HOSPITAL GOVERNANCE IN BRITISH COLUMBIA

by

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May 1995
Pamela Ann Azad

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This study examined hospital governance in British Columbia. Considered to be one of the most important issues facing the healthcare industry today, hospital governance is nevertheless an ill-defined and poorly understood concept. Foundational and exploratory in nature, the study's primary objectives were: a) to define hospital governance within the context of British Columbia; b) to examine the structural and functional relationships among key participants; c) to investigate decision-making responsibilities; d) to investigate what, if any, variations exist in the governance of acute care, long term care, and specialized care hospitals; and e) to explore the critical issues which face hospital governance today and in the future under New Directions policy initiatives.

All hospitals (N=107) in the province were studied, with the exception of diagnostic treatment centers, private for-profit facilities, military, and federal institutions. Utilizing documentary examination, survey administration, and interview techniques, the study included hospital chief executive officers (N=106), hospital board members (N=735), hospital board chairs (N=106), and selected high ranking senior officials from the Ministry of Health who had direct responsibility for hospital activities (N=15).

Results of the study provide for in-depth demographic board profiles, and show that hospital governance is similarly defined across all hospital categories as “a complex relationship of overlapping structures and activities which has the responsibility and the authority to oversee the organization’s operation and to ensure its commitment of
providing optimum health care to its residents." The study identifies the key participants of hospital governance and delineates sixteen activities considered to be under the hospital board’s domain. Seven issues are identified as being critical for hospital governance in the future. Although there was general agreement as to the individuals most often responsible for recommending and implementing activities brought before the board, there were considerable perceptual differences between participants as to who possesses final decision-making responsibility. Data results consistently demonstrated important differences in responses between the hospital and Ministry populations.

The study shows that overall, the participants of hospital governance are generally satisfied with the traditional roles and structures of hospital boards and are overwhelmingly dissatisfied with New Directions policy initiatives. This study further suggests that due to the discrepancies in priorities, perceptions, and ideologies of the hospital and Ministry populations, hospital governance is in a highly volatile and transitive state.
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CHAPTER 1.0
INTRODUCTION

Hospital governance has become one of the most salient issues facing the health care industry today (AUPHA, 1991). As hospitals face the ever increasing challenges of providing safe and effective yet efficient operation, hospitals and their boards are being forced to re-examine their structures, roles, and relationships not only within the broader context of a health care system, but also to society as a whole (Alexander, 1993; Baker, 1992; Shortell, 1988; Somers, 1971; Umbdenstock, 1987). But how and why has governance, in particular hospital governance, become such an important centerpiece for organizational operation, and why does it still retain such ambiguity?

1.1 Foundations of Governance

A historical review reveals that early civilizations, such as the Misericordia of A.D. 1240 Italy, had decision-making groups which functioned similarly in both structure and process to present day boards (Tocqueville, 1945). However, despite its long-standing presence in society, the topic of governance garnered little interest in any professional or academic arena until the 1970’s (Kelly, 1972). It was at this time that governance was seen as a potentially powerful vehicle for including the state, the public, and the private sector in decision-making activities. Education, corporate business, and the political and economic disciplines came to use various forms of governance arrangements not only as a
management support, but also as a means to view the world. Governance, therefore, provided a locus from which the social interactions of society could be focused and examined (Thompson, 1991).

1.2 Governance Within the Context of Health Care

Heightened interest in the examination of governance within the health care arena followed a similar course. As the scientific model of health care evolved during the late 19th and early 20th centuries, medical sciences transformed hospitals from custodial institutions for the sick and poor into focal points for safe and effective care for entire communities (Shortell, 1988; Stevens, 1989). Hospital board members at this time were predominantly affluent citizens who contributed large sums of money and resources to establish and equip hospital facilities. Their involvement in governance activities however was generally relegated only to functional and daily financial operations.

The end of World War I brought an increase in the size and complexity of hospitals, and with it, additional demands and responsibilities for board members. Because these individuals no longer had the time or resources to administer and financially support their hospitals, business managers or “superintendents” were hired for day-to-day affairs (Shortell, 1988). Hospital governance had evolved into largely a supervisory role, allowing the superintendents to function as managers.

Shortell (1988), Stevens (1989) and Starr (1949) suggest that five major factors guided
the progression of hospital governance's role into its present day mode: (1) the regulation of hospital construction, costs, quality of care and utilization factors; (2) an increase in the stringency and complexity of labor relations; (3) continuing advances in medical science and technology; (4) court rulings which more firmly established institutional responsibility and liability; and (5) an increase in public expectation regarding the delivery of health care and the accountability of hospitals to their communities. Due to the complex and interdisciplinary nature of health care today, present day hospital boards now find themselves in the precarious positions of having to balance and mediate the demands of the medical staff and hospital employees with those of the community, government and other external agencies (Kovner, 1974).

1.3 The Canadian Heath Care System

As in health care systems throughout the world, The Canadian health care system is a unique and intricate composition of organizations and services (Sutherland and Fulton, 1988; Crichton, et al., 1990). Predominantly formulated on the philosophies of egalitarianism and executive federalism, Canada’s ideological focus has generally been one of collective liberalism (Marchak, 1985).

Health care at the national level was first given rudimentary consideration under the British North America Act of 1867 (BNA Act) which addressed and defined the federal and provincial separations of power. Under the BNA Act, provinces were given
the authority and responsibility to provide health services to its inhabitants. Two of the later legislations, the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Act of 1966, addressed the much needed and necessary requirements for instituting an equitable national health plan. Funding for these two legislations was later delineated in 1977 through the Federal Provincial Fiscal Arrangements and Established Programs Financing Act (EPF) which identified a federal:provincial cost-sharing formula. Originally based on a 50:50 split between federal:provincial fiscal contributions, more recent EPF rates have varied depending on the availability of federal monies (Sutherland and Fulton, 1988; Crichton, et.al., 1990).

Although the importance of these foundational legislations cannot be understated, the benchmark of Canada’s health care system is unquestionably the Canada Health Act of 1984 (The Act), which formally enacted the five principles of portability, accessibility, comprehensiveness, universality, and public administration into legislation. As the foundation of Canada’s health care delivery plan, The Act is the blueprint for health care policy, provincial health care acts, and therefore hospital governance in Canada today.

To satisfy the tenets of The Act, Canada’s health care system has developed an elaborate network of organizations which are dynamic, interdependent, and interrelated in both structure and process. While all of Canada’s provinces are bound by the jurisdictions under The Act, each province may operationalize its health care mandate according to its own unique requirements and priorities. For example, by placing impetus on shifting population demographics, geographic considerations, or provincial economic conditions,
two provinces may set aside similar funding for acute care capital costs. However the net
distributive allocation of provincial funding may be considerably different. Therefore,
despite one federal health mandate, Canada has in fact twelve separate and unique health
care systems.

1.4 Health Care in the Province of British Columbia

The period up to the late 1970's was a favorable one for British Columbia's health care
system. Due to the enactment of federal legislations, hospitals in particular were
guaranteed virtually unfettered financial support of programs and services. Funded
according to occupancy on a per diem basis, hospitals frequently accrued fiscal deficits in
the face of rising health care costs (Annual Report, Ministry of Health, Province of British

By 1982 however, the face of hospital funding started to change. Due to alterations in
federal:provincial funding arrangements, an aging population, changes in technology and
the expectations of society among other factors, health care was consuming ever
increasing amounts of provincial budgets (Barer, 1988). British Columbia responded by
initiating the fiscal restraint program of line-by-line budgeting, believing that a single lump
sum to hospitals for overall operation would alleviate skyrocketing costs. This approach
initially had positive results. Hospitals however, particularly those in acute care, continued
to run deficit balances and health care expenditures continued to rise. By 1996, in
anticipation of further deteriorations in health care finances, services, and delivery, most of Canada's provinces had called for a Royal Commission review of their respective health systems to investigate how best to deal with the perceived health care crisis (Deber, 1992). In 1991, British Columbia followed similar suit by appointing its own Royal Commission on Health Care and Costs (Province of British Columbia, 1991).

With the start of a new decade, the early 1990's ushered in the third phase of health care reform. Based on the recommendations of the now completed Royal Commission reports, virtually all of Canada's provinces were attempting some aspect of hospital de-institutionalization. In support of the proposition that the decentralization of hospital services to community based programs would decrease costs and enhance patient care, provinces developed various approaches to modify their infrastructures and health care delivery practices.

At present, all of Canada's provincial health care systems are undergoing some degree of health care policy reform. Due to changes in demographics, manpower and financial resources, broader definitions of health care and its delivery, and the rapid evolution and challenges posed by medical sciences and technology, all of Canada's provinces are beginning to explore new avenues for decentralization and health care reform.

In British Columbia, the concept of regionalization has recently emerged as a concomitant strategy to further augment the decentralization process (British Columbia
Health Association, 1992). Focusing on the prevention of service and program
duplication, cost-containment, and enhanced community involvement in health care
delivery decision-making, the provincial government released its newest health care policy
strategy in February, 1993 via the document entitled *New Directions for a Healthy British
Columbia* (Province of British Columbia, 1993). Referred to more commonly as *New
Directions*, the British Columbia government's approach to reform, is system-wide vs.
sector specific and as stated in the plan, strives to achieve the following five goals:
1) better health, 2) an enhanced respect of health care providers, 3) greater public
participation and responsibility, 4) more effective management of the new health system,
and 5) a health care system which brings health care and its delivery closer to home

1.5 Hospitals and Hospital Governance in British Columbia

Although all sectors of provincial health care systems play an interactive role with
respect to changes in policy directions, hospitals are generally considered to be the tour de
force not only as the impetus for change but also as the focus of reform. Due to the central
roles which they fulfill within their communities and also due to the large amount of
resources which they utilize in fulfilling their functions, hospitals have always been of
particular interest to the researcher. Barer (1988) states that approximately forty percent
of all provincial expenditures in health care are incurred by acute care hospitals. Therefore, hospitals are often the most visible targets of any change in health policy direction.

The designation of an organization as a hospital is specified at the provincial level under the Hospital Act of each respective province. While some exceptions do exist primarily in the long term care industry, hospitals in Canada and thus British Columbia are generally considered to be non-profit in origin (Hospital Act of British Columbia, 1961). Although global operations are centrally mandated through the Ministries of Health (MOH) via the provision of centralized funding, historically, the provincial governments have delegated authority and responsibility to individual hospital societies and their boards of trustees (BOT) to define and achieve organizational objectives. These hospital societies and boards of trustees have in turn consigned overall responsibility for organizational operation to the hospital’s governing body, and its chief executive officer (CEO) (British Columbia Society Act, 1979). (Figure 1).

Up to the most recent changes in policy direction, membership on the board of trustees was legislatively defined at the provincial level, and ensured at least one government representative on all hospital boards. Furthermore, although hospital boards were often categorized according to their elected or appointed status, boards in reality were always generally a blend of appointed and elected members (Caldwell Partners, 1992). (Figure 2).
Figure 1. THE TRADITIONAL HOSPITAL GOVERNANCE SYSTEM
WITHIN BRITISH COLUMBIA

- Society Defines Values - Determines Societal Values For Specific Points in Time
  - Establishes Value-Based Environment

- Government/MOH - Develops Rules and Regulations Provides Funding
  - Establishes Policies
  - Creates Institutions Which Reflect Societal Values

- Hospital Societies - Defines Membership of Hospital Governance Bodies
  - Ensures Institutions Are Consistent With Local Environments

- Hospital Boards - Develops Institutional Policies For Organizational Operation
  - Determines Specific Policies

- Hospital CEO - Oversees Management Operations of the Facility
  - Undertakes and Manages Strategic and Operational Plans

Figure 2. THE TRADITIONAL HOSPITAL GOVERNANCE STRUCTURE
WITHIN BRITISH COLUMBIA
The British Columbia Royal Commission on Health Care and Costs (1991) and the subsequent New Directions strategy outlined a different role and structure for hospitals and their governing bodies however. Focusing primarily on the recommendation of bringing health care closer to home, British Columbia’s newest health care policy strategy proposes the dissolution of traditional hospital governance bodies in favor of community health councils (CHCs) and regional health boards (RHBs). Shifting the ideological focus away from hospitals and the medical model towards an expanded community health paradigm, CHCs and RHBs will be expected to collaboratively function as the new cornerstones of health care delivery and decision-making (Province of British Columbia, 1993) (Figure 3).

In theory, CHCs will be established at the local level and will be composed of a 1/3:1/3:1/3 split in membership through ministerial appointment, public municipal election, or designated representation from other elected bodies (e.g., schools boards, municipal councils, etc.). While there may be some differences between communities, CHC’s will be expected to identify local health care needs, prioritize and plan local health services, and integrate, coordinate, and manage all health care services delivered by hospitals, health care agencies, and other related facilities (Province of British Columbia, 1994; The Canadian Hospital Association, 1993).
Figure 3. THE PROPOSED HOSPITAL (HEALTH CARE) GOVERNANCE STRUCTURE WITHIN BRITISH COLUMBIA UNDER NEW DIRECTIONS

SOCIETY → Society Defines Values → Determines Societal Values For Specific Points in time

Establishes Value-Based Environment

GOVERNMENT (MOH) → Government/MOH Establishes Policies → Develops Rules and Regulations Provides Funding Defines Core Services

Creates Institutions Which Reflect Societal Values

REGIONAL HEALTH BOARDS (RHBs) → Defines Health Needs of Region Allocates Funds to CHCs

Membership composed of representatives from CHCs and ministerial appointment

COMMUNITY HEALTH COUNCILS (CHCs) → Defines Health Needs of Community Allocates Funds to Local Hospitals, Agencies, and Other Institutions

Membership composed of representatives from municipal public election, ministerial appointment, and appointment from other elected bodies (e.g., school boards, etc.)

HOSPITALS → PUBLIC HEALTH AGENCIES → OTHER HEALTH CARE INSTITUTIONS
RHBs will act as general administrative overseers of respective CHCs, and will be responsible for planning, coordinating, and managing health care resources and their delivery on a regional level. In addition, RHBs will have the expanded responsibility of allocating regional global health care budgets to CHCs based on communities' identified and prioritized needs (Province of British Columbia, 1993; Province of British Columbia, 1994).

Under New Directions, the traditional roles, structures, and functions of hospital governance will change. As resources continue to be shifted away from in-hospital services toward more community-focused care, hospitals which were once the heart of health care, will be just one of multiple agencies and institutions vying for community and regional health care dollars (Figure 3). As CHCs and RHBs continue to replace individual hospital boards and become the governing bodies for multi-facility health care planning, decision-making, and delivery, the phrase “hospital governance” will give way to the more correct term of “health care governance”.

The ubiquitous yet mercurial entity which we presently call hospital governance is in a state of transition. As an industry issue, few topics garner as much attention - or controversy. At issue therefore is to better understand the status of hospital governance within British Columbia and to investigate the various perspectives and decision-making processes among its key participants.
1.6 Purpose of Study

Despite widespread and increased interest in hospital governance as a research focus, few investigations have examined the topic from the Canadian perspective. Most studies have instead focused on the hospital system within the United States (Alexander, 1991; Gill, 1989; Shortell, et. al., 1984). Due to the term’s generic popularity, “governance” has now become somewhat of a catch-all term for describing any group with legal responsibility for policy-making, quality of care, or organizational management (Slee, 1991). Moreover, despite the considerable availability of literature on the subject, there are few analytical or empirical studies to guide future research due to an absence of a precise, or industry-wide accepted definition (Marin and Mayntz, 1991). Even further inspection of the studies which do exist finds that most are either prescriptive or normative in scope, and again, based largely upon the U.S. experience (Carver, 1990; Kovner, 1978; Umbdenstock, 1988).

Concomitantly, many experts are making extremely profitable incomes proselytizing on how boards should be run, who should run them, and how they can become more effective (Carver, 1990; Zander, 1993). But, how can Canadian practitioners and academics learn a “better”, or more “correct” way of governing hospitals if we have not yet determined what exactly “hospital governing” is and what hospital governance is presently doing within a Canadian contextual framework?
Strong research of a Canadian nature does of course exist. Researchers such as Baker (1992), Wilson (1991), and Rozovsky (1980) have made outstanding contributions to the field with their work on policy, standards, and legalities issues. However, Canadian researchers who have expressed an interest in investigating the relationship between hospital governance, its roles, structures and decision-making processes have often been discouraged by such limiting factors as funding, manpower, politics, or time (Canadian College of Health Service Executives, 1992). As more prestigious and well respected organizations herald in the need to make research into hospital governance a higher priority, it becomes apparent that this topic offers considerable investigative and practical merit (Canadian Hospital Association, 1993; Canadian College of Health Service Executives, 1994; British Columbia Health Association, 1994; Association of University Programs in Health Administration, 1991).

1.6.1 Objectives of Study

This study will contribute to the existing knowledge of hospital governance in Canada by viewing the topic through the lens of British Columbia. More succinctly, this study will be exploratory and foundational in nature and will have five study objectives:

(a) To define hospital governance within the context of British Columbia.
(b) To examine the structural and functional relationships among the key participants in hospital governance.

(c) To examine the decision-making responsibilities of key participants.

(d) To investigate what, if any, variations exist in the governance of acute care, long term care, and specialized hospitals in British Columbia.

(e) To examine the critical issues which are facing hospital governance today in its transitional state under the New Directions initiative.

1.6.2 Research Questions

In order to meet these objectives, several research questions are identified:

(a) How is hospital governance defined in British Columbia?

(b) Are there differences in the way hospital governance is defined either between hospital categories or among key participants?

(c) Who are the key participants of hospital governance?

(d) What are the structures of hospital governance?

(e) Do these structures differ among hospital categories?

(f) What are the roles and functions of hospital governance?
(g) Do these roles and functions differ among hospital categories or between key participants?

(h) What are the main decision-making responsibilities among the key participants?

(i) How do decision-making responsibilities differ among key participants and between hospital categories?

(j) What are the implications of New Directions with respect to hospital governance?

(k) What are the perceptions of key participants regarding hospital governance under New Directions?

(l) What are the challenges and issues facing hospital governance in the future?
CHAPTER 2.0  
LITERATURE REVIEW

2.1 Confusion Over Definition

The term governance is a commonly found but ill-defined concept. A review of the literature indicates that an explicit definition is generally not provided. Rather, assumptions are made by many authors regarding its meaning, composition, and application. While there remains to be some degree of variance in the literature over proper nomenclature, the implied definition of the term suggests that it is the chief executive officer (CEO) and the BOT who form a health care organization’s governing body and possess the overall authority and responsibility for its operation. In addition, it appears that at least within the field of health care, the terms “board of directors”, “hospital board”, “governing board”, and “boards of trustees” equate synonymous meaning (Kovner, 1978; Miles and Snow, 1978; Pfeffer, 1981; Alexander, 1988; Shortell and Kaluzny, 1988; Shortell, 1989; Zuckerman, 1990).

Baker (1992) has observed that the term governance suffers from a confusion between governance responsibilities and governance structures. Whereas some authors have defined and viewed governance from the perspective of policy development, authority, and decision-making responsibilities which ensure the well-being and survival of the organization, others have examined governance from a more structural vantage point,

However, with the notable exceptions of Baker (1992) and Alexander (1991), few authors have addressed in any detail the interplay of roles, structures, and functions as the cause of confusion in definition. These blurring of perspectives may be located in the complex roles of medical personnel, administration, and hospital governing bodies. Whereas policy-making may be a shared process by all three groups in some hospitals, this function may be the sole responsibility of the board in others. Similarly, many management functions such as capital budgeting, the closing of beds, or changing the types of services provided may be differentially shared. Therefore, how one defines hospital governance becomes a very important question, particularly within a Canadian setting. The manner in which a province, in this case British Columbia, defines and views hospital governance affects not only the roles, functions, and relationships of governance, but also the overall services and delivery of health care as well.

2.2 Approaches to the Study of Hospital Governance

Hospital governance's role, at least historically, was to function as the organization's chief protectorate, legitimizer, social buffer, and ethical and social agent (Mintzberg, 1983; McManus, 1990; Wachel, 1991). In theory, the board, and more specifically, the chairman
of the board (COB), was expected to act as the organization's "overseer" and obtain -or maintain- the necessary resources the organization needed in order to remain productive. The CEO was delegated the authority to administer and manage the affairs of the facility on a day-to-day basis. Together, the BOT and the CEO were to work as a collaborative team in establishing organizational direction.

