THESE BARRIERS OR CHALLENGES?

If yes, what type of Board training or support might be beneficial in dealing with these barriers or challenges?

Do you believe that the election/appointment approach (i.e. blended boards) provides your Board with an effective membership? Yes/ No
Please comment.

Section 2.0 Board Function

FOR EACH OF THE FOLLOWING STATEMENTS, PLEASE INDICATE HOW IMPORTANT YOU BELIEVE EACH EXPERIENCE IS IN ACHIEVING AN EFFECTIVE BOARD.

SECTION 2.0 BOARD EXPERIENCE	Not Important	Somewhat Important	Very Important
Knowledge of government activities	( )	( )	( )
Prior Board experience	( )	( )	( )
Healthcare experience	( )	( )	( )
Political affiliation	( )	( )	( )
Professional expertise (legal, financial, etc.)	( )	( )	( )
General business knowledge	( )	( )	( )
Understanding of local community issues	( )	( )	( )
Representation by special interest groups	( )	( )	( )
Understanding of strategic planning processes	( )	( )	( )
Knowledge on monitoring program development and evaluation	( )	( )	( )

Table 8/2.2

FOR EACH OF THE FOLLOWING STATEMENTS, PLEASE INDICATE HOW IMPORTANT YOU FEEL YOUR PERSONAL EXPERIENCE HAS BEEN TO YOUR BOARD'S DELIBERATIONS.

SECTION 2.1 BOARD CONTRIBUTION	Low	Average	High
Knowledge of government activities	( )	( )	( )
Prior Board experience	( )	( )	( )
Healthcare experience	( )	( )	( )
Political affiliation	( )	( )	( )
Professional expertise (legal, financial, etc.)	( )	( )	( )
General business knowledge	( )	( )	( )
Understanding of local community issues	( )	( )	( )
Representation by special interest groups	( )	( )	( )
Understanding of strategic planning processes	( )	( )	( )
Knowledge on monitoring program development and evaluation	( )	( )	( )

Table 8/2.2

PLEASE INDICATE TO WHAT DEGREE THE FOLLOWING STATEMENTS REFLECT YOUR EXPERIENCE AS A DISTRICT HEALTH BOARD MEMBER.

SECTION 2.2 BOARD FUNCTION	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Board meetings are run effectively.	( )	( )	( )	( )	( )
During discussions all Board members are encouraged to provide input.	( )	( )	( )	( )	( )
In general, Board members provide constructive appraisal of the Board's activities.	( )	( )	( )	( )	( )
The Board is usually provided with sufficient information to make an informed decision.	( )	( )	( )	( )	( )
My expectations, at the time I was appointed/elected to the Board are consistent with my experience to date.	( )	( )	( )	( )	( )
There is too much material to review before Board meetings.	( )	( )	( )	( )	( )
In making decisions, the Board is provided with sufficient alternative courses of action before making a decision.	( )	( )	( )	( )	( )
Overall, the Board receives less information than required to get a good understanding of an issue.	( )	( )	( )	( )	( )
Information currently provided to the Board:					
• Allows monitoring of performance against plans.	( )	( )	( )	( )	( )
• Is a complete and fair representation of the facts.	( )	( )	( )	( )	( )
• Is received in a timely manner for effective decision-making.	( )	( )	( )	( )	( )
• Gives a historical perspective.	( )	( )	( )	( )	( )
• Gives a future-oriented perspective.	( )	( )	( )	( )	( )
• Explains significant issues, changes, or problems affecting the DHB.	( )	( )	( )	( )	( )
There is a team approach when addressing issues.	( )	( )	( )	( )	( )
Members are unable to resolve conflicting positions.	( )	( )	( )	( )	( )
All members have an equal opportunity to express their views at meetings.	( )	( )	( )	( )	( )
Members feel comfortable expressing opposing views at meetings.	( )	( )	( )	( )	( )
The Board has established the necessary committees.	( )	( )	( )	( )	( )
Board committees have defined role.	( )	( )	( )	( )	( )

Table 10/2.3/Table 16/3.1/Table 17/4.1

Section 3.0 Board Decision-Making

BASED ON YOUR EXPEREINCE AS A BOARD MEMBER, PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS REGARDING BOARD FUNCTION.

SECTION 3.0 BOARD DECISION-MAKING	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The Board is constrained by legislation and regulations.	( )	( )	( )	( )	( )
Government provides a consistent message about health reform expectations.	( )	( )	( )	( )	( )
Our Board's strategic plan, vision, mission, and values are aligned with those of government.	( )	( )	( )	( )	( )
Government has articulated specific performance targets that it expects the Board to achieve.	( )	( )	( )	( )	( )
Government expects the Board to undertake public policy initiatives that are not compatible with operational performance targets.	( )	( )	( )	( )	( )
This Board has been criticized for decisions made by other government bodies.	( )	( )	( )	( )	( )
Decisions made by this Board are reconsidered too often.	( )	( )	( )	( )	( )
Decision-making is difficult because some Board members represent special interests rather than corporate interests.	( )	( )	( )	( )	( )
Decision-making is difficult because some Board members do not understand the issues facing the Board.	( )	( )	( )	( )	( )
Debates on matters before the Board may result in changes to the original proposal.	( )	( )	( )	( )	( )
The Board makes major changes to the policy recommendations of staff.	( )	( )	( )	( )	( )
This Board often acts as a "rubber-stamp" for conclusions reached by management.	( )	( )	( )	( )	( )
This Board clearly articulates its desired outcomes for the organization.	( )	( )	( )	( )	( )

Table 18/4.2/Table 23/4.4

Please feel free to provide us with any other comments you may have regarding the questionnaire or regarding your experiences as a Board Member.

