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Attending to the Health Needs of African Nova Scotians: Exploring the Role of District Health Authorities

by

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Submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

at

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For Debbie, Mary, Marcus and Micah
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Abstract

This research was an examination of the composition and knowledge base of governing boards responsible for health care in Nova Scotia to determine the extent to which they facilitate and/or impede efforts to attend to the health needs of African Nova Scotians, a historically oppressed social group. Feminist ethics serves as the normative framework for this inquiry. The research consists of a critical examination of public sector governance theory and health reform in Nova Scotia, a demographic survey of Nova Scotia’s District Health Authorities (DHA) and Community Health Boards (CHB) and a case study of Capital District Health Authority (CDHA). Qualitative interview and documentary data were interpreted by means of a hybrid of methods including discourse analysis, reflexive ethnography and ethnography.

Results from the demographic survey of DHAs and CHBs indicate that governing boards consist primarily of individuals who are Caucasian, middle-aged, affluent, well-educated, married or widowed and either working or retired. Visible Minorities are either underrepresented or not represented at all.

Key informants from the Health Association of African Canadians identified a lack of data and research on health issues, limited access to culturally appropriate primary care services, a lack of attention to the broad determinants of health and racism as being prevalent health issues affecting the Black community.

Data from the case study of CDHA indicate that organizational leaders demonstrate a good understanding of their responsibility to attend to the health needs of their catchment population. There are, however, barriers to attending to the needs of African Nova Scotians including a lack of awareness of Black culture, a lack of data on health issues specific to the Black community, a complex workload, a lack of funding, and challenges managing competing interests in the priority setting process.

Policy alternatives including raising awareness, finding alternative approaches to representation and building trusting relationships were identified. Opportunities exist for the Board to further develop organizational policies to promote diversity management and cultural sensitivity. CDHA can play a leadership role in building partnerships among the Black community and various stakeholders that have an interest in improving the health of African Nova Scotians.
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Thanks to the Board and Senior Management of Capital District Health Authority. Special thanks to Maura Davies. Thanks to the Health Association of African Canadians for supporting my research. A special note of thanks to Wanda Thomas Bernard for her advice, support and encouragement.

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Thank you to my parents, Evelyn and Gino Maddalena for always believing in me and for housing and feeding me on my many trips to Halifax. Finally, I want to thank my family for their patience, constant encouragement and assistance throughout my doctoral studies: my wife Debbie and my children Mary, Marcus and Micah.
Chapter 1: Introduction

Systemic racism is the big umbrella that we live under. It's real and it's alive and well. And we would be very naïve if we said it doesn't exist, because it does. (Member, Health Association of African Canadians)

1.0 Introduction

The principal aim of this research is to examine governing boards responsible for health care in Nova Scotia to determine the extent to which they facilitate and/or impede efforts to attend and respond to the health needs of African Nova Scotians. In particular I seek to understand and identify hidden institutional practices — primarily at the level of the governing Board — that serve as barriers and sources of failure to adequately respond to the health needs of African Nova Scotians and other vulnerable populations.

In this introductory chapter I begin by describing the motivation for my research and a brief description of my research questions. I then present feminist ethics as the normative framework for my research and provide a description of the epistemologies I use to support my inquiry. I conclude with an overview of my thesis.

This inquiry draws on available evidence that describes the history and present day circumstances for many African Nova Scotians as being characterized by hardship, discrimination, injustice, exclusion, and institutionalized racism (BLAC, 1994; Head & Clairomont, 1989; Enang, 2002). While there is a dearth of research on the health status of African Nova Scotians, extensive research conducted in the United States has shown that African Americans have reduced access to health services and poorer health status than the general population (Manton et al., 1987; O'Hare, 1987; Rich, 2000). The available data for African Nova Scotians suggests similar patterns of poor health status and reduced service availability (Enang, 2002). It is an assumption of this research that this inequality in health status and inequitable access to health services — the causes of which are rooted in a history
of racism and socio-economic deprivation – is unfair and unjust. Furthermore, these differences in health status and access to services are avoidable (Mackenbach et al., 2002).

Governing boards in health care are vested with considerable formal authority and play an important role in decision-making and setting policy related to the allocation and delivery of health care services. Because of the boards' unique position in the hierarchy of decision-making in health care, their role in attending to the health needs of diverse social groups should be critically examined to determine if by their action, or inaction, they contribute to poor health status among African Nova Scotians. Thus my research is a qualitative exploration of the role played by governing boards in health care – as decision-maker and policy-maker – in attending to populations whose circumstances predispose them to poor health status. The decision-making practices of governing boards, as they relate to serving the health needs of vulnerable populations are, for the most part, an unexamined area of inquiry.

This thesis is concerned with promoting justice by identifying and eliminating sources of oppression through better understanding the role of organizational practices within health care governing boards with specific concern for the question of how boards attend – or do not attend – to the needs of one social group, in this case, African Nova Scotians. While this critical evaluation of the practices of governing boards is concerned generally with a description of "what is", I am ultimately concerned with the important normative question of "what ought to be?" Thus this inquiry is an exploration of how to make this transition and to facilitate this I conclude my analysis with recommendations for action in the Nova Scotian context.
1.1 Research Questions

In this research I provide a critical review of the history of governance and health reform in Nova Scotia, a demographic survey, and a qualitative examination of a case study of Capital District Health Authority (CDHA) to explore answers to four interrelated questions: 1) What is the role of governing Boards in health care in Nova Scotia? 2) What is the demographic profile of District Health Authorities (DHA) and Community Health Boards (CHB) in Nova Scotia? 3) How does the Capital District Health Authority assess, understand and attend to the health needs of minority populations, in particular African Nova Scotians? and, finally, 4) How can CDHA modify its governance and management structures and processes to ensure they attend and respond to the health needs of African Nova Scotians?

My inquiry examines how governing boards attend to the health needs of African Nova Scotians from two distinct perspectives: first, from the perspective of the governing board and their senior management staff, and second, from the perspective of African Nova Scotians. To answer my research questions I employ a qualitative methodology and engage in a discourse analysis of board practices.

1.2 Normative Framework

1.2.1 Feminist Ethics

Ethics, or moral philosophy, has a distinct action-guiding aspect and is concerned primarily with questions of right and wrong conduct and moral obligation (Pojman, 1998). I situate my inquiry in the realm of ethics and I have adopted feminist ethics as the normative framework – and source of motivation – for my research (Sherwin, 1992, 1996, 1998).
Most feminist theories share the common belief that women as a group are oppressed, and that the work of feminists is political in nature, i.e. focused on individual and social change to eliminate all forms of oppression (Letherby, 2003; Sherwin 1996). Feminists also seek to understand the nature and consequences of social group interactions and cultural norms and how these arrangements impact on people's moral, social, political and economic standing in society. It is this reflective study of social group interactions, and the intention of reducing oppression, that form the basis for feminist ethics (Walker, 1998).

Briefly, feminist ethics can be characterized

...by its commitment to the feminist agenda of eliminating the subordination of women – and other oppressed persons – in all of its manifestations. The principal insight of feminist ethics is that oppression, however it is practiced, is morally wrong. Therefore, moral considerations demand that we uncover and examine the moral injustice of actual oppression in its many guises. ... If we want moral change and not mere moral platitudes, then the particular practices that constitute oppression of one group by another must be identified and subjected to explicit moral condemnation; feminists demand the elimination of each oppressive practice (Sherwin, 1992, p. 54).

In feminist ethics sources of oppression are a significant point of interest and include gender, class, disability, sexual orientation and race. My research is not specifically concerned with "gender-specific patterns of harm that constitute women's oppression" (Sherwin, 1992, p.13). Rather, in my thesis, I focus on "race" as a source of group oppression in the Black community. This is not to say that gender is not also an important variable (as are disability, class, sexual orientation, and other sources of oppression). All of these categories intersect with those of race and all are worthy of exploration. In this thesis, however, I have chosen to focus explicitly on the category of race and acknowledge its complex manifestation.

Feminist ethics – and its concern for identifying and eliminating sources of oppression – has informed and motivated my examination of governing boards. I employ
qualitative methodology and conduct a critical discourse analysis of data collected with the express aim of making "invisible" board practices "visible" in terms of how questions of race are addressed.

Feminist ethics, as the normative framework guiding this research, demands that policies and practices in society be examined to determine whether the practice in question maintains, exacerbates, or lessens existing patterns of oppression (Sherwin, 1992, 1996). Marilyn Frye (1983) suggests that feminists should approach all institutional practices with questions that examine how power is used to help or hinder a particular group. For example, applying Frye's approach to the structures and practices of governing boards raises the following line of questioning: How are governing boards structured and how do they use their power? Whose interests do the Board's existence and practices serve? Do their decisions benefit some groups and disadvantage others? Are governing Boards and their Senior Managers part of structures that tend to confine, reduce and immobilize some groups?

Governing boards in health care — as an institution in our society vested with considerable authority and decision-making capacity — have the power to perpetuate dominant cultural values. Thus the potential exists for boards to further perpetuate the oppression of African Nova Scotians by not attending to their health needs, by excluding them from decision-making processes on issues that affect their health, and by not ensuring they receive an equitable share of health care resources. Boards also possess the power to help reduce or reverse the patterns of harm that potentially contribute to the oppression of Nova Scotia's Blacks.

Throughout this thesis I characterize African Nova Scotians as being an "oppressed group." For the purposes of this research project I am using the definition of oppression as
conceived by Iris Marion Young (1990). Briefly, Young defines oppression as a complex
notion that is more than the traditional definition of "...the exercise of tyranny by a ruling
group" (p.40). Rather, Young views oppression as being more insidious, systemic and deeply
imbedded in the norms, structures and values of the institutions of society. Young (1990)
states:

In this extended structural sense oppression refers to the vast and deep
injustices some groups suffer as a consequence of often unconscious
assumptions and reactions of well-meaning people in ordinary interactions,
media and cultural stereotypes, and structural features of bureaucratic
hierarchies and market mechanisms – in short, the normal processes of
everyday life. (p.41)

Furthermore, Young states that, "The systemic character of oppression implies that an
oppressed group need not have a correlate oppressing group." (p. 41). Young argues that
while it is challenging to classify the necessary conditions that constitute the oppression of a
group, all oppressed people share the common feature of the "...inhibition of their ability to
develop and exercise their capacities and express their needs, thoughts and feelings" (p. 40).
Young identifies five "faces" or distinguishing features that characterize oppression:
exploitation, marginalization, powerlessness, cultural imperialism and violence. Young
believes that a group is oppressed if its members experience at least one of the five "faces."
Because African Nova Scotians as a social group have in the past experienced and continue
to experience all five "faces" of oppression as defined by Young, I argue that African Nova
Scotians – as a social group – are oppressed.

In the same context, I am using the definition of a social group as proposed by
Young (1990). She defines a social group as "...a collective of people who have affinity with
one another because of a set of practices or a way of life; they differentiate themselves from
or are differentiated by at least one other group according to these cultural forms" (p.186).
Social groups can be defined in terms of gender, race, culture, ethnicity, age, religion, disability or sexual orientation (among others) and these designations often serve to afford privilege and advantage for some, and disadvantage and vulnerability for others. Because of their oppressed status, African Nova Scotians, as a group, are vulnerable with respect to health matters, i.e. they are at an "...increased relative risk of adverse health outcomes" (Flaskerud & Winslow, 1999, p.69).

From the outset of my research I found the terminology describing social groups such as African Nova Scotians problematic. In this thesis I will use the terms "oppressed group" and "vulnerable group" to describe African Nova Scotians but at the same time I acknowledge an inherent problem with categorizing an entire social group using these terms. The Black community in Nova Scotia is diverse and made up of individuals, many of whom would not consider themselves as either oppressed or vulnerable. There are many other terms that are used to describe Blacks (as a social group) in Nova Scotia including for example, "marginalized population", "racialized minority" and, "visible minority". Each of these terms is problematic and limited in its ability to capture the history, vibrancy and diversity of this community. Among Blacks in Nova Scotia there are individuals who are well educated and some that are not well educated, some with no disabilities, and others with multiple disabilities, rich and poor, etc.

Some would argue that using descriptive terms such as "oppressed", or "vulnerable" to describe African Nova Scotians represents a form of racial stereotyping of an entire community and these terms fail to adequately reflect the broad diversity of viewpoints and characteristics of African Nova Scotians themselves. In this thesis I use the terms "oppressed group" and "vulnerable group" in a very specific manner, and I deliberately apply these terms to African Nova Scotians as a social group and not to individuals. Despite the
ability for words to categorize and stereotype a social group, the use of terminology, as
descriptors, can help to advance our understanding of the general features and experiences
of a social group.

