Devolving authority for health care in Canada's provinces: 2. Backgrounds, resources and activities of board members

Education

Éducation

Jonathan Lomas, MA; Gerry Veenstra, MA; John Woods, BSc

Mr. Lomas is Professor in the Department of Clinical Epidemiology and Biostatistics and the Centre for Health Economics and Policy Analysis, McMaster University; Mr. Veenstra is in the Department of Sociology and the Centre for Health Economics and Policy Analysis, McMaster University; and Mr. Woods was with the United Kingdom National Health Service, and is now with the Faculty of Nursing, McMaster University, Hamilton, Ont.

This article has been peer reviewed.

Can Med Assoc J 1997;156:513-20

Abstract

Objective: To obtain information from the members of the boards of devolved health care authorities and evaluate their orientations in meeting the expectations of provincial governments, local providers and community members.

Design: Mail survey, conducted in cooperation with the devolved authorities, in the summer of 1995.

Setting: Three provinces (Alberta, Saskatchewan and Prince Edward Island) with established boards and 2 (British Columbia and Nova Scotia) with immature boards.

Participants: All 791 members of boards of devolved authorities in the 5 provinces, of whom 514 (65%) responded.

Outcome measures: Sociodemographic background, training, experience and activities of board members as well as their use of information.

Results: There were systematic differences between established and immature boards in regard to training, information use and actual and desired activities. Members spent 35 hours per month, on average, on work for their board. Members were largely middle-aged, well educated and well off. Only 36% were employed full time. Nine out of 10 had previous experience on boards, more often in health care than in social services. They were least pleased with their training in setting priorities and assessing health care needs and most pleased with their training in participating effectively in meetings and understanding their roles and responsibilities. The information for decision-making most available to them was information on service costs (68% said it was available "most of the time" or "always") and utilization (64%); the least available information was that on key informants' opinions (47%), service benefits (37%) and citizens' preferences (28%). Board activity was dominated by setting priorities and assessing needs, secondarily occupied with ensuring the effectiveness and efficiency of services and allocating funds, and least concerned with delivering services and raising revenue. The match between activities desired by members and actual activities was significantly poorer for members of immature boards than for those of established boards.

Conclusions: The responses concerning these structural variables suggest that board members are most likely to meet the expectations of provincial governments. Fewer appear well equipped to accommodate the views of their providers and even fewer to incorporate the perspectives of their community.

Résumé

Objectif : Obtenir des renseignements des membres des conseils auxquels on a cédé des pouvoirs dans le domaine des soins de santé et évaluer leurs orientations lorsqu'il s'agit de répondre aux attentes des gouvernements provinciaux, des fournisseurs locaux et des membres de la communauté.

Conception : Sondage postal, réalisé au cours de l'été 1995 en collaboration avec l'administration à laquelle on a cédé des pouvoirs.

IN THIS SERIES

Articles in the series on *Devolving authority for health care in Canada's provinces*:

1. An introduction to the issues (1997;156:371-7)
2. **Backgrounds, resources and activities of board members**
3. Motivations, attitudes and approaches of board members (Mar. 1)
4. Emerging issues and prospects (Mar. 15)

← For prescribing information see page 585

Contexte : Trois provinces (Alberta, Saskatchewan et Île-du-Prince-Édouard) dont les conseils étaient établis et 2 autres (Colombie-Britannique et Nouvelle-Écosse) qui avaient des conseils en devenir.

Participants : Les 791 membres des conseils des administrations auxquels on a cédé des pouvoirs dans les 5 provinces : 514 (65 %) d'entre eux ont répondu.

Mesures des résultats : Antécédents sociodémographiques, formation, expérience et activités des membres des conseils, ainsi que l'utilisation qu'ils font de l'information.