This perspective is of course a simplistic one and does not take into consideration the intricate relationships of power and authority which are embodied within organizations and within the act of governing today (Kovner, 1978; Shortell, 1984; Starr, 1949).

While extensive writings do exist which specifically address the topics of hospital trusteeship, the roles and responsibilities of CEOs and board members, and the act of effective governance, an examination of the literature clearly demonstrates a lack of research applicable to the Canadian hospital experience. For example, the investigation of hospital governance within the purely corporate paradigm has produced numerous and serious gaps for practical application. Corporate governance is usually profit-maximizing in origin, possesses a governance body which is largely specific and professional in character, and generally acts on behalf of the corporation's stockholders (Leighton, 1990; Alexander, 1991). With the possible exception of the multi-hospital for-profit hospital system present in the U.S., the corporate paradigm is generally considered to be too business oriented for general hospital application (Kovner, 1990; Alexander, 1990; Pfeffer, 1973; Shortell, 1989). Concomitantly, this perspective contrasts sharply with the non-
profit, often non-professional and egalitarian philosophy which embodies the health care system within Canada today.

Kovner (1990) however offers three alternative viewpoints from which to examine hospital governance.

Building upon the corporate model, the first views the board as a steward of the community with a focus towards the improvement of the health status of the population (Seay and Sigmond, 1989). The second viewpoint regards the board as a strategic decision-maker and requires board members to develop certain skills that would enable them to become risk takers and experts in such areas as marketing, mergers, and acquisitions in order for the hospital to maintain competitive viability (Shortell, 1989). In the third viewpoint, boards are perceived as rational advisors. In this scenario, board members offer their expertise, advice, and assistance to senior management with respect to overall policy development and financial planning. Final decision-making however lies under the domain of hospital administration.

Under these frameworks, different viewpoints suggest different relationships, different responsibilities, and different accountability structures. However, like earlier perspectives, Kovner’s model has been criticized as being too simplistic. Nevertheless, Kovner does offer a plausible managerial and categorical perspective of hospital boards (Alexander, 1991).

But are these categories applicable to the Canadian setting?
Certainly, it is expected that hospital governance in Canada will differ in important respects from hospital governance in the United States. Canada does not possess the myriad of regulatory agencies, multi-system ownerships, and financial and governmental arrangements which the United States hospital system has employed. Concomitantly, Canada’s ideology of barrier free access to health care suggest substantially different orientations to hospital governance.

2.3 In Search of a Unifying Governance Theory

Even in recognition of the obvious disparate characteristics of hospital governance, why is the topic so difficult to grasp from a theoretical perspective? The answer is threefold.

Impediments to the advancement of research into hospital governance have not only originated from difficulties associated with topical and methodological conceptualizations, but also due to barriers associated with confidentiality and the piercing of the corporate veil (AUPHA, 1991). Equally important however is the fact that governance does not in itself possess a singular grounding theory. Alexander (1991) states that there is a myth that a universal governance model exists. Unfortunately, research clearly demonstrates that the entity of governance has evolved from numerous multidisciplinary perspectives; namely those from sociology, economics, and management theory (Fennel and Alexander, 1989; Alexander, 1991; Morlock, 1986).
The 1933 paper by Berle and Means (Berle and Means, 1964), known as the “Berle and Means Hypothesis”, was the first to discuss the separation of ownership and management via the establishment of a board of directors (Leighton, 1990). Although rarely mentioned in articles today, it remains as one of the most important research articles published to date in the field.

Power and authority as they relate to governance cannot be adequately discussed without referring to the seminal work of Max Weber (1947), who first described organizational bureaucracy and the division of labor. Weber’s model of hierarchical design is still considered to be the prototype for most hospitals in North America today. Furthermore, its relevance from a practical perspective is critical when one discusses organizational re-structuring, and governance’s role within society.

Power within organizations was extensively examined by French and Raven (1960), who summarize that power and authority are derived from multiple sources and are a process of social interaction. In their examination of the various types of power, French and Raven postulate that positional power - such as that possessed by the CEO or board chair - may in fact be significantly eroded if the referent, expert, or coercive power of a subordinate/rival is substantial. Later applications of French and Raven’s work generally focus on power and authority as it practically relates to role differentiation and leadership development (Starkweather, 1988; Morton, 1992; Umbdenstock, 1988; Gill, 1989).

However, most of today’s literature on governance decision-making and the organizational relationships between its key participants examines the issue via some
aspect of agency theory (Alexander, 1993). Derived from the fields of social and financial economics, agency theory focuses on the relationship between incentives and contracts and individual and organizational outcomes (Alexander, 1993, Jensen and Meckland, 1976). An overview of the theory postulates that an individual or group - the principal - employs or engages another person or group - the agent - to perform some service or act which necessitates the delegation of some decision-making authority to the agent (Jensen and Meckling, 1976; Eisenhardt, 1989, Alexander, 1993). In more practical and applicable terms, agency theory suggests that within for-profit hospitals, due to the separation of ownership and management, the governing board acts as a surrogate for the principals (owners or stockholders) of the facility. In not-for-profit hospital scenarios such as those generally found within British Columbia, the principals are individuals from within the community which the hospital serves. Acting as surrogates for the principals, hospital boards contract services and oversee the actions and activities of its agents (hospital staff, hospital management, and medical staff) (Alexander, 1993).

According to agency theory, conflicts or perceptual differences in decision-making or of structural /functional relationships may arise when agents’ personal preferences do not necessarily align with those of the organization (Eisenhardt, 1985; Eisenhardt, 1989; Fama and Jensen, 1983; Jensen and Meckling, 1976; Fama, 1980). A medical director who favors to keep hospital beds open in order to maintain the number of physician admissions will surely come into conflict with a management preference to close beds due to cost
constraints. Conversely, hospital management may come into conflict with the hospital board with respect to requests for new capital equipment purchases or salary increases.

But, are the lines of demarcation between the agents and principals of hospitals as clear cut as agency theory suggests? If so, within the context of British Columbia, where do the CEO and MOH lie? Do individuals always act and make decisions in their own best interests or is there room for altruistic behavior in decision-making? And what about differential bases of power? Agency theory fails to recognize variances in power and authority even between individuals from “equal” or lateral positions.

2.4 Statement of the Problem

Before these and other questions can be answered, it would be helpful to first ascertain from a Canadian perspective a more precise definition of what exactly hospital governance is, who its key members are and what hospital governance does. Because each province has its own unique ideology regarding health care and its delivery, a definition and examination of hospital governance’s structural and functional relationships within a provincial context - in this case British Columbia - is necessary for both practical and academic reasons. Once a more localized composite is obtained, it can then be potentially tested for application and generalizability or transferability against other provinces within Canada. Secondly, much is written about the how-to’s of effective governance decision-making, but what exactly are the hospital boards of this province deciding? What are their
main decision-making responsibilities and activities? And, who decides what? Finally, as New Directions continues to transform the health care system within British Columbia, what are the implications, issues and challenges facing hospital governance today and in the future?

2.5 Hypotheses

This study postulates four hypotheses:

(a) That the term “hospital governance” will be similarly defined across acute care, long term care, and specialized hospital categories within British Columbia.

(b) That variances will exist in the perceptions of decision-making and responsibility among the key participants of hospital governance both intra- and inter-categorically.

(c) That the traditional structures and processes of hospital governance are in a volatile and transitional state under New Directions.

(d) That there will be general agreement among key participants as to the problems, issues, and challenges facing hospital governance now and in the future.
CHAPTER 3.0
PROCEDURE AND METHODOLOGY

3.1 Design and Methodology

This study is exploratory in nature and utilizes a multi-method research design incorporating both qualitative and quantitative data via the techniques of survey, interview, and documentary examination (Ong, 1993).

The exploratory and multi-method approach was selected for this study not only because of the ill-defined and poorly understand nature of the topic being investigated - hospital governance - but also because of the inherent strengths of combined methodologies. Hakim (1987) states that in research which has highly complex relationships, valid conclusions cannot often be made from a singular methodology. Concomitantly, Brewer and Hunter (1989) state that in cases where topics are largely undefined or require multi-faceted clarification, it is often preferable to examine the problem from different vantage points.

For these reasons, multi-method research offers the most plausible design for this study and presents a strong basis for methodological triangulation because it allows for multiple measurement from multiple viewpoints. Whereas the methodologies of surveying, interviewing, and documentary examination present their own unique strengths and
weaknesses, multi-method research triangulation overcomes any singular shortcomings of each respective methodology by offering increased confidence and validity through the agreement of data sets that have been derived from multiple sources (Ong, 1993).

3.2 Parameters of Study

3.2.1 Population and Area of Study

This study examines all hospitals within British Columbia and comprises the following persons: (a) All individuals who are chief executive officers, or senior administrators of hospitals within British Columbia as identified in the Canadian Hospital Directory 1993-1994, (b) all hospital boards as identified under the Societies Section of Regional Programs- Ministry of Health 1994, and (c) selected senior Ministry of Health officials at the minister, deputy minister, assistant deputy minister, or executive director position who have provincial responsibility over various aspects of hospital operation as identified by the most recent organizational chart published by the Ministry of Health, Spring, 1994. Private for-profit hospitals, federal institutions, military facilities, and diagnostic treatment centers as defined by the Peer Group Classification listing established by Ministry of Health were excluded from this study due the unique nature of their organizational mandates and their funding criteria and relationships.

3.2.2 Period of Study
This study was conducted over a five month period between the dates of June 17, 1994 to November 30, 1994. As stated in the Introduction of Chapter 1, the hospital industry is currently considered to be in a highly transitional state due to the effects - or anticipated effects - of New Directions policies. Therefore, this study’s empirical data will only deal with information collected within the above five month time frame. However, due to the practical and generalizable nature of the study, findings and their potential ramifications are discussed in both a present and future context.

3.3 Procedure

This study consisted of five stages (Figure 4).

The first stage involved the examination of documents necessary to identify the participants and boundaries of the study, as well as a review of all relevant literature for academic and analytical support. The goals of stage one were to focus the topic of study, identify and assign study participants to either an acute care, long term care, or specialized care category, and to establish survey item creation.

The second stage focused on the development of the survey and a pilot test of the instruments on a random sampling of study participants. The goal of stage two was to identify any particular problems or issues associated with survey clarity, participant selection, or construct validity.
Figure 4. STUDY PROCEDURE

Stage 1
Clarify topic and focus of study
Establish study boundaries and identify/categorize study participants
Creates items

Stage 2
Develop survey/instrument
Pilot test instruments for clarity and construct validity
Revise/finalize survey instruments

Stage 3
Administer survey instruments
Review data to develop study questions
Finalize interview questions

Stage 4
Randomly select interview participants
Conduct personal and taped telephone interviews

Stage 5
Analyze survey and interview results
Form conclusions
The third stage was the actual mailed administration of the surveys to study participants. The goals of stage three were to ascertain the perceptions and opinions from all key participants and to utilize the data obtained from the surveys to develop the study interview.

The fourth stage consisted of conducting in-person and taped telephone interviews of randomly selected study participants utilizing questions largely based upon survey content. The purposes of stage 4 were to provide participants with the opportunity to respond in greater detail to questions asked and to provide for further intra-study validity.

The fifth stage of the study was that of data analysis, data comparison, and conclusion formulation.

3.3.1 Stage 1 - Documentary Examination

Following a review of all necessary research and data support material, the study’s focus, population, and research parameters were defined. Item creation for stage two survey design was based upon Marsh (1982) and Bailey’s (1987) work on construct validity of scaling and the assessment of domain coverage of particular constructs. Prior to the start of the formal study, all necessary university documentation were submitted and approved by the University of British Columbia’s Faculty of Graduate Studies and the University Ethics Review Committee (Appendix A-1).
The Canadian Hospital Directory of 1993-1994 was then consulted to compile a list of all current CEOs or chief administrators of hospitals within British Columbia. Each hospital was then assigned to either an acute care, long term care, or specialized care category depending on where fifty-one percent or more of their hospital beds were designated as defined in the Directory. A second list, that of the names of all board chairs/presidents and operational hospital boards within the province, was developed from the Regional Programs Society Section document received from the Ministry of Health - department of institution administration and support services. A third list, detailing the names and positions of senior Ministry of Health personnel, was then developed by reviewing the most recent organizational chart obtained from the Ministry of Health - minister's office (Appendix A-2).

3.3.2 Stage 2 - Survey Pre-Testing

Stage 2 commenced with the development of preliminary survey instruments 1 (intended for CEOs, board chairs and board members) and 2 (intended for Ministry of Health officials). Utilizing both open and closed ended questions and nominal and ordinal measurement techniques, the surveys were developed in accordance with the guidelines stipulated by Bailey, and Sudman and Bradburn (1982). Two surveys were necessary because study participants from the Ministry of Health were not in direct positions to lead or govern over specific hospitals. Therefore, questions which dealt specifically with aspects of individual board demographics or professional relationship and decision-making
issues as they applied to each respective hospital were invalid and thus deleted. In all other ways, preliminary surveys 1 and 2 were identical.

To further support the construct validity of the study, the survey instruments were pilot tested in a random sampling of subjects. Due to the smaller proportions of subjects in both the specialized hospital and Ministry of Health categories, sample sizes for the pilot test were adjusted accordingly (Figure 5). Once completed, all responses obtained from the pilot test were analyzed for clarity, procedural qualities and reliability based upon Hunt, Sparkman, and Wilcox's (1982) criteria for designing and evaluating pretest studies.

3.3.3 Stage 3 - Survey Administration

Stage 3 was the actual mailed administration of the final survey instruments with accompanying permission letters, listings of Peer Group Classifications, and return postage to all study participants (Appendices B-1, B-2). Surveys intended for ministerial participants were mailed directly to each individual at their respective Ministry of Health office. Surveys for CEOs were personally addressed and mailed to individual hospitals. Surveys for board chairs and board members were mailed as collective packages to the respective hospitals at the request of CEOs for confidentiality and privacy purposes and also for both economic and practical considerations. Once hospitals received the survey packages, the surveys were then distributed to individual board members and chairs.

As surveys were returned, results were examined, coded for computer tabulation and analysis, and utilized as a foundation for the construction of the interview instrument.
Figure 5. DISTRIBUTION OF RANDOMIZED PILOT STUDY PARTICIPANTS

SURVEY 1

Acute Care Hospitals: 5 CEOs, 5 Board Chairs, 5 Board Members
Long Term Care Hospitals: 5 CEOs, 5 Board Chairs, 5 Board Members
Specialized Care Hospitals: 1 CEO, 3 Board Chairs, 3 Board Members

SURVEY 2

Ministry of Health Officials: 2 Deputy Ministers, 2 Executive Directors
Once stage 3 was complete, all surveys were then stored in a locked storage area awaiting the completion of the defense.

3.3.4 Stage 4 - Interview Administration

Finalizing the triangulation of methodologies, stage 4 focused on structured interview instruments based upon Sudman and Bradburn's model for interview design. Expanding further upon items explored in stage 3 surveys, the interviews were administered to a random sampling of study participants and incorporated both open and closed question techniques. Again, due to the variability between category populations, sample sizes were proportionately adjusted (Figure 6).

Following the same logic for item validity as in surveys 1 and 2, interview 1 was developed for hospital CEOs, board chairs and board members, whereas interview 2 focused on Ministry of Health officials. In all other ways, the interviews were identical (Appendices C-1, C-2). Subject inclusion in the interview component of the study was through the written agreement to participate by individuals via the survey permission document and through computerized random selection.

Although the interview method of choice was the in-person interview, geography, time, and financial constraints precluded this exclusive approach. As a result, the taped telephone interview was used as an adjunctive approach.

Data collected from the interviews were analyzed, compared and stored in similar capacity to that of stage 3 surveys.
INTERVIEW 1

Acute Care Hospitals: 10 CEOs, 5 Board Chairs, 10 Board Members
Long Term Care Hospitals: 5 CEOs, 4 Board Chairs, 10 Board Members
Specialized Care Hospitals: 1 Board Chair, 5 Board Members

INTERVIEW 2

Ministry of Health Officials: 3 Senior Officials
3.3.5 Stage 5 - Data Analysis

The last stage of the study began with multi-method variable analysis and the comparison of intra- and inter-categorical data and ended with the formulation of conclusions. Due to the complex nature of the study, a variety of analytical tools supported by the Microsoft Office computer software program CORREL were utilized:

- Chi square ($x^2$) - utilized to test associations between variables.
- Analyses of variance - utilized to compare differences by utilizing F-tests between means and to obtain standard deviations.
- t-Tests - employed to test the differences between the means of two sample groups.
- Mantel-Hanszel Test - used to test associations between two variables that can be categorized into strata.

3.4 Methodological Limitations

Although the utilization of a multi-method approach to research design substantially decreases concerns associated with singular methodologies, nevertheless, real or potential limitations are always present due to a multitude of variables and the adage of Murphy's Law.
Because of the highly controversial and transitional state of hospital governance in British Columbia, some respondents expressed reservation in offering unbridled opinions about New Directions, or the Ministry of Health’s involvement in hospital governance or provincial health care affairs. Conversely, by the very nature of respondent bias, those individuals who agreed to participate in the study may in fact have been those with the most extreme variability of opinions.

Thirdly, factors associated with the inherent nature of survey and interview techniques offer further methodological limitations. People may be more or less willing to participate freely in taped telephone interviews than those conducted in-person. Mailed surveys may never reach their destination or might be displaced by a harried assistant or overloaded hospital mail system. Item creations, no matter how many times pre-tested, may remain confusing or vague to a small percentage of the study population.

And finally, finances, geography, and time offered additional plausible limitations for study methodology.
CHAPTER 4.0
RESULTS, ANALYSIS, AND DISCUSSION

4.1 Review of Study Objectives and Research Questions

This study had five objectives: 1) To define hospital governance within the context of British Columbia; 2) To examine the structural and functional relationships among the key participants of hospital governance; 3) To examine the decision-making responsibilities of key participants; 4) To investigate what, if any, variations exist in the governance of acute care, long term care, and specialized hospitals in British Columbia; 5) To examine the critical issues which face hospital governance today in its transitional state under the New Directions initiative.

In order to achieve these objectives, the following twelve research questions were investigated via survey and interview techniques: 1) How is hospital governance defined in British Columbia?; 2) Are there differences in the way hospital governance is defined either between study population categories or among key participants?; 3) Who are the key participants of hospital governance?; 4) What are the structures of hospital governance?; 5) Do these structures differ among hospital categories?; 6) What are the activities of hospital governance?; 7) Do these activities differ among hospital categories or between key participants?; 8) What are the main decision-making responsibilities among the key participants?; 9) How do decision-making responsibilities differ among key participants and between hospital categories?; 10) What are the implications of New
Directions with respect to hospital governance?; 11) What are the perceptions of key participants regarding hospital governance under New Directions?; 12) What are the challenges and issues facing hospital governance in the future?

Results obtained have been tabulated in a condensed format to allow for a more concise analysis and discussion of empirical data. Expanded versions of data sets and sub-group analyses are included as enclosed appendices. Sub-group analysis included: gender analysis, hospital peer group analysis, hospital classification analysis, and intra- and inter-categorical analysis. It should be noted that although sections 4.2 - 4.43 do not directly address the research objectives, they nevertheless provide important demographic and background support for the study.

4.2 Documentary Examination Results

Documentary examination provided the foundational data for the study. As Table 1 demonstrates, a total of 107 hospitals were included in the study with 69% of the total hospital population considered to be acute care, 24% long term care, and 7% specialized care as identified by summarative bed allocations in the Canadian Hospital Directory.

In the CEO category, \( N = 106 \) instead of 107 due to the fact that 1 acute care CEO was responsible for 2 acute care hospitals. Similarly, in the COB category, \( N = 106 \) as 1
Table 1  Number, Percentage, and Gender Distribution of Hospital Populations

<table>
<thead>
<tr>
<th>Hospital Designation</th>
<th>Total N</th>
<th>Acute Care</th>
<th>Long Term Care</th>
<th>Specialized Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total hospitals</td>
<td>107</td>
<td>74 (69%)</td>
<td>26 (24%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>* Total CEOs</td>
<td>106</td>
<td>73 (69%)</td>
<td>26 (24%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>Male CEOs</td>
<td>81</td>
<td>53 (65%)</td>
<td>21 (26%)</td>
<td>7 (9%)</td>
</tr>
<tr>
<td>Female CEOs</td>
<td>25</td>
<td>20 (80%)</td>
<td>5 (20%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>** Total COBs</td>
<td>106</td>
<td>73 (69%)</td>
<td>26 (24%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>Male COBs</td>
<td>68</td>
<td>42 (61%)</td>
<td>20 (30%)</td>
<td>6 (9%)</td>
</tr>
<tr>
<td>Female COBs</td>
<td>38</td>
<td>31 (82%)</td>
<td>6 (15%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

* One CEO managed two acute care hospitals.
** One board administered over two acute care hospitals.
board administrated over two acute care hospitals. Otherwise, totals in both the CEO and COB categories mirrored overall hospital distributions.