1.2.2 Epistemology

Historically, qualitative research has been evaluated based on its ability to
conceptualize the world and to communicate a story, a message or an idea (Vidich & Lyman,
2000). It is supported by epistemologies that suggest there are no single universal truths, but
rather truths are multiple, and socially constructed by the participant and the researcher. In
this thesis I draw on two complementary epistemological traditions: social constructivism
and feminist standpoint theory.

In social constructivism, the assumption is that there is no single reality, or truth, but
rather reality and knowledge are socially constructed in part through the subjective lens of
the researcher’s social, political, cultural, and gender values (Guba & Lincoln 1994 cited in
Campbell & Wasco, 2000; Schwandt, 2000). This is in stark contrast to positivist traditions
where the assumption is that there is a single "truth" waiting to be discovered by an
objectively situated researcher. In social constructivism, the researcher plays an important
role because it is through the subjective experiences and values of the researcher that
research questions are formulated and data are collected and interpreted. Thomas Schwandt
(2000) states,

Most of us would agree that knowing is not passive – a simple imprinting of
sense data on the mind – but active; that is the mind does something with
these impressions, at the very least forming abstractions or concepts. In this
sense, constructivism means that human beings do not find or discover
knowledge, so much as we make or construct it. We invent concepts,
models, and schemes to make sense of experience, and we continually test
and modify these constructions in the light of new experience (p. 197).
Because there is no single truth or reality to be discovered, the qualitative researcher engages participants in a process of interactive dialogue that explores ideas and experiences and together they create these socially constructed realities as a way of making sense of a complex world (Campbell & Wasco, 2000). In this respect the generation of knowledge is both a social and relational process that is highly dependent on context. By "relational" I mean that as humans we are interdependent and "embedded in a complex web of intimate and larger social relations" (Mauthner & Doucet, 2003, p. 422). Hence, our experiences are not isolated events, but rather take place in a particular social, political and historical context. Schwandt (2000) further clarifies this process and suggests, "...there is an inevitable historical and socio-cultural dimension to this construction. We do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, language and so forth" (p. 19). The qualitative researcher plays a central role in the research process, deciding what questions to ask, who to interview, what to observe, how to interpret the data, and what to include in the final representation of the data (Mantzoukas, 2004).

Earlier in this chapter I described this research as being motivated by an interest in feminist ethics, not because this research is concerned specifically with gender issues – because it is not – but rather because feminist ethics is concerned with identifying and eliminating all forms of oppression (Sherwin, 1992). Feminist standpoint epistemology also provides a useful approach for examining the multiple perspectives that view a single problem or issue by acknowledging those various perspectives as legitimate sources of knowledge (Campbell & Wasco, 2000). In this research I attempt to bring together and benefit from three perspectives, or standpoints: those of the governing board members of Capital District Health Authority and their senior management staff, key informants from
the Health Association of African Canadians and my own perspective as an in/outsider to
the organization. Sherwin (1996) states:

The location of the knower influences what is observed/observable, what is
known/knowable, and what each of us experiences in the world. The
location of a particular knower is shaped by reference to many factors:
gender, age, class, race, ethnicity, political orientation, sexual orientation, and
disability, as well as by the historical circumstances of one's life. (p. 4-5)

Researchers adopting a feminist standpoint epistemology seek to engage individuals
in describing how their experiences in the social world are shaped by their ethnicity, gender,
and social class and their perceptions of how their impoverished or privileged circumstances
can shape how they interact with their surroundings and influence their lives (Campbell &
Wasco, 2000). In my research I draw on the experiences and perceptions of members of the
Board of CDHA, and I explore with them their perceptions of how they understand and
attend to the health needs of African Nova Scotians. In this case study I am interested in the
governing Board of CDHA because it is an example of a sophisticated social structure, that
draws on a rich tradition of health system governance, that is vested with considerable power
to set priorities, allocate resources, deliver health services and set policy that affects the
public's health. I will examine the governing board's "normal procedures of everyday life"
(Young, 1990, p. 41) and seek to make visible the practices that have remained, for the most
part, invisible. The membership of governing boards tends to reflect a narrow demographic
profile (predominately social elites) and with this comes the potential for boards in health
care to promote dominant social values such as racism, classism, sexism etc.

I also interview key informants from the Black community to see what factors
influence the health status of their community and how the system is or is not meeting their
needs. I examine evidence that suggests that the poor health status of African Nova
Scotians as a social group is partly the result of the oppression that they have endured living in a society that is rife with racism and classism.

The outcomes of this research can serve to promote systemic changes in the ways governing boards are structured and the ways they function. This, in turn, can serve as a means to promote the health and well being of African Nova Scotians and other vulnerable populations. Therefore, a social constructivist and feminist standpoint epistemology can serve to promote these ends.

1.3 Thesis Overview

In Chapter Two I describe my general rationale and approach to answering my research questions with a particular focus on research methods and data collection and analysis.

In Chapter Three I provide, as background information, a brief history of African Nova Scotians as a cultural group and a discussion on the current state of knowledge regarding the health status of African Nova Scotians. I also examine the concept of racism and the impact that racism has on the health status of racialized groups, such as African Nova Scotians. As part of this research I interviewed representatives from the Health Association of African Canadians (HAAC). The purpose of the HAAC interviews was twofold. First, because health status data and research specific to African Nova Scotians is limited, my objective was to seek first-hand knowledge of health issues from the perspective of key-informants who live and work in the Black community. Second, my objective was to seek input from representatives from the Black community on their perceptions of how the health care system understands and attends to their needs. I will present the data from the
HAAC interviews in Chapter Three – as a means to fill a gap in knowledge regarding health status – and in Chapter Six, the case study of Capital District Health Authority.

In Chapter Four I examine the academic literature on various theories of governance and discuss how this has shaped the practice of governing boards in health care. In particular, I explore the aims and objectives of governance as it applies to the public sector, and more specifically, publicly funded health care organizations. I also provide a brief history of Nova Scotia's foray into health reform and discuss how this has influenced the work of governing boards in Nova Scotia and their approach to promoting health. In addition, I examine how the concept of public participation has helped to shape the role of governing boards as they exercise trusteeship in a reformed health system.

In Chapter Five I present the findings of a demographic survey of Nova Scotia's nine District Health Authorities and 37 Community Health Boards. In this survey I attempt to answer one of my research questions, namely, what is the demographic profile of District Health Authorities and Community Health Boards in Nova Scotia? In this survey I seek to determine the general demographic composition and level of cultural and ethnic diversity present on governing boards in health care. While the demographic survey helps to answer some questions, it is limited in its ability to shed light on the actual processes of decision-making and how board members and senior managers understand their role as decision-makers in health care.

In Chapter Six I present the case study of Capital District Health Authority. In this chapter I focus on answering my research question, "How does the Capital District Health Authority assess, understand and attend to the health needs of minority populations, in particular African Nova Scotians?" The case study consists of a qualitative examination of the CDHA as an organization with a particular focus on the structures and processes of the
governing board. The case study consists of a document review and interviews with Board Members and Senior Managers. In particular, I explore how they perceive their role as governors and senior managers, and how they understand, assess and address the health needs of African Nova Scotians. I end Chapter Six with a brief presentation of interview data that examines policy options for remedial action.

In the final chapter, I build on the lessons learned from theoretical discussion on governance and health reform, the results of the demographic survey and the case study of CDHA and examine what these data mean in terms of answering my research questions. I explore various strategies by which changes can be incorporated into the work of CDHA to enable it to respond more appropriately to the health needs of the Black community. I also propose a research agenda that builds on the work of this thesis.
Chapter 2: Research Methods

I cannot understand the journey of an African Nova Scotian...and because I don't understand it...then I am at risk of discounting it as whining...you see that happen and you see that in people's talk...and it's normal human nature because you don't want to see the worst of our society. You don't want to see that...because you don't want to have to face it. You don't want to have to face it in yourself. (Senior Manager, CDHA)

2.0 Introduction

I begin this chapter with some thoughts and reflections on my approach to the research process and I describe some of the considerations and challenges associated with research design and implementation. Following this, I present my research methods including approaches to data collection, analysis and presentation of results.

2.1 Setting the Context

As a preamble to the research methods section of this chapter I offer a few introductory thoughts and observations as a means to provide the reader with some insight into how my own subjectivity has influenced my approach to this research. Moreover, I believe it is important to acknowledge that as a researcher I come with my own beliefs, values and experiences that both motivate and influence my approach to conducting the research and this, in turn, has influenced my analysis and presentation of the data.

The motivation for this research stems from my professional experience as a Chief Executive Officer for two healthcare organizations over a period of 10 years. My personal beliefs regarding social justice led to a growing awareness that governing boards – as an example of an elitist power structure – may perpetuate oppression through seemingly benevolent intentions. In this regard I acknowledge that I bring to this research many assumptions that have shaped my inquiry and analysis. For example, I believe that volunteer
board members and their management staff are generally committed, thoughtful individuals that are motivated to serve the public because they sincerely want to 'do the right thing', and make good decisions in the public's interest. However, while Board members and Senior Managers, as individuals, are well intentioned, they are part of a larger social system that upholds racist and classist views.

Conducting research on governing boards presents special challenges. A review of the literature on governing boards revealed a very limited amount of material that critically examines the decision-making capacity of non-profit governing boards and boardroom culture. I can only speculate that one of the reasons for this is that, for the most part, governing boards in health care still operate in relative seclusion. My own experience leads me to believe that while the board is revered as the key decision-making body of an organization, for most of the organization’s staff—below the senior management level—and parties external to the organization, the work of the Board continues to be shrouded in mystery. Boards generally meet after regular working hours, in a sequestered boardroom, out of view of the mainstream activity of the organization. Furthermore, in Nova Scotia at least, board meetings are held in private and are closed to the public, media and general staff. There are even times when the Board meets in camera, excluding all senior management staff (with the exception of the Executive Secretary for the Board).

Normally only executive management staff attend Board and committee meetings. When "outsiders" are invited to attend a portion of the board meeting, administrative staff often choreographs their entrance to, and exit from, the meeting (and often the content of their presentation to the Board). Furthermore, Board decisions are normally communicated through management staff to the organization, thereby further distancing the Board from scrutiny or criticism.
There is also the possibility that those in positions of power – Board members and senior managers – are reluctant to be the focus of research because of the potential threat of being criticized. This is particularly true in the politically charged environment within which health care decision-makers function. Lee (1993) suggests that in organizations where there is a strong internal normative order there may be a reluctance to have outsiders (whose values may be perceived as unsympathetic or just different) engage in studying their behaviours.

Another reason boards are not often the subject of study is because there has been a tendency in social research to study the powerless, not the powerful (Lee, 1993). Lee (1993) states, "...there has been a tendency for social scientists to study 'down' rather than 'up'; directing their attention towards the relatively powerless rather than at elites, powerful organizations or the state apparatus" (p.8).

This leads me to another concern that emerged early in my research. In Nova Scotia there is a long history of institutionalized racism and distrust between the Black community and the social and political establishment (BLAC, 1994; Clairmont & McGill, 1987; Head & Clairmont, 1989; Africville Genealogical Society, 1992; Pachai, 1989, 1990). My research examines how District Health Authorities (DHAs) in Nova Scotia have (or have not) attended to the health needs of a historically vulnerable and oppressed group, namely African Nova Scotians. My experience in the health care system leads me to believe that, in general, health organizations in this province have not devoted significant energies to attending to the health needs of minority or vulnerable populations. As a result I have been conscious, since the early stages of my project, that my research is probing a socially and politically sensitive subject and that the results of my research, if unfavourable, may reflect
poorly on Nova Scotia's health boards, especially the Board and management of CDHA which is, in this research, the subject of scrutiny.

I am aware that my insider status as a former CEO and my role as researcher create an ethical challenge for me as insider/researcher and this has undoubtedly affected my approach to, and presentation of, my research. Rainwater and Pittman (1967) describe this potential ethical concern. They state,

...this concern for the effect of findings on public issues sensitizes one to the question of how research results will be interpreted by others, and to his responsibility to anticipate probable misuses, and from this anticipation attempt to counteract the possibility of misuses. That is, though we do not feel a researcher must avoid telling the truth because it may hurt a group (problems of confidentiality aside) we do believe that he must take this possibility into account in presenting his findings and make every reasonable effort to deny weapons to potential misusers (p.362-3).