Résultats : On a constaté des différences systématiques entre les conseils établis et ceux qui sont en devenir en ce qui a trait à la formation, à l'utilisation de l'information et aux activités réelles et souhaitées. Les membres des conseils consacraient en moyenne 35 heures par mois aux activités de leur conseil. Il s'agissait surtout de personnes d'âge mûr, instruites et à l'aise. Seulement 36 % d'entre eux travaillaient à plein temps. Neuf sur 10 avaient déjà siégé à des conseils, plus souvent dans le domaine des soins de santé que dans celui des services sociaux. Ils étaient le moins satisfaits de leur formation en établissement des priorités et évaluation des besoins en soins de santé et des plus satisfaits de leur formation en participation efficace à des réunions et compréhension de leurs rôles et responsabilités. Les renseignements nécessaires à la prise de décision auxquels ils avaient le plus accès portaient sur les coûts des services (68 % ont déclaré que ces renseignements étaient disponibles «la plupart du temps» ou «toujours») et sur l'utilisation (64 %). Les renseignements les moins disponibles portaient sur les avis de personnes-ressources clés (47 %), les services assurés (37 %) et les préférences de la population (28 %). Les conseils s'occupaient surtout d'établir des priorités et d'évaluer les besoins. Suivaient les activités visant à assurer l'efficacité et l'efficience des services et de la répartition des fonds et, en dernier lieu, la prestation des services et les activités de financement. La concordance entre les activités souhaitées par les membres et les activités réelles était beaucoup moins bonne pour les membres des conseils en devenir que pour ceux des conseils établis.

Conclusion : Les réponses relatives à ces variables structurelles indiquent probablement que les membres des conseils répondront aux attentes des gouvernements provinciaux. Ceux qui semblent dotés des moyens suffisants pour tenir compte des vues de leurs fournisseurs sont moins nombreux et ceux qui intègrent les points de vue de leur communauté le sont encore moins.

In the first article in this series (*Can Med Assoc J* 1997;156:371-7), we provided an overview of the devolution of authority for health care to subprovincial levels that is occurring in all of Canada's provinces except Ontario. We highlighted that the main structural feature that differs among the systems in the 9 provinces is the scope of services controlled by each devolved authority — varying from institutions only in Newfoundland and New Brunswick to a substantial array of human services in Prince Edward Island. We noted, however, that no province had yet devolved authority for the budget for physicians' services or drugs. Furthermore, whether a board is elected or appointed is likely to be a distinguishing characteristic in the future, although by the end of 1995 only Saskatchewan had held direct elections.

We emphasized that the design of these new structures involves not only devolution of some formal powers from the provincial government but also centralization to the new boards of 2 previously fragmented and decentralized local sources of power: the managerial powers of providers and institutions and the lobbying powers of community members. We concluded that the real power of each devolved authority will be determined less by its structural design and more by the way it resolves the competing expectations of 3 parties — the provincial government, the providers and the community members.

To assess how boards could resolve these tensions, in the summer of 1995 we undertook a survey of the board members of all of the devolved authorities in British Columbia, Alberta, Saskatchewan, Nova Scotia and Prince Edward Island. Details of province selection, survey methods and response rates are contained in our first article. In this article, we report the survey results concerning structural aspects such as the backgrounds of the 514 respondents, their perceived information use and the types of decisions their boards were making. When relevant, we quote from some of the 40% of respondents who added open-ended comments in a section provided in the survey.

Analysis

We report mean overall values and, in most cases, mean values for each province. Depending on the response categories, we used 1-way analysis of variance or the χ^2 test to determine significant differences among provinces. Analyses were undertaken with the use of SPSS, version 6.01 (SPSS Inc., Chicago, 1993).

