

# Devolving authority for health care in Canada's provinces:

## 1. An introduction to the issues

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### Abstract

IN 9 OF CANADA'S 10 PROVINCES, much of the decision-making in health care has recently been devolved to local authorities. Provincial governments want this new governance structure to at least contain costs and improve service integration. However, there has been little evaluation of devolution to determine whether these and other goals are being met. Although devolved structures in the provinces vary somewhat with respect to the number of tiers, accountability mechanisms, degree of authority and method of funding, the only structural element that varies substantially is the scope of services under the authority of local boards. The real authority of the boards depends, however, on their negotiated compromises among 3 areas of tension: the provincial government's expectations, the providers' interests and the local citizens' needs and preferences. The boards' abilities to negotiate acceptable compromises will largely determine their effectiveness. This article introduces a survey of the members of 62 boards in 5 provinces for which the response rate was 65%, with 514 of 791 board members responding.

### Résumé

NEUF DES 10 PROVINCES DU CANADA ont cédé récemment aux autorités locales une grande partie de la prise des décisions relatives aux soins de santé. Les gouvernements des provinces espèrent que cette nouvelle structure de régie aura au moins pour effet de limiter les coûts et d'améliorer l'intégration des services. On a toutefois peu évalué le transfert de ces décisions pour déterminer si ces buts, notamment, sont atteints. Même si les structures déléguées dans les provinces varient un peu quant au nombre de niveaux, aux mécanismes d'imputabilité, au degré d'autorité et au mode de financement, le seul élément structurel qui varie pour la peine, c'est l'envergure des services relevant de la compétence des conseils locaux. Le pouvoir réel des conseils dépend toutefois des compromis qu'ils ont réussi à établir entre 3 domaines de tension : les attentes du gouvernement provincial, les intérêts des fournisseurs et les besoins et les préférences de la population locale. Les capacités des conseils de négocier des compromis acceptables détermineront en grande partie leur efficacité. Cet article présente un sondage réalisé auprès des membres de 62 conseils dans 5 provinces. Le taux de réponse s'est établi à 65 % : 514 des 791 membres des conseils ont répondu.

**D**iscussion about devolving powers to the regional level, and about this being a good thing for Canadian health care, is not new.<sup>1</sup> However, at least 2 things are new in the 1990s. First, devolution is no longer merely being discussed; it is being implemented in every province except Ontario. Second, there is, paradoxically, less agreement than before on whether devolution is a good thing for Canadian health care. Indeed, there is a great deal of scepticism about it. Recent reviews by the CMA<sup>2</sup> and the Ontario Premier's Council on Health, Well-being and Social Justice<sup>3</sup> concluded that there has been little evaluation of devolved authority for health care.

Despite this scepticism, most provinces are using devolution as the latest panacea for the woes of their health care systems. During the late 1980s and early 1990s nearly every province produced a "blueprint for change" for its health care



### Education

### Éducation

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system through a royal commission or task force.<sup>4,5</sup> Both the woes and proposed solutions documented during these exercises were remarkably consistent. The solutions all involved devolving at least some authority to local levels in order to contain costs, improve health outcomes, increase the flexibility and responsiveness of care delivery and better integrate and coordinate services. In other words, devolution was largely seen as an instrumental means to achieve other ends, not as an end in itself.

These changes arguably constitute the most radical restructuring of medicare since its inception, with far-reaching implications for governments, citizens, physicians, hospitals and other interest groups.<sup>6</sup> Little, however, has been written in the popular press or in academic journals about this “leap in the dark.” Given the concerns about the efficacy of this approach to health policy, it is important to document, monitor and evaluate progress as these devolved authorities become the governance mechanism for health care in 9 of the 10 provinces.<sup>7</sup>

The 4 articles in this series contribute to this process. In this article we give a brief overview of the structure of devolution in each province. We highlight the fact that only the scope of services controlled by devolved authorities differs substantially among jurisdictions. We then show the importance of negotiation in determining each board’s real power and describe the 3 areas of tension in negotiation: the provincial government’s delegation of powers, the providers’ relinquishment of management rights and the local population’s communication of needs and wants. Finally, we introduce the methods we used to conduct a survey of more than 500 members of 62 boards responsible for devolved authority in 5 provinces. In the next 2 articles, we will use the data from the survey to document the characteristics, activities and attitudes of the board members. The last article will outline emerging issues and concerns as well as the importance of continuing evaluation.