As a result, I argue that my research can be appropriately characterized as "socially sensitive research". Sensitive research is defined as research where, "...there are potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research" (Seiber & Stanley as cited in Lee, 1993, p.3). The concept of sensitivity is contextual and dependent on the circumstances surrounding the research problems, the mode of research, and the environment within which the research is taking place (Lee, 1993). Lee & Renzetti (1993) state that, "The sensitive nature of a particular topic is emergent. In other words, the sensitive character of a piece of research seemingly inheres less in the topic itself and more in the relationship between that topic and the social context within which the research is conducted" (p. 5).

There are several implications associated with conducting sensitive research. In the case of my research, there is the potential that Board members may feel that they (individually or collectively) are "on trial" or that their performance is being evaluated. The possibility exists that the results of the research may favour one party or another and be used
as leverage for social change, or that the outcomes of the research may be unpredictable. As Lee (1993) states, "...elites, powerful organizations and governments are often sensitive to the way in which their image is portrayed" (p.9). To some degree these concerns are warranted. By initiating the research there is the very real potential for the results to be used as leverage by the Black community (or other minority groups) to initiate social change and, conversely, the CDHA may also use the results to facilitate constructive change within the organization. The potential for the research to influence change is not necessarily a negative outcome of the research, but rather one that is unpredictable.

Having stated the challenges associated with conducting sensitive research I feel it necessary to clarify that the CDHA Board and Senior Management staff were, from the outset, amenable to participating in this research project, though not all Board members or Senior Managers agreed to participate. In subsequent discussions with Board members and management staff who agreed to participate in the interviews there was a genuine interest in the outcomes of the research and a sincere desire to implement change.

2.2 Research Questions

In this research I am interested in examining governing boards to determine the extent to which they facilitate and/or impede efforts to attend and respond to the health needs of African Nova Scotians. This research is primarily concerned with answering four questions:

1. What is the role of governing Boards in health care in Nova Scotia?

2. What is the demographic profile of District Health Authorities and Community Health Boards in Nova Scotia?
3. How does the Capital District Health Authority assess, understand and attend to the health needs of minority populations, in particular African Nova Scotians?

4. How can CDHA modify their governance and management structures and processes to ensure they attend and respond to the health needs of African Nova Scotians?

The first research question examines the role of governing boards in health care in Nova Scotia and is central to the thesis. To answer this question I discuss, in Chapter Four, the literature on governance theory, the history of governing boards in health care and how Nova Scotia's conception of health reform has shaped avenues (and created barriers) for public participation in health care decision-making.

One of the principles of health reform was to put decision-making in the hands of citizen volunteers and as a result one important question that arises from this transformation is whether these lay volunteer board members are serving as "trustees" or "representatives."

This is an important distinction to make because if a board member is serving as a trustee they are, by definition, authorized to make decisions based on behalf of the public. If, however, one serves on the board as a "representative" they are expected to bring forward the views and perspectives of their constituency and vote on matters in accordance with the "will of the people," which implies the presence of some process to facilitate consultation and consensus. In this instance the Board member should seek to reflect the views of the citizens they are supposed to represent, in particular those citizens who will be impacted by the Board's decisions. This is problematic, however, for disadvantaged and minority social groups because their needs and concerns often go unnoticed. Hence understanding the demographic composition of governing boards is important.

The second research question explores this issue of the demographic profile of governing boards in health care in Nova Scotia. To answer this question, I conducted a mail
survey of voting members of Nova Scotia nine DHAs and 37 CHBs (Chapter Five). The purpose of the Demographic Survey was to compile a demographic profile of District and Community Health Board members in Nova Scotia. I am interested in clarifying the composition of governing boards as a prelude to examining the perceptions and understanding of trustees and senior managers as it relates to their role in attending to the health needs of African Nova Scotians.

I am concerned that the demographic profile of governing boards may have a direct or indirect impact on decision-making. Results from demographic surveys of health boards in Canada and the United States (public, not-for-profit) show that governing boards tend to be comprised of individuals that are predominately white, middle-aged, well-educated, affluent, married or widowed, and retired or employed, i.e. social and professional elites (Alexander et al., 2001; Frankish et al., 1998). While the literature in this area is limited, there is a concern that a lack of cultural diversity on governing boards may impact on the board's ability to attend to differences in health needs in minority communities (Brown, 2002; Carver & Carver, 1997; Guterbock & London, 1983; Kouri). In this thesis I explore the potential benefit of increasing the diversity of governing boards, and finding alternative means to involve groups such as African Nova Scotians in the governance process, especially when the Board's decisions impact on these social groups.

The third research question is concerned with how trustees and senior managers of the Capital District Health Authority assess, understand and attend to the health needs of minority populations, in particular African Nova Scotians. To answer this question I conducted an indepth, qualitative case study of the governing board of Capital District Health Authority. The purpose of the Case Study of CDHA (Chapter Six) is to increase understanding of how Trustees and Senior Managers of health organizations perceive,
understand and fulfil their fiduciary, legislative and moral responsibility of meeting the unique health needs of African Nova Scotians. During the interviews with Board members and Senior Managers I explore their understandings and knowledge of the African Nova Scotian community and their health needs. I also examine how the Board goes about the process of determining health needs generally, and how the Board sets priorities and allocates resources.

My final research question focuses on how CDHA can modify its governance and management structures and processes to ensure the organization adequately attends and responds to the health needs of African Nova Scotians. This research also involves the exploration of policy options that can increase the awareness of Trustees and Senior Managers of the health needs and concerns of African Nova Scotians and means by which the Black population can play a meaningful role in the governance process. In this regard I examine policy alternatives that have the potential to help governing boards become more inclusive of vulnerable populations in their decision-making. To accomplish this I examine policy options that are suggested by Board members, senior managers and by key informants from the Black community. I conclude with some recommendations that can assist health organizations develop governance processes that are inclusive and attentive to the health needs of minority and vulnerable populations.

2.3 Research Methods

As a preamble to this section I feel it necessary to share some of my rationale for choosing my various approaches – methods – to this research. I employ a variety of research methods to facilitate my inquiry, each with a specific objective in mind and because they provide a different perspective in the general schema of my research. To begin, my overall
approach to the research is qualitative as opposed to quantitative, and this choice was deliberate because my research is an exploration of the role of DHAs. I have always been intrigued by the potential of qualitative research to examine and explain the world around us. I particularly like Denzin and Lincoln's (2000) definition of qualitative research. They define qualitative research as

a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural surroundings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them (p.3).

The general nature of governing boards can be characterized as enigmatic. While at a theoretical level the goals and objectives of boards are relatively straightforward, the means by which they achieve their objectives are complex, contextual, steeped in a rich history and tradition, and subject to the vagaries of human interactions. Board processes and boardroom culture cannot easily be isolated and studied as individual events, but rather there is a richness, a blending of phenomena, that occurs as board members come together to exercise trusteeship.

Regan (1991) acknowledges the challenge of describing the role of trustees and governing boards. He states, "Because we are not dealing with a mathematical equation, [describing the work of boards] is more like an impressionist painting than a photograph" (p.2). The best that one can hope to accomplish when describing the work of boards is to provide a perspective, an interpretation, that draws together various phenomena that characterize the work of boards. It is for this reason that I have chosen to use a qualitative case study as my primary research method.
This research is an exploration, a foray, in a manner of speaking, into one particular dimension of the work of governing boards, specifically the role that governing boards play in assessing and attending to the health needs of African Nova Scotians. The holistic approach offered by qualitative research methods is particularly well suited to this kind of examination.

2.3.1 Reflexive Ethnography and Insider Status

Throughout this thesis I have incorporated both my role as a researcher and my professional experience working with governing boards as a means to illuminate the discussions on boardroom culture, trusteeship and management. In this regard I reference Ellis and Bochner (2000) who describe reflexive ethnography as a form of inquiry where the researcher, "...uses their own experiences in the culture reflexively to bend back on self and look more deeply at self-other interactions" (p.740).

One of the factors that facilitated this research was my "insider" status. More accurately, to use Sandra Acker's (2001) typology, I would be classified as an "indigenous outsider." Acker defines an indigenous outsider as "...someone who belongs to the category, yet takes a different view than those fully encapsulated within the category and for that reason is seen by the community to be at least a partial outsider" (p.162).

I was trained (dare I say indoctrinated) in the culture of executive management in the health care setting and I understand very well the dynamics, norms, etiquette and internal social control mechanisms of the Boardroom environment. While I have never been associated with the CDHA Board as an employee, I believe my insider knowledge from work with a comparable body has been advantageous in the development of my research questions and in obtaining access to the otherwise closed environment, or inner sanctum, of
Boardroom culture. My insider status also permitted me the opportunity to engage in discussions with interview participants and organizational staff with, as a starting point, a common knowledge base and understanding of the circumstances and rules that govern how Boards function. It also allowed me to probe into areas of Board operations that other researchers, who were unfamiliar with the Boardroom environment, might not have known to exist.

In keeping with the reflexive character of my writing, I realize that while I had the benefit of insider knowledge, I also faced the challenge of trying to see the board and its activities through the eyes of a researcher, searching for the "anthropologically strange or novel". Critically examining an organizational structure that I was a part of for more than 10 years was both difficult and liberating. During the course of this thesis I present examples of how this insider/researcher dynamic influenced my approach to the research process.

There are also sections of my research, in particular the case study that are distinctly ethnographic and descriptive in character and are derived from my professional experience working with Boards. I present this material as a means to give the reader insight into some of the day-to-day features of the environment within which governing boards and their executive management staff function.

2.3.2 A Historical and Theoretical Account of Governance and Health Reform

In Chapter Four I engage in a theoretical and reflexive account of the history and role of governing Boards in Canada with a particular focus on the evolution of governing boards in Nova Scotia. In this regard I describe how the role of governing boards in health care has been shaped by their historical development and this, in turn, has affected the way
governing boards understand and fulfil their legislated and fiduciary obligations and how individual DHA board members exercise trusteeship.

Because of my professional involvement in various aspects of the health care system and health reform in Nova Scotia over the past 20 years, much of the discussion on health reform is told from my own perspective, as an insider who had the opportunity to be a part of the many deliberations and activities. In this regard I draw, once again, on the methodological approach of reflexive ethnography.

2.3.3 Demographic Survey

The Demographic Survey was conducted during the period March to October 2003. A mail-survey consisting of 11 questions was sent to all voting board members currently serving on Nova Scotia's nine District Health Authorities and 37 Community Health Boards (See Appendix A). The Board of the IWK Health Centre was invited to participate in the survey and was the only board in the province that did not respond to the invitation to participate. All other boards agreed to participate in the survey. The basic design and approach to the demographic survey was based on similar surveys (Brunelle et al., 1998/99; Frankish et al., 1998; Lewis et al., 2001).

The demographic survey represents an effort to compile a demographic profile of health boards in the following areas: length of service on the board, age, gender, self-identified ethnic/cultural background, highest level of educational attainment, marital status, total household income (before taxes), number of dependants, work/employment status, field of employment, and dis/ability status.

The survey process was initiated by first sending each DHA and CHB a letter of introduction. The letter of introduction explained the nature of the research project in
general, the objectives of the Demographic Survey, and included an invitation to participate in the Survey and a request for a list of their current Board members (See Appendix B). Following receipt of the list of Board members a survey package was mailed to each Board member. This survey package contained a letter of introduction, a Research Information Sheet and Consent Form, the Demographic Survey and a Self-Addressed Stamped Envelope (See Appendix C). A reminder notice was sent four weeks following the initial mail-out (See Appendix D). A second reminder notice (including a full survey package) was sent in September of 2003 (See Appendix E).

All surveys were entered into Microsoft Excel 97 spreadsheet program and tabulation of data was done using this program.

2.3.4 Case Study as Method

This case study is an exploration into one particular dimension of the work of governing boards, specifically the role that governing boards play in assessing and attending to the health needs of a historically oppressed group. But this closer examination of one phenomenon can only be accomplished by examining the Board as a whole, in a given context.

As with most case studies, the case of interest exists within a particular physical, economic, historical, political and social context (Stake, 2000). In other words, while all governing boards across Canada share similar characteristics and responsibilities, each is unique by virtue of the social, political and historical milieu within which the Board operates.