Gender distribution analysis showed that male CEOs outnumbered female CEOs by a 3:1 margin. The gender ratio for COBs was substantially smaller with male board chairs outnumbering female chairs by only 1.6 to 1. A more detailed discussion of these findings will follow with Table 5 and the analysis of professional experience.

Although documentary examination of the general literature suggested that not-for-profit hospital board membership sizes averaged in the 11-15 range (Gill, 1989), definitive documentation for British Columbia was not readily available. All hospitals within the province are required to register their organizations with the Provincial Corporate Registry (Government of British Columbia, 1995). However, accessing specific information regarding each hospitals’ board was complicated and problematic due to variances in registrant’s names and prohibitive time and cost factors. Secondly, neither the Ministry of Health nor any other professional organization requests or maintains hospital board member specifics as all formal correspondences with hospital boards are conducted through respective hospital CEOs or board chairs. The Ministry further advised that although anyone could apply to obtain more detailed information regarding individual hospital board membership under the Freedom of Information Act (1993), the possibility of the application being approved was remote due to security and confidentiality purposes.
This sentiment was similarly echoed by several hospital CEOs. Although each hospital defines the nature and mandate of their board through their respective bylaws, numerous CEOs still expressed concern over the possibility of breaches in board member privacy. Therefore, for the preliminary stages of the study, it was assumed that hospital boards on average consisted of 15 members. Verification or negation of this supposition would be substantiated through data obtained via the pilot study, survey 1, and interview 1.

Table 2 of documentary examination results show the distribution of the Ministry of Health population. Fourteen officials were included in the study, of which, 14% were Deputy Ministers, 22% were Assistant Deputy Ministers, and 64% were Executive Directors. Actual positions within the MOH organizational chart are detailed in Appendix A-2.

Gender distributions within this population reflected an almost 2:1 split overall in males over females and also the preponderance (80%) of women in Executive Director positions. As was the case with gender distributions within hospital populations, possible rationales for these findings will be discussed in association with Table 5.

4.3 Pilot Study Results

One additional question was added (question 12, Appendix B-1) to survey 1 to assist with data organization and analysis. This was necessary because hospital peer group and classification categories could not provide the necessary information needed to assign
Table 2  Identified Number, Percentage, and Distribution of MOH Population

<table>
<thead>
<tr>
<th>Item</th>
<th>Total N</th>
<th>Deputy Minister</th>
<th>Assist. Deputy Minister</th>
<th>Executive Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Officials</td>
<td>14</td>
<td>2 (14%)</td>
<td>3 (22%)</td>
<td>9 (64%)</td>
</tr>
<tr>
<td>Male Officials</td>
<td>9</td>
<td>2 (22%)</td>
<td>2 (22%)</td>
<td>5 (56%)</td>
</tr>
<tr>
<td>Female Officials</td>
<td>5</td>
<td>0 (0%)</td>
<td>1 (20%)</td>
<td>4 (80%)</td>
</tr>
</tbody>
</table>
hospitals to either an acute care, long term care, or specialized care designation. Because preliminary data from the pre-test suggested that hospital boards averaged 12 members, it was decided that survey packages consisting of 15 surveys for each respective hospital would be adequate to cover hospital board member and board chair populations. Finally, all individuals involved in the pilot study were re-entered into the general survey/interview population.

4.4 Survey and Interview Results

4.4.1 Response rates

Table 3 reflects the distribution of survey response rates in all hospital population categories. A total of 947 surveys were mailed out, and overall, 71.4% were returned. The CEO return rate was 75.5%, the COB return was 73.4%, and the BM return was 70.4%. Even within the acute care and long term care hospital categories, there was an overall average of a 75% return. Notable exceptions to these findings were found in all sub-groups of the specialized care category where overall return rate averaged only 55%.

Although low return rates in this category were disappointing from a practical perspective, statistically, they were insignificant. Reasons most often cited by individuals in this group who chose not to participate in the study generally focused on the fact that they had limited time due to their involvement in other academic studies.
Table 3  Distribution of Survey Response Rates* - Hospital Populations

<table>
<thead>
<tr>
<th>Hospital Designation</th>
<th>Total N</th>
<th>Acute Care</th>
<th>Long Term Care</th>
<th>Specialized Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Surveys</td>
<td>947</td>
<td>511</td>
<td>338</td>
<td>98</td>
</tr>
<tr>
<td>Return Rate</td>
<td>676 (71.4%)</td>
<td>369 (72.2%)</td>
<td>254 (75%)</td>
<td>53 (54%)</td>
</tr>
<tr>
<td>Total CEOs</td>
<td>106</td>
<td>73</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Return Rate</td>
<td>80 (75.5%)</td>
<td>55 (75%)</td>
<td>21 (81%)</td>
<td>4 (57%)</td>
</tr>
<tr>
<td>Total COBs</td>
<td>106</td>
<td>73</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Return Rate</td>
<td>78 (73.4%)</td>
<td>54 (74%)</td>
<td>20 (77%)</td>
<td>4 (57.7%)</td>
</tr>
<tr>
<td>Total BMs</td>
<td>735</td>
<td>365</td>
<td>286</td>
<td>84</td>
</tr>
<tr>
<td>Return Rate</td>
<td>518 (70.4%)</td>
<td>260 (71%)</td>
<td>213 (75%)</td>
<td>45 (54%)</td>
</tr>
</tbody>
</table>

* Response rates were identical for males and females in all categories with the exception of acute care CEOs. In this sub-group, there was an 85% return rate for males and a 50% return rate for females. Chi square was utilized to determine the statistical significance of actual data results with expected returns. This was found to be statistically significant ($p<.001$).

** Results for Specialized Care demonstrated substantially lower return rates. However due to a low N for this group (N = 4) results are statistically insignificant.
Table 4 reflects the response rates from individuals comprising the MOH population. As the table demonstrates, Ministry returns (71%) are similar to those of hospital groups (71.4%). Reasons cited by the four Ministry officials who chose not to participate in the study include: unfamiliarity with the topic of hospital governance (N= 2), and lack of interest in the study (N= 2). Further sub-group breakdown within the table delineates responses by gender and position.

4.4.2 Professional Experience

Table 5 offers an interesting look at the professional experience of all individuals within the study and shows a number of significant findings. First, within the category of “time in present position”, it is seen that CEOs overall have been in their present position for only approximately six years. This finding corroborates the results of other studies which have examined the rapid turnover of hospital CEOs across North America (Canadian College of Health Service Executives, 1992; and Healthcare Executive, 1992). Possible reasons cited for this phenomenon include an increase in mergers, consolidations, and regionalization of hospital facilities and their resulting decrease in CEO positions, increased expectations placed upon CEOs to provide enhanced services in the face of shrinking budgets, and personal and familial stress associated with often long, irregular, and demanding workdays.

The second striking feature of Table 5 is the result of a single-tailed t-test (p < .005)
Table 4  Distribution of Survey Response Rates - MOH Population

<table>
<thead>
<tr>
<th>Item</th>
<th>Total N</th>
<th>Return Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Surveys</td>
<td>14</td>
<td>10 (71%)</td>
</tr>
<tr>
<td>Total Males</td>
<td>9</td>
<td>6 (67%)*</td>
</tr>
<tr>
<td>Total Females</td>
<td>5</td>
<td>4 (80%)**</td>
</tr>
</tbody>
</table>

* 1 Deputy Minister, 1 Assistant Deputy Minister, and 4 Executive Directors.

** 4 Executive Directors.
Table 5  Professional Experience of Study Populations (Years)

<table>
<thead>
<tr>
<th>Position</th>
<th>Time in Present Position</th>
<th>Total Time in Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care CEOs</td>
<td>5.7</td>
<td>10.8</td>
</tr>
<tr>
<td>Acute Care COBs</td>
<td>4.0</td>
<td>6.4</td>
</tr>
<tr>
<td>Acute Care BMs</td>
<td>4.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Long Term Care CEOs</td>
<td>6.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Long Term Care COBs</td>
<td>6.2</td>
<td>4.5</td>
</tr>
<tr>
<td>Long Term Care BMs</td>
<td>3.4</td>
<td>5.4</td>
</tr>
<tr>
<td>Specialized Care CEOs</td>
<td>1.6</td>
<td>7.9</td>
</tr>
<tr>
<td>Specialized Care COBs</td>
<td>1.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Specialized Care BMs</td>
<td>3.6</td>
<td>3.3</td>
</tr>
<tr>
<td>MOH Officials</td>
<td>1.1</td>
<td>8.3</td>
</tr>
</tbody>
</table>
which shows that CEOs and COBs in both the acute care and long term care categories have been in their present positions substantially longer than their counterparts in specialized care facilities. Both positions in acute and long term care average approximately five years. This contrasts sharply with an average of 1.7 years for specialized care CEOs and COBs. While these values tend to become more dilute and average out in the overall time in health care category, overall time results for these comparative groups are still statistically significant (p < .003). An explanation for this finding is probably due to both the intensity of the regionalization movement within the Lower Mainland and its resulting destabilization of the labor force, but also due to the change of administration at B.C. Women’s Hospital, known formerly as The Salvation Army Grace Hospital.

Interestingly, board members’ time in their present positions shows consistency across all three hospital categories. Values ranging from 3.4 to 4.3 years (3.6 years for BMs in specialized care), appear to suggest two things. The first is that despite the perception by the public that hospital board members retain their positions for extended periods of time, the results clearly show that this is not the case. The second is that consistent board membership may in fact provide additional stability and continuity for hospital operation during periods of uncertainty and change.

The third significant finding of Table 5 is the result of sub-group analysis for gender in the acute care CEO category. In both the time in present position (males 6.8 years, females 5.4 years), and total time in health care categories (males 12.5 years, females, 8.1
years), male CEOs clearly possess more experience than their female peers (p < .005). Although it is unclear why there was a statistical difference in only the acute care CEO group, these numbers most likely reflect the fact that women up until the late 1980’s had great difficulty in penetrating the glass ceiling beyond that of Vice-President (Morrison, 1992). In time, one would expect these ratios to become more equitable as increasing numbers of qualified women vie for CEO positions. However, this assumes a constant or expanding CEO job pool. As plans to regionalize and consolidate hospitals continue, the long term implications of this result may be unfavorable not only for female executives but also for CEOs in general.

Finally, the fourth significant finding demonstrated in Table 5 is that MOH officials have been in their present positions for only 1.1 years. This phenomenon suggests two highly polar possible explanations. The first, offered by Ministry individuals (82%) who were interviewed for the study, states that MOH personnel are routinely rotated through a variety of job positions in order to gain valuable and diverse experience. The second explanation, offered by all hospital sub-groups (77%) via survey question 18 and through the interview, suggests that the provincial government is experiencing difficulty in operationalizing its New Directions mandate. As a result, the MOH has attempted to “parachute” various individuals into leadership positions in hopes of aiding the process.

Regardless of whatever reason supports this finding, 92% of all individuals interviewed within the hospital population stated that the lack of current experience and/or
the frequent turnover of MOH personnel has negatively affected continuity and effective communication between the Ministry and provincial hospitals.

4.4.3 Educational and Professional Backgrounds

Table 6 presents an overview of the educational and professional backgrounds of the study population and offers four significant findings. With respect to level of education, the results overwhelmingly demonstrate the fact that the majority of all subgroups in all categories possess a university education. It is of interest to note that 86% of long term care CEOs possess a university degree compared with that of 85% for acute care CEOs. Although these percentages are statistically insignificant, they are nevertheless important from a practical perspective due to a common perception within the hospital industry that long term care CEOs “work their way up the ladder” and often lack university preparation. The above percentages in conjunction with data previously discussed in Table 5 clearly shows this perception to be untrue.

In the categories of area of educational focus and primary occupation, it is important to compare the results of CEOs with those of both COBs and BMs across all categories. The results show that all CEOs in acute care, long term care, and specialized care stated that their major area of education was that of health care, with business following as a distant second. Board chairs and board members stated the exact reverse and chose business as the predominant focus of their educations followed distantly by health care. This same sub-group split was also generally found within the primary occupation
<table>
<thead>
<tr>
<th>Position</th>
<th>Highest Level of Education</th>
<th>Major Area of Education</th>
<th>Primary Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care CEOs (N= 55)</td>
<td>85%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>Long Term Care CEOs (N= 21)</td>
<td>86%</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>Specialized Care CEOs (N=4)</td>
<td>75%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Acute Care COBs (N=54)</td>
<td>80%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Long Term Care COBs (N=20)</td>
<td>70%</td>
<td>5%</td>
<td>25%</td>
</tr>
<tr>
<td>Specialized Care COBs (N=4)</td>
<td>75%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Acute Care BMs (N=260)</td>
<td>64%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Long Term Care BMs (N=213)</td>
<td>72%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Specialized Care BMs (N=45)</td>
<td>67%</td>
<td>24%</td>
<td>9%</td>
</tr>
<tr>
<td>MOH Officials* (N=10)</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* For Major Area of Education in MOH group, 80% stated “other” (eg., sociology, political science, public administration)
category, as 100% of all CEOs selected health care as their profession whereas COBs and BMs selected business (p < .001). The only exception in this area was that of the long term care COB sub group (40%) which stated that retirement was their primary occupation (Appendix D-1).

While these findings are not surprising - numerous studies have already discussed the educational preparation and professional orientation of hospital boards (Caldwell Partners, 1992; Canadian College of Health Service Executives, 1992; Umbdenstock, 1992; Carver, 1990; Kovner, 1991) - they do provide interesting food for thought when discussed in contrast to MOH results.

Although 100% of Ministry officials possessed a university education, 0% had business degrees and only 10% received their university training in health care. A substantial 80% stated that their academic focus was either in sociology, political science, or public administration. In the area of primary occupation, results showed more consistency with those of CEOs in that 90% of all MOH officials stated that health care was their current profession. However, an interesting 10% stated that their profession was that of “man of the people”.

The preponderance of humanities based individuals in positions of leadership within the MOH appears to suggest that the Ministry is consistent with its mission to provide a more liberal definition of health care within a communities context. While the educational preparation of senior Ministry officials certainly departs from the traditional business and
health care disciplines, individuals nevertheless possess substantial professional experience. As Table 5 demonstrated, even though the time in present position value was low (1.1 years), overall time in health care (8.3 years) was within the range of results obtained from the hospital population. Indeed, utilization of an f-test showed no statistical difference in overall time in health care between CEOs in all categories and MOH officials.

But was the government's decision to hire individuals with neither health care nor business educations for senior leadership positions seen as a positive and progressive step? According to results obtained in question 18 of the survey and through the interview, an overwhelming majority (71%) of respondents within the hospital population felt it was not. Of those respondents who did express dissatisfaction, 85% stated that Ministry officials appear to lack a realistic understanding of the issues and challenges associated with hospital and financial operation today.

4.4.4 Board Structure and Composition

Table 7 discusses board structure and composition. Supporting earlier results found in the pilot study, hospitals in each of the three categories averaged 12 members. This finding was somewhat surprising because it is generally assumed that special care hospitals have larger board sizes due to the number of appointed members. But this was not found to be the case.
Table 7  
**Board Structure and Composition**

<table>
<thead>
<tr>
<th>Hospital Designation</th>
<th>Acute Care</th>
<th>Long Term Care</th>
<th>Specialized Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Membership</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Males</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Females</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td># Appointed</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td># Elected</td>
<td>6</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 8  
**Appointed vs. Elected Members Within Specialized Care Hospitals**

<table>
<thead>
<tr>
<th></th>
<th>Average # Appointed</th>
<th>Average # Elected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Care CEO</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Special Care COB</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Special Care BM</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Gender distributions within hospital boards were previously examined by Caldwell Partners (1992) in a study of 100 trustees from across Canada. Their results suggested a strong preponderance of male trustees over female trustees by an almost 9:1 margin. While it was anticipated that male trustees would outnumber females trustees in this study, ratios similar to those found within the CEO and board chair populations (Table 1) were expected. Surprisingly, the results showed an even male:female split across all hospital categories.

The reasoning behind the divergence of this study’s results with those of the Caldwell study is unclear. It could be due to the fact that the Caldwell study had a substantially lower N. Secondly, although the Caldwell study did not discuss the specific population demographics or methodologies utilized to collect and analyze data, it could be that study designs were substantially different. Thirdly, a more practical perspective may simply be that British Columbians have made an effort to be more equitable with respect to gender representation on hospital boards.

The one outstanding outlier of this table was that of appointed:elected members within the specialized care category (p < .01). Whereas respondents from all sub groups across the acute care and long term care categories agreed that there was an even split (6 appointed and 6 elected) between memberships, responses from the specialized care population showed a wider variation (Table 8). Overall board size still averages 12 with this group. However, the specialized care population appears to display some degree of
confusion over the exact delineation of appointed vs. elected members. This most likely is a result of the transitive state of regionalization within the Lower Mainland and the shuffling of positions between and within boards. While a definitive conclusion for this item cannot be drawn, it is nevertheless reasonable to assume that the specialized care CEO response (11 members appointed, 1 elected) is the one which most closely reflects reality. The reason for this inference is twofold:

First it is a generally well known fact that most, if not all, members of specialized care hospital boards are appointed by the provincial government, the municipal government and various professional organizations due to the unique nature of their organizational mandates. Secondly, it is usually the CEO who possesses the most current information regarding the status of governance and/or administrative structures within his/her respective hospital. Therefore, while a 11:1 mix of appointed to elected members may appear unusual for acute care or long term care hospitals, these values probably approximate the norm for specialized care facilities.

4.4.5 Hospital Peer Groups and Role Classifications

Diagrams 5a, 5b, 5c, and 5d reflect the peer group breakdown for hospitals in the study (Appendix D-2). Originally developed as a conceptual and comparative tool by the MOH to review hospital performance, all hospitals within British Columbia are assigned to one of ten categories. Although the actual mechanics of how the Ministry designates
Hospital Peer Groups

5a. Total Hospitals

5c. Long Term Care Hospitals

5b. Acute Care Hospitals

5d. Specialized Care Hospitals
hospitals to particular peer groups is complex, a variety of characteristics, such as total number of beds, total operational budget, referral base, and scope of hospital care, are taken into consideration. Still somewhat contentious from a methodological and analytical perspective, hospital peer groups nevertheless have become an accepted tool for inter-hospital comparison.

Facilities designated to peer group 8 were omitted from the study because they offered predominantly only treatment and diagnostic services. Otherwise, the distribution of hospitals within the study is as follows:

Peer group 1 exclusively comprises the province’s five major teaching hospitals. Peer group 2 consists of the large regional referral centers. Peer group 3 includes predominantly acute care community hospitals. Peer group 4 reflects a 7:5 split in acute care to long term care hospitals at the community level. Peer group 5 hospitals are generally smaller in size and consist primarily of acute care facilities. Peer groups 6 and 7 represent forty-five small, local hospitals mostly of acute care designation. Peer group 9 is exclusively that of long term care facilities. And, peer group 10 consists entirely of the specialized care hospitals.

The original plan of the study anticipated using hospital peer groups singularly as the primary tool for inter-hospital comparisons. It is an accepted industry-wide comparative device, and upon superficial inspection, appears to possess methodologically homogenous groups with respect to acute care:long term care mix (hospitals in peer groups 1, 2, 9, and
10). However, closer inspection of the peer groups reveals that hospitals in the remaining categories (peer groups 3-7) are extremely heterogeneous. Therefore, from both a practical and a methodological perspective, peer group comparisons alone were not sufficient.

Secondly, because this study wanted to examine results across population bases and referral areas, delineated hospital/community demographics were needed. Although hospitals in peer groups 1, 2, 7, and 10 provided fairly clear demographic breakdowns, hospitals in other peer groups (peer groups 3, 4, 5, and 6) presented a more complex mix. For these reasons, it was decided to also include hospital role classifications as an additional comparative device.