Section 4.0 Board Member Demographics

PLEASE SELECT AND RANK ONLY THE TOP THREE INTERESTS YOU REPRESENT ON YOUR BOARD.

Section 4.0 Board Member Demographics	Primary Interest	Secondary Interest	Tertiary Interest
The people of the community in which you reside	( )	( )	( )
Clients/customers of the district	( )	( )	( )
The citizens of Saskatchewan	( )	( )	( )
The current provincial government	( )	( )	( )
The Minister of Health	( )	( )	( )
A particular interest group	( )	( )	( )
Other **(Please specify)**	( )	( )	( )

Table 7/2.1

IN ORDER TO ASSIST US IN ANALYZING THE INFORMATION YOU PROVIDED, **PLEASE CIRCLE THE APPROPRIATE RESPONSE.**

HOW LONG HAVE YOU BEEN A BOARD MEMBER?

< 1 year 1-3 years 4-6 years > 6 years

HOW DID YOU BECOME A BOARD MEMBER?

Elected Appointed

YOUR GENDER?

Male Female

Thank you for taking the time to complete this questionnaire.

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Appendix B

Summary of Subject's Comments

Manitoba Survey

The board could be more effective if the Department of Health would give the board more autonomy to make decisions. The policies and initiatives of the government are often made for political gain and do not necessarily address the RHA concern.

I spent 3 yrs and 3 months of relative frustration on the board. I resigned after this duration in spite of an extension to my term because I felt that I was not making an effective contribution as a director. (*note: frustration was with governance structure and the lack of planning and making any changes to better the system*)

Signed (*provided signature*) as one happy board member.

I have answered the survey based on previous board. I'm not sure how new appointments will affect the function of our board.

Training opportunities have been good. We are now reaching a point where we are going to have to make some major decisions on facility location and consolidation. This will be an interesting and challenging time for the board!

I was not sure that I should respond to this questionnaire as I was one of those board members who was not reappointed. I have really enjoyed being a part of the RHA and am disappointed that political appointments were very evident in the process.

Funding is not there for effective operational plans and needs, even those identified by government. Funding is not fair to all areas, have and have not areas.

There is a need for aboriginal board members to liase with aboriginal organizations.

We are a policy directed board, which I believe boards should be, however there should be a much higher percentage of time spent entirely on planning, long range or I believe boards will fail.

Saskatchewan Survey

Management decisions often read about in the local news media and board members are not privy to the information.

The Carver Model is a failure because our deficits are a result of a head in the sand attitude shown be a model.

Lack of governance understanding, lack of understanding of "process" to initiate change or to establish concrete, measurable ends.

If larger districts are forced, I feel that it should be done realistically to avoid increasing community competition and infighting. I also believe bigger is not always better, Regina has been rescued ($$'s) many times!

I've come to feel my role as a board member is a 'joke'. We take all the flak for government decisions or indecisions. They may be a time when it is difficult to find members.

Being a Board Member has helped me gain insight into the complex structure of the health system. Also a more keen appreciation of the health system and deeper knowledge of how various segments operate.

When new programs are put out by Government its what has to be done. Whether there is money in place or staffing in place the project has to be done. It would appear that sometimes I think government does not have a vision for a good and efficient healthcare system.

I've had a great experience as a board member!!

As a board we are improving quickly in weak areas.

I have always been interested in the healthcare field and have learned a lot while serving as a board member. I'm sure the public has no idea about the amount of time it takes to attend meetings, conventions and reading literature before meetings etc.

Our management team is wonderful and has made this whole experience a pleasure.

Have had considerable discussion on what board model to follow, no clear agreement.

A lot less work and a lot less focus on the future, than I thought there would be.

I feel more information needs to be made public, in the media, paper, or some way to inform the public why there are waiting lists! What the costs of different surgeries are, etc. Seems people are in the dark – what solutions are available.

Government asks Boards for a 3-5 year plan but does not have one itself.

The government has interfered significantly – our autonomy has almost disappeared.

I have answered based on our past experiences, we have recently hired a new CEO and I feel that with his help a lot of these questions will be answered more positively.

CEO is our problem.

Very often we only hear the version our CEO wants us to hear. Info appears on meeting day and we do not have time to read before we are asked for an opinion or decision.

We have been criticized indirectly, as a result of decisions by government. We were forced to make decisions that were unpalatable for lack of financing or funding (due to fiscal restraints).

Quite frankly I don't see the need for boards. I feel I have no use as a board member and it's a waste of my time and our money.

Districts are big enough. If I were any further from central office, I would not be serving as a board member.