Case study as a research method is widely recognized as a useful tool for examining the various dimensions of a particular social phenomenon (Gillham, 2000; Orum et al., 1991; Sjoberg et al., 1991; Stake, 2000; Yin, 1994). There are many definitions of "case study" and
all are very similar. I have chosen to use the definition proposed by Anthony Orum and colleagues (1991) wherein they define a case study as, "...an indepth, multifaceted investigation, using qualitative research methods of a single social phenomenon" (p. 2). In this regard the Capital District Health Authority is the subject of interest and the particular social phenomenon of interest is the manner by which the CDHA assesses and attends to the health needs of African Nova Scotians.

The literature describes several advantages to utilizing case study as a research method. First, examining a single case provides an opportunity to study human events and actions in their natural settings (Orum et al. 1991). Second, case study as a research method permits a holistic approach to examining a complex problem and it permits a rich description of the history and context of the social phenomenon of interest (Orum et al, 1991). Board deliberation and decision-making processes are complex and take place within a social and political context and these factors can best be articulated through multiple data collection approaches and schemes of inquiry.

Most often case study research is criticized on the issue of reliability. Orum and colleagues (1991) state:

Consequently, it is sometimes said that the case study, like all other kinds of qualitative research, is vulnerable to the idiosyncratic biases of the investigator and can be at best descriptive because it can invoke no more general principles than those supplied by its own data. Therefore, the interpretations and claims of qualitative research are likely to be too unreliable to permit the construction of solid scientific evidence (p.18).

I respond to this criticism in the following manner. To somehow seek to generalize the work of governing boards by collapsing all governing boards into a single category diminishes the importance of context and the interplay of individual personalities and local politics. Yet at the same time I know that while each board is unique, boards across Canada face similar
limitations, constraints and opportunities as they go about their work. This case study will
describe the experiences of one board, and in doing so it will illuminate some of the
challenges that all boards face as they try to fulfil a daunting mandate to improve the health
of populations within a limited funding envelope.

2.4 Data Collection

2.4.1 Interviews

The case study interviews took place on two fronts: first, nine interviews with Board
members and senior management staff and second, five key informant interviews with
representatives of the Health Association of African Canadians (HAAC). In general, the
interviews served as an ideal method for data collection because they provided rich and
detailed information. Because this research is exploratory in nature, semi-structured
interviews, the kind utilized in this research project, permitted a degree of freedom of
expression typically not found in surveys or structured interviews, thus allowing the
researcher and participant the opportunity to explore new ideas or concepts that arose
during the course of the interview (Creswell 1994; Fontana & Frey 2000).

The interviews ranged in length from 45 minutes to 1 hour and 45 minutes. Prior to
the interviews, in an effort to allay any concerns, I reviewed with the participant the
questions and issues that would be covered during the interview and answered any questions
they had regarding the interviews specifically and the research project generally. While a
similar format was employed for all interviews (Board members, Senior Managers and
HAAC representatives) a different set of interview questions was used during the HAAC
interviews (See Appendix F and Appendix G). All interviews took place at a time and
location that was convenient for the participant. All interviews were audio-taped and
transcribed verbatim. Tapes and interview transcripts will be kept in a secure, locked cabinet for a period of 5 years, then destroyed. Transcripts were coded manually for relevant topic areas and for unique narratives.

2.4.1.1 Board Members and Senior Managers

Fifteen Trustees and eleven Senior Managers (CEO and Vice-Presidents) from the Capital District Health Authority were invited to participate in in-depth, semi-structured interviews (See Appendix H). These letters were followed up with personal e-mails and then telephone calls. The letter and follow-up requests to participate in the interview process resulted in four board members and five senior managers agreeing to participate in the interview process.

The low level of participation can be attributed to several possible factors including lack of interest, lack of time or unavailability during the research period due to other commitments, the sensitive nature of the research, and concerns about how the information would be presented. It is also possible that Board members and senior managers did not want to participate because of concerns about confidentiality arising from the small number of potential participants. As Rainwater and Pittman (1967) state,

The problem of confidentiality becomes much more complicated when the group one studies is small, and when the individuals in it are necessarily considered responsible for the behaviour of all the other members as well as their own (p.364).

While Board members speak as individuals they also identify with their role as a member of a collective unit – the Board – and this may have inhibited their desire to participate in the research as interviewees. This relates to previous concerns that I raised about conducting sensitive research and the problems that arise from engaging participants in this kind of research.
2.4.1.2 Health Association of African Canadians (HAAC)

The Health Association of African Canadians (HAAC) is a Nova Scotia-based organization that was founded in 2000. The membership of the HAAC is diverse and is comprised of practising health professionals, academic researchers and members of the Black (and non-Black) communities. The Mission Statement of HAAC reads as follows,

The Health Association of African Canadians (HAAC) is a community based organization that exists to promote the health and well-being of African Canadians living in Nova Scotia through community mobilization, development, and leadership in research. (www.haac.ca)

There are a limited number of research studies that examine the health status of African Nova Scotians. The purpose of the interviews with representatives of HAAC was to seek first-hand information from the perspective of key informants who are health professionals and researchers who live and work closely with the African Nova Scotian community regarding their perceptions of health problems that exist in the Black community. The key informants from HAAC were able to speak from various standpoints providing multiple perspectives into health issues facing the Black community. They spoke as African Nova Scotians, as health professionals with a research interest in health issues facing the Black community and they spoke from personal experiences living and working in the Black community. While the interviews with HAAC members were originally intended to fill a gap in knowledge of health issues in the African Nova Scotian community, the participants were also asked about their perceptions of how the health system serves the needs of the Black community.

A letter of introduction was sent to the Co-Chairs of HAAC (See Appendix I) informing them of my research and inviting them, or representatives of their organization, to participate in the research project as potential interviewees. My request was reviewed at a
regular meeting of HAAC and by way of formal motion they agreed to participate in the research project. I was sent, via e-mail, a name and telephone listing of the general membership and a "preferred listing" of nine members who were identified as having particular knowledge of health issues in the Black community. Because this phase of the research was conducted during the summer months I was able to make contact and speak with only five of the nine individuals. Every participant from HAAC that I was able to contact and speak with directly agreed to participate in the research.

2.4.2 Document Review

The primary objective of the document review was to gain an overall understanding of the history of CDHA as an organization and to examine documentary data related to governing board activities. The document review also served as a means of triangulating and confirming data obtained from other sources.

The CDHA is a large, complex organization and therefore I limited my document review to the following sources: minutes of Capital District Health Authority (including regular meetings of the Board, Sub-Committees and Special Committees of the Board, and Annual General Meetings), Board evaluations (self and external), accreditation reports, orientation manuals for the Board, financial, business and strategic planning documents, governance policies, Community Health Board Plans, and documents prepared by the Board for public distribution (including brochures, memoranda, reports, press releases, etc.). The review of Board documentation spanned the time period from the Board's inception in December 2000 until January of 2005.
2.5 Analysis

I interpreted the interview and documentary data through a hybrid of methods including discourse analysis, thematic analysis, reflexive ethnography and ethnography. The overarching mode of analysis for the interview data was to engage in a critical analysis of the discourse surrounding the role of Trustees and Senior Managers in attending to the unique health needs of African Nova Scotians. In discourse analysis the underlying assumption is that the use of language – the presence (or absence) of words, phrases, statements – is used to create and convey perspectives of reality and ideology and this use of language as text or narrative can be subject to analysis (Fairclough, 1989; Van Dijk, 1993).

In this regard I understand discourse analysis to be an approach to analysis and not a method and that it is concerned with the way in which texts are constructed and situated in terms of their social, political and historical context (Cheek, 2004). One of the assumptions of discourse analysis is that language does not have universal meaning and it is not value-neutral. Rather language reflects particular meanings assigned by both the speaker and the listener and is dependent on context (Cheek, 2004). In my analysis I also draw on an approach referred to as Critical Discourse Analysis (CDA) (Fairclough, 1989).

The objective of CDA is to uncover the ideological assumptions that are hidden in the words of our written text or oral speech in order to resist and overcome various forms of power over or to gain an appreciation that we are exercising "power over", unbeknownst to us. CDA aims to systematically explore often opaque relationships between discursive practices, texts, and events and wider social and cultural structures, relations, and processes. It strives to explore how these non-transparent relationships are a factor in securing power and hegemony, and it draws attention to power imbalances, social inequities, non-democratic practices, and other injustices in hopes of spurring people to corrective actions (Fairclough 1993, cited in McGregor, 2003)

Regarding the analysis of the trustee and senior manager interview data and documentary data, I was interested in examining three general topic areas to determine the
Board's understandings of both their authority and their responsibility to attend to the Black community. First, to identify, categorize and examine the responses of the participants to determine prevalent understandings of their role as it pertains to addressing the health needs of African Nova Scotians. Second, to examine the role of information as it relates to identifying health needs, the role of information as a support or rationale for action (or inaction), for decision-making and the general problems associated with information management. Finally, to explore potential policy options to address the issues identified including minority representation on governing boards, education and awareness and opportunities for building relationships.

The story to be told in this research is constructed with the assistance of the stories of the participants: the trustees and managers and key informants from the African Nova Scotian community and it is filtered through my own experiences and values. The combination of interview data, fieldnotes, personal experience and secondary data sources (including a wide variety of documentary sources internal and external to the organization) also permitted triangulation of concepts arising from the interviews.

2.6 Ethics Approval Process

The Research Ethics Board (REB) of the Capital District Health Authority approved this research project. The CDHA REB and the Dalhousie RHB have a reciprocal agreement whereby all research conducted in CDHA must be approved by the CDHA REB. The ethics approval process was uneventful with the exception of one issue related to the requirement for someone from CDHA to take responsibility for the conduct of the study. This is, apparently, standard process with clinical studies; a senior CDHA clinician co-signs and oversees the conduct of the study. This requirement, however, created some challenges
for my research because the REB did not recognize my Supervisors from the University as being able to fulfil this oversight role. Working through the Office of the Vice-President of Research, an individual, Maura Davies, Vice President, Organizational Development, was identified to serve as Capital Health sponsor and organizational contact. While the potential for conflict of interest existed – between oversight role and, as a member of the Senior Management staff, a potential participant in the research – this did not, to my knowledge, occur. This individual served less in an oversight role and more as an internal organizational ally, serving as a facilitator through whom I could access individuals and organizational documentation, in her words, "a friend in camp".

2.7 Consent Issues

The maximum number of potential participants in this research representing CDHA Board and Senior Management was limited to 15 Trustees and 11 Senior Managers. Because of the small numbers, issues of confidentiality were of paramount concern. Because of the relatively small numbers of members in HAAC there were similar concerns regarding confidentiality. All interview participants were assured of confidentiality in any report or publications of the research material. All interview participants signed a written consent form (See Appendix J and K). The consent form for CDHA Board members and senior managers and HAAC participants noted that because there were a limited number of participants in this research study it would not be possible to guarantee anonymity in all instances, but that insofar as it was possible, attempts would be made to present the results and analysis in an aggregate form without information that would reveal the participant's identity.
Chapter 3: African Nova Scotians

I think we have to be honest and open and say yes, racism does exist because so many people are trying so...so hard to be nice. We don’t want nice. You need to say yes it exists and make an honest effort to really say okay let us work together and look at...getting Black kids to go into education that will put them into the health professions. We have to start with the education system because the education system...that’s where the shutdown starts. I mean there are some teachers out there who need some education...you know... just because you’re Black doesn’t mean you are stupid. (Member, Health Association of African Canadians)

3.0 Introduction

In this chapter I present, as background information, a discussion on the history, culture and health status of African Nova Scotians. I also present the findings from the interviews with key informants from the Health Association of African Canadians. The purpose of these interviews was to fill a gap in the literature on the health issues facing the Black community in Nova Scotia. Racism, as a determinant of health, is a recurring theme in this research and in this chapter I discuss the various forms of racism and the impact of racism on the health of African Nova Scotians.

3.1 African Nova Scotians – History

To begin, Nova Scotia is a small maritime province located on the eastern coast of Canada. The 2001 Census indicates that the population of Nova Scotia was 944,765 and of those 34,525 (3.7%) were listed as "Visible Minorities" and 19,670 were listed as "Black" (2.1%). Census figures show that African Nova Scotians account for 57% of "Visible Minorities" in the province and they currently represent the largest population of indigenous Blacks in Canada. The geographic catchment area of the Capital District Health Authority is home to 66% (approximately 14,000) of Nova Scotia’s Black population (Statistics Canada 2001).
This research draws on available evidence that describes the history of African Nova Scotians as being characterized by hardship, discrimination, injustice, exclusion, and institutionalized racism — a pattern that has persisted from their arrival in the early 1600's until recent times (BLAC, 1994; Clairmont & Magill, 1970, 1987; Head & Clairmont, 1989).