## Comparison among provinces

### A brief overview

Some provinces have introduced both an upper, regional tier and a local tier of devolved governance; others have established only a single tier at either the district or regional level. If we include only the upper tier in each province, Canada now has 123 devolved authorities in health care. Adding the lower tiers in British Columbia, Manitoba and Nova Scotia, many of which are not yet in place, would bring the number close to 250. The size of the population served by an authority varies widely, from 7000 people in the southern Kings County region of Prince Edward Island to more than 1 million people in the capital regions of Quebec and British Columbia.

Provinces are, however, at different points in their implementation of devolved authority (Table 1). Broadly speaking, the provinces can be divided into 2 groups on the basis of the maturity of their implementation. Of the 5 provinces in which authorities are more established, Quebec, New Brunswick, Saskatchewan and Prince Edward Island started implementation before 1994, and Alberta implemented its authorities so rapidly that tasks being performed by the boards reflect greater maturity. Of the 4 provinces in which authorities are immature, Newfoundland, Nova Scotia and British Columbia have completed initial implementation, and Manitoba has started it. The only “undeveloped” locations in Canada are now Winnipeg, which is excluded from Manitoba’s plans, and Ontario, which has signalled its lack of interest in devolving significant authority.<sup>8</sup>

### Comparing the structural designs

Numerous taxonomies have been proposed to compare and contrast the structures of devolved authorities.<sup>2,3,5,7,9-11</sup> Design features that may be compared include the number of tiers, the type of accountability mechanism, the degree of decision-making authority, the method of funding and the scope of services covered. Although such structural comparisons may offer a useful starting point, they fail to capture the nuances of context that determine the character of devolution in each province.

Furthermore, most of the structural variables do not yet appear useful in comparing Canadian jurisdictions. The provinces proposing 2-tier structures have been slow to implement the second tier, and this level of authority

**Table 1: Implementation of devolved authority for health care in Canada’s provinces**

Province	Start date of implementation*
<b>Established boards</b>	
Quebec†	Fall 1991
New Brunswick	Summer 1992
Saskatchewan	Summer 1993
Prince Edward Island	Fall 1993
Alberta	Summer 1994
<b>Immature boards</b>	
Newfoundland	Spring 1994§
Nova Scotia	Winter 1994
British Columbia	Winter 1994
Manitoba‡	Spring 1996

\*The date of the first appointments of board members.

†Quebec already had a regional structure; this was the start of reformed regional structures.

‡Devolved authority in Manitoba covers only rural and northern areas of the province; it does not include Winnipeg.

§Regional community health boards were established on this date; regional institutional boards were initiated in the spring of 1995.



may never become significant. The type of accountability (elected v. appointed board members) may become salient because many of the provincial structures plan to move to elected boards. Currently, however, all of the boards, except Saskatchewan's 30 District Health Boards, are appointed.<sup>12</sup>

The planned degree of decision-making authority is relatively uniform among the jurisdictions. None of the boards has any role in raising revenue (except that some collect local contributions for the capital costs of new construction), but all are responsible for local planning, setting priorities, allocating funds and managing services for greater effectiveness and efficiency, within provincially defined broad core services. Many also have some role in delivering services, or at least in employing service providers other than physicians.

The local boards receive funding from the provincial governments through global budgets that are based on, but are usually lower than, historical spending levels for the population served. Although many structures intend to follow Saskatchewan's lead and move to needs-based per-capita funding,<sup>13</sup> this move is being approached cautiously.

Hence, the 9 provinces effectively have 1-tier structures, with mainly appointed boards that have been given broad decision-making authority (constrained, however, by the absence of power to raise revenue and by provincial determination of core services). They are largely funded by reduced global budgets that are not calculated on the basis of explicit population need. This leaves the scope of services as the main distinguishing structural characteristic.

The scope of services varies significantly among the provinces, ranging from hospital care only in New Brunswick to broad human services in Prince Edward Island (Table 2). No province has yet included physicians'

services or drugs as part of the devolved budget. Nevertheless, in some provinces responsibility for human resource planning, including planning of physician resources, has been devolved to local authorities for their jurisdiction.

The variable scope of services in each province partly reflects differences in the main objectives of each provincial government. The narrower the scope of services, the more likely it is that the principal objective of the reform was to improve efficiency (and therefore reduce expenditures) or to increase integration and coordination. In New Brunswick, for instance, only hospital care was devolved, and the aggregation of hospitals under 1 board in each region was used to rationalize ancillary services and the number of beds. The broader the scope of services, the more likely it is that the province was concerned with broad population health. Saskatchewan's changes, for instance, were accompanied by a "wellness model"; in Prince Edward Island, there is much discussion of the social determinants of health.