Identified and included as part of the survey (survey 1, Appendix B-1), hospital role classifications provide important information about hospitals' role within their communities. Although not as frequently used as peer group comparisons by the MOH, it nevertheless provides for a different perspective when classifying and categorizing hospitals.

Whereas both hospital peer group and hospital role classification analyses demonstrate glaring methodological shortcomings when used alone, together, they can be utilized as a valuable multi-method tool for extremely in-depth inter-hospital comparisons. Furthermore, the utilization of both methodologies created the unexpected but surprisingly positive effect of substantially increasing intra-study validity.
Table 9 presents an overlay of peer group categories with those of hospital role classification for this study’s hospital population.

4.4.6 Preferred Sites for Patient Care Service Delivery

Building upon this approach, study population preferences in the types of services delivered within hospitals can be closely examined (survey item 13). As evident in Table 10, it is seen that with respect to extended care, primary acute care, secondary acute care, and intermediate care, all groups agreed on the site of care delivery. However, results for rehabilitative care, tertiary acute care, and personal care, show quite varied responses.

The preferred site for rehabilitative care delivery was that of specialized hospitals in 83% of overall respondents. But, detailed sub-group analysis reveals that 64% of long term care BMs in peer group 4 (N=39) felt that rehabilitative care belonged in an acute care setting. While it can be seen in Appendix D-2 that 70% of peer group 4’s hospitals lie within Level C communities - e.g., those of 18,000-150,000 people, the reason for this response was still not immediately apparent. The answer to this statistical skew was found in the interview. Almost 95% of long term care BMs interviewed expressed frustration over the perception that their hospitals were “dumping grounds” for patients which larger acute care facilities could no longer accommodate or place. These individuals felt that acute care hospitals were more appropriate settings for these patients because these facilities could offer enhanced services and a broader scope of care.
Table 9  **Frequencies of Hospital Peer Group and Hospital Role Classification**

<table>
<thead>
<tr>
<th>Peer Group (#N)</th>
<th>Level A</th>
<th>Level B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
<th>Level F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (4)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (8) 1 long term care</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4 (12) 5 long term care</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 (12) 2 long term care</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 (25) 4 long term care</td>
<td>17</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7 (20) 2 long term care</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9 (12) 12 long term care</td>
<td>3</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41</td>
<td>25</td>
<td>23</td>
<td>7</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>
### Table 10. Study Population Preferences in Site for Delivery of Care

<table>
<thead>
<tr>
<th>Type of Care: Extended</th>
<th>Type of Care: Primary Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Site</td>
<td>Responses</td>
</tr>
<tr>
<td>Acute care</td>
<td>29</td>
</tr>
<tr>
<td>Long term care</td>
<td>631</td>
</tr>
<tr>
<td>Specialized care</td>
<td>17</td>
</tr>
<tr>
<td>Home*</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Care: Secondary Acute</th>
<th>Type of Care: Intermediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Site</td>
<td>Responses</td>
</tr>
<tr>
<td>Acute care</td>
<td>639</td>
</tr>
<tr>
<td>Long term care</td>
<td>4</td>
</tr>
<tr>
<td>Specialized care</td>
<td>41</td>
</tr>
<tr>
<td>Home</td>
<td>1</td>
</tr>
</tbody>
</table>

*Although the category of “home” was not included as an option in the survey, a substantial but statistically insignificant number of respondents added this item for intermediate care.*
Acute care hospitals were selected as the most appropriate site for tertiary care delivery by 70% of all respondents. However, sub-group analysis reveals that once again, 85% of long term care BMs in peer group 4 (N=47), and also that 78% of specialized care BMs in peer group 10 (N=45) felt this service belonged in specialized care facilities. During the interview, long term care board members continued to express concern over the “inappropriate placement” of patients within their facilities, whereas specialized care BMs simply felt that their facilities could offer the best treatment for individuals requiring tertiary acute care.

Finally, the preferred site for personal care presented a somewhat puzzling picture. As Table 11 and Appendix D-3 demonstrate, responses were highly variable and suggest both confusion and division among the study’s populations. Although 42% of all respondents felt that personal care was best delivered in long term care facilities, “home” was the second most frequent choice (24%). As earlier referred to in Table 10, “home” as a site option was written in by a low percentage of respondents across all care categories.

<table>
<thead>
<tr>
<th>Preferred Site</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>100</td>
<td>15</td>
</tr>
<tr>
<td>Long term care</td>
<td>287</td>
<td>42</td>
</tr>
<tr>
<td>Specialized care</td>
<td>133</td>
<td>19</td>
</tr>
<tr>
<td>Home</td>
<td>165</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>685</td>
<td>100</td>
</tr>
</tbody>
</table>
While statistically insignificant, it nevertheless provides for interesting discussion.

Initially, it first appeared that these results mirrored the New Directions philosophy of bringing health care closer to home. However, upon closer inspection, 31% of all respondents within the BM and COB categories and 30% of all MOH officials stated that they were unsure what personal care was. Augmentation of these findings with the fact that 20% of all Ministry officials felt that all types of health care services should be delivered at home, makes the formulation of a single conclusion difficult.

4.4.7 Defining Hospital Governance

Item fourteen of the survey serves to define hospital governance within the context of British Columbia. As Table 12 reveals, 51% of all respondents agreed that definition C by Williams and Torrens (1988) was most appropriate. The second most popular choice was that of definition D by Knudsen (1990) at a distant 27%. Definition B (Kovner, 1990) was the third most frequent selection at 16%, whereas definitions A (Baker, 1992) and E (none of the above) were selected by only 6% of the total population.

Although definition C was clearly the preferred choice, further sub-group analysis reveals statistically significant findings within five groups:

(a) Acute care CEOs - 35/55 (62%) chose definition B. Of the 35 respondents in this group, 19 (54%) were CEOs from peer groups 1-4. Of considerable importance is the fact that these 19 responses constitute the entire bulk (100%) of all acute care CEOs within
Table 12  Defining Hospital Governance

<table>
<thead>
<tr>
<th>Definition*</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care CEOs</td>
<td>4</td>
<td>35</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>55</td>
</tr>
<tr>
<td>Acute Care COBs</td>
<td>4</td>
<td>2</td>
<td>33</td>
<td>12</td>
<td>2</td>
<td>53</td>
</tr>
<tr>
<td>Acute Care BMs</td>
<td>0</td>
<td>43</td>
<td>134</td>
<td>80</td>
<td>3</td>
<td>260</td>
</tr>
<tr>
<td>Long Term Care CEOs</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Long Term Care COBs</td>
<td>0</td>
<td>3</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Long Term Care BMs</td>
<td>0</td>
<td>18</td>
<td>120</td>
<td>60</td>
<td>15</td>
<td>213</td>
</tr>
<tr>
<td>Specialized Care CEOs</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Specialized Care COBs</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Specialized Care BMs</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>22</td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td>MOH Officials</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>9</td>
<td>111</td>
<td>351</td>
<td>186</td>
<td>29</td>
<td>686</td>
</tr>
<tr>
<td>% of Total</td>
<td>1%</td>
<td>16%</td>
<td>51%</td>
<td>27%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Definition A - It is the responsibility of hospital boards to ensure the survival and well-being of an organization (Baker, 1992).
Definition B - Governance pertains to strategic organizational decision-making and the related distribution of authority and legitimacy necessary to make those decisions (Kovner, 1990).
Definition C - It is the board's responsibility to oversee the organization's operation and ensure its commitment to provide optimum health care to its residents of the community (Williams and Torrens, 1988).
Definition D - Hospital governance is a complex relationship of overlapping structures and responsibilities between boards of trustees, medical staff, and administration (Knudsen, 1990).
Option E - None of the above
peer groups 1-3. And, as previously discussed in section 4.4.5, peer groups 1-4 represent the largest (class B-E) of the acute care hospitals within the province.

(b) Acute care BMs - In support of the above results, BMs in peer groups 1 (20/29 - 70%) and 2 (23/39 - 60%) also favored definition B. Similar to the demographic split of the above acute care CEO population, peer groups 1 and 2 are class E and D hospitals and consist of only the major acute care teaching or regional facilities.

(c) Long term care CEOs - While providing only a small N (N=5), all long term care CEOs from peer groups 3 and 4 nevertheless agreed with acute care CEOs and acute care BMs in selecting definition B. These CEOs represent the largest of the provinces long term care facilities.

(d) Specialized care BMs - This small population reflects a slightly different perspective towards defining hospital governance with 49% choosing definition D and 42% selecting definition C. All specialized care BMs are from peer group 10, class F hospitals.

(e) MOH - Results obtained from Ministry officials show that 50% of all respondents chose definition B and that 40% chose definition C.

Because sub-group analysis clearly reflected varying results within distinct study populations, the definitions themselves were more closely examined to ascertain what qualitative differences they possessed which would encourage respondents to choose one definition over the other. Indeed, it was found that while superficially similar, each
definition (except selection E - "none of the above") appeared to place emphasis on different operational words or phrases.

For example, definition A focuses on the word "responsibility" and the phrase "survival and well being of the organization".

Definition B, the preferred choice of acute care and long term care CEOs from the province's larger hospitals focuses on the phrases "strategic organizational decision-making" and "authority and legitimacy".

Definition C, the preferred choice in 51% of the overall study population emphasizes the word "oversee" and the phrase "commitment to provide optimum health care to residents of the community".

Definition D, the second most frequent selection in all respondents focuses on the phrase "complex relationship of overlapping structures and responsibilities".

Following deeper review of these definitions, the reasons for variations between sub-group selections became more clearly apparent.

The CEO sub-groups which chose definition B were predominantly from hospitals in large community or metropolitan areas. Due to their size and large operational budgets, these hospitals generally embrace a more "corporate" organizational structure - similar to that of other large organizations - and necessitate the need for CEOs with strong business
acumen. It seems logical therefore that CEOs within this category would select a more corporately aligned definition, such as the one proposed by Kovner.

This reasoning also appears to support the finding within the acute care BM sub-group. These individuals sit on the province’s largest acute care hospital boards, and as demonstrated in sections 4.4.3, and 4.4.5, were educated and presently work in business environments.

The selection of definitions C and D within the specialized care BM category seems to reflect the uniqueness of their institutions. As specialized care facilities, these hospitals house patients from across the province via community and regional referrals and are often regarded as the vanguard for progressive health care delivery. These hospitals also possess boards who are generally appointed and which reflect a diverse cross-section of professions. It seems natural therefore, that these individuals selected definitions which provide a broader definition of community health and address the complexity of board structures and relationships.

The selection of definitions B and C by Ministry respondents appears to support the premise that the MOH’s premiere mandate, by virtue of their position, is to provide health care services to the citizens of British Columbia. However, it also suggests that they are keenly aware of the need to provide these services in an efficient and fiscally responsible manner.
Although definition C was the preferred choice by overall study respondents, definitions B and D offered viable alternatives for 43% of the population. Therefore, by integrating key concepts provided in definitions B and D with those offered by Williams and Torrens, this study offers a new definition of hospital governance:

Hospital governance is a complex relationship of overlapping structures and activities which has the responsibility and the authority to oversee the organization’s operation and to ensure its commitment of providing optimum health care to its residents.

Although specific to the province of British Columbia for the purposes of this study, it is hoped that this definition nevertheless offers strong transferability and applicability to other hospitals across Canada.

4.4.8 The Activities of Hospital Governance

Although no single study provides an encompassing list of the activities of hospital governance, a thorough review of the literature suggests that twenty-eight activities are generally associated with the topic (item 15 of the study survey). Due to the break in the pattern of homogeneity of responses, a 70% cut-off level of agreement was selected. Table 13 demonstrates that sixteen (items 1-16 of the table) were considered to be governance activities within British Columbia hospitals. However, the table also shows that three activities (items 26-28 of the table) were not. Interestingly, 100% of all respondents felt that there was no differentiation in the types of hospital governance activities across acute care, long term care, and specialized care facilities (Appendix D-4).
Detailed analysis of Table 13 also reveals interesting and statistically significant findings within three areas:

(a) Long term care CEOs - Even though 93% of overall respondents felt that policy-making was a hospital governance activity, 6/21 (20%) of long term care CEOs felt that it was not. Although low from a percentage perspective, this finding is nevertheless important because these 6 CEOs represented the bulk of all responses from long term care hospitals within small or rural communities (levels A and B).

A second interesting finding within the long term care CEO sub-group reveals that 11/21 (52%) respondents felt that networking was not considered to be a hospital governance activity. Again, this value contrasts sharply with that of a 76% agreement rate in overall respondents. Of special note with this result is the fact that these 11 respondents represent 100% of all long term care CEOs in peer groups 3-7. The remaining 10 long term care CEOs are concentrated exclusively in peer group 9.

Explanations for these findings were found in the interview. Because these CEOs were almost exclusively from small and rural long term care facilities, networking was generally not considered to be an activity of high importance. Secondly, 92% of all CEOs interviewed within this category stated that policy-making was most often the responsibility of the CEO.
Table 13  Governance Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>% Yes Responses</th>
<th>Activity</th>
<th>% Yes Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Long Range Planning</td>
<td>99%</td>
<td>17. Health and Safety</td>
<td>58%</td>
</tr>
<tr>
<td>2. Community Relations</td>
<td>97%</td>
<td>18. Patient Care</td>
<td>57%</td>
</tr>
<tr>
<td>3. Financial Planning</td>
<td>96%</td>
<td>19. New Programs and Services</td>
<td>57%</td>
</tr>
<tr>
<td>4. Policy-making</td>
<td>93%</td>
<td>20. Legal Matters</td>
<td>55%</td>
</tr>
<tr>
<td>5. Quality Assurance</td>
<td>92%</td>
<td>21. Hospital Administration</td>
<td>43%</td>
</tr>
<tr>
<td>6. Hospital Accreditation</td>
<td>89%</td>
<td>22. Research and Development</td>
<td>42%</td>
</tr>
<tr>
<td>7. Capital Budgeting</td>
<td>89%</td>
<td>23. Staff Disciplinary Action</td>
<td>38%</td>
</tr>
<tr>
<td>8. Operational Budgeting</td>
<td>83%</td>
<td>24. Labor Negotiations</td>
<td>37%</td>
</tr>
<tr>
<td>9. Medical Credentialing</td>
<td>81%</td>
<td>25. Contract Negotiations</td>
<td>31%</td>
</tr>
<tr>
<td>10. Capital Construction</td>
<td>81%</td>
<td>26. Day-to-Day Hospital Operation</td>
<td>26%</td>
</tr>
<tr>
<td>11. Contact with the MOH</td>
<td>79%</td>
<td>27. Employee Hiring and Firing</td>
<td>23%</td>
</tr>
<tr>
<td>12. Networking</td>
<td>76%</td>
<td>28. Plant Operations</td>
<td>10%</td>
</tr>
<tr>
<td>13. Medical Ethics</td>
<td>74%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Fundraising and Marketing</td>
<td>74%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Professional Ethics</td>
<td>73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Utilization Management</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(b) CEOs in all hospital categories - While only 43% of overall study respondents felt hospital administration to be an activity of hospital governance, further sub-group breakdown shows an additional significant result. That is that only 14% of all CEOs across all categories agreed to include hospital administration. This result sharply contrasts with those obtained from COBs (63%) and BMs (45%) who felt that hospital administration should be included. Furthermore, considering that 61% of acute care COBs wanted to include day to day hospital operation as a hospital governance activity (overall response of only 26%), normative articles suggesting “inappropriate” board insurgences into the domain of administration may be well founded (Zander, 1993, Carver 1990; Umbdenstock and Hageman, 1984).

(c) MOH officials - Of all the statistical outliers within this section, results obtained from Ministry officials provided for the most surprising and divergent contrast. Whereas the activities of long term financial planning, hospital accreditation, quality assurance, networking, and policy-making were easily included within the 70% or greater rate of agreement, MOH officials overwhelmingly felt otherwise (Table 14).

As Table 14 demonstrates, Ministry results reveal substantial differences in opinion. While it could be argued that the Ministry views the activities of long term financial planning, networking, and policy-making as the primary responsibility of the provincial government, the results show glaring inconsistencies with their own government policies
<table>
<thead>
<tr>
<th>Activity</th>
<th>Overall Study Results</th>
<th>MOH Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term financial planning</td>
<td>96%</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital accreditation</td>
<td>89%</td>
<td>40%</td>
</tr>
<tr>
<td>Quality assurance</td>
<td>92%</td>
<td>50%</td>
</tr>
<tr>
<td>Networking</td>
<td>76%</td>
<td>0%</td>
</tr>
<tr>
<td>Policy-Making</td>
<td>93%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 14  Comparison of Results in Hospital Governance Activities
and directives which call for enhanced planning, integration, and fiscal responsibility by provincial hospitals (New Directions, 1993).

Of equal significance, is that Ministry officials do not feel that hospital accreditation and quality assurance - generally considered to be two of the premiere benchmarks of hospital operation - as activities of hospital governance. Although reasoning behind these results remain somewhat puzzling, it appears that the Ministry seems to lack a general understanding and practical appreciation of what hospital boards do.

4.4.9 The Key Participants of Hospital Governance

Those individuals who are considered to be the members of hospital governing boards are detailed in Table 15. Overall examination of the table shows that within the hospital population, the CEO, the COB, the BMs, and the Chief of Medicine (COM) were overwhelmingly seen as the key participants of governance. MOH officials and “other” individuals (e.g., Vice-Presidents, etc.,) were clearly not included. Examination of sub-group analysis however reveals some additional interesting findings.

(a) MOH - Both the MOH and hospital populations felt that the MOH was not to be considered as a member of hospital governance. However, 58% of the long term care population and 36% of the acute care population felt that the MOH should be. With respect to this long term care group, support for this finding (90%) came from CEOs, board chairs, and board members within peer group 9. Deviant acute care responses were
Table 15  Percentage Agreements in Selection of Key Participants of Hospital Governance

<table>
<thead>
<tr>
<th>Key Participant Category</th>
<th>CEO</th>
<th>COB</th>
<th>BM</th>
<th>COM</th>
<th>V.P.</th>
<th>MOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents' Category</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care (N=369)</td>
<td>96%</td>
<td>100%</td>
<td>96%</td>
<td>77%</td>
<td>22%</td>
<td>36%</td>
</tr>
<tr>
<td>Long Term Care (N=254)</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>90%</td>
<td>14%</td>
<td>58%</td>
</tr>
<tr>
<td>Specialized Care (N=53)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>77%</td>
<td>11%</td>
</tr>
<tr>
<td>MOH (N=10)</td>
<td>20%</td>
<td>100%</td>
<td>100%</td>
<td>20%</td>
<td>33%</td>
<td>20%</td>
</tr>
<tr>
<td>Overall (N=686)</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>83%</td>
<td>23%</td>
<td>42%</td>
</tr>
</tbody>
</table>
concentrated in CEOs from peer groups 4 and 5 and, interestingly, all acute care COBs from peer groups 1 and 2. While it could be suggested that peer group 9 hospitals experience a higher degree of Ministry involvement in hospital governance affairs, the explanation for the significant findings in peer group 4 and 5 hospitals and the surprising COB results within peer groups 1 and 2 are not immediately apparent.

(b) Vice-President (V.P.) - While only 23% of the overall population felt the V.P. to be a member of hospital boards, 77% of all respondents within the specialized care category chose to include this position. In further agreement of this finding were all 8 acute care CEOs from peer groups 1 and 2 and all 5 of the long term care CEOs from peer groups 3 and 4. Considering the higher profiles and larger portfolios V.P.s assume within the province's larger hospitals (peer groups 1-4), it seems logical that CEOs within these facilities would consider V.P.s as valuable members of the board - particularly those in the positions of Vice-President of finance or Vice-President of patient care services.

(c) Chiefs of Medicine (COM) - 83% of overall respondents agreed that the Chief of Medicine is a member of the hospital board. However, as was the case with Vice-Presidents, acute care CEOs from peer groups 1 and 2 and long term care CEOs from peer groups 3 and 4 overwhelmingly agreed with the inclusion of this position. Similar reasoning as that used for including Vice-Presidents as members of the board could also be used to explain the intensity of agreement between large hospital CEOs and their support of the Chief of Medicine as a board trustee.
However, the inclusion of the Chief of Medicine as a key participant of hospital governance presents a much more complex picture. While a clear majority of overall respondents in the survey (83%) considered the COM to be a member of the hospital board, 92% of all interview participants (items 36 and 37 of the interview) stated that they should not be. Citing the potentials for conflict of interest by virtue of their positions and method of appointment to the board, study participants echoed the sentiments of one of the most frequently debated topics within the hospital industry today - should physicians be allowed to sit on the hospital board? (Duke University, 1990; Caldwell Partners, 1992; Healthcare Executive, 1992).