Table 1: Characteristics of members of boards of devolved authorities

Characteristic	All boards *n = 514*	Provinces with established boards: Alberta *n = 106*	Saskatchewan *n = 200*	Prince Edward Island *n = 22*	Provinces with immature boards: British Columbia *n = 152*	Nova Scotia *n = 34*	*p* value (and degrees of freedom)
Length of appointment, months	15	13	21	16	9	10	< 0.01 (4500)
Mean no. of board meetings attended	26	31	39	21	12	9	< 0.01 (4475)
Mean time spent on board activities, hours per month (and standard deviation)	34.6 (25.3)	52.5 (30.8)	29.2 (18.6)	10.5 (4.4)	33.9 (24.5)	28.4 (21.1)	< 0.01 (4493)
Sex, % female	52	52	49	41	57	55	NS‡
Age group, % of members							NS
< 35 yr	4	3	2	14	3	12	
35–64 yr	83	84	85	77	81	76	
≥ 65 yr	14	13	13	9	16	12	
Education level, % of members							0.01 (8)
< High school graduation	8	5	9	9	9	3	
High school or college graduation	45	51	52	32	39	24	
University degree	47	44	39	59	53	73	
Annual income level, % of members							NS
< $20 000	3	2	2	5	5	3	
$20 000–$50 000	34	37	40	42	26	23	
> $50 000	63	61	59	53	69	74	
Employment status, % of members*							
Employed full time	36						
Employed part time	15						
Self-employed	13						
Homemaker	20						
Retired	22						
Other†	9						
% from a minority ethnic group	10	11	7	9	12	9	NS
% employed in health or social services	18	6	25	27	12	36	< 0.01 (4)

*Total is more than 100 because respondents checked all categories that applied. Data by province were not readily available.
†Other = unemployed and full-time and part-time students.
‡NS = not significant.

Results

Time commitment

Being a health board member has been much more time-consuming and demanding than what I originally believed.

In our initial selection of provinces, we intended to strike a balance between those with established boards and those with immature boards. Table 1 shows that, in provinces with established boards (Alberta, Saskatchewan and Prince Edward Island), board members attended a mean of 21 meetings or more. In the provinces with immature boards (British Columbia and Nova Scotia), members attended a mean of 12 meetings or fewer.

The most mature boards are those in Saskatchewan, where the mean time a member had served since his or her appointment was almost 2 years and the mean number of meetings attended was 39. Alberta and Nova Scotia illustrate the variation in intensity of implementation of devolved authority among the provinces. Although the mean time since appointment to a board differs by only 3 months between these 2 provinces, a typical member in Alberta has attended more than 3 times as many meetings as his or her Nova Scotian counterpart (31 v. 9). Overall, in the 5 provinces surveyed, members spent a mean 34.6 hours per month on board activities. The provincial mean time spent on board-related work ranged from 10.5 to 52.5 hours per month.

What backgrounds do board members bring to the task?

The Minister of Health selected board members by their backgrounds and what they could contribute to the health reform process. I was appointed because some people believed that my management and people skills would be of some help in a difficult situation.

The background and experience of each board member likely influence the relative weight the board places on the expectations of the provincial government, local providers and community members. We assumed that at least 3 aspects of a board member's background and experience would be influential: sociodemographic characteristics (Table 1), experience as a board member (Table 2) and training and orientation for the task (Table 3).

Sociodemographic background

Extreme time commitment for health board members results in many retired persons' involvement.

The board members' sociodemographic characteristics only partially reflected those of the population (Table 1). Members were generally middle-aged, well educated (almost half had at least 1 university degree) and relatively well off (almost two-thirds had incomes of more than $50 000). Only 36% were employed full time, and 22% were retired. Of the members, 18% were employed in health care or social services, but this proportion ranged from 6% to 36% among the provinces.