### ***The influence of continuing negotiation***

Ultimately, however, the nature of a devolved authority, including the degree of power it can wield, is related less to its structural characteristics than to the outcome of the negotiation process that is an integral part of devolution.<sup>14</sup>

An illustration of this fact is the provincial governments' unwillingness to relinquish financial control over 2 of the 3 biggest expenditure areas in health care — physicians' fees and drugs. These circumstances are less than optimal for devolved authorities that are intent on integrating and coordinating the primary care sector. Commentators in Quebec have noted that the regulatory powers reserved by the provincial government seriously compromise the discretionary power of the Regional Councils.<sup>15</sup> In Saskatchewan, the provincial government has placed a 1-way "valve" on funds for acute care institutions; district boards have the discretion to move funds out of the sector, but not into it.

It is important to distinguish between different degrees of devolved power. Mills and associates<sup>9</sup> characterize 3 states along a continuum of devolution.

- *Decentralization*: Spatial redistribution of administrative authority to local offices of the central government.
- *Decentralization*: Transfer to a local authority of some decision-making within a significantly constrained set of centrally determined guidelines and standards.
- *Devolution*: Transfer to a local authority of significant decision-making, with only broad principles determined by central government.

Where devolved authorities lie on this continuum is

**Table 2: Scope of services under the authority of the devolved boards in Canada's provinces\***

Scope	Province
Institutions (hospitals or nursing homes or both)	Newfoundland New Brunswick
Health care (institutions plus services such as home care, public health and addiction services)	Nova Scotia Manitoba Saskatchewan Alberta British Columbia
Health and social services (health care plus community support services and social assistance)	Quebec
Human services (health and social services plus public housing, corrections and juvenile services)	Prince Edward Island

\*Physician services and drugs are outside of the scope of devolved authorities in all of the provinces.



only partly determined by their formal structural characteristics; it is heavily influenced by the negotiating process. The negotiations take place not only between each provincial government and its subprovincial authorities but also between the subprovincial authorities and the providers and citizens in their jurisdictions.

Much of the current subprovincial decision-making in Canada probably falls within deconcentration or decentralization. Most provincial governments are still wary about relinquishing full powers to these local authorities. The structures in New Brunswick and Newfoundland, and to a lesser extent Quebec, are particularly constrained in both scope and powers and are probably best characterized as deconcentrated. Those in Alberta, Saskatchewan and Prince Edward Island have the greatest autonomy and may emerge with truly devolved authority in the coming years. Those in the remaining provinces — Nova Scotia, Manitoba and British Columbia — are currently firmly in the decentralization state, operating within specific, centrally determined administrative and fiscal constraints.

As we noted in the introduction, we have little evaluative information to help judge which state is preferable for achieving which policy objectives. For instance, many analysts have expressed concern about equity of service provision in a fully devolved system.<sup>16-18</sup>

Furthermore, even within a province, the extent to which devolved authorities are willing to exercise their power, because of the reactions of either their providers or their citizens, may vary.<sup>19</sup> This makes it difficult to generalize not only about interprovincial but also about intraprovincial variations in the power of devolved authorities on the basis of structural descriptions. Structural descriptions fail to tell us how the tensions inherent in devolution are resolved by each board. Continuing negotiation is an integral part of devolution.

## Tensions inherent in devolved authority

### *Centralizing to decentralize*

Devolved authorities are granted their powers from 3 sources. The provincial government gives them legitimacy by formally devolving powers to plan and to allocate provincial funds. From local health care providers and institutions they acquire or procure management rights to reorganize and reform service delivery. From the local or regional population have come their credibility and mandate to represent the citizens' needs, wants and preferences.

Thus, each authority embodies not only decentralized formal powers passed down from the provincial government but also centralized informal powers garnered "up"

from citizens and individual institutions or providers. For instance, the 17 regional boards in Alberta replaced more than 200 boards for hospitals, health units and long-term care and mental health facilities. The 30 district boards in Saskatchewan replaced more than 400 local boards. This consolidation reflects the sentiments of many of the provincial royal commissions and task forces, which not only supported the development of devolved structures but also commented on the excessive decentralization of health care, which made coordinated management of the system impossible.<sup>5</sup>

Individual citizens seeking personal services are now (at least theoretically) less influential than groups of citizens expressing a community need. Individual hospitals, stripped of their autonomous boards and grouped with others under devolved authority, can no longer plan in isolation from the needs of the whole system. Physicians and other providers are increasingly hampered in their efforts to locate their practices where they desire. Instead, they must comply with the human resource plans of the devolved authority. Most of this shift in influence is done in the name of better managing the health care system. Indeed, the business-management literature has underlined this apparently paradoxical need to "centralize in order to decentralize."<sup>20</sup>

Each devolved authority is therefore situated at the nexus between the provincial government's expectations, the providers' interests and the citizenry's needs, wants and preferences.<sup>6</sup> Tensions among these are inevitable.