Indeed, the positions of Chief of Medicine and/or the President of the medical staff and the V.P. of Medicine represent two distinct camps of allegiance. While there are variations between hospitals as to their exact roles and titles, the Chief of Medicine/President of the medical staff are individuals who are elected to these positions by fellow physicians and are in turn appointed to the hospital board on an ex-officio basis. As such, these individuals often function as medical liaisons for professional activities and are expected to protect the interests and represent the perspectives of the hospital medical staff on issues discussed at the board level. The V.P. of Medicine on the other hand is a hired employee of the hospital, a member of the senior executive, and although a physician, considered to be a member of the hospital management team.
Given the remarkable schism between the survey vs. interview results and the overwhelming perception that the Chief of Medicine is in a constant state of conflict of interest, how then have physicians, via their positions as Chiefs of Medicine or Presidents of the medical staff, become so solidly regarded as members of hospital governance? The literature suggests two reasons.

The first is that the historical evolution of medicine as a profession provided physicians with the authority, legitimacy, and perceived objectivity needed to be regarded as the singular experts on patient care (Starr, 1949; Stevens, 1989). The second builds upon the first, and adds that as North America embraced the scientific model of health care, physicians alone possessed the necessary knowledge needed to capitalize on a profession dominated by imperfect information (Starr, 1949, Conrad and Kern, 1990).

The concepts of singular authority and imperfect information are the two premises which appear to support the findings of Ministry officials. Significantly different than results found within the hospital population, the MOH feels that the key participants of governance are the board chair (100%), board members (100%), and members of the general public (100%). The reason behind not including the CEO and Chief of Medicine as key participants of hospital governance can probably best be explained by using a quotation obtained during the interview from one of the senior Ministry officials who participated in the study:
CEOs and Chiefs of Medicine unduly and inappropriately influence the opinions and actions of hospital boards because of their positions of power and authority. Most boards are unfortunately simply lead down the garden path and rubber-stamp CEO decisions”.

“The Chief of Medicine should only attend board meetings when invited - for example on issues which deal specifically with problems associated with the medical staff - and only then on an ad hoc basis. CEOs should only function as secretaries for the board, taking notes for the meeting, etc. Their active presence on the board should be on a non-voting basis, by invitation only, and only when the board needs further advisement on an administrative matter”.

This opinion was similarly held by 70% of the Ministry population. The reason for inclusion of the general public by the Ministry population clearly reflects the New Directions community perspective of participative decision-making.

Should then the COM be considered a key participant of hospital governance? The Caldwell Partners study suggests that most hospitals consider senior physicians to be members of their governing boards - and that this trend is growing (Caldwell Partners, 1992). This study’s results for British Columbia’s hospitals however present clearly mixed opinions.

4.4.10 Responsibilities and Decision-making in Hospital Governance

Item 17 of the survey investigates participant responsibilities and decision-making within hospital governance bodies. This complex question is important because it not only examines the processes of hospital governance in greater detail, but it also clearly demonstrates that the key participants of governance possess divergent perceptions as to their roles and responsibilities, particularly in the area of decision-making.
Again utilizing a ≥70% agreement level, Table 16 shows that within the recommending and implementing categories, overall agreement was met in both these areas in 13 of the 20 activities, with the CEO as the clearly definitive choice. The remaining 7 activities reflect slightly different results.

Table 16a. delineates a further breakdown of the recommending category. Within 5 of the 7 activities, (e.g., selecting the chair of the board, type of board membership, type of services offered, hospital mission, and the sharing of services between facilities), board chairs and CEOs agreed 71% of the time. Board members agreed with CEOs in two areas (appointments to the board, and the sharing of services), and agreed with board chairs in one (shared services).

Table 16b. demonstrates that within the category of implementation, overall consensus was achieved in 6 of the 7 activities.

It is extremely important to note that while Tables 16a. and 16b. statistically reflect those items which did not achieve a 70% agreement rate, overall, study respondents nevertheless demonstrated consistent agreement with each other as to the identification of individuals most often responsible for recommending and implementing various board activities.
Table 16

Hospital Population Affirmative Responses - Responsibilities and Decision-Making in Hospital Governance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Recommending</th>
<th>Individual Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>New programs</td>
<td>CEO (70%)</td>
<td>CEO (82%)</td>
</tr>
<tr>
<td>Budget increases</td>
<td>CEO (85%)</td>
<td>CEO (85%)</td>
</tr>
<tr>
<td>Hiring the COM</td>
<td>CEO (70%)</td>
<td>CEO (70%)</td>
</tr>
<tr>
<td>Firing the COM</td>
<td>CEO (75%)</td>
<td>CEO (75%)</td>
</tr>
<tr>
<td>Hiring V.P.s</td>
<td>CEO (95%)</td>
<td>CEO (95%)</td>
</tr>
<tr>
<td>Hiring department heads</td>
<td>CEO (74%)</td>
<td>CEO (80%)</td>
</tr>
<tr>
<td>Liaising with community agencies</td>
<td>CEO (85%)</td>
<td>CEO (70%)</td>
</tr>
<tr>
<td>Negotiating contracts with the MOH</td>
<td>CEO (75%)</td>
<td>CEO (85%)</td>
</tr>
<tr>
<td>Capital expansion</td>
<td>CEO (80%)</td>
<td>CEO (78%)</td>
</tr>
<tr>
<td>Goals and objectives</td>
<td>CEO (72%)</td>
<td>CEO (76%)</td>
</tr>
<tr>
<td>Use of consultants</td>
<td>CEO (70%)</td>
<td>CEO (89%)</td>
</tr>
<tr>
<td>Bed closures</td>
<td>CEO (72%)</td>
<td>CEO (85%)</td>
</tr>
<tr>
<td>Discontinuation of services</td>
<td>CEO (70%)</td>
<td>CEO (87%)</td>
</tr>
</tbody>
</table>
Table 16a.

**Responsibilities and Decision-Making in Hospital Governance - Recommending**

<table>
<thead>
<tr>
<th>Activity</th>
<th>CEOs</th>
<th>BMs</th>
<th>COBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment to the board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Selecting the chair of the board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Type of board membership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New medical technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Type of services offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Mission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Sharing of services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual(s) Responsible</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment to the board</td>
<td>BMs</td>
<td>BMs</td>
<td>Society</td>
</tr>
<tr>
<td>*Selecting the chair of the board</td>
<td>BMs</td>
<td>COB</td>
<td>BMs</td>
</tr>
<tr>
<td>*Type of board membership</td>
<td>BMs</td>
<td>Society</td>
<td>BMs</td>
</tr>
<tr>
<td>New medical technology</td>
<td>V.P</td>
<td>COM</td>
<td>COM</td>
</tr>
<tr>
<td>*Type of services offered</td>
<td>CEO</td>
<td>BMs</td>
<td>CEO</td>
</tr>
<tr>
<td>*Mission</td>
<td>CEO</td>
<td>BMs</td>
<td>CEO</td>
</tr>
<tr>
<td>*Sharing of services</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
</tbody>
</table>

* CEOs and board chairs agreed on the individual responsible for recommending 5 of the 7 board activities (71%).
Table 16b.

**Responsibilities and Decision-Making in Hospital Governance - Implementation**

<table>
<thead>
<tr>
<th>Activity</th>
<th>CEOs</th>
<th>BMs</th>
<th>COBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment to the board</td>
<td>BMs</td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Selecting the chair of the board</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Type of board membership</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>New medical technology</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
<tr>
<td>Type of services offered</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
<tr>
<td>Mission</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
<tr>
<td>Sharing of services</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
</tbody>
</table>

*CEOs, board members and board chairs agreed in 6 of the 7 implementation activities. CEOs and board members disagreed with board chairs as to the individual responsible for implementing appointments to the board.*
However, the category of deciding presents a very different picture. Table 17a. is an overview of participant responses and shows that overall agreement of ≥70% was achieved in 10 activities (e.g., hiring of V.P.s, hiring of department heads, selecting the chairmanship of the board, the type of board membership, deciding on new medical technologies, types of services offered, hospital mission, hospital goals and objectives, sharing services with other facilities, and discontinuing services).

Table 17b. shows that the remaining 10 activities reflect considerably different results.

Gross analysis of this table shows that CEO and board member responses were consistent 90% of the time, whereas the agreement rate for either CEO or BM responses matching those of the board chairs’ was ≤ 10%.

Interestingly, it can be seen that board chairs within this group felt that they should have final decision-making responsibility for activities in these areas. While this phenomenon was seen throughout the peer groups, a strong preponderance of this finding was consistently seen in COBs within acute care hospitals in peer groups 1-3. Additional significant sub-group analyses are as follows:

(a) New programs - While overall respondents felt this to be primarily a board member or board chair responsibility, all 8 acute care CEOs in peer groups 1 and 2 felt that decision-making for this activity fell under their domain. Secondly, 13/21 (62%) of all long
## Table 17a. Responsibilities and Decision-Making in Hospital Governance - Deciding

*Who Should Decide*

<table>
<thead>
<tr>
<th>Activity</th>
<th>CEOs</th>
<th>BMs</th>
<th>COB$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiring of V.P.s</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
<tr>
<td>Hiring of department heads</td>
<td>CEO</td>
<td>CEO</td>
<td>CEO</td>
</tr>
<tr>
<td>Chairmanship of the board</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Type of board membership</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>New medical technology</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Types of services offered</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Mission</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Goals and Objectives</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Sharing of services</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
<tr>
<td>Discontinuation of services</td>
<td>BMs</td>
<td>BMs</td>
<td>BMs</td>
</tr>
</tbody>
</table>

*Overall agreement rate of $\geq 70\%$ between study participants.*
**Table 17b. Responsibilities and Decision-Making in Hospital Governance -**

**Activities Not Achieving a >70% Agreement Rate**

<table>
<thead>
<tr>
<th>Activity</th>
<th>CEOs</th>
<th>BMs</th>
<th>COBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>New programs</td>
<td></td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Budget increases</td>
<td></td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Hiring COM</td>
<td></td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Firing COM</td>
<td></td>
<td>COB</td>
<td>COB</td>
</tr>
<tr>
<td>Liaising with community agencies</td>
<td>CEO</td>
<td>CEO</td>
<td>COB</td>
</tr>
<tr>
<td>Negotiating contracts with MOH</td>
<td>CEO</td>
<td>CEO</td>
<td>COB</td>
</tr>
<tr>
<td>Appointments to the board</td>
<td>BMs</td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Capital expansion</td>
<td>BMs</td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Use of consultants</td>
<td>BMs</td>
<td>BMs</td>
<td>COB</td>
</tr>
<tr>
<td>Bed closures*</td>
<td>BMs</td>
<td>BMs</td>
<td>COB</td>
</tr>
</tbody>
</table>

*In the interview, Ministry officials were posed the question “Suppose a hospital considered closing beds. In your opinion, who should recommend, decide, and implement this activity?” - 100% of MOH officials stated that the CEO generally recommends and implements this activity, whereas BMs possessed final decision-making authority.*
term care CEOs and 12/55 (22%) of acute care CEOs felt that the Ministry of Health should have final say in this area. Although long term care CEO responses were distributed widely across the hospital peer groups, the 12 acute care CEO results were concentrated solely in peer groups 4-7.

(b) Budget increases - Overall respondents again agreed that any increases in hospital budgets rested upon the decisions made by board members and board chairs. However, all 13 of the acute care CEOs in peer groups 1-3 felt this to be their responsibility. In contrast, 11/21 long term care CEOs and 107/213 (50%) of long term care board members, favored Ministry involvement. Once again, the long term care responses represented a wide variety of peer groups.

(c) Hiring and firing the Chief of Medicine - The decision to hire or fire the Chief of Medicine showed extremely interesting splits in opinion. Overall, both board members and board chairs felt that these responsibilities rested on their respective shoulders. CEOs in general felt that board members should hire the Chief of Medicine, but that board chairs should be responsible for his/her firing. However, further in-depth sub-group analysis shows that all 8 acute care CEOs in peer groups 1 and 2, all 45 specialized care board members in peer group 10 and all acute care board chairs in peer groups 1-3 felt that hiring and firing the Chief of Medicine should be their decision.
(c) Appointments to the board - Although study respondents showed a split between preferences between board members: board chairs across all peer groups, 60% of all board chairs felt this decision to be predominantly theirs.

(d) Liaising with community agencies and negotiating contracts with the MOH - Most study respondents felt that final decision-making in these activities rested with the CEO. However, a proportionately high number of CEOs in peer groups 1-3 (100%) stated that responsibility for decision-making in these areas was theirs. In sharp contrast, was the finding that board chairs in these same categories felt that they should possess the final word on whether or not to liaise with community agencies or negotiate contracts with the Ministry of Health.

(e) Bed closures - While study respondents predominantly selected the board in general as the most frequent choice to decide whether or not a hospital closes beds, 54% of all board chairs felt that this decision was their responsibility.

Although the results obtained from question 17 provide highly complex findings, a number of summarative conclusions can nevertheless be made. The first, is that the members of hospital boards are remarkably consistent in their agreement as to which individuals are generally responsible for recommending and implementing hospital governance activities. The second, is that there is considerably more divergence of opinions in study participants when they are asked to identify the individuals responsible for decision-making in the identified activities. The third, is the evidence that board chairs,
in particular those within peer groups 1-3, perceive their decision-making roles and responsibilities within hospital boards very differently from how CEOs or board members see them. And fourth, it is clear that some sub-groups, such as acute care CEOs in peer groups 1-3, or long term care CEOs within smaller facilities see their decision-making responsibilities differently than their peers in other hospitals.

But why do board chairs, or for that matter acute care CEOs from peer groups 1-3, or long term care CEOs from these smaller hospitals, see decision-making in a different light?

It could be that by virtue of their positions, board chairs feel incumbent upon themselves to exhibit “leadership” within the board and attempt to use their positions of power and authority to direct the actions of others. French and Raven (1960), Starkweather (1988), Mintzberg (1983), and others have frequently referred to the use of positional power as a commonly used management tool in health care organizations. With respect to the deviation seen within the CEO population, a rational explanation could be that because these individuals are in positions which expect higher levels of responsibility and accountability, it seems logical therefore that they would want a greater voice in decision-making. Long term care CEOs in smaller facilities on the other hand may feel more comfortable in having Ministry involvement when making the final decisions on various activities.

Even of greater importance however is the question of the impacts these variant decision-making perceptions have on overall hospital governance operation. Are there
frequent power struggles - for example between acute care CEOs and acute care board chairs - going on in the boardrooms of British Columbia hospitals? Are the key participants of hospital governance satisfied with the way they make decisions and with the relationships they have with each other?

Fortunately, 91% of all hospital respondents in the interview stated that they were satisfied with the way their boards made decisions and conducted the overall affairs of the hospital. When questioned about the potential for power struggles, or areas of conflict, 82% of all hospital respondents stated that occasional conflict at the board level was inevitable. However, when tensions did run high, they were generally attributed to discussions surrounding complex issues as opposed to difficult interpersonal relationships between board members. Finally, when questioned if there was “a better way” to identify, or decide the fate of issues placed before the board, 89% of hospital respondents stated that they were satisfied with the manner in which their facilities recommended, approved, and implemented hospital policy.

4.4.11 Critical Issues Facing Hospital Governance - Hospital Governance in the Future

Item 18 of the questionnaire and remaining interview questions serve to provide insight into the critical issues which face hospital governance today, and the impacts which New Directions will have on hospital governance in the future. Due to the transitional state of hospital governance and the controversy surrounding the implementation of New Directions policies, it was anticipated early on in the study that this area would provide for
interesting - and perhaps even provocative - discussion. However, the extent and intensity of participants’ opinions were extremely surprising.

Across all hospital categories, board members (95%), board chairs (91%), and CEOs (72%) voiced frustration, concern, and even anger over how the Ministry is proceeding with the implementation of New Directions and the ramifications of its policies on hospitals and hospital boards.

Table 18a. outlines the five most frequently stated issues identified by study participants. As the table shows, acute care and long term care respondents overwhelmingly agreed that New Directions, the Labor Accord, the struggle to maintain basic services in the face of continuing budget cuts, the lack of leadership by the Ministry, and the lack of a long term provincial health care plan were the five most critical issues facing hospital governance today. Specialized care facilities identified 4 of the same 5 critical issues as those above, namely those of New Directions, the Labor Accord, the struggle to maintain services in times of fiscal constraint, and the lack of long term planning. Ministry of Health respondents offered substantially different perceptions than those of the hospital populations and stated that the integration and rationing of health services, the need to redefine health care, the need to establish stronger fiscal restraints, the loss of voluntary hospital boards, and the implementation of New Directions were the five most pressing issues.
Table 18a. **The Five Most Critical Issues Facing Hospital Governance**

<table>
<thead>
<tr>
<th>Acute Care Hospitals</th>
<th>Long Term Care Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Labor Accord (94%)</td>
<td>1. <strong>New Directions</strong> (97%)</td>
</tr>
<tr>
<td>2. <strong>New Directions</strong> (94%)</td>
<td>2. The Labor Accord (91%)</td>
</tr>
<tr>
<td>3. Lack of MOH leadership (94%)</td>
<td>3. Lack of MOH leadership (91%)</td>
</tr>
<tr>
<td>4. Maintaining services/budget cuts (93%)</td>
<td>4. Maintaining services/budget cuts (90%)</td>
</tr>
<tr>
<td>5. Lack of long term planning (93%)</td>
<td>5. Lack of long term planning (90%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialized Care Hospitals</th>
<th>Ministry of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>New Directions</strong> (89%)</td>
<td>1. Need for stronger fiscal restraints (100%)</td>
</tr>
<tr>
<td>2. Maintaining services/budget cuts (87%)</td>
<td>2. <strong>New Directions</strong> (98%)</td>
</tr>
<tr>
<td>3. The Labor Accord (83%)</td>
<td>3. Integrating/rationing services (90%)</td>
</tr>
<tr>
<td>4. Lack of long term planning (77%)</td>
<td>4. The loss of voluntary boards (90%)</td>
</tr>
<tr>
<td></td>
<td>5. The need to redefine health care (89%)</td>
</tr>
</tbody>
</table>
It is of interest to note, that although participants were asked to list only 5 critical issues, 74% of overall respondents within the hospital population listed 8 items. With an agreement rate of 81%, these study participants added the following three critical issues: poor communication and direction from the Ministry of Health, the government’s use of political games (broken promises/contractual agreements) when deciding health care services and delivery, and the rapid turnover/lack of practical understanding by Ministry bureaucrats.

Following the identification of the critical issues, respondents were then asked to provide any recommendations they might have which would “improve” hospital governance in the province (Table 18b). Responses from the acute care and long term care hospitals once again showed remarkable consistency with each other and also brought into clearer focus the startling degree of dissatisfaction present among study participants in these two categories. Interestingly however, specialized care hospitals diverged from the general hospital population in this question and offered recommendations similar to those provided from the Ministry.

Why did the specialized care hospital recommendations differ so substantially from those obtained from acute care and long term care facilities? Why are the Ministry’s perspectives so different from those who govern within the province’s hospitals? And finally, what issues or actions prompted study participants - particularly those within the
Table 18b. Respondent Recommendations to Improve Hospital Governance

Acute Care Hospitals

1. No more deals like the Labor Accord. The present one is too costly for hospitals (93%).

2. The MOH should provide hospitals with enough money to cover and maintain existing services (92%).

3. The MOH can fine tune the present health care system (e.g., decrease service duplications, consolidate services, streamline costs, etc.,) but leave hospital boards as they are (90%).

4. The MOH should stop the political games, honor contractual agreements, and make health care decisions based on equability and need (85%).

5. The MOH should provide stronger and more consistent leadership/communication (83%).

Long Term Care Hospitals

1. The MOH can fine tune the present health care system (e.g., decrease service duplications, consolidate services, streamline costs, etc.) but leave hospital boards as they are now (94%).

2. The MOH should provide hospitals with enough money to cover and maintain existing services (93%).

3. No more deals like the Labor Accord. The present one is too costly for hospitals (90%).

4. The MOH should provide stronger and more consistent leadership/communication (89%).

5. The MOH should stop the political games, honor contractual agreements, and make health care decisions based on equability and need (87%).