Table 3: Percentage of board members who ranked their training and orientation as inadequate, adequate or excellent

Area of training and orientation	Inadequate	Adequate	Excellent
Setting priorities	25	60	15
Health care needs assessment	32	54	14
Effective participation in meetings	15	55	30
Roles and responsibilities	17	60	23
Current health care issues	16	63	21
Health care legislation and guidelines	30	59	11

Table 2: Percentage of board members with experience on other boards

		Provinces with established boards			Provinces with immature boards		
Type of experience	All boards	Alberta	Saskatchewan	Prince Edward Island	British Columbia	Nova Scotia	*p* value (and degrees of freedom)
Any experience	89	99	90	86	86	63	< 0.01 (4)
Experience on a health care board	70	79	70	56	68	54	NS
Experience on a social services board	44	58	34	61	46	41	< 0.01 (4)
Experience on a board in another sector	83	90	84	86	80	63	< 0.05 (4)
Previous government appointment to any board	33	41	32	50	27	19	< 0.05 (4)

Board experience

I have worked on boards over the years in education, community colleges and government insurance, and also in the cooperative movement. I don't agree with all the board members having worked in the health field. We have a good representation from different professions, which I think is excellent.

Nine out of 10 board members had experience on some kind of board, and one-third had a previous formal appointment to a board by government (Table 2). Except in Prince Edward Island, more members had experience on health care boards (70%) than on social service boards (44%).

Orientation and training

Table 3 outlines board members' evaluation of the adequacy of their training in 6 areas. The areas with the most difficulty appeared to be "setting priorities," "health care needs assessment" and "health care legislation and guidelines," with one-third of respondents stating that their training in these areas was inadequate. The best training and orientation received was in areas related to the general conduct of governance, including "effective participation in meetings" and "roles and responsibilities."

Provincial differences largely reflected the boards' different degrees of maturity. Members from British Columbia and Nova Scotia, for instance, expressed more concerns about their training in health care needs assessments and setting priorities than did members from the other, more mature boards, many of whom had actually undertaken needs assessments and set priorities. There were large contrasts between provinces. In Nova Scotia 55% of board members found needs-assessment training inadequate, whereas in Prince Edward Island no board members were unhappy with this training. In the former province the boards were still in the process of organizing their structure, whereas in the latter the government had already required each board to undertake needs assessments for its region.

Information available for decision-making

Decisions are made mostly by looking at the budget, not at health needs.

The view of this board member certainly seemed to reflect the general availability of information (Table 4). Information on population needs was available for decision-making less often than information on service costs or service utilization. Even less available was information on key informants' opinions, service benefits or citizens' preferences. If we assume that information influences decision-making, then we could infer that one of the provincial governments' main expectations — cost control — would be given a greater weight than provider interests, as expressed through key informants' opinions, or community members' views, as expressed through citizens' preferences.

Provincial differences again reflected the different degrees of maturity of the boards. In the less mature boards in British Columbia and Nova Scotia the members consistently found that less information of all types was available. This lack of availability was reflected in board members' feelings about the adequacy of information for decision-making. Although two-thirds of respondents overall felt that they were generally given enough information to make good decisions, only about one-half of

Table 4: Percentage of board members who indicated that they had various types of information available before making decisions "most of the time" or "always"

		Provinces with established boards			Provinces with immature boards		
Type of information	All boards	Alberta	Saskatchewan	Prince Edward Island	British Columbia	Nova Scotia	*p* value (and degrees of freedom)
Service costs	68	74	80	77	43	56	< 0.01 (4)
Service utilization	64	71	67	73	51	70	< 0.05 (4)
Population needs	50	60	48	73	48	24	< 0.01 (4)
Key informants' opinions	47	60	51	41	37	22	< 0.01 (4)
Service benefits	37	39	43	55	26	23	< 0.01 (4)
Citizens' preferences	28	31	33	46	18	11	< 0.01 (4)
Enough information to make good decisions	67	74	73	77	57	45	< 0.01 (4)
Information given in a way that makes it easy for the member to understand	76	86	80	82	67	60	< 0.01 (4)

the members of immature boards (compared with three-quarters of the members of established boards) felt this way. There was a similar pattern according to board maturity in the proportion of members (76% overall) who felt that information was at most times or always provided in a way that made it easy for them to understand.

Activities of the boards

We asked respondents not only about the activities in which their boards were actually engaged but also about the activities in which they thought their boards should be engaged.

Declared activities of the boards

Boards are shifting in the approaches we employ in carrying out the governance responsibilities as we gain more experience.