African Nova Scotians were some of the province’s earliest settlers (not counting Aboriginal peoples). Records indicate that the earliest record of Blacks in the region was in 1608 when a young slave boy was brought to New France in the company of his slave-master (Henry, 1973). There were three main waves of Black immigration to Nova Scotia beginning in the period immediately following the American War of Independence (1775-1783). During the War of Independence the American Blacks, both slaves and free Blacks, were promised 'freedom, protection and resettlement' if they agreed to fight on the side of the British (Pachai, 1990). Of the estimated 40,000 to 50,000 American immigrants pledging allegiance to the British flag (90% of whom were White) approximately 30,000 settled in Nova Scotia (Pachai, 1990).

The promise of freedom, land and provisions did not occur, however, for the majority of the 3500 Black Loyalists that arrived in this first wave of immigration. Their hope for a better life in Nova Scotia was short lived because the racism, marginalization and cruelty they had experienced in American society was present also in Nova Scotia (Clairmont & Magill, 1987). After many years of hardship and exclusion from the benefits afforded to other settlers, many of the Black Loyalists left Nova Scotia to settle in Sierra Leone in the period between 1792 and 1800 and later in Trinidad in 1821 (Clairmont and Magill 1987).

The second wave of immigration of Blacks to Nova Scotia occurred in 1796 when approximately 550 Trelawney Maroons were deported from Jamaica and were settled on the lands previously occupied by the Black Loyalists in the Preston area in Nova Scotia. In
Jamaica the Maroons had been engaged in guerrilla warfare against the British. A truce was reached on the commitment from the British that the Maroons could remain in Jamaica but this agreement was not honoured and the Maroons were deported to Nova Scotia in 1796 (BLAC, 1994). Again, the hostile climate, poor living conditions and persistent marginalization led to the majority of the Maroons emigrating from Halifax to Sierra Leone in 1800 (Clairmont & Magill, 1987).

The third wave of immigration of Blacks to Nova Scotia occurred in the period immediately following the War of 1812 when approximately 2000 "Refugee Blacks" arrived in Nova Scotia. During this time the British once again offered freedom and land to every American-owned slave who would run away from their slave-masters and pledge allegiance to the British flag (Clairmont & Magill, 1987; Grant, 1980; Pachai, 1990). For many of the Refugee Blacks their first winter in Nova Scotia was spent in an encampment – normally used as a prison – on Melville Island in Halifax's Northwest Arm (Grant, 1980, Pachai, 1990).

During the War years many of the Refugee Blacks were able to find work in Nova Scotia. At the end of the War in 1814, however, the economic boom fueled by the war effort collapsed and the Refugee Blacks – last hired and first to lose jobs – experienced social and economic hardships similar to their Loyalist predecessors (Grant, 1980). For many African Nova Scotians their existence was so impoverished and the discrimination they faced so severe that they chose to emigrate to Trinidad, Sierra Leone, Jamaica, or Bermuda.

Blacks who remained in Nova Scotia experienced problems in obtaining land grants and provisions to ensure their survival. Most of the African Nova Scotian settlers were forced to live on unproductive lands, generally situated on the outskirts of towns, while the more favorable land grants went to white settlers (Clairmont & Magill, 1970; Grant, 1980;
Head & Clairmont 1989). Communities such as Africville, Preston, Cherry Brook, Lake Loon, Maroon Hill, Beechville and Hammonds Plains in Halifax County, Birchtown in Shelburne County, Acaciaville, Jordantown and Conway in Digby County and Delap's Cove, Thorne's Cove and Inglewood in Annapolis County are examples of this settlement pattern. The three main waves of immigration ended in the early 1800s. Since that time immigration of Blacks to Nova Scotia has been on an individual or family basis (Clairmont & Magill 1970). In recent times, there has been a growing number of immigrants from African and Caribbean countries.

The long-term impact of slavery, harsh treatment and persistent marginalization on the Black settlers in Nova Scotia cannot be underestimated. Years of poor living conditions, racism, hostile treatment and a widespread lack of acceptance and integration into Nova Scotia society has led to the creation of a Black community that has been, and continues to be, oppressed. Donald Clairmont and Dennis Magill (1970) state

...it is impossible to understand the contemporary socioeconomic condition of Black Nova Scotians without realizing that Nova Scotia was at one time a "slave society" and without appreciating the conditions of immigration and settlement of free Blacks in Nova Scotia. One must appreciate, also, the educational deprivation which, until recently, has characterized Black communities. These factors and their socio-psychological implications have combined to keep Blacks in poverty, and to make it exceptionally difficult for them to acquire an equitable share of society's wealth. The groundwork for the subordination of the Blacks as a people in Nova Scotia was laid by the early existence of a slave society. (p.5-6).

While slavery was never formally instituted by statute in Nova Scotia there is evidence of commercial trading in Black slaves in the province in the middle 1700s (Clairmont & Magill, 1987). It has been proposed that the presence of a culture that condoned slavery in Nova Scotia contributed to "...insidious psychological concomitants of institutionalized
oppression that includes attitudes of white superiority, which remain deeply rooted and form a self- and race-hatred among the Blacks themselves" (Clairmont and Magill, p.7).

3.2 **Racism and the Impact of Racism on Health**

The concepts of race and racism are common threads that recur throughout this thesis. Therefore, it is worthwhile to discuss some definitions of race and racism and explore how racism has impacted on the health status of African Nova Scotians.

The concept of race is problematic. The colloquial use of the term "race" implies that there are genetic differences among people that are identifiable and objective. There is a widely held belief in our society that the differences between races of people can be defined primarily by genetics even though there is no scientific merit to support this argument (Witzig, 1996). The Canadian Oxford Dictionary (2001) defines "race" as, "Each of the major divisions of humankind, having distinct physical characteristics" (p. 1188). It is acknowledged that this conception of race, first introduced in 1749 and still widely accepted in everyday language, is limited (Cooper & David, 1986). Skin colour remains the single most important trait used to classify "races" (and usually in comparison to white skin) as opposed to other distinguishing features such as height, facial features, hair, or other genetic traits (Cooper & David, 1986).

Williams and Warren (1994) in their paper entitled, "The Concept of Race and Health Status in America" discuss the need to understand the etiology of race and its relation to the differential health status among racial or ethnic groups. They state, "There is more genetic variation within races than between them, and racial categories do not capture biological distinctiveness" (Williams and Warren, 1994, p. 13). Furthermore, they argue that identification of race is more a reflection of social values than a reflection of genetic
variation. Because the creation of "race" is often used as a foundation for racist social values, the use of racial taxonomies as a means to categorize individuals in the field of medicine is of great concern.

Race is a socially constructed taxonomy that reflects the intersection of particular historical conditions with economic, political, legal, social and cultural factors, as well as racism. The components of race are interrelated and can combine to affect each other and other societal outcomes in additive and interactive ways. We focus on differences in skin color, not because the genes linked to skin color have been shown to be critical determinants of disease patterns, but because in our society skin color (race), is a centrally determining characteristic of social identity and obligations, as well as a key determinant of access to desirable resources (Williams and Warren, 1994, p.28).

It is widely accepted that there is no discrete package of genetic differences, or markers, that can adequately separate and distinguish between or among races of people (Cooper & Kennelly, 1994; Cooper & David, 1986; Williams & Warren, 1994; Witzig, 1996). Race therefore, is not a biological concept grounded in scientific evidence, but rather it is a social construct that reflects racist ideals of racial superiority and inferiority (Jones, 2000; Williams & Warren, 1994; Witzig, 1996).

There are many definitions of "racism" and all are very similar. As an overarching definition I cite the Canadian Oxford Dictionary (2001), which defines racism as, "1. a belief in the superiority of a particular race. 2. Prejudice based on this. 3. Antagonism towards other races, esp. as a result of this prejudice" (p. 1188). For the purposes of this thesis I have adopted the following specific definitions of racism. In each instance individuals who are subjected to racism are usually of a different ethnicity and/or skin colour than the dominant social group. Individual racism is defined as racism that is experienced at a personal level, for example, in instances where individuals are subjected to overt racial insults, name-calling or violence (Utsey et al. 2000). Institutional racism is defined as,
...differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests itself as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed institutionalized racism is often evident as inaction in the face of need. Institutionalized racism manifests itself both in material conditions and in access to power (Jones, 2000, p.8).

Karlson and Nazroo (2002) also note that institutionalized racism is often embedded in policy and accepted by society as "normal" and therefore is often more invisible than other forms of racism. Finally, internalized racism is defined as acceptance by members of the racialized groups of the negative messages about their own abilities and negative worth (Jones, 2000). This is often manifested in such behaviours as self-devaluation, resignation, helplessness, embracing the dominant culture's values and believing that "the White man's ice is colder" (Jones, 2000, p.1213).

In the past 50 years much has been written on racism and its impact on health status. Thomas (2001) characterizes racism as, "...a pathogen with biological consequences" (p.1046). Racism has been a persistent feature of Canadian society, and has been institutionalized in the form of legislation and public policy, since the arrival of European settlers in the 1600s (Canadian Council on Social Development, 2002; Driedger & Halli, 2000; Jackson, 2002).

The body of research examining the impact of racism on health status is diverse and spans many disciplines. Regardless of the various ways that racism is defined, the literature on racism and its detrimental impact on health is unambiguous (Boardman, 2004; Cain, 2003; Corin, 1994; Enang, 2002; Galabuzi, 2004; Harrell et al., 2003; Karlson & Nazroo, 2002; Kieger, 2003; Nazroo, 2003; Physicians for Human Rights, 2003; Rich, 2000; Thomas, 2001; Utsey et al., 2000; Williams & Warren, 1994). In short, any form of racism is potentially harmful to the health of its victims and the more pervasive and overt the racism,
the greater the negative effects on health. Karlson and Nazroo (2002) observe that "...the different ways in which racism manifests itself (as interpersonal violence, institutional discrimination, or socio-economic disadvantage) all have independent detrimental effects on health, regardless of the health indicator used" (p. 624). Exposure to racism is a stressful event in one's life and persistent, long-term exposure to racism often manifests itself in both mental and physical pain and disease (Utsey et al, 2000).

Racism impacts on educational and employment opportunities and this, in turn, affects health by limiting social and economic means by which individuals maintain and promote health (Jin et al, 1995; Rich, 1999). The Canadian Labour Congress study entitled, "Is Work Working for Workers of Colour?" (Jackson, 2002) details significant disparities for workers of colour in Canada. Jackson states, "The evidence is clear that systematic racism is very much a factor in the Canadian job market. Racialized workers are paid less, enjoy less security, and are much more vulnerable to poverty than other workers" (p.18).

The Canadian Council on Social Development in their study prepared for the Canadian Race Relations Foundation entitled, "Unequal Access: A Canadian Profile of Racial Differences in Education, Employment and Income" (2002), detail similar findings. They conclude that while the Canadian labour force is becoming increasingly diverse, there are still barriers to equal opportunity in the workplace and that racism continues to be ubiquitous in Canadian society.

Nova Scotia has a lingering legacy of racism. I review briefly three examples that document the impact of institutionalized racism on the African Nova Scotian community (two reports and one historical event).
3.2.1 Royal Commission on the Donald Marshall Jr. Prosecution

The Royal Commission on the Donald Marshall Jr. Prosecution (1989) was established to examine the circumstances surrounding the wrongful conviction of Donald Marshall Jr., a young Mi'Kmaq man who served 11 years in prison for a murder he did not commit. The Commission was also given the task of examining the extent and causes of racial discrimination and political favouritism in Nova Scotia's justice system. The Commission concluded that racial discrimination towards visible minorities and Aboriginal peoples in Nova Scotia's justice system was widespread. In the fall of 1987 the Royal Commission initiated a research project to investigate and make recommendations regarding racial discrimination against Blacks in the criminal justice system of Nova Scotia (Head & Clairmont, 1989).