Specialized Care Hospitals

1. Provide hospitals with enough money to cover and maintain existing services (86%).

2. Health care service organizations need to learn to cooperate vs. compete with each other (81%).

3. There is enough money in the system- existing resources need to be utilized/rationed more effectively (75%).

MOH

1. The province needs to implement New Directions as quickly as possible. Hospital boards need to be replaced by CHCs and RHBs in order to more smoothly implement the regionalization of services (98%).

2. Hospitals should operate more efficiently and cost-effectively and learn to cooperate with each other more (95%).

3. The concept of health care needs to be redefined encompassing a more holistic, community -based perspective (95%).
acute care and long term care hospital categories - to express such intensely negative opinions?

The explanation as to why the recommendations from specialized care hospitals differed so from their acute care and long term counterparts may lie with the supposition that these facilities simply are different. Although specialized care facilities possess many of the same physical and quantitative characteristics as those of larger acute care hospitals (primarily peer group 1), it could be argued that the similarities end there.

For example, it was shown that specialized care board members were largely appointed and in their positions for substantially shorter periods of time than their fellow counterparts in either acute care or long term care facilities.

Secondly, the specialized care population defined hospital governance in a broad, collective light (definitions C and D), reflecting their provincial referral focuses of care.

But thirdly, and perhaps most importantly, it could be argued that specialized care hospitals are in “protected” positions within the provincial health care system due to the unique nature of their mandates. Because they do not experience many of the competitive pressures and frustrations which face the general hospital population, it seems reasonable to assume that they would therefore see the issues and problems of hospital governance differently.
As an illustrative case in point, the following example is offered. A patient within the Lower Mainland requiring the services of an acute care hospital can select 1 of 7 to attend. If the provincial government decided to close one of these facilities, the patient would still have 6 to choose from. However, should this same patient require the services of a pediatric intensive care or the expertise found only in a cancer facility, then this patient must go to a specialized care hospital.

It is not of course being suggested that specialized care facilities do not experience increasing pressure to be fiscally responsible - certainly they are. The critical issues and the activities and decisions made at the board level within specialized care hospitals have been shown to be similar to those within acute care and long term care facilities. But, the practical reality which embraces these organizations is nevertheless very different. It seems logical to assume therefore, that this mitigating environment would result in more moderate and variant perspectives.

The wide discrepancy between MOH responses and those of the general hospital population appears to be a result of differences in educational backgrounds and practical experience. Whereas the hospital populations generally received their educations in health care and business administration, Ministry officials were primarily humanities graduates, with degrees in sociology, political science and public administration. Secondly, most of the hospital participants have been in their present positions for approximately 5 years.
This contrasts sharply with Ministry officials who have been in their present jobs for only 1.1 years. Finally, although Ministry officials overall have been in the profession of health care approximately 8 years, it is difficult to ascertain in what positions or capacities they have previously served. It is entirely possible that the Ministry population could have extensive experience in health care yet be inexperienced in the complexities of hospital operation and administration.

Given the liberal focus and mission of the MOH respondents, it comes as no surprise that these individuals would possess liberal and broadly mandated perspectives. It further follows that these perspectives would be profoundly different than those of individuals who are trained largely as managers and who are concentrated in a singular locus (hospitals) of wide-scale change.

The explanation for the third posed question which queries the reasoning behind the intensity of responses seems to be multi-dimensional and is best examined through results found in the interview.

Although detailed sub-group analysis did not show many significant findings, it was seen that responses from CEOs, particularly in peer groups 1 and 2, were generally more muted than those found in other groups. A possible explanation for this finding could be that due to the focuses of their education and professional experience, CEOs in this category possess a “bigger picture” of health care, and therefore better understand and support the Ministry’s efforts. However, on the other hand, it should be noted that 4
CEOs during the interview stated that they would answer questions only if they were guaranteed complete anonymity, because they “did not want their responses to come back and haunt them.” These 4 CEOs constituted nearly 1/4 of the CEO interview population (N=15).

Additional important findings of the interview are listed below:

(1) Most hospital respondents (75%) stated that they agreed to become members of hospital governance because they wanted to do something positive for their communities. However, 25% saw hospital governance as a springboard for municipal, provincial, or federal politics.

(2) On average, key participants spend 6-10 hours /week working as volunteers on board activities.

(3) The majority of hospital respondents (73%) felt that Ministry officials frequently made decisions which affected their hospitals without first consulting them. A further 88% stated that would prefer a more participative approach to decision-making. This finding contrasts sharply with MOH respondents (100%) who stated that decision-making with hospitals and their boards was a two-way process.

(4) All study participants stated that they were aware of the government’s plan to regionalize services and to establish CHCs and RHBs in lieu of present hospital boards (New Directions). Surprisingly, only 57% of hospital participants agreed with this plan in
theory, and only 46% stated their support for the plan in practice. As would be expected, 100% of Ministry participants voiced their support for the plan in theory and practice.

(5) Most of the hospital participants (83%) felt that the government had not thoroughly thought through the plan of New Directions and regionalization prior to its implementation and suggested that multi-site pilot studies would have been a more logical approach. Approximately 40% of all CEOs (primarily from peer groups 1-3) wondered why the government chose not to include MSP, pharmacare, and religious organizations under the regionalization umbrella. Nearly 30% of all hospital respondents called the government’s plan a “multi-million dollar social experiment”.

(6) While 95% of all CEOs stated that they understood their roles and responsibilities under the plan, 68% of the combined board member and board chair populations still expressed confusion over the regionalization concept. With respect to the effectiveness of the direction and communication of the plan, Ministry officials (100%) stated that they have spent “millions of dollars barraging hospitals and health care agencies with educational information” and felt that they have done an acceptable to above average job. The majority of hospital participants (69%) however rated the government’s performance as “poor” or “very poor”. Sadly, 42% of this population repeatedly referred to New Directions as “No Directions”.

(7) When questioned if New Directions was economically sound, 100% of Ministry respondents stated that it was. This compares with 57% of CEOs, 47% of all board
members and 43% of all board chairs who agreed that New Directions will prove to save money in the long run. Interestingly, only 36% of all hospital respondents and only 33% of Ministry respondents felt that New Directions would improve the health care of British Columbians. Although 17% stated that they were unsure of New Direction's long term impacts on health, 64% of all study participants (67% of Ministry respondents) stated that the major purpose of New Directions was to make the present health care system more efficient.

(8) Finally, 64% of overall hospital respondents felt “negative” or “somewhat negative” towards the proposed changes to hospital governance under New Directions. Only 36% of this population saw the proposed changes as acceptable. Many questioned whether New Directions was in fact decentralizing decision-making at all. Nearly 89% of all hospital participants expressed concern over whether the goal of true community involvement and decision-making will ever be achieved due to the mix and method of selection for appointed elected members, the criteria for regional and community service delivery, the lateral shift in administrative layering, and the cost-shifting of funding from Victoria to the respective regions and communities as monies from the federal government become scarcer commodities due to continuing cuts in transfer payments. All individuals within the study were aware that New Directions will eventually eliminate hospital governance as we presently know it, and replace it instead with a new paradigm, more commonly referred to as “health care governance”.

CHAPTER 5.0

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

5.1 Summary and Conclusions

The purpose of this study was to examine hospital governance within the context of British Columbia. Often referred to as one of the most important issues facing the health care industry today, hospital boards across Canada and North America are experiencing profound changes and are being forced to re-examine their roles and relationships not only within the broader context of health care, but also to society as a whole.

However, hospital governance is an often an ambiguous and poorly-defined term. In order to obtain an accurate understanding and appreciation of the topic, all hospitals within the province - with the exception of diagnostic treatment centers, private for-profit facilities, military, and federal institutions, were included in the study. Secondly, to gain perspectives from a different vantage point, identified senior MOH officials who had responsibilities for hospitals were also included in the study.

Pre-study assumptions as to the key participants of hospital governance were based on industry practices and literature support which suggested that CEOs, board members and board chairs were generally considered to constitute the memberships of hospital boards.
Utilizing empirical data obtained through documentary examination, survey, and interview methodologies, this study found the following:

(a) That there was general agreement across all respondent categories as to the definition of hospital governance. Defined as “a complex relationship of overlapping structures and activities which has the responsibility and the authority to oversee the organization’s operation and to ensure its commitment of providing optimum health care to its residents”, this finding satisfies the first study objective and supports study hypothesis #1:

Objective #1: To define hospital governance within the context of British Columbia.

Hypothesis #1: That the term “hospital governance” will be similarly defined across acute care, long term care, and specialized care hospital categories within British Columbia.

b) That the key participants of governance are the CEO, the board chair, and board members. Survey results also overwhelmingly found that the Chief of Medicine was considered to be a member of the board. Results obtained from the interview however suggested that due to the conflicts of interest inherent in the nature of their positions, Chiefs of Medicine should not sit on hospital boards.

All participants of the study were generally well educated at the university level, with hospital participants most often having degrees in business or health administration. Ministry officials generally had educational preparation in the humanities.
Examination of the professional experience of the study population showed that the hospital population averaged approximately 5 years in their present positions and 6 years overall in health care. However, the MOH population presented substantially less times in their current positions and averaged only approximately 1.5 years.

The structure and composition of hospital boards showed remarkable consistency across all hospital categories and demonstrated that most boards consist of 12 members with equal representation of genders. With respect to the number of members who are appointed vs. elected, long term care and acute care hospitals were again similar with a 6:6 split. Results for specialized care facilities appear to reflect their provincial referral mandates, and demonstrated a slightly different mix of membership with 8 members appointed and 4 elected.

Study respondents generally agreed with each other as to the preferred sites for delivery of care. However, utilizing hospital peer groups and hospital role classifications as a comparative tool, detailed sub-group analysis showed that the categories of personal care, tertiary care, and rehabilitative care showed more variable results and reflected the growing trend for home care.

(c) That data clearly demonstrated (utilizing a ≥70% agreement rate) that there are 16 activities (long range planning, community relations, financial planning, policy-making, quality assurance, hospital accreditation, capital budgeting, operational budgeting, medical credentialing, capital construction, contact with the Ministry, networking, medical ethics,
fundraising and marketing, professional ethics, and utilization management) associated with hospital governance. Data also showed that three activities (day-to-day operation, employee hiring and firing, and plant operations) clearly were not. Interestingly, there was no differentiation in activities across hospital categories.

(d) That study participants generally agreed as to which individuals were responsible for recommending and implementing various activities. However, there was substantial variation in participants' perceptions with respect to decision-making. Interestingly, board chairs in particular perceived their roles and responsibilities differently than other members do. Fortunately, results obtained from the interview do not suggest dysfunctional governance operation or routine power struggles within British Columbia hospital boards.

Items (b) through (d) satisfy study objectives #2, #3, and #4 and support hypothesis #2:

**Objective #2:** To examine the structural and functional relationships among the key participants of hospital governance.

**Objective #3:** To examine the decision-making responsibilities of key participants.

**Objective #4:** To investigate what, if any, variations exist in the governance of acute care, long term care, and specialized care hospitals.

**Hypothesis #2:** That variances will exist in the perceptions of decision-making and responsibility among the key participants of hospital governance.
(e) That there was general agreement within the hospital population as to the most critical issues which face hospital governance today. In preferential order, these issues are: 1) **New Directions;** 2) the Labor Accord; 3) the lack of leadership demonstrated by the Ministry of Health; 4) the difficulty in maintaining services during a time of continuing budget cuts; 5) the lack of a long term health plan.

The hospital populations also generally agreed in their recommendations on how to “improve” hospital governance within the province and vocalized strong dissatisfaction with the government’s overall performance: 1) fine tune the present health care system if necessary, but leave hospital boards essentially as they are; 2) no more deals like the Labor Accord; 3) provide hospitals with enough money to cover and maintain existing services; 4) stop the political games, honor contractual agreements, and make health decisions based on equitability and need; 5) provide stronger and more consistent leadership/communication.

All study respondents were aware of the proposed changes to hospital boards under **New Directions,** and in general saw the move to a health care governance paradigm via the creation of CHCs and RHBs as a negative one.

f) In almost all areas of the study (e.g., educational preparation, time in present position, identification of key participants, identification of the activities of hospital governance, and the identification of the critical issues and recommendations to “improve” hospital governance), responses obtained from the Ministry population were substantially different
than those from the general hospital populations and reflected a divergent and strongly socialistic perspective.

Given the target population of the study, the state of hospital governance in the province, and the ideological posturing of the provincial government, it was anticipated that some participants’ responses would be critical of the present government’s policies and initiatives. However, the intensity of responses, the degree of anger, and the frequent expression of frustration and uncertainty regarding the future of hospitals and health care governance was surprising and uniformly negative.

These findings satisfy the last of the study objectives and support the final two research hypotheses:

**Objective #5:** To examine the critical issues which are facing hospital governance today in its transitional state under *New Directions* initiatives.

**Hypothesis #3:** That there will be general agreement among key participants as to the problems, issues, and challenges facing hospital governance now and in the future.

**Hypothesis #4:** That the traditional structures and processes of hospital governance are in a volatile and transitional state under *New Directions*.

### 5.2 Implications

The implications of this study are discussed from two perspectives (a) implications for hospital governance and (b) implications for further research.
It would appear that many results obtained from this study do offer theoretical support for both the power typologies provided by French and Raven (1960), and agency theory (Jensen and Meckling, 1976; Fama, 1980). For example, the conflicting findings found in the survey and interview with respect to whether or not physicians should be included as governance members can be addressed by French and Raven's reference to expert power. Given the nature of their loyalties to their respective medical staffs, the Chief of Medicine and/or the President of the Medical Staff are clearly in a conflict of issue position. However, due to their technical knowledge acquired through years of specialized training, physicians have exerted their power to secure a formidable presence at the table of hospital boards. Considering that society still perceives physicians as the pinnacles of patient care, physicians will demand and continue to receive a place on hospital - or health care - boards. Similar parallels could also be made with regards to the respective legitimate powers of CEOs and board chairs and their perceptual differences in final decision-making responsibility.

Secondly, the relationships between the key participants of hospital governance can be approached from an agency theory perspective. Agency theory predisposes that hospitals act as principals, boards as surrogates for the principal, and CEOs and physicians as agents. The theory goes on to suggest conflicts of interests are inherently natural for both the positions of CEO and Chief of Medicine due to the focus of their loyalties (e.g., CEOs and their responsibility to manage the organization, Chiefs of Medicine and their responsibility to protect the interests of the medical staff). Agency theory postulates that in
situations where goal conflict does exist, agents will most often act to pursue their own interests rather than those of the principal (Alexander, 1993). These conflicts in turn provide fertile soil for perceptual differences and power struggles between individuals and the decisions they make.

While agency theory is most often approached from a micro-organizational perspective, it is thought-provoking to hypothetically extrapolate this theory to a more macro-level. For example, in British Columbia, the provincial government has the power to allocate funds, and define the facilities and services offered by its public hospitals. Furthermore, by law, the Hospital Act explicitly delineates the necessary responsibilities and authorities required of hospital boards through the various sections of the Act. However, because each hospital must act to secure its yearly operational budget, and apply to expand operation from the provincial government, do hospitals truly act as principals? Furthermore, because CEOs sit on hospital boards in the dual capacity as both policy formulators (generally considered to be a board responsibility) and as organizational administrators (most often seen as a management domain), do they as Mintzberg (1983) and others suggest possess more power than other key participants in influencing board decision-making? Following the posits of agency theory, a broader provincial context appears to indicate therefore that the government acts as the principal, hospitals and their boards act as agents, and physicians, CEOs, and hospital employees function in various degrees as lower level agents to their respective hospitals.
This premise may be one of the rationales which helps to explain the schism in responses between the Ministry and hospital populations. Considering the nature and the time frame of the study, it was expected that critical responses might be evoked. However, the extent and intensity of the criticisms suggest a problem much deeper than directed resentment over the dissolution of hospital boards.

The government’s practice of developing unilateral policies based predominantly on the recommendations of bureaucrats who are - or are at least perceived to be - practically inexperienced places them woefully out of step with the realities of hospital governance and hospital operation today. The frequent turnover of Ministry staff and their preponderance in humanities education further helps to underline the sharp perceptual contrasts between the Ministry population and the general hospital population who possesses substantially more professional experience and educational backgrounds in business and health care. While there is no conclusive list of desirable attributes a senior bureaucrat - or for that matter a board member, CEO, or Chief of Medicine - should embody in an ideal world, perceptions are nevertheless important. A government which leads or appears to lead from a pedestal, accepts little or no input from others, and places perceptively inexperienced political appointees in positions of leadership cannot help but to create a hostile and chaotic environment. Furthermore, the philosophical foundations of New Directions policy initiatives may very well have a strong philosophical foundation from the government’s perspective. It certainly allows the government to seize the opportunity to redefine and restructure health care and its delivery from its own unique
vantage point. However, the overwhelming majority of hospital study participants felt that the policies, the implementational plans and the underlying theories which support **New Directions** are at best poorly articulated, and at worst are poorly conceived and poorly operationalized.

Considering the overwhelming dissatisfaction and frustration over Community Health Councils, Regional Health Boards, and **New Directions** policies, one has to wonder if British Columbia is indeed in the midst of a multimillion dollar social experiment. Although most of Canada’s hospital boards are undergoing some degree of dissolution/regionalization, it has been suggested that the move towards regionalizing services is the latest “trend” within health care administration.

Certainly, the concepts which support the regionalization of health services and the development of community and regional health boards appear to make sense. The benefits of decentralized decision-making, the consolidation of services, and the elimination of duplication are well known to administrators and managers. However, due to the paucity of literature and evidential support on the topic, particularly from a longitudinal perspective, it is unclear whether or not the dissolution of hospital boards in favor of CHCs and RHBs is a step in the right direction. Most of the study respondents did feel that health care could be more efficiently managed. But an impressive 91% of the study population - the CEOs, board chairs and board members who are currently managing our
hospitals - stated that they were generally satisfied with the present hospital governance system.

The longevity and history of British Columbia’s present health care system indicate that it has generally functioned rather well. Furthermore, many international organizations such as the World Bank and the World Health Organization have consistently rated Canada’s health care system as one of the best in the world (World Bank, 1995). However, attempts are being made to dislocate it under New Directions policies. The shifting of decision-making responsibilities away from hospitals and their boards toward a “communities” focus will undoubtedly create areas of conflict and uncertainty as experienced professionals are replaced by newcomers to “governance”. As hospitals and health services continue to amalgamate under smaller and smaller governance umbrellas, the need for the skills of hospital administrators in their traditional roles will certainly diminish. While some CEOs undoubtedly will have added responsibility and authority as they assume leadership positions in the regional health network as multi-organizational health administrators, the majority of hospital CEOs who still possess jobs will have to accept the realities of a smaller voice in decision-making and a smaller role in community health planning for their hospitals.

Even of greater importance however is the strong probability of the development of new and competitive health related power bases within communities and regions. In the
past, interest groups which attempted to influence governance decision-making were
generally centered around the abortion debate. But, with the advent of increased
community participation in health care decision-making, special interest groups have
already attempted to exert their influence on Community Health Councils and Regional
Health Boards either through direct membership or via magnified community profiles.
Citing community need and cost efficiency, these groups have begun to “compete” for
community/regional health care dollars under the New Directions mandate. It is entirely
probable that as competition for scarce health care resources becomes even tighter, power
struggles between community based groups - or even between CHCs and RHBs - will
create conflict and force new health care alliances between groups and organizations in
order to obtain a greater share of community support for their programs.

In the long run, these power struggles or alliances may or may not prove to be
beneficial to health care in general. From a political perspective however, the
establishment of increased community decision-making/competition is a brilliant strategic
move because it absolves the government of its direct accountability to provide
comprehensive health services while still allowing it to retain its fiscal clout. Regional
health boards and community health councils will now be forced to make the tough
decisions and deal with their ramifications which were in the past, under the purview of
the provincial government. Either way, the structure and operation of hospitals and the
manner in which health care decisions will be made under New Directions policies will
provide a very different health care system for British Columbians in the future.
The implications of this study for future research suggest four possible areas. The first would be to investigate in greater detail the power differentials which are present between board members, possibly focusing on a models developed by French and Raven or Mintzberg.

The second would be to examine governance as it pertains to non-hospital health care organizations to see whether or not findings can be transferable and generalizable across a variety of health care settings.