### *Devolved authorities and their provincial governments*

The devolved authorities are acutely aware that the provincial governments that created them also control their budgets and the rules under which they operate. To this extent, the devolved boards could be the locally based enforcers of the provincial government's expectations; that is, they could be deconcentrated arms of their parent body. However, in some provinces, such as Saskatchewan, there is a move to determine needs-based funding formulas objectively. This trend may afford the devolved authorities some protection from arbitrary fiscal punishment if they deviate from the provincial government's expectations.

There is still, however, a "rulebook," which often expresses the requirements for delivery of core services. Such documents have been completed or are being developed in Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland. Most core-service documents are introduced with general wording, in order to allow the devolved authorities significant discretion. To date, however, few devolved authorities have ventured far



from traditional allocations of funds. Only time will tell whether the authorities will make radical departures from accepted patterns of local resource allocation and whether, in response, provincial governments will feel compelled to tighten the wording of core-service documents and reduce the authorities' discretion.

### ***Devolved authorities and providers***

In setting up the devolved authorities, most of the provinces excluded providers from the boards. This decision has added to the concern expressed by many providers that the reforms look more like centralization than decentralization. Many providers feel excluded from the new channels of advice and influence.<sup>21</sup> In response to these concerns, several provinces have taken measures to increase provider involvement. In Alberta and British Columbia, for instance, human resource strategies were negotiated with the health care unions before the reforms were implemented. Physician concern has been accommodated through such measures as creation of regional medical advisory committees (in Alberta), temporary placement of physicians on boards (in Prince Edward Island), eligibility of physicians to run for board positions (in Saskatchewan) and inclusion of physicians as a defined constituency of the board (in Quebec).

Nevertheless, most provincial governments and their devolved boards believe that their role will be more compromised than facilitated if providers and their interests retain direct decision-making power. The boards must often accommodate reduced global budgets, which have adverse effects on providers. The tension resulting from these situations will likely be amplified as the associations and unions representing providers reorganize to focus on the regional or local level.<sup>6</sup>

### ***Devolved authorities and their citizenry***

Devolved authorities' best protection from becoming enforcers on behalf of provincial governments or being held captive by provider interests may be their credibility as effective local representatives of their citizens' needs and preferences. The difficulty is differentiating local needs, expressed by well-informed citizens seeking the public interest, from local wants, expressed by narrowly informed citizens seeking satisfaction of self-interest. One of the devolved authorities' biggest challenges will be to gain credibility by discriminating between these 2 forms of community expression and placing different values on them, while maintaining cordial relations with the entire community. Good information will be a necessary, although likely not a sufficient, element in achieving this goal.<sup>22,23</sup>

Nevertheless, the role of the local citizenry in devolved authorities remains unclear, partly because of the failure to distinguish between citizen input and governance. Citizen input into decisions made at the local level on local matters — local planning and allocation — is one option. This, however, is not the same as community governance, which involves elected local citizenry making the decisions for their locality. Citizen input implies only community participation through advice and input to experts. Citizen governance implies a pre-eminent role for elected local citizens, regardless of their level of knowledge, and a lesser role for experts. These 2 approaches appear to have become inextricably intertwined in Canada's current debates over the governance of devolved authorities. The confusion has arisen despite evidence that most citizens wish only to be consulted and that they expect and prefer that "the experts" take responsibility for actually making the decisions.<sup>24</sup>

In their attempts to negotiate compromise, devolved authorities must decide how to weigh the sometimes competing views of the provincial government, providers and citizens. In dealing with the provincial government, their legitimacy and formally devolved power are at stake. In dealing with the providers, their ability to manage reform without making workers disgruntled is at stake. And, in dealing with the local citizenry, their credibility is at stake.

### **The survey**

The way in which each devolved authority resolves these tensions will be influenced mainly by the members of its board. As a first step in evaluating devolved authority in Canada, we surveyed board members in 5 provinces. We wished to answer such questions as Who are these people, and what is their experience? What are their activities, and what do they see as their task? What motivates and concerns them? What are their attitudes toward the tensions described earlier?