The Report raised serious concerns regarding the criminal justice system's inability to meet the expectations of the public in ensuring "equal justice under the law." The Report also found that institutional practices of the justice system tended to reflect negative attitudes towards people who are socio-economically deprived or who are from racialized minority groups, in particular Aboriginal people and African Nova Scotians. The Report was unambiguous in its condemnation of the current practices in the justice system. The authors state,

It is inexcusable that people of non-White racial background can be treated with ill-disguised hostility in a court of law. It should be the first order of business of the Provincial Government to change this situation wherever it exists. This is a matter in which the government has the power to take immediate action. It does not have to wait for a change in public opinion (p. 71).
The researchers found that Blacks face discrimination in the criminal justice system at every step in the process from arrest by police to differential treatment in courts by judges, to sentencing and incarceration (including length of sentence, and treatment in correctional institutions) (Head & Clairmont, 1989). Poor treatment in the criminal justice system however is not a new problem, but rather is the result of a long history of racism in Nova Scotia. The researchers state,

From their initial involvement as slaves in Nova Scotia through a long period of Jim Crow practice to the more subtle racism still extant in contemporary society, the Black population has been obstructed from sharing fully and participating fully in Nova Scotian society. The implications are as hypothesized, namely lower socio-economic well-being, whether it be employment, income, education and so forth. These factors in conjunction with racism are clearly associated with perceptions and reality of disadvantage when Blacks become involved with the criminal justice system (Head & Clairmont, 1989, p.43).

In summary, the Report found widespread evidence of racial discrimination against Blacks in the Nova Scotia criminal justice system (Head & Clairmont, 1989).

3.2.2 Black Learners Advisory Committee (BLAC) Report

The Black Learners Advisory Committee (BLAC) was established by the government of Nova Scotia in 1992. The Committee was mandated to engage the African Nova Scotian community in a participatory research process to identify "issues, concerns and desires" of the Black community with a particular emphasis on examining the presence of racism in the education system.

The Report found that the early settlement patterns of segregated Black communities carried over into the Province's approach to education. For example, the Report documents how in 1811 the Province passed legislation that provided a government subsidy to communities that could raise between 50 and 200 pounds sterling to enable them to build a
school house and hire a teacher. The state of persistent poverty experienced by most Black communities led to circumstances where education was simply out of reach for most families. These impoverished circumstances were prevalent despite repeated efforts on the part of the Black communities to petition the Province to improve education for their children.

In 1865 Nova Scotia passed legislation to establish free and compulsory primary education for all children and at the same time passed legislation enabling the province to establish segregated schools for Black children. The education offered to Black children was of inferior quality and the teachers and resources available to support the education programs for Black children were inadequate. Segregation in the education system was a significant barrier to achieving equal education (and equal opportunity in society) for Black learners (BLAC, 1994). Despite repeated protests from the Black community, segregation remained a dominant feature of Black education until the 1960s \(^3\). The last "Black school" in Nova Scotia to close was the Partridge River School in 1978 (BLAC, 1994).

Integration of Black students into public schools created new problems for Black learners. Two centuries of racial discrimination "...spilled over into the classroom resulting in racial stereotyping and low expectations on the part of teachers and racial name calling by White students. Black students were routinely counseled away from the academic stream into the general stream and drop-out rates soared" (p.26). On a variety of measures the academic performance of Black students was poor in comparison to non-Black students.

The BLAC Report paints a very dismal picture of institutionalized racism against Black learners in Nova Scotia's education system.

The history of Black education in Nova Scotia is largely one of exclusion and neglect legalized through discriminatory legislation and enforced by the racial attitudes of White society. For more than two hundred years, the Black population of this province has been systematically denied an education on
an equal footing with the White population leading one Canadian historian to write of Nova Scotia that, "In education we find the most significant manifestation of colour prejudice in Canadian history" (BLAC, 1994 p. 1).

3.2.3 Africville

The Black community of Africville was located on the extreme north end of Halifax Peninsula on the shore of Bedford Basin. The community's historical presence can be traced to the mid-1800s and records indicate that the population of Africville never exceeded 400 people. According to former residents, Africville was a vibrant and close-knit community and, not unlike other Black communities in Nova Scotia, the heart and soul of the community was centered around the activities of the local church, in this case the Seaview Baptist Church (Africville Genealogical Society, 1992).

Since its founding, the community of Africville did not receive the same level of public services as did the remainder of Halifax peninsula. Beginning in the early 1900s leaders in Africville petitioned the City to upgrade the services in the areas of policing, postal services, roads, electricity, schools, safe drinking water and sanitation services. Head and Clairmont (1989) write, "In spite of repeated delegations to City Hall and to the Provincial Government, water, electricity, transportation services, sewage disposal, and other civic services were never provided" (p. 12). Over a period of many years living conditions in the small community had deteriorated to a point where the lack of sanitation and safe drinking water posed a significant health hazard to its residents. The lack of maintenance and upgrading of the community's infrastructure eventually led City officials to propose that the community be razed and its residents relocated to more appropriate housing.

When the forced relocation of Africville's residents was being contemplated public officials cited the results of several studies that documented substandard housing, unsafe drinking water, inadequate sewage services and the close proximity to the city dump as
reasons to destroy the remaining community infrastructure rather than invest in upgrading services. City officials repeatedly argued that the costs associated with upgrading services to an appropriate level were prohibitive (Head & Clairmont, 1989). While a small number of residents supported this view, the majority were opposed to the City's policy of expropriation and forced resettlement (Africville Genealogical Society, 1992).

Leaders in the Black community viewed their resettlement as just another example of white supremacy and overt systemic racism. Protests opposing the City's decision went unheeded. Finally, in July 1962, the Development Department of the City of Halifax made the announcement that the community of Africville would be razed and the residents would be resettled in other areas of the city. During the period from 1964 to 1970 many of the residents of Africville were relocated to Mulgrave Park, an urban public housing project in Halifax's North End (their belongings moved in City dump trucks) and their homes were bulldozed (Head & Clairmont, 1989; Clairmont, 1992).

Clairmont (1992) states that for many Nova Scotian Blacks "...Africville represented the essence of the Black experience in Nova Scotia – in its church soul, in its struggle against racism and even in its location, off the beaten path, on the fringe of white neighbourhoods" (p. 36). The story of Africville has become well known in the history of race relations in Canada. For many, the razing and forced resettlement of the residents of this small, close-knit Black community in the 1960s has come to symbolize the Black experience in Nova Scotia (Clairmont, 1992). On June 22, 1985 Seaview Memorial Park was established to commemorate the community of Africville.

I conclude this section with a quote from Emily Friedman (2002), who, in light of the above commentary on the presence of racism in the criminal justice and education
systems and in the case of Africville, sums up the challenges facing the health care system in Nova Scotia.

Any health system reflects the society that created it, and only an extremist or the utterly naïve would claim that there are not significant problems of racial or ethnic (and religious, gender, age, sexual orientation, and so on) bigotry in this society – and in every other society on earth. Some of that is bound to leak into health care. This is not just a public health problem or a demographic inevitability; this is an ethical issue for health care (Friedman, 2002, p.6).

The three examples above serve to illustrate the presence of racism in Nova Scotia's social institutions and the need to be aware of the impact that racist values and practices have on the health of racialized minorities. In the next section I examine more closely the current knowledge regarding the health status of African Nova Scotians.

3.3 The Health Status of African Nova Scotians

While only a limited amount of research has been conducted thus far on the health status of African Nova Scotians, extensive research conducted in the United States has shown that African Americans have reduced access to health services and poorer health status than the general population (Cain, 2003; Friedman, 2002; Karlson & Nazroo, 2002; Manton et al., 1987; Nazroo, 2003; O'Hare, 1987; Physicians for Human Rights, 2003; Rich, 2000; Thomas, 2001; Satcher, 2003). The available data for African Nova Scotians suggest similar patterns of poor health and reduced service availability (BLAC, 1994; Cancer Care Nova Scotia, 2001; Enang, 2002; Sharif, 2000; Thomas-Bernard & Wein, 2001; Thomas-Bernard, 2002).

Possible explanations for this difference in health status between Blacks and non-Blacks in other jurisdictions include racism, socio-economic deprivation, social exclusion, persistent marginalization, the location of health services, lack of transportation, under-
representation of Blacks in the health care system, cultural insensitivity, and genetics (Enang, 2002; Manton, et al. 1987; Nazroo, 2003; O’Hare, 1987; Rich, 2000; Satcher, 2003; Watson, 2001).

While one cannot definitively generalize these results to the Canadian setting, the population health literature on the health status of African Americans documents a strong relationship between racism and poverty and racism and poor health status (Humphries & van Doorslaer, 2000; Marchand et al, 1998; Memon, 2002; Ross, et al, 2000; Santana, 2002).

A study conducted by Josephine Enang (2002) summarized the research that examines the health status of Black women in Nova Scotia. She identified a number of illnesses that affect Blacks disproportionately when compared to the non-Black population. In this study she relied on American data that found chronic diseases such as diabetes mellitus, cardiovascular diseases, cerebrovascular diseases, cancer, HIV/AIDS, hypertension, lupus, sickle cell disorder and sarcoidosis as being more prevalent in the Black population (Enang, 2002). Conditions of low socio-economic status, systemic racism, geographic isolation and the effects of social exclusion further exacerbate health problems in this population (Enang, 2002).

In an effort to fill this gap in knowledge regarding the health status of African Nova Scotians, I interviewed representatives from the Health Association of African Canadians (HAAC). During the interviews the participants spoke very personally about their own and their families’ experiences with the health care system and their professional assessment of prevalent health issues in the African Nova Scotian community.

Racism was identified as a significant determinant of health in the Black community. For the sake of presenting the interview data in an organized fashion, I have divided the following discussion on racism and its impact on health into three general categories.
corresponding to the different types of racism: experiences with inter-personal racism, experiences with institutional racism and experiences with internalized racism. While I have created three separate categories, there is often overlap or multiple interpretations of different experiences with racism.

3.3.1 Inter-Personal Racism

While all of the HAAC participants spoke of the pervasive nature of racism and some reported anecdotal evidence of its impact on health care interactions, they did not report extensively on their own personal stories of inter-personal racism. Personal experiences with racism were varied and ranged from personal threats or insults, to perceiving subtle changes in people’s expressions or being deliberately ignored. Rather, interview participants spoke more of racism and their knowledge of the detrimental impact of racism on the health status of the Black community generally. Participants described these experiences as being harmful to self-esteem and physical health in various ways.

Grace-Edward Galabuzie (2004) argues that persistent marginalization as a result of being exposed to racism can have the negative effect of deterring individuals from seeking treatment in the health system. During the interviews participants cited fear of individual or personal racism as a reason why Black people may choose to not seek necessary health care, even in situations where their illness is life threatening.

People don’t know how they are going to be treated. If you have to go into a hospital how are you going to be treated? Fear of racism, experiencing racism…and it’s real…I’ve had people talk to me about that. The young woman I talked about who was a client and as we were going through…palliative care with her I was told that she was actually diagnosed with breast cancer 5 years before. They told me…she was afraid to have surgery, she was afraid they were going to take her children. She had so much fear. She was afraid that as a poor Black woman that if she went ahead and had surgery they would take away her children. And to go and stay away
from health care...because they are afraid. And a lot of that fear is rooted in racism. (HAAC)

This fear of accessing appropriate health care goes beyond just being afraid of racist treatment, but extends into fear that the physicians will not have the specific knowledge to treat illness affecting Black people.

If I have to go to a doctor I think long and hard how about what's happening to my body. And some of that is fear of what may be happening to my body and the other is if I go will somebody take the time to properly diagnose me and I am not sure. I had a mole on the inside of my leg and it was sore and I went to see [my doctor] and she looked at it and ...said it looks brown. So I said to her that is because my skin is brown ...and she said well I never really thought of that. She had a fourth year medical student with her so I asked him do you get any kind of information on skin tones and skin colour when you are looking at diseases and he said no. I was really quite surprised that they don't teach that...so that makes me a little bit skeptical about going to a doctor for things. [If] you don't know what's happening outside...then I have some problems with you knowing inside my body when you are looking at my heart or my liver or my lungs (HAAC).

Fear of racism and how this affects Black people's decision to access the health system is something that Black people learn from personal experience and from the experiences of friends and family. It is a learned behaviour.