The third would be to include the public’s perceptions as to the operation and performance of hospital governance within the province. Considering that Canada’s health care system is founded on the public model, it would fascinating to gauge the public’s perspectives on the topic.

Finally, this study should be repeated once the CHCs and RHBs are functioning and operational. It will be interesting to compare how governance is defined, who are its key participants, and what its activities and responsibilities are.
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Certificate of Approval

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Department</th>
<th>Number</th>
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<td>Eni, G.</td>
<td>Health Care/Epidemiology</td>
<td>B94-0227</td>
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Institution(s) Where Research Will Be Carried Out

UBC Campus

Co-Investigators

Azad, P., Graduate Studies

Sponsoring Agencies

Title

Hospital governance in British Columbia

Approval Date: JUN 16 1994

Term (Years): 3

Amended: No

Modification of: No

Certification:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Dr. R. Cortein
Dr. I. Franks, Associate Chairs

Dr. R. D. Spratley
Director, Research Services

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
Appendix B-1

Permission Letter, Survey 1 and Accompanying Peer Groups

Date

Mr/Ms.
Position
Hospital
Address

RE: CONSENT TO PARTICIPATE IN THE STUDY OF HOSPITAL GOVERNANCE IN BRITISH COLUMBIA

I am a graduate student [Ph.D. Interdisciplinary] at the University of British Columbia with interest in defining how hospitals are governed in the Province. In particular, I wish to examine the structures, the processes and the associated decision-making responsibilities relating to hospital governance.

This study will help explain the meaning of governance in B.C.; how the activities of governing differ within and among various hospital groups; who takes part; who makes decisions; and how are they made. To better understand the differences between and among hospital groups, all long term care, acute care, and specialized hospitals within the province will be included in the study.

Only members of senior management at the President or Chief Executive Officer level, members of Boards of Trustees and selected officials of the Ministry of Health will be requested to answer survey questions which will take approximately 20 minutes to complete. From among them, a few persons will be selected by chance for a further 20 minutes of interview. For your convenience, I have enclosed 3 copies of this letter and associated questionnaire for distribution to members of your hospital's Board of Trustees.

I am therefore requesting your participation in the study. If you agree to participate, your name as well as the names of all those taking part will not be used in any identifiable manner. All information which may be of a confidential nature will not be linked in any identifiable way to you or your hospital. In particular, in order to ensure confidentiality, all information relating to the study will be stored in a computer in an office at UBC which will only be accessible to myself. Following the conclusion of this study, the thesis defence, and the publication of research results, all stored information will be destroyed or shredded after 9 months.

Please note that you can refuse to participate in the study or choose to withdraw at any time as your participation is entirely voluntary.

If you have any questions concerning the study or any other concern you may have, please feel free to contact me at any of the following addresses:
If you are willing to participate in the study, please complete the section below, detach and return or fax to me at your earliest convenience.

Thank You.

Yours Truly,

Pamela Azad, B.S., (Nurs); M.S. (Health Admin.)
Ph.D. Candidate. (Inter Discipl.)

To: Ms. Pamela Azad, 2204 Garymede Drive, Kamloops, B.C.; V1S 1P2

I have received a copy of the consent form and I agree to participate in the study of Hospital Governance in British Columbia.

[Please check one]:

- Survey only:
- Interview only:
- Survey & Interview:

Name:

Position:

Hospital/Facility:

Signature:

Date:
Thank you for agreeing to participate in this study. Your responses to these questions will assist in understanding how hospital governance functions in the province of British Columbia. It is expected that this questionnaire will take 20 minutes or less to complete.

Please answer the following questions to the best of your knowledge.

SECTION A - DEMOGRAPHIC INFORMATION (Questions 1-13)

1. Please check one below
   Sex: Male _____
   Female _____

2. What is your position?
   (Select one)
   Chief Executive Officer
   Chair of Board of Trustees
   Board Member
   Ministry of Health Official
   Other
   (Please Specify)

3. How long have you held your present position?
   (Select one)
   Less than 1 year
   1-2 years
   3-5 years
   6-10 years
   11-15 years
   16 - 20 years
   Over 20 years
4. How long have you worked in or been associated with health care (eg., as a board member, chief executive, etc.)? (Select One)

- < 1 year
- 1-5 years
- 6-10 years
- Over 10 years

5. What is your highest level of education? (Select one)

- Elementary
- Secondary
- College
- University
- Other (please indicate)

6. Which of the following categories most closely describe the area of your major education? (Select one)

- Health care
- Business
- Education
- Political Science
- Other
- (Please specify)

7. What is your primary occupation? (Select one)

- Health Care
- Business
- Education
- Political Science
- Homemaker
- Retired
- Other
- (Please Specify)
8. At present how many members are in your Board of Trustees?  Code____

Male  # ____
Female # ____
Total  # ____

9. How does your hospital obtain members for your Board of Trustees  Code____
(Select one or appropriate combination)

Number of members appointed _____
Number of members elected _____
Other _____
Please specify ________________

10. The Ministry of Health has categorized hospitals in British Columbia according to peer groups as listed below. In which peer group does your hospital belong? (Please refer to attached listing). (Select one)

Peer group 1 ________________
Peer group 2 ________________
Peer group 3 ________________
Peer group 4 ________________
Peer group 5 ________________
Peer group 6 ________________
Peer group 7 ________________
Peer group 9 ________________
Peer group 10 _______________

11. The Ministry of Health has also classified hospitals in British Columbia according to their role. Which of the following classifications below best describes your hospital? (Select one)

Community Hospital - Level A
(Serves a small - up to 6,000 - or isolated community) _____

Community Hospital - Level B
(Serves a medium - up to 18,000 - or semi-rural community) _____
-131-

Community Hospital - Level C  
(Serves large - 18,000 to 150,000 - or urban community)  

Regional Hospital - Level D  
(Serves as a referral base for 75,000 to 150,000 people)  

Regional Hospital - Level E  
(Serves as a major provincial referral, teaching and research center)  

Jurisdictional or Provincial Hospital - Level F  
(Serves a specialized population and is owned and operated by a government authority)  

12. In what category is your hospital's greatest (50% or more) Code___
allocation of beds?  
(Select one)  

   Acute Care _____
   Long Term Care _____
   Specialized Care _____
   (i.e., pediatrics, maternity, cancer, etc.)

13. In your opinion, for each of the types of services listed below, Code ___
please indicate with an [X] the most appropriate hospital classification of their delivery.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Acute Care Hospital</th>
<th>Long Term Care Hospital</th>
<th>Specialized Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Extended care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary acute care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION B - DEFINING GOVERNANCE

14. Hospital governance has been variously defined. Please select a definition from the list below which most closely matches your own. (Select one)

A) It is the responsibility of hospital boards to ensure the survival and well being of an organization. (Baker, 1992)

B) Hospital governance pertains to strategic organizational decision-making and the related distribution of authority and legitimacy necessary to make those decisions. (Kovner, 1990)

C) It is the board’s responsibility to oversee the organization’s operation and ensure its commitment to provide optimum health care to residents of the community. (Williams and Torrens, 1988)

D) Hospital governance is a complex relationship of overlapping structures and responsibilities between boards of trustees, medical staff, and administration. (Knudson, 1990)

E) None of the above

F) If you selected E, how would you define “governance” in your own words? Please use the space below.
15. In your opinion, which of the following activities pertain to hospital governance in (a) acute care hospitals, (b) long term care hospitals, and (c) specialized hospitals? Code ___

<table>
<thead>
<tr>
<th>Activity</th>
<th>Acute Care Hospital</th>
<th>LTC Hospital</th>
<th>Specialized Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Capital budgetting</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>b) Operational budgetting</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>c) Strategic or long range planning</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>d) Policy making</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>e) Hospital administration</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>f) Medical credentialing and staff privileges</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>g) Community relations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>h) Fundraising and marketing</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>i) Labor negotiations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>j) Day-to-day hospital operations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>k) Contact with the Ministry of Health</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>l) Patient care</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>m) Legal matters</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>n) Long term financial planning</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>o) Research and development</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>p) Medical ethics</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>q) Professional ethics</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>r) Staff disciplinary actions</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>s) Capital construction</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>t) Networking</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>u) Contract negotiations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>v) Employee hiring and firing</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>w) Quality assurance</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>x) Development of new programs and services</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>y) Health and safety</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>z) Plant operations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>aa) Hospital accreditation</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>bb) Utilization management</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
16. In your opinion, please indicate those individuals you consider as the key participants of hospital governance in British Columbia. (Please select yes or no for each item below)

Yes  No

a) Hospital chief executive officer
b) Chair of board of trustees
c) Board member
d) Chief of medical staff
e) Ministry of Health officials
f) Other
   (eg., Vice-Presidents, Dept. directors, etc.,)
   (Please add any additional key participants)

17. In your opinion, who has the responsibility for (a) recommending, (b) deciding, and (c) implementing the following activities within your hospital. Please identify the appropriate individual in the spaces below. [eg., CEO, Chief of Medical staff (COM), Chair of Board of Trustees, (COB), Ministry of Health official (MOH), Department head (DH), etc.]

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommending</td>
<td>Deciding</td>
<td>Implementing</td>
</tr>
</tbody>
</table>

a) New programs
b) Budget increases
c) Hiring Chief of medical staff
d) Firing Chief of medical staff
e) Hiring Vice-Presidents
f) Hiring department heads
g) Liaising with community agencies
h) Negotiating contracts with MOH about health matters
18. In your opinion:

(A) List the 5 most critical issues facing governance in British Columbia today.

(i) ________________________________

(ii) ________________________________

(iii) ________________________________

(iv) ________________________________

(v) ________________________________

(B) Do you have any recommendations which might “improve” hospital governance in British Columbia? Please provide your comments in the space below.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for taking the time to complete this survey.
PEER GROUP CLASSIFICATIONS

PEER GROUP 1

Vancouver Hospital and Health Sciences Center
St. Paul’s Hospital
Fraser Burrard Hospital Society
Greater Victoria Hospital Society

PEER GROUP 2

Lion’s Gate Hospital
Surrey Memorial
Burnaby Hospital
Kelowna General Hospital
Royal Inland Hospital
Nanaimo Regional Hospital
Prince George Regional Hospital

PEER GROUP 3

Langley Memorial Hospital
Richmond General Hospital
Peace Arch District Hospital
Vernon Jubilee Hospital
Penticton Regional Hospital
Chilliwack General Hospital
Matsqui-Sumas-Abbotsford General Hospital
Trail Regional Hospital

PEER GROUP 4

Saint Mary’s Hospital
St. Vincent’s Hospital
Mount St. Joseph Hospital
Delta Hospital
Cowichan District Hospital
Saanich Peninsula Hospital
St. Joseph’s General Hospital
Campbell River and District General Hospital
Mission Memorial Hospital
Maple Ridge Hospital
Cranbrook and District Hospital
West Coast General Hospital

PEER GROUP 5

Powell River General Hospital
St. Mary’s Hospital (Sechelt)
Shuswap Lake General Hospital
Cariboo Memorial Hospital
Kootenay Lake District Hospital
Fort St John General Hospital
Dawson Creek and District Hospital
G.R. Baker Memorial Hospital
Prince Rupert Regional Hospital
Bulkley Valley District Hospital
Mills Memorial Hospital
Kitimat General Hospital

PEER GROUP 6

Squamish General Hospital
Lady Minto Gulf Islands Hospital
Princeton General Hospital
Enderby and District Memorial Hospital
Summerland General Hospital
South Okanagan General Hospital
Queen Victoria Hospital
Nicola Valley General Hospital
Ashcroft and District Hospital
Golden and District Hospital
Lillooet and District Hospital
Ladysmith and District General Hospital
Fraser Canyon Hospital
Creston Valley Hospital
St. John Hospital
Burns Lake and District Hospital
100 Mile District General Hospital
Fort Nelson General Hospital
Kimberly and District Hospital
Fernie and District Hospital
Sparwood General Hospital
Windermere District Hospital
Boundary Hospital
Castlegar and District Hospital
Wrinch Memorial Hospital
PEER GROUP 7
St. Bartholomew's Hospital
Dr. Helmcken Memorial Hospital
St. George's Hospital
Port Hardy Hospital
Port McNeil and District Hospital
Slocan Community Hospital
Victorian Hospital
Arrow Lakes Hospital
McBride and District Hospital
MacKenzie and District Hospital
Chetwynd General
Stuart Lake Hospital
Tofino General Hospital
Port Alice Hospital
Tahsis Hospital
R.W. Large Memorial Hospital
Bella Coola General Hospital
Queen Charlotte Islands General Hospital
Stewart General Hospital
Cassiar Hospital

PEER GROUP 9
Louis Brier Hospital
Pacific Health Care Society
St. Michael's Hospital
Mount St. Mary's Hospital
Juan de Fuca Hospital
Overlander Hospital
Trillium Extended Care Hospital
Manno Hospital
Mount St. Francis Hospital
Pouce Coupe Community Hospital
The Mater Misericordiae Hospital
St. Vincent's Arbutus Hospital

PEER GROUP 10
B.C. Women's Hospital
Children's Hospital
B.C. Cancer Agency
Sunny Hill Hospital
Holy Family Hospital
G.F. Strong Hospital
Queen Alexandra Hospital
Appendix B-2

SURVEY 2

HOSPITAL GOVERNANCE IN BRITISH COLUMBIA

Thank you for agreeing to participate in this study. Your responses to these questions will assist in understanding how hospital governance functions in the province of British Columbia. It is expected that this questionnaire will take 20 minutes or less to complete.

Please answer the following questions to the best of your knowledge.

SECTION A - DEMOGRAPHIC INFORMATION (Questions 1-8)

1. Please check one below
   Sex: Male ___
   Female ___

2. What is your position?
   (Select one)
   Chief Executive Officer ___
   Chair of Board of Trustees ___
   Board Member ___
   Ministry of Health Official ___
   Other ___
   (Please Specify) ____________________________

3. How long have you held your present position?
   (Select one)
   Less than one year ___
   1-2 years ___
   3-5 years ___
   6-10 years ___
   11-15 years ___
   16-20 years ___
   Over 20 years ___
4. How long have you worked in or been associated with health care (eg., as a MOH official, board member, chief executive, etc.)? (Select one)

   - Less than one year ____
   - 1-5 years ____
   - 6-10 years ____
   - Over 10 years ____

5. What is your highest level of education? (Select one)

   - Elementary ____
   - Secondary ____
   - College ____
   - University ____
   - Other ____
   - (Please Specify) ______________________

6. Which of the following categories most closely describe the area of your major education? (Select one)

   - Health care ____
   - Business ____
   - Education ____
   - Political Science ____
   - Other ____
   - (Please Specify) ______________________

7. What is your primary occupation? (Select one)

   - Health care ____
   - Business ____
   - Education ____
   - Political Science ____
   - Homemaker ____
   - Retired ____
   - Other ____
   - (Please Specify) ______________________
8. In your opinion, for each of the types of services listed below, please indicate with an [X] the most appropriate hospital classification of their delivery.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Hospital Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care</td>
<td></td>
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<tr>
<td>Extended Care</td>
<td></td>
</tr>
<tr>
<td>Primary Acute Care</td>
<td></td>
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<tr>
<td>Secondary Acute Care</td>
<td></td>
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<tr>
<td>Tertiary Acute Care</td>
<td></td>
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<tr>
<td>Activation/Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>(Please Specify)</td>
<td></td>
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</tbody>
</table>

**SECTION B - DEFINING GOVERNANCE**

9. Hospital governance has been variously defined. Please select a definition from the list below which most closely matches your own. (Select one)

A) It is the responsibility of hospital boards to ensure the survival and well-being of an organization. (Baker, 1992)  

B) Hospital governance pertains to strategic organizational decision-making and the related distribution of authority and legitimacy necessary to make those decisions. (Kovner, 1990)
C) It is the board’s responsibility to oversee the organization’s operation and ensure its commitment to provide optimum health care to residents of the community. (Williams and Torrens, 1988)

D) Hospital governance is a complex relationship of overlapping structures and responsibilities between boards of trustees, medical staff, and administration. (Knudson, 1990)

E) None of the above

F) If you selected E, how would you define “governance” in your own words? Please use the space below.

________________________________________________________

________________________________________________________

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SECTION C- GOVERNANCE ACTIVITIES AND PROCESSES (Questions 10-11)

10. In your opinion, which of the following activities pertain to hospital governance in (a) acute care hospitals, (b) long term care hospitals, and (c) specialized hospitals?  

<table>
<thead>
<tr>
<th>Acute Care Hospital</th>
<th>LTC Hospital</th>
<th>Specialized Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Capital budgeting</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b) Operational budgeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Strategic or long range planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Policy making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Hospital administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Medical credentialing and staff privileges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Community relations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code ______
h) Fundraising and marketing
i) Labor negotiations
j) Day-to-day hospital operations
k) Contact with the Ministry of Health
l) Patient care
m) Legal matters
n) Long term financial planning
o) Research and development
p) Medical ethics
q) Professional ethics
r) Staff disciplinary actions
s) Capital construction
t) Networking
u) Contract negotiations
v) Employee hiring and firing
w) Quality assurance
x) Development of new programs and services
y) Health and safety
z) Plant operations
aa) Hospital accreditation
bb) Utilization management
cc) Other
(Please specify)

11. In your opinion, please indicate those individuals you consider as the key participants of hospital governance in British Columbia. (Please select yes or no for each item below)

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Hospital chief executive officer</td>
<td></td>
<td></td>
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<tr>
<td>b) Chair of board of trustees</td>
<td></td>
<td></td>
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<tr>
<td>c) Board member</td>
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</tbody>
</table>
**Section D - Responsibilities and Decision-Making**

12. In your opinion, who has the responsibility for (a) recommending, (b) deciding, and (c) implementing the following activities within your hospital. Please identify the appropriate individual in the spaces below. [eg., CEO, Chief of Medical staff (COM), Chair of Board of Trustees (COB), Ministry of Health official (MOH), Department head (DH), etc.]

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend</td>
<td>Decide</td>
<td>Implement</td>
</tr>
<tr>
<td>a) New programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Budget increases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Hiring Chief of medical staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Firing Chief of medical staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Hiring Vice-Presidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Hiring department heads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Liaising with community agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Negotiating contracts with MOH about health matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Appointments to BOT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) Chairmanship to BOT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) Type of membership of BOT</td>
<td></td>
<td></td>
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<tr>
<td>l) New medical technology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) Capital expansion</td>
<td></td>
<td></td>
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<tr>
<td>n) Type of services offered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o) Mission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p) Goals and objectives</td>
<td></td>
<td></td>
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<tr>
<td>q) Shared services with other organizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. In your opinion:  Code____

(A) List the 5 most critical issues facing governance in British Columbia today.

(i) ____________________________________________________________

(ii) __________________________________________________________

(iii) __________________________________________________________

(iv) __________________________________________________________

(v) __________________________________________________________

(B) Do you have any recommendations which might “improve” hospital governance in British Columbia? Please provide your comments in the space below.

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Thank you for taking the time to complete this survey.
Appendix C-1

INTERVIEW 1

Name: ___________
Hospital: ___________
Position: ___________

Defining Governance:
1. In your own words, what does the phrase “hospital governance” mean to you?
2. In your opinion, who are the key participants of hospital governance?
3. Within your institution, are there persons who should /shouldn’t be involved in hospital governance?
   - If yes, what are their positions?
4. Outside of your hospital, are there persons who should/shouldn’t be involved in hospital governance?
   - If yes, what are their positions?

The Structures and Functions of Governance:
5. In your hospital, who sits on the board of trustees? (e.g., the Chairman of the Board, members of the board, President of the hospital, etc.)
   A) In your hospital, what other positions should be included/deleted?
   B) With respect to hospitals in general, what other positions should be included/deleted?
6. According to your hospital’s organizational chart, what are the expected reporting relationships of the positions stated in question 5?
   A) In policy
   B) In practice
7. At the present time, what is the structural relationship between your hospital and: (a) the Ministry of Health and (b) your community (e.g., regional board, community health council, etc.)?
8. At the present time, how satisfied are you with your hospital’s linkages and relationships with: (a) your community, and (b) the Ministry of Health?
9. In your opinion, would you prefer to see a different governance relationship: (a) within your hospital, (b) in your community, and (c) with the Ministry of Health
   - Please elaborate on your answer
10. On average, how many hours per week do you spend participating in governance activities?
    A) Less than 1 hour per week
    B) 2-5 hours per week
    C) 6-10 hours per week
    D) 11 hours or more per week
Decision-Making Processes and Responsibilities:

11. In your opinion, please state the five most important decision-making responsibilities or activities of hospital governance.