The main preoccupation of boards appeared to be priority setting and needs assessment as well as, to a somewhat lesser extent, ensuring the effectiveness and efficiency of services and allocating funds. Almost 50% of board members saw themselves as "rarely" or "never" involved in delivering services, and an overwhelming 87% stated that they were rarely or never involved in raising revenue (Table 5). The preoccupation of boards with needs assessment contrasts with board members' responses indicating the somewhat poor availability of information on population needs and the marked unavailability of information on citizens' preferences (Table 4).

The pattern of activities reported by respondents was clearly related to the maturity of the boards. The established boards were significantly more involved than the immature boards in all types of activities, except setting priorities, in which all boards were equally and pivotally involved, and raising revenue, in which all boards were equally uninvolved.

Desired activities of the board members

I have had a sense of frustration on the board, as I believed health reform was based on the focus on prevention and community-based services. I do not feel this is the direction we're going.

Although board members' desired priority in activities was similar to their actual priority, there was 1 notable exception. Members accorded ensuring the effectiveness and efficiency of services the highest priority for what their board should be doing, despite the fact that it appeared to trail both priority setting and needs assessment in what the boards were actually doing. They expressed even less desire to be involved in raising revenue than they actually were.

To assess any likely feelings of frustration (such as that expressed in the quotation), we compared desired and perceived actual activities for each board member (Table 6). We documented the number of board members for whom their 2 most desired activities were completely matched, only partially matched or not matched at all by their boards' top 2 actual activities. These data indicate that there were some grounds for frustration: for only 39% of members was there a complete match, and for 37% there was no match between their most desired activities and the board's actual main activities. This potential for frustration appears to be most marked in the immature boards, where there was no match between most desired priorities and activities on which the board was actually spending most of its time for more than half of the respondents.

Discussion

We showed significant differences among provincial devolved authorities in almost all areas, especially between the established boards in Alberta, Saskatchewan and Prince Edward Island, on the one hand, and the immature boards in

Table 5: Percentage of board members who indicated that their board was "quite," "very" or "extremely" involved in selected activities

		Provinces with established boards			Provinces with immature boards		
Activity	All boards	Alberta	Saskatchewan	Prince Edward Island	British Columbia	Nova Scotia	*p* value (and degrees of freedom)
Setting priorities	88	93	89	100	82	93	NS
Assessing community needs	82	85	86	91	78	60	< 0.01 (4)
Ensuring effectiveness and efficiency of services	74	89	81	77	56	48	< 0.01 (4)
Allocating funds	72	86	81	73	52	42	< 0.01 (4)
Delivering services	52	65	62	41	30	35	< 0.01 (4)
Raising revenue	13	18	15	14	8	3	NS

British Columbia and Nova Scotia, on the other. For instance, among members of the immature boards, information was generally perceived to be less available, and there was significantly less congruence between these members' desired activities and the boards' actual activities. This discrepancy between desired and actual activities likely represents the time that the immature boards had spent on less exciting organization and set-up activities. It appears that boards start their task with their own organization before focusing on priority setting and needs assessment. Only later do they ensure effectiveness and efficiency of services, allocate funds and, on some boards, deliver services.

The members' time since appointment in the 2 provinces with immature boards was only a few months shorter than in Alberta, yet members in Alberta showed the highest degree of congruence between desired and actual activities and reported that a relatively large amount of information was available. This indicates that the intensity of the time commitment (a mean of 52.5 hours per month and 31 meetings attended for board members in Alberta v. a mean of 33.9 hours per month and 12 meetings attended for those in British Columbia), is probably a better indicator of board maturity, activities and information use than the time the board has been in existence. Board maturity is a function of activity as much as of age.