...and I think it does make people hesitant to go to the health system. They have heard horror stories, a lot of fact, fiction and if you don't understand what's going on...you know if you don't understand what's being said to you and its all mysterious mumble-jumble anyway that whole health system towards a lay person and if you add to it racism, and people treating you bad, looking down, and maybe your diction isn't as clear as it should be and I think that makes you hesitant...you can't help...which is sad in a way, because our health care is free for everybody... (HAAC)

Often the anxiety associated with personal decisions to seek health care is compounded by the additional fear that they may experience racism or that their concerns may not be taken seriously. Repeated exposure to racism serves to create cultural norms and may serve as a reason for Black people to not seek appropriate health care.
3.3.2 Institutionalized Racism

Participants also spoke of the impact of institutionalized racism on the health of their community. In this instance I understand institutionalized racism to be defined as "...differential access to the goods, services, and opportunities of society by race" (Jones, 2000, p.8). Institutionalized racism in the health care system is manifested as a range of practices that have the untoward effect of creating barriers to accessing services by racialized groups including for example, a lack of cultural competency on the part of care providers, diminished access to health services, and inadequate funding for appropriate community services, etc. (Galabuzi, 2004). Furthermore, Galabuzi (2004) believes institutionalized racism stems from healthcare institutions being Eurocentric in their focus and that white cultural norms impose a cultural hegemony on racialized communities. Iris Marian Young (1990) identifies this universalization of the dominant groups' norms as a form of "cultural imperialism." Young states

Cultural imperialism consists in a group's being invisible at the same time that it is marked out and stereotyped. Cultural imperialist groups project their own values, experience, and perspective as normative and universal. Victims of cultural imperialism are thereby rendered invisible as subjects, as persons with their own perspective and group-specific experience and interests. At the same time they are marked out, frozen into a being marked as Other, deviant in relation to the dominant norm. (p.123)

HAAC participants readily acknowledged that many of the health problems in Black communities are directly attributable to institutionalized racism that exists in Nova Scotian society generally and in the health system specifically.

Systemic racism is the big umbrella that we live under. It's real and it's alive and well. And we would be very naïve if we said it doesn't exist, because it does. I think that when we look at the Black community, hypertension, the diabetes, the heart disease, the obesity...I think racism impacts health. I think that the hypertension which comes certainly young, I mean I have hypertension and I've had it since I was 41...and that's a long time. And I
think that is just the whole impact of living...because I think that you absorb a lot. There are lots of stressors there. (HAAC)

In the following section of dialogue the participant describes a situation where a patient, who is waiting to see a physician, is doubtful that the surgeon (who is a Black man) is actually a surgeon and not just a technician.

Anyway...those are the kinds of things you see. Cleaners...and no one would question whether that person was the cleaner. Black man comes and he's the surgeon...he can't be...and that's just an example...that goes on all the time. So that's probably the most visible in what you see in terms of the African Nova Scotian and you can see how this connects with the education system. People are not being educated, not getting out of high school and not getting into university...if you look at the health sections at Dalhousie and you look at who is in the programs...who are the students in the programs, who are the faculty teaching in the programs. You know, so it runs deep. (HAAC).

In this instance the participant describes how when you picture Black people working in the health care system they are the cleaners and kitchen workers and not the professional staff. The participant also links the lower status of Black health care workers to the education system beginning with Black youth not graduating from high school and not entering health professional programs because the institutionalized racism that exists in the education system has not been addressed.

Another example of institutionalized racism is in the different ways that non-whites are considered in the processes of health care. The Apgar Score is a method used to assess the well being of the newborn infant and is performed by nursing staff at regular intervals following birth. The Apgar Score is an assessment of heart rate, respiratory effort, muscle tone, reflex, irritability, and colour (Miller & Keane, 1978).

Or Black babies, losing their first point of Apgar Score at birth. Within the first minute they are already labelled abnormal because they are not pink like Caucasian babies, so there is no way to describe the normal healthy newborn Black baby. So I think those are all issues that I think impact on our health because yes, maybe it doesn't mean anything that your baby is already
abnormal at birth and loses one point, but I think all of this builds in your psyche and after some time I realize that I'm not good enough. (HAAC)

Here again, the dominant group's values and experiences are seen to be universal; the "colour" in the Apgar Score is assumed to be that of a Caucasian infant. A non-white child's score is rated lower because they are not "pink" at birth. There is no recognition that a child could be anything but Caucasian.

Repeatedly during the interviews with key informants from HAAC racism was cited as being a prominent determinant of health issue needs to be addressed. Racism exacerbates many other health and social issues that affect the Black community. For many Blacks in Nova Scotia their personal encounters with racism have been a life-long experience.

I'd say that racism is cultural here...it's part of the culture of Nova Scotia and the only way to change that is to change the systemic issues and begin to eek them out. Maybe the next generation. (HAAC)

On a more general level, other health issues identified by HAAC representatives included issues related to not seeing themselves reflected in the system (as health professionals, in client literature, etc.), a lack of primary prevention services dedicated to Black health issues and a lack of culturally appropriate care. This closely relates to the interpretation of institutionalized racism as being "...inaction in the face of need" (Jones, 2000, p.8)

HAAC participants also cited the lack of access to credible, culturally sensitive research as being a significant health concern to their community and an example of institutionalized racism.

The top health issue...number one for me...would be the lack of research. Because if you do not have information about what is wrong with you I think that is a problem in itself. The external evidence indicates that people are getting sick...but we have no documented material to say how many people. So for example, if we say that we have incidence of high blood
pressure...how many of these people are from the Black community? We
don’t have any statistics on these things. (HAAC)

... that’s one of the things we talked about, the need for research, the need
for some positive data that we could go to the powers that be, the policy
makers and say...well look, this is what’s happening in our community.
(HAAC)

The problem however, goes beyond just having access to basic health related data
from the Black community. Interviewees from HAAC expressed concerns about the
manner in which research is conducted in the Black community and the lack of culturally
appropriate and culturally sensitive research. In the following section of dialogue a
participant describes a concern over the research community not wanting to do research on
Black health issues because of a concern that it may be perceived as racist. The view is
expressed that research that takes into consideration race and racism is an essential
component to keep a community healthy.

So that is a big concern... the kinds of research that needs to be done ...And
to do it in a way where people stop patronizing and say well you can’t do that
because people will think you are racist or prejudiced if you starting talking
about skin colour but I think there is some merit to the fact that my skin is
brown and your skin is white right? Or different colours. ...It’s about our
health. ... I think that’s a major health concern in terms of being able to
keep a community healthy is to be able to find a way to do research that will
answer some of those questions. (HAAC)

In contrast, in the following narrative the participant speaks of a research project
that was developed without any consultation with the Black community. This is perceived as
taking advantage of the Black community as a research subject for the benefit of the
researcher and not bringing "something directly back to the community as well." The view
is also expressed that more research needs to be done and that it needs to be done in
partnership with the Black community because without this partnership the credibility of the
research is called into question.
Of course more of it (research) is needed. But it also needs to be done in a way that is culturally sensitive. There is for example, I know...I know of research being done by some faculty people at Dalhousie in a school not to be identified on diabetes in our community. But they have not talked to the Health Association of African Canadians about it. They have not talked to the Black women’s health group about it. They haven't talked to the Association of Black Social Workers about it. What are they doing? And they haven't talked to some very well known public diabetics in the Black community (laugh). So what in the heck are they doing? And they got tons of money to do it. When I hear stories like that I become quite furious, because we need good, credible, culturally sensitive, culturally relevant research...and it needs to be done in a way that brings something directly back to the community as well. If that relationship with the community isn't there then I would really question the whole credibility. (HAAC)

Throughout the interviews HAAC representatives consistently conceptualized health as being more than just accessing health services and the treatment of disease. They were fluent in the language of "population health" and the issues they identified as being "health problems" extended into social, economic and political arenas encompassing the broad determinants of health. For example, they would cite a problem such as the impact of low literacy skills and poor compliance with drug or treatment regimens and then discuss this in terms of dropping out of school at an early age, and how this affects employment opportunities, self-esteem and well-being. Or they would speak knowledgeably about how unemployment and poor housing can lead to mental stress and alcoholism or drug addiction.

I think racism has affected (our health) because of the educational level that you attain. You know...simple things. I remember I would go to some people's houses and they didn't know how to read and write but they were given prescriptions from the pharmacists, just handed the [prescriptions]...they didn't know what "take twice a day" meant. Do you know... if you should take them with food...what times to take them. A lot of older people have grade one, two or three. You know they are not really functionally literate. You know what that does to your health? You don't know how to take your pills properly, you don't know what interacts with what. You don't know what food cuts down on the potency of the pills. Its due to systemic racism, not being able to go to school. Economics... because a lot of people left school at an early age to be able to self-support the family... and just not being welcomed. (HAAC)
This is significant because the broader determinants of health are widely recognized as playing an important role in the health and well being of communities (Evans et al, 1994; Raphael, 2004). It is clear that from the interview data that improvement in the overall health status of African Nova Scotians is directly linked to the ability to influence those broader determinants of health.

Racism is a huge one. I think if you look at the determinants of health the biggest ones would be education, housing and employment. I think those are three huge ones. If you don't have employment you can't have a house. If you don't have education you can't get a job to have a house. If you are experiencing racism in all of those areas you know how can you function as a healthy human being? (HAAC)

### 3.3.3 Internalized Racism

During the interviews several of the participants described how internalized racism translated into differential care, diminished access to health services, and poor health status. In this instance I understand internalized racism to be defined as "...acceptance by members of the racialized groups of negative messages about their own abilities and negative worth" (Jones, 2000, p.1213).

And that speaks to some of my experience as a health care provider. You go into work, to work with a Black family and they are questioning my skill, I have to prove to them because they do not believe that as a Black person I am capable of being a nurse. I have had people tell me, "Oh if I see a Black physician I am not too sure that he knows or she knows what he's doing" and stay away because they have been taught to believe, or society has engrained in them that they are not good enough to be doctors, nurses, or professionals and so they believe so about them and but they also believe that any other person who looks like them cannot do these things. (HAAC)

In this instance the participant describes how internalized racism is manifested in the lives of African Nova Scotians from the perspective of the health professional. While for many in society acquiring a professional designation would bring with it a rise in social status and a sense of authority, for many African Nova Scotians it places them in a no-win
situation. They find themselves doubly vulnerable to racism because they are discriminated against by other non-Black health professionals and by members of their own community. It is easy to see how this kind of discrimination from within and from without may lead to a sense of powerlessness and how this could perpetuate the belief for many Black youths that becoming a health professional is "not their place."

There was a general consensus among HAAC representatives that mental health problems were a hidden but nonetheless significant problem in the Black community. Issues such as low self-esteem, feelings of social exclusion, addictions, alcoholism, domestic violence, depression and anxiety were felt to be widespread in the Black community. These health issues were often directly attributed to the detrimental impact of racism and were further exacerbated by poverty.

Finally, during the interviews respondents frequently cited specific diseases that they felt were more prevalent in the Black population (but lacked the research evidence to confirm their suspicions) including hypertension, diabetes, prostate cancer, lung cancer, mental health problems, and addictions (gambling, alcohol, drugs).

3.4 Summary

The overarching message that emerged from the interviews with HAAC representatives was that systemic, institutionalized racism in the health system and in other social institutions continues to have a negative impact on the health status of members of the Black community. Moreover, they spoke of how racism promotes social exclusion and exacerbates the negative experiences of poverty and its impact on low self-esteem and their overall mental health status. Participants were fluent in the language of population health
and clearly described the role that the broad social and economic determinants of health play in the health of the African Nova Scotian community.

HAAC representatives acknowledged the importance of providing culturally appropriate health care to the Black community and removing the barriers to accessing care that stem from racist policy and attitudes. Key informants expressed the view that for meaningful change to occur to ameliorate the effects of systemic racism, the nature of those changes must also be systemic.
Chapter 4: Governance

And [we] have not focused on high risk, sub-populations who may not be getting their needs met as particularly as they could be. I think there is always a push-pull on those things. If you focus all your attention on a group or a good chunk of your attention on a group, it means that there is less attention spent on others. And you need to get that balance right. We've all seen populations who hijack health agendas and who have taken a fair amount of resources...often needed to work with their problems, but it meant that others didn't get those resources. This is always a complicated thing. And I see one of the issues of the Board as being necessary to think that through as...the guardians of how the system is going to work in that sense. (Board Member, CDHA)

4.0 Introduction

Governance is a central and unifying theme in my thesis. The purpose of this chapter is to provide an overview of public sector, institutional governance in health care. I examine the common conceptions of governance and the evolution of governing boards in health care generally, and more specifically, the evolution of District Health Authorities in Nova Scotia. Furthermore, I describe how the ideals of public participation have, over time, been incorporated into our current notion of governance and describe some of the consequences, both positive and negative, that have resulted from this paradigm shift. In this regard I examine the governance literature regarding citizen participation in health care decision-making.