Most board members have a very clear understanding of the issues in healthcare. Board members are frustrated by government's lack of clear direction…….. Boards feel they are looked upon as not "knowing" enough to make decisions or give advice and direction.

Affiliate Survey

Board Committees are too staff dominated.

Government messages regarding health reform are not always consistent in my opinion there is a difference between health reform and the policies of health reform.

Sometimes a very tough job, but very rewarding, excellent experience and opportunity.

I am on the Board as the representative of the ELCIC, and as such I have felt that the primary function for me is to mediate the interests of the church with those of the Board and institution.
We have a super competent CEO, but he sometimes, despite considerable effort on his part, has difficulty in not being a manipulator pf Board's thinking to comply with his own.

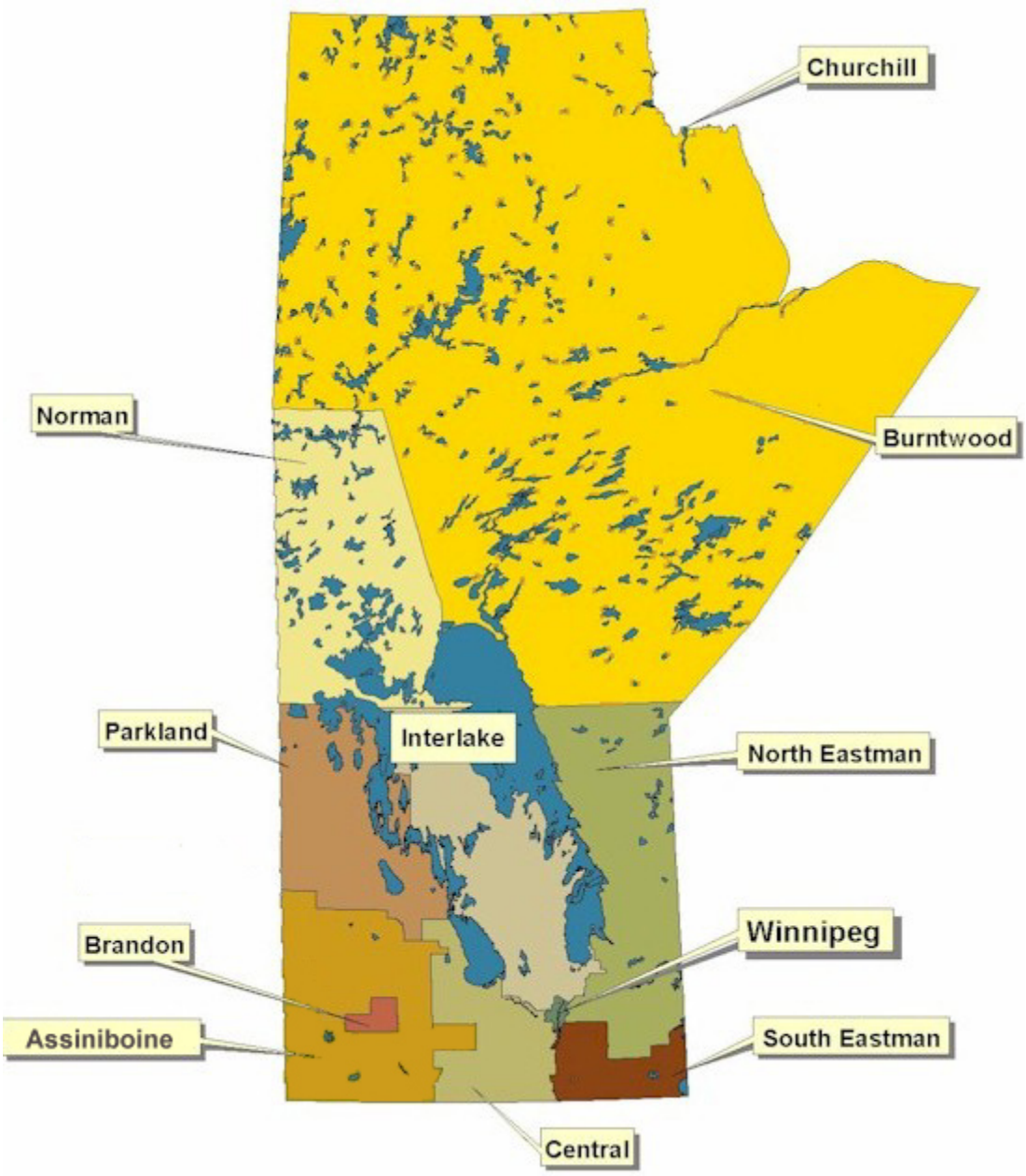
We need to do a better job of setting objectives and performance measures.

Board members have a lot of confidence in the CEO who is a person of vision.

My experience as a Board member has been rewarding and meaningful. I feel I have been able to contribute ideas and to influence the organization.

Appendix C

Manitoba Regional Health Authorities[16]



[16] At the time of the Fellowship survey the Assiniboine Region was actually two regions, Southeastman and Marguette. Winnipeg Regional Health Authority had just been established by amalgamating the past Winnipeg Hospital and Community Authorities together.

Appendix D

Saskatchewan Regional Health Authorities