### ***Survey design and sampling***

We designed a mail survey about board members' demographic characteristics, activities, attitudes and resources. The survey was pretested among a convenience sample of 5 members of health boards in provinces not included in the survey, and it was then revised accordingly. Details of the survey's content and administration are available elsewhere.<sup>25</sup>

We selected 5 provinces according to 3 criteria.

- (1) The scope of authority of the devolved boards in the province was at least health care. (This excluded Newfoundland and New Brunswick.)



- (2) The 5 selected provinces were geographically dispersed. (We selected 3 from western Canada and 2 from eastern Canada.)
- (3) The 5 selected provinces included a mix of established and immature boards. (We selected 3 provinces with established boards — Alberta, Saskatchewan and Prince Edward Island — and 2 with immature boards — British Columbia and Nova Scotia.)

Except in Prince Edward Island, it was impossible to mail surveys directly to the board members' residences. We therefore used the devolved authority as the unit of sampling. We obtained addresses for each devolved authority office from the provincial governments and contacted each office to request participation. Participation involved agreement to encourage completion of the survey by all board members and to distribute the surveys and up to 2 follow-up reminders to all board members, either by mail or at board meetings.

In return, participating authorities were to receive a copy of the results for their own province and for the other 4 provinces.

The survey was conducted between April and August 1995, starting when each board agreed to participate. All participating boards were recruited by June 1, and final responses were received by Sept. 1. The need to go through each board to gain access to board members somewhat lengthened the usual follow-up period. As a result, the mean follow-up period for each board was 9 weeks.

### Response rates

Table 3 shows the response rates. More than 80% of the boards participated, and 65% of these boards' members completed surveys. We had no data on board members who did not respond, and we were therefore unable to compare them with the respondents, but we did contrast the characteristics of the responding and nonresponding boards. There were no systemic differences between the responding and nonresponding boards in terms

**Table 3: Rates of participation and response to the survey of members of the boards of devolved authorities, by province**

Province	Participation rate among boards, % (and no.)	Response rate among board members, % (and no.)
British Columbia	70.0(14/20)	74.1(152/205)
Alberta	70.6(12/17)	61.6(106/172)
Saskatchewan	90.0(27/30)	63.7(200/314)
Nova Scotia	100 (4/4)	54.0 (34/63)
Prince Edward Island	100 (5/5)	59.5 (22/37)
Total	81.6(62/76)	65.0(514/791)

of rural versus urban location, population size covered or northern versus southern location. Response rates were, however, slightly lower among immature boards than among established ones. Therefore, our responses are probably slightly biased toward the views and characteristics of members of more established boards. This bias is counteracted somewhat by the high response rate (74%) among board members in British Columbia, a province with largely immature boards.

### Caveats and conclusions

In the next 2 articles we will present the results of our survey. The next article will focus on structural aspects of devolved authorities, such as the demographic characteristics of the board members, their experience and training, the kinds of activities they engage in and the kinds of information they have. The third article in the series will look at cognitive aspects such as board members' motivations, their feelings about the board as a decision-maker and their attitudes toward the tensions they face.

When interpreting these results, there are 3 caveats. First, the boards in British Columbia and Nova Scotia were at an early stage in their development during the survey period. As a result, answers to some questions were likely based more on expectations than on experience. Second, although all of the boards in Nova Scotia and Prince Edward Island participated, the number of respondents from these provinces was small, making generalization from these provinces less certain than generalization from the other provinces. Finally, when we surveyed the Saskatchewan boards, they comprised only appointed members; since October 1995 two-thirds of these boards' members have been elected. Since only about one-third of the appointees stood for election (and we do not know their success rate), future surveys of the boards in Saskatchewan could produce results quite different from those presented in this series.

The board members largely welcomed our survey, and more than 200 (39%) provided extensive comments in an optional open-ended section of the survey. One Alberta respondent said, "Thank you for developing the survey. It has made me think more about what we are doing. I look forward to seeing the results, especially from other provinces."

We also obtained a sense from these comments that board members were struggling, albeit enthusiastically, with their task and had a strong desire for any information. On the one hand, they wanted reassurance about how they were approaching the task and ideas from other provinces, and, on the other hand, they wished to share their experiences. Most of them were aware that, as one Nova Scotia respondent said, they were "the foot-soldiers



of health reform,” and many of the comments reflected the tensions described earlier. A comment by one of the Saskatchewan board members summarizes well the current state of devolved authorities in Canada: “Dealing with reduced budgets, new approaches that have never been tried, bringing together competing communities and interest groups, developing a totally new structure with few guidelines in place . . . this is definitely a challenge!”

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