Although we cannot judge the direction of causality, we observed that the large time commitment by board members appears to be related to their employment status and, possibly, to other sociodemographic characteristics. Only one-third were full-time employees; most of the others had an employment status that offered flexible use of time, such as retirement, part-time employment or self-employment. Men and women were equally represented, but young people were significantly underrepresented at the expense of middle-aged people. This age bias was presumably related to the extensive board experience of members — 9 out of 10 had served on other boards.

The relation between the scope of services under a board's authority and the background of its members was evident in comparing the background of board members in Prince Edward Island, where boards cover broad human services, and in the other provinces, where health care is the focus. Board members in Prince Edward Island were far more likely than those in other provinces to have had a previous appointment to a social services rather than a health care board.

Finally, we looked for indications of how board members would weigh the potentially competing expectations of the 3 sources of their power and legitimacy — provincial government, providers and community members.

Relation to expectations of the provincial government

Board members may be influenced toward meeting government expectations as a result of the fact that one-third of the members had been appointed to another board, commission or agency by the federal or provincial government. Also, cost and utilization data were the most available forms of information for decision-making, and board members' most desired activity was improving the effectiveness and efficiency of services. These findings may indicate significant attention to the provincial governments' expectations concerning efficiency and cost control. Counted against these factors was the relatively unsatisfactory orientation of board members toward provincial health care legislation and guidelines.

Relation to providers' expectations

Representation of the interests of providers appeared to vary among the provincial authorities. In Saskatchewan, Nova Scotia and Prince Edward Island one-quarter to one-third of the board members were employed in health care or social services, indicating that the provider point of view could influence decisions in these provinces. Nova Scotia authorities, in particular, appeared to have strong representation from provider and other expert interests. As well as having the lowest levels of previous board experience and the highest levels of education and income, 1 in 3 board members in Nova Scotia were also employed in health care or social services.

Table 6: Percentage of board members for whom 2, 1 or none of their desired activities matched the 2 actual activities engaged in most by their board* (see Table 5 for activities)

		Provinces with established boards			Provinces with immature boards	
No. of desired activities matched with actual activities	All boards	Alberta	Saskatchewan	Prince Edward Island	British Columbia	Nova Scotia
2	39	50	46	32	24	27
1	24	27	26	32	22	12
None	37	23	29	36	53	62

*The difference between the 2 groups of provinces was significant ($p < 0.01$, 8 degrees of freedom).

In contrast, boards in British Columbia and Alberta had only 10% or less of their members employed in health care and social services. This fact may indicate active attempts in these provinces to exclude providers from board membership, although not necessarily from input on board decision-making.

Relation to community members

The needs and perspectives of members of the local community appeared to be most poorly represented. Although local needs assessment is obviously a high-priority activity for the boards, respondents noted the relatively poor availability of information on needs, the marked unavailability of information on citizens' preferences and the somewhat unsatisfactory nature of the members' training in needs assessment. Furthermore, the sociodemographic characteristics of board members indicated that a disproportionate number of them were middle-aged and well educated and earned a high income.

If, therefore, structural aspects of the boards of devolved authorities are likely to lead members toward meeting the expectations of a particular party, that party is likely to be the provincial government that created the authorities. In some provinces, however, this bias may be tempered with the expectations of the local providers, who are represented by employees in health care and social services. The expectations and needs of members of the local community appear less likely to be incorporated into decisions if the implications of background characteristics, resources and prescribed activities are taken at face value. Nevertheless, these structural aspects may be counteracted by the motivations, attitudes and actual approaches of the board members. These cognitive variables will be the focus of the next article in this series.

The survey reported in this series was funded by the Ontario Premier's Council and the HealthGain program of Glaxo Wellcome Canada. Mr. Woods' contribution was provided by the UK National Health Service Trainee Program. The Centre for Health Economics and Policy Analysis receives partial funding from the Ontario Ministry of Health.

Reprint requests to: *Jonathan Lomas, Centre for Health Economics and Policy Analysis, McMaster University, 1200 Main St. W, Rm. HSC-3H28, Hamilton ON L8N 3Z5; fax 905 546-5211*

For prescribing information see page 594 →