12. In your opinion, who should have the responsibility for establishing hospital governance activities within the Province of British Columbia?
   A) In your hospital
   B) In hospitals in general

13. In your opinion, who has the responsibility for establishing hospital governance activities within the Province of British Columbia?

14. According to your organizational chart, please state how a policy in your hospital (e.g., the establishment of a new program) is: (a) identified, (b) approved, and (c) established

15. With respect to question 14, are you satisfied with the processes associated with the: (a) identification, (b) approval, and (c) establishment of hospital policy?

16. Again with respect to question 14, is there a “better” way to: (a) identify, (b) approve, and (c) establish hospital policy?

17. Describe the process of decision-making between your hospital and the Ministry of Health regarding the: (a) identification, (b) approval, and (c) implementation of a new policy direction (e.g., the introduction of a new program or the deletion of an existing one)

18. In your opinion, what would be the ideal process of decision-making between: (a) your hospital and the Ministry of Health, and (b) hospitals in general and the Ministry of Health?

19. Let’s suppose that there is a need to close beds within your hospital. Who: (a) initiates the discussion, (b) approves the decision, and (c) implements the decision?
   A) In policy
   B) In practice

20. With respect to governance, what should be the decision-making activities of the: (a) CEO, (b) the board chairperson, (c) board members, (d) Ministry of Health, and (e) others?

21. Again with respect to governance, what are the decision-making activities of the: (a) CEO, (b) the board chairperson, (c) board members, (d) the Ministry of Health, and (e) others?
Hospital Governance and the Future:

22. Are you aware of the government’s plan to “regionalize” health care in order to bring it “closer to home” (e.g., New Directions)?

23. In your experience to date, how satisfied are you with this plan?
   - Please describe specific aspects of your answer: (a) In theory, and (b) In practice

24. Do you think New Directions is economically sound?
   - Why/why not?

25. Do you think that New Directions will “improve” the health care of British Columbians?
   - Why/why not?

26. Prior to New Directions, how satisfied were you with hospital governance in British Columbia?
   A) Very dissatisfied
   B) Somewhat dissatisfied
   C) Satisfied
   D) Somewhat satisfied
   E) Very satisfied

27. With respect to hospital governance under New Directions, what changes do you envision for: (a) your hospital, (b) other hospitals, and (c) health care in general?

28. In the future, how do you envision the structural relationship between your hospital and: (a) your community, and (b) the Ministry of Health?

29. In the future, how do you envision the processes of decision-making between your hospital and: (a) your community, and (b) the Ministry of Health?

30. Do you feel the proposed changes to hospital governance under New directions are:
   A) Very negative
   B) Somewhat negative
   C) Acceptable
   D) Somewhat positive
   E) Very positive

31. In your opinion, how clearly has the Ministry of Health communicated its regionalized governance plan under New Directions?
   A) There has been very poor communication from the Ministry of Health
   B) There has been poor communication from the Ministry of Health
   C) There has been acceptable communication from the Ministry of Health
   D) There has been above average communication from the Ministry of Health
   E) There has been excellent communication from the Ministry of Health

32. How clearly does your facility understand its position and role under the regionalization plan?
   A) We do not understand our position and role at all
   B) We understand our position and role to some degree
   C) We fully understand our position and role
33. Overall, how would you rate the implementation of New Directions so far?
   A) Very poor
   B) Poor
   C) Fair
   D) Above average
   E) Excellent

34. In your opinion, will the Ministry of Health under New Directions have: (a) greater ability to exercise control regarding regional health care issues - e.g., centralization of decision-making, funding allocations, etc., (b) lesser ability to exercise control regarding regional health care issues - e.g., decentralization of decision-making, funding allocations, etc., or (c) there will be no change?

35. In your opinion, will regional boards under New Directions have: (a) greater ability to exercise control regarding regional health care issues, (b) lesser ability to exercise control regarding regional health care issues, or (c) the same ability to exercise control over regional health issues as hospital boards do now?

36. In your opinion, should individuals who work in health care facilities also have the right to serve on their boards?
   - Why/why not?

37. In your opinion, should “professionals” such as nurses, physicians, etc. be allowed membership on hospital boards?
   - Why/ why not?

38. Are you concerned with “special interest groups” (e.g., AIDS, Pro-life, etc.) gaining a majority membership on your board?
   - Why/why not?

39. With respect to question 38, have special interest groups ever become a “problem” with respect to governance in your hospital?
   - Please elaborate

40. Under New Directions, do you see the topic of special interest groups becoming: (a) less of a problem, (b) more of a problem, or (c) there should be no change from the present.

41. Are you interested in sitting on your region’s health board?
   Why or why not?

42. In your opinion, what do you see as the impediments or obstacles in: (a) the process, and (b) the implementation of the New Directions governance plan?

43. With respect to question 42, what suggestions do you have to improve the process or implementation of New Directions?
Appendix C-2

INTERVIEW - 2

Name:____________

Position at Ministry of Health:__________

Defining Governance:

1. In your own words, what does the phrase “hospital governance” mean to you?

2. In your opinion, who are the key participants of hospital governance?

3. At the present time, do you feel that there are persons who should/shouldn’t be involved in hospital governance?
   - If yes, what are their positions?

The Structures and Functions of Governance:

4. At the present time, what is the structural relationship between the Ministry of Health and: (a) hospitals, and (b) communities?

5. At the present time, how satisfied are you with the Ministry of Health’s relationship with: (a) hospitals, and (b) communities?

6. In your opinion, would you prefer to see a different governance relationship: (a) within hospitals, and (b) communities?
   - Please elaborate on your answer

Decision-Making Processes and Responsibilities:

7. In your opinion, please state the five most important decision-making responsibilities or activities of hospital governance.

8. In your opinion, who should have the responsibility for establishing hospital governance activities within the province of British Columbia?

9. In your opinion, who has the responsibility for establishing hospital governance activities within the province of British Columbia?

10. Please describe the process of decision-making between the Ministry of Health and hospitals regarding the: (a) identification, (b) approval, and (c) implementation of a new policy direction (e.g., the introduction of a new program or the deletion of an existing one)

11. In your opinion, what would be the ideal process of decision-making between the Ministry of Health and hospitals?
12. With respect to governance, what should be the decision-making activities of the: (a) CEO, (b) the board chairperson, (c) board members, (d) the Ministry of Health, and (e) others?

13. Again with respect to governance, what are the decision-making activities of the: (a) CEO, (b) the board chairperson, (c) board members, (d) the Ministry of Health, and (e) others?

Hospital Governance and the Future:

14. Are you aware of the government's plan to “regionalize” health care in order to bring it “closer to home” (e.g., New Directions)?

15. In your experience to date, how satisfied are you with this plan?
   - Please describe specific aspects of your answer: (a) in theory, and (b) in practice

16. Do you think New Directions is economically sound?
   - Why/why not?

17. Do you think New Directions will “improve” the health care of British Columbians?
   - Why/why not?

18. Prior to New Directions, how satisfied were you with hospital governance in British Columbia?
   A) Very dissatisfied
   B) Somewhat dissatisfied
   C) Satisfied
   D) Somewhat satisfied
   E) Very satisfied

19. With respect to hospital governance under New Directions, what changes do you envision for: (a) hospitals, and (b) health care in general?

20. In the future, how do you envision the structural relationship between the Ministry of Health and: (a) hospitals, and (b) communities?

21. In the future, how do you envision the processes of decision-making between the Ministry of Health and: (a) hospitals, and (b) communities?

22. Do you feel that the proposed changes to hospital governance under New Directions are:
   A) Very negative
   B) Somewhat negative
   C) Acceptable
   D) Somewhat positive
   E) Very positive

23. In your opinion, how clearly has the Ministry of Health communicated its regionalized governance plan to hospitals?
   A) There has been very poor communication from the Ministry of Health
   B) There has been poor communication from the Ministry of Health
   C) There has been acceptable communication from the Ministry of Health
   D) There has been above average communication from the Ministry of Health
   E) There has been excellent communication from the Ministry of Health
24. Overall, how would you rate the implementation of New Directions so far?
   A) Very poor
   B) Poor
   C) Average
   D) Above average
   E) Excellent

25. In your opinion, will the Ministry of Health under New Directions have: (a) greater ability to exercise control regarding regional health issues - e.g., centralization of decision-making, funding allocations, etc., (b) lesser ability to exercise control regarding regional health issues - e.g., decentralization of decision-making, funding allocations, etc., or (c) there will be no change?

26. In your opinion, should individuals who work in health care facilities have the right to serve on their boards?
   - Why/why not?

27. In your opinion, should “professionals” such as nurses, physicians, etc., be allowed membership on hospital boards?
   - Why/why not?

28. Are you concerned with “special interest groups” (e.g., AIDS, Pro-life, etc.) gaining majority memberships on hospital boards?
   - Why/why not?

29. With respect to questions 28, have special interest groups ever become a “problem” with respect to hospital governance in this province?
   - Please elaborate

30. Under New Directions, do you see the topic of special interest groups becoming: (a) less of a problem, (b) more of a problem, or (c) there should be no change from the present

31. In your opinion, what do you see as the impediments or obstacles in: (a) the process, and (b) the implementation of the New Directions governance plan?

32. With respect to question 31, what suggestions do you have to improve the process of implementation of the New Directions governance plan?
Appendix D-1

Primary Occupation

<table>
<thead>
<tr>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCEO</td>
<td>55</td>
<td>100%</td>
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<tr>
<td>LTCCEO</td>
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<td>LTCCB</td>
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<td>45%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>SCCB</td>
<td>4</td>
<td>0%</td>
<td>75%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>ACBM</td>
<td>260</td>
<td>16%</td>
<td>40%</td>
<td>12%</td>
<td>0%</td>
<td>10%</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>LTCBM</td>
<td>213</td>
<td>20%</td>
<td>34%</td>
<td>6%</td>
<td>10%</td>
<td>4%</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>SCBM</td>
<td>45</td>
<td>2%</td>
<td>78%</td>
<td>11%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td>MoH</td>
<td>10</td>
<td>90%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Appendix D-2

Hospital Peers Groups and Role Classification

**ACUTE CARE RESPONSES (N=number of hospitals in group)**

<table>
<thead>
<tr>
<th>Peer Group (N)</th>
<th>ACCEO</th>
<th>ACCB</th>
<th>ACBM</th>
<th>Total AC</th>
<th>Tot AC+LTC+SC</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (4)</td>
<td>3</td>
<td>2</td>
<td>29</td>
<td>34</td>
<td>34</td>
<td>E (100%)</td>
</tr>
<tr>
<td>2 (7)</td>
<td>5</td>
<td>4</td>
<td>39</td>
<td>48</td>
<td>48</td>
<td>D (100%)</td>
</tr>
<tr>
<td>3 (8) 1LTC</td>
<td>5</td>
<td>4</td>
<td>40</td>
<td>49</td>
<td>59</td>
<td>C (85%), B (15%)</td>
</tr>
<tr>
<td>4 (12) 5LTC</td>
<td>6</td>
<td>6</td>
<td>56</td>
<td>68</td>
<td>115</td>
<td>C (70%), B (30%)</td>
</tr>
<tr>
<td>5 (12) 2LTC</td>
<td>8</td>
<td>7</td>
<td>31</td>
<td>46</td>
<td>53</td>
<td>B (93%), A (7%)</td>
</tr>
<tr>
<td>6 (25) 4LTC</td>
<td>16</td>
<td>15</td>
<td>24</td>
<td>55</td>
<td>91</td>
<td>A (66%), B (37%)</td>
</tr>
<tr>
<td>7 (20) 2LTC</td>
<td>12</td>
<td>16</td>
<td>41</td>
<td>69</td>
<td>86</td>
<td>A (100%)</td>
</tr>
<tr>
<td>9 (12) 12LTC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>137</td>
<td>A (22%), C (78%)</td>
</tr>
<tr>
<td>10 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>F (100%)</td>
</tr>
<tr>
<td><strong>tot</strong></td>
<td>55</td>
<td>54</td>
<td>260</td>
<td>369</td>
<td>676</td>
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</table>

**LONG TERM CARE RESPONSES (N as above)**

<table>
<thead>
<tr>
<th>Peer Group (N)</th>
<th>LTC CEO</th>
<th>LTC CB</th>
<th>LTB BM</th>
<th>Tot LTC</th>
<th>Tot all Groups</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (4)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>34</td>
<td>E</td>
</tr>
<tr>
<td>2 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>D</td>
</tr>
<tr>
<td>3 (8) 1LTC</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>59</td>
<td>C</td>
</tr>
<tr>
<td>4 (12) 5LTC</td>
<td>4</td>
<td>4</td>
<td>39</td>
<td>47</td>
<td>68</td>
<td>see ACResp</td>
</tr>
<tr>
<td>5 (12) 2LTC</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>53</td>
<td>see ACResp</td>
</tr>
<tr>
<td>6 (25) 4LTC</td>
<td>3</td>
<td>3</td>
<td>30</td>
<td>36</td>
<td>91</td>
<td>A (60%), B (40%)</td>
</tr>
<tr>
<td>7 (20) 2LTC</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>17</td>
<td>86</td>
<td>A</td>
</tr>
<tr>
<td>9 (12) 12LTC</td>
<td>10</td>
<td>10</td>
<td>117</td>
<td>137</td>
<td>137</td>
<td>see ACResp</td>
</tr>
<tr>
<td>10 (7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>F</td>
</tr>
<tr>
<td><strong>tot</strong></td>
<td>21</td>
<td>20</td>
<td>213</td>
<td>244</td>
<td>676</td>
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</table>

**SPECIALIZED HOSPITALS RESPONSES**

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>SCCEO</th>
<th>SCCB</th>
<th>SCBM</th>
<th>Tot SC</th>
<th>Tot all groups</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (7)</td>
<td>4</td>
<td>4</td>
<td>45</td>
<td>53</td>
<td>53</td>
<td>F</td>
</tr>
</tbody>
</table>
## Appendix D-3

Sub-group analysis of Personalized Care Delivery

<table>
<thead>
<tr>
<th>Position</th>
<th>Acute</th>
<th>Long Term</th>
<th>Spec</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCEO</td>
<td>11%(6)</td>
<td>78%(43)</td>
<td>0%(0)</td>
<td>11%(6)</td>
</tr>
<tr>
<td>ACCB</td>
<td>0%(0)</td>
<td>13%(7)</td>
<td>66%(33)</td>
<td>21%(11)</td>
</tr>
<tr>
<td>ACBM</td>
<td>17%(43)</td>
<td>61%(159)</td>
<td>15%(40)</td>
<td>9% (24)</td>
</tr>
<tr>
<td>LTCCEO</td>
<td>0%(0)</td>
<td>33%(7)</td>
<td>0%(0)</td>
<td>67%(14)</td>
</tr>
<tr>
<td>LTCCB</td>
<td>30%(6)</td>
<td>0%(0)</td>
<td>5%(1)</td>
<td>65%(13)</td>
</tr>
<tr>
<td>LTCBM</td>
<td>10%(21)</td>
<td>28%(59)</td>
<td>27%(57)</td>
<td>35%(76)</td>
</tr>
<tr>
<td>SCCEO</td>
<td>0%(0)</td>
<td>100%(4)</td>
<td>0%(0)</td>
<td>0%(0)</td>
</tr>
<tr>
<td>SCCB</td>
<td>0%(0)</td>
<td>100%(4)</td>
<td>0%(0)</td>
<td>0%(0)</td>
</tr>
<tr>
<td>SCBM</td>
<td>67%(30)</td>
<td>0%(0)</td>
<td>0%(0)</td>
<td>33%(15)</td>
</tr>
<tr>
<td>MoH</td>
<td>0%(0)</td>
<td>40%(4)</td>
<td>0%(0)</td>
<td>60%(6)</td>
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</table>
### Hospital Activities - Ranking by Group

<table>
<thead>
<tr>
<th>CEO's</th>
<th>CB's</th>
<th>BM's</th>
<th>MoH</th>
</tr>
</thead>
<tbody>
<tr>
<td>planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Long term finan.</td>
<td>3. Capital bud.</td>
<td>3. Medical Cred.</td>
<td>3. Fund Raising</td>
</tr>
<tr>
<td>planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Operational Budget.</td>
<td>13. Fund Raising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Patient Care</td>
<td>16. Prof.Ethics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Contact with MoH</td>
<td>17. Legal matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Research and Develop</td>
<td>20. Patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Legal Matters</td>
<td>22. Hosp ADMIN.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Hospital Admin.</td>
<td>24. Staff Discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Day to day hosp.oper.</td>
<td>27. Day/day hosp.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Employee Hire/Fire</td>
<td>28. Plant operations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **CEO's**
  - Strategic/long range planning: 100%
  - Capital Construction: 95%
  - Long term financial planning: 94%
  - Hosp. Accreditation: 93%
  - Med. Credentialling: 91%
  - Comm. Relations: 86%
  - Qual. Assurance: 83%
  - Fund Raising: 83%
  - Policy Making: 83%
  - Capital Budgeting: 76%
  - Medical Ethics: 73%
  - Networking: 73%
  - Operational Budget: 63%
  - Utilization Manag.: 61%
  - New Program/servic.: 58%
  - Patient Care: 46%
  - Contact with MoH: 43%
  - Health and safety: 38%
  - Profes.Ethics: 35%
  - Research and Develop: 35%
  - Staff Discipl.Action: 26%
  - Legal Matters: 24%
  - Labour Negot.: 18%
  - Hospital Admin.: 14%
  - Plant Operations: 14%
  - Contract negotiations: 11%
  - Day to day hosp.oper.: 11%
  - Employee Hire/Fire: 10%

- **CB's**
  - Long term fin. planning: 98%
  - Capital Const.: 96%
  - Capital bud.: 95%
  - Quality assur.: 94%
  - Strat.Planning: 91%
  - Policy making: 90%
  - Med.Credent.: 89%
  - Comm.Relat.: 86%
  - Contact c MoH: 85%
  - Hosp.Accred.: 85%
  - Oper.Budget: 83%
  - Networking: 80%
  - Fundraising: 83%
  - Health/Safety: 75%
  - Med.Ethics: 74%
  - Prof.Ethics: 66%
  - Utilization Man.: 73%
  - Legal matters: 65%
  - Hosp.Admin.: 63%
  - Patient care: 63%
  - Cont. c MoH: 58%
  - Utilization: 57%
  - Health/Safety: 57%
  - Med. Credent.: 50%
  - Prof. Ethics: 50%
  - Day/day hosp. op: 50%
  - Patient care: 50%
  - Staff Discipline: 50%
  - New Prog/Serv: 50%
  - Employ.Hire/Fire: 50%
  - Plant operations: 50%

- **BM's**
  - Community Relations: 100%
  - Strat.Planning: 99%
  - Medical Cred.: 95%
  - Fund Raising: 90%
  - Qual.Assuran.: 90%
  - Capital Const.: 89%
  - Prof.Ethics: 83%
  - Networking: 80%
  - Health/Safety: 75%
  - Utilization: 73%
  - Hosp. Admin.: 72%
  - Legal Matters: 70%
  - Cont.c MoH: 68%
  - Res/Devel.: 64%
  - StaffDiscipl.: 60%
  - New Prog/Serv: 58%
  - Health/Safety: 54%
  - Plant operations: 50%
  - Cont.Negotiat.: 48%
  - Networking: 48%
  - LTFin.Plan: 48%

- **MoH**
  - Strat./lon.run. plan.: 93%
  - Hosp. Accred.: 90%
  - Capital Const.: 89%
  - Cap.Budgeting: 70%
  - Qual.Assuran.: 70%
  - Capital Const.: 60%
  - Prof.Ethics: 59%
  - Legal Matters: 58%
  - Cont.c MoH: 57%
  - Hosp.Admin.: 52%
  - Labour negot.: 48%
  - Day/day hosp.: 48%
  - Labour negot.: 45%
  - Staff Discipline: 45%
  - Cont.negotiat.: 44%
  - New Prog/Serv: 40%
  - Day/day hosp.: 40%
  - StaffDiscipl.: 39%
  - Legal Matters: 38%
  - Plant operations: 38%
  - Cont. c MoH: 38%
  - Fund Raising: 38%