In this chapter I draw on the extensive literature that exists on the subject of governance, primarily from the fields of health services administration, business, community health, social sciences, law, medicine and economics. I situate the role of governing boards in the context of the Canadian health care system where there are many forces that influence the delivery of health services, the development of health policy and ultimately, the health of populations. While in legislation at least, the governing board represents the key decision-making body in terms of health service delivery, its decision-making ability is constrained
and limited by many forces, both internal and external to the formal health system. These limitations affect the capacity of governing boards to attend to the health needs of the population in general and more specifically, the health needs of populations such as African Nova Scotians.

Here I begin an exposition of the complex relationship that exists between governing boards, as a social institution, and the health of African Nova Scotians and in this regard it is worthwhile examining more closely what the term "governance" means.

4.1 Governance Defined

Governance is a complex concept that has been the subject of political and academic debate for a long time and there is an extensive literature on the subject that spans many disciplines. Governance, in its broadest sense, is both a process and a desired outcome. To use a metaphor, governance is the vehicle (the means), the journey (the process) and the destination (the outcome) all in one.

The terms "governance" and "government" are used, often synonymously, to describe how countries, provinces, not-for-profit, for-profit, governmental and non-governmental organizations are controlled and managed (Plumtre & Graham, 2000). Tim Plumtre and John Graham (2000) believe that governance became a distinct concept when the processes of government became more complex. They cite for example, ancient Greece wherein the 'government' and the process of 'governing' took place in the city centre when citizens met to debate and resolve matters of civic importance. When representative democracy became necessary due to growing populations and expanding geographical boundaries of the state, 'government' increasingly took on a role that was more distant from the direct participation of individual citizens. Representative democracy led to the separation
of citizens from their direct role in governance and thus "government" evolved into a formal institution. In this respect "governance" has come to be defined in relation to the complex interactions among government as an institution, social organizations, and the citizenry (Plumtre & Graham, 2000).

Forest and colleagues (1999) identify three structural levels of governance:

1. **Macro level**  This refers to central or national levels of authority for example governments that have a responsibility for the public sector as a whole (e.g. federal or provincial governments);

2. **Meso Level**  This refers to regional or functional authorities that have responsibility for a broad range of services or a particular geographic area, for example specified geographical jurisdictions or territories, or municipal governments;

3. **Micro Level**  This level of governance typically refers to the management of individual organizations, for example, corporations, charities, community organizations, or health organizations.

While the structural levels of governance described above do not permit precise categorization, my thesis is primarily concerned with the micro- and meso-level of governance, in particular governance of publicly funded health organizations, and more specifically, District Health Authorities in Nova Scotia.

Goverance, when applied to the level of an organization, describes the process by which small or large organizations set direction and manage their affairs and delineate how decision-makers are held accountable for their choices. There are many definitions of organizational governance and most are very similar (Alexander, 1991; Gill, 2001; Houle, 1989; Kovner, 1990; NSDOH, 2000). A compilation of the various definitions of organization-level governance would read as follows: organizational governance is a **process**
whereby a group of individuals (a Board of Directors) is given authority (typically by government) to act on behalf of a larger population (which in most cases refers to the community at large) to make decisions about the well-being of the organization (fiduciary responsibilities), and to be held accountable (to whomever the Board is responsible) for their decisions (Gill, 2001; Kovner, 1990; Plumtre & Graham, 2000).

Hospitals and health care organizations such as District or Regional Health Authorities are an example of the most complex form of organizational structure (Shortell & Kaluzny, 2000). This complexity is the result of the interplay among the types of services provided — which tend to be technical and human resource intensive — and the relationships among the various levels of health professional staff, management personnel, the governing board and ancillary organizations, and the multiple accountabilities to key stakeholders including the community and government.

One of the unique features of publicly funded health care organizations is that the ultimate responsibility and accountability for fulfilling the legislative mandate of the organization rest with a Board of Directors that is made up primarily of community members who are unpaid volunteers (Sutherland & Fulton, 1992). In health care, governing boards are responsible for the overall management and stewardship of the organization and for this reason governing boards — and the processes of governance — are central to serving the health needs of the citizenry.

The term "governance" by itself has no normative content, (Gill 2001) yet the health care literature is replete with descriptions of the characteristics of "good governance" in healthcare organizations (Bader, 2000; Caddy, 2001; Carver, 1997; Gill, 2001; Graham et al., 2003; Jenings et al., 2002; Johnson 1994; Kovner, 1990; NSDOH, 2002; Orlikoff & Totton, 2002; Plumtre & Graham, 2000; Shinkman, 1999). Simply stated, "good governance" is
about successfully achieving desired results and achieving them in the right way, where the "right way" is defined in terms of a process that is consistent with the values of democracy and social justice (Gill, 2001). Good governance is about the Board (as representatives for the community(s) to whom the Board is responsible) being able to effectively understand and achieve their primary responsibilities. Increasingly, however, the concept of good, or effective, governance in health care organizations is being defined in terms of the level of meaningful citizen participation in the process of governance (Gill, 2001; Plumtre & Graham, 2000).

Within the category of institutional governance there are two general models employed: for-profit (also known as corporate governance) and not-for-profit (or non-profit). There are many similarities between for-profit and non-profit governance and there are also some important differences.

4.1.1 For-Profit (Corporate) Governance

The legal status of for-profit corporations in Nova Scotia is defined in The Nova Scotia Companies Act (1989). The Companies Act states that for an organization to be incorporated the company must have a Board of Directors that will oversee the management and be responsible for the corporation. The composition and size of the board will vary depending on the size and objectives of the corporation. The role of the corporate board is to act as representatives for the owners, or shareholders. The primary function of the Board consists of directing and monitoring the organization and selecting and evaluating the Chief Executive Officer. The specific responsibilities of Corporate governing boards are listed in Table 1 below.
Table 1
Responsibilities of the For-Profit (Corporate) Board

1. To protect the assets and seek the best interests of the shareholders of the corporation;
2. To hire and evaluate the Chief Executive Officer and to engage in succession planning;
3. To monitor the financial performance of the corporation;
4. To monitor the impacts of corporate activities on society;
5. To ensure the integrity of the corporation and to ensure management policies are in place; and,
6. To retain authority over decisions that are not delegable, for example authorizing payment of dividends to shareholders (Waldo, 1985, p.17-32).

In terms of liability, Board members of for-profit corporations can be held liable for their actions by the shareholders and their protection is limited to the conditions stated in the liability clauses in the articles of incorporation (Nova Scotia Companies Act 1989). Board members serving on for-profit boards are typically chosen by the CEO or the Board for their expertise and they are usually paid for their service on the board. In the corporate model of governance, the CEO can also serve as the Chair of the Board, a feature that does not exist in the traditions of not-for-profit governing boards (Alexander & Weiner, 1998; Houle, 1989; Waldo, 1985).

4.1.2 Not-for-Profit Governance

Not-for-profit boards generally receive their authority directly from Legislation; for example, Nova Scotia's District Health Authorities receive their authority from Bill 34, the District Health Authorities Act (2000). Alternatively, not-for-profit and charitable community groups can incorporate and be legitimized under the provisions of the Societies
Act (1993). The Legislation or articles of incorporation serve to specify the objectives, authority and raison d'etre of the organization.

In most not-for-profit organizations Trustees, or Board members, serve on a voluntary basis and are not remunerated for their service. Depending on the size, most non-profit organizations will hire or designate a Chief Executive Officer to carry out activities on behalf of the Board. The Board functions as a collective entity with individual members having no special authority simply by virtue of their membership on the Board (Houle, 1989; Kovner, 1990; Pointer, 1995). Within the non-profit governance model there are several approaches to governance that can be employed, depending on the aims, funding sources, membership/ownership, and size of the organization. The traditional or tripartite model of governance is the most common form of governance structure and is characterized by three distinct levels of authority (Board, CEO and staff) where the Board of Directors has the ultimate responsibility to set policy and is held accountable for the decisions they make, a Chief Executive Officer who is the sole employee of the Board and is responsible for managing the staff of the organization who, in turn, provide the actual services for the organization (Gill, 2001; Houle, 1989). The traditional model of governance has been universally applied to District Health Authority and hospital structures across Canada.

The functions and responsibilities of a not-for-profit board are, in general, similar to the core responsibilities of the for-profit corporation and are outlined in Table 2.
Table 2
Responsibilities of the Not-for Profit Board

1. **Mission and Values Identification**: The Board is responsible for establishing the organizational mission and ensuring that the organization is achieving its objectives within a framework of agreed upon values. The Board needs to assure itself that the strategic direction it sets is a reflection of the values and interests of the community it serves;

2. **Plan, Develop and Monitor Progress**: The Board establishes strategic, long-term goals for the organization based on a vision of what the organization, in an ideal sense, should look like in the future. The Board monitors the progress that is being made on the strategic goals it has identified;

3. **Hiring the Chief Executive Officer**: The Board has only one employee for whom it is directly responsible: the CEO who manages and directs all other employees within the organization. It is the responsibility of the Board to hire and evaluate the performance of the CEO.

4. **Policy Determination**: The Board establishes internal policies to ensure the organization can achieve its desired ends in a consistent and fair manner within an accepted regulatory framework. Examples of typical Board policies are, procurement policies, spending policies, Conflict of Interest Guidelines, policies on confidentiality, investment management policies, independent audit contracts, and so forth.

5. **Legal and Regulatory Compliance**: The Board should satisfy itself that all ethical and legal responsibilities are fulfilled;

6. **Financial Viability**: The Board is responsible for ensuring adequate financial resources are available to fulfill the organization’s mission and objectives, and to ensure the organization remains fiscally viable;

7. **Monitoring Quality of Care**: In health care organizations one of the primary responsibilities of the Board is to monitor the quality of care being delivered.

8. **Self-Evaluation**: The Board is responsible for periodic self-evaluation, or if deemed appropriate, to request external evaluation of its operations.

Source: Houle, 1989; Inglis et al., 1999; Jennings et al., 2002; Kovner, 1990; Peregrine & Schwartz, 2001; Sasso, 2003; Umberstock and Hageman, 1990

To summarize, for-profit and not-for-profit boards share a fiduciary and moral responsibility to the community to which the Board is responsible (either shareholders or a
general or specific community) and both are held accountable for the activities of the organization (Houle, 1989; Waldo, 1985).

The primary differences between the two models are their sources of funding and fiduciary duties of the trustee. Corporate boards receive their funding through revenues generated by the corporation and not-for-profit organizations can receive their funding through a variety of governmental, corporate or charitable sources. In the case of District Health Authorities, the bulk of the funding comes from government transfers and lesser amounts come from other revenue streams including, for example, preferred services, co-pay, third party sources (e.g. insurance), business ventures and charitable donations.

The final difference between for-profit and not-for-profit boards focuses on the individual duties of the trustee, or board member. From a legal perspective the trustee in the not-for-profit model has three fiduciary duties: the duty of care, the duty of loyalty and the duty of obedience (Sasso, 2003). The for-profit director, however, only has the duty of care and the duty of loyalty. Briefly defined, the duty of care refers to the mandate "...that the board discharge its directorial functions with a certain level of diligence and competence" (Sasso, 2003, p. 1523). The duty of care is concerned primarily with procedural issues and usually demands that a trustee act in good faith and exercise due diligence in carrying out their duties as a board member (Sasso, 2003). The expectation is not that trustees have specialized skills or that they achieve the highest standard of the duty of care possible, but rather that the board member act with "common sense and informed judgement" on issues brought before the board (Sasso, 2003). The duty of loyalty requires that the trustee pursue the interest of the organization rather then personal, professional or other vested interests (Sasso, 2003).
The duty of obedience refers specifically to the trustee's fidelity to the mission of the organization. Regarding the duty of obedience Peggy Sasso (2003) states,

Instead of answering only to a financial bottom line, the not-for-profit must also answer to its mission. Given that the not-for-profit is held in the public trust for the benefit of society, it follows that mission fulfilment is roughly equivalent to enhancing shareholder value in the for-profit sector. And it is this standard of accountability that is given legal meaning in non-profit corporate law as the duty of obedience. Thus, the duty of obedience resembles the trustee's duty to administer in compliance with the founding purpose. In the not-for-profit corporate sector this translates into two specific sub-duties: a duty to ensure that the institution obeys the laws that govern and regulate it and a duty to make sure that the institution continues to operate for the purpose for which it was formed (p. 1528-1529).

The duty of obedience is unique to the not-for-profit sector chiefly because the interpretation of the duty of obedience "...is defined and informed by both the standard of review applied by the courts and by who is legally empowered to enforce the duty" (Sasso, 2003, p. 1530). In other words, in the for-profit sector the shareholder has the power to sue the board for failing to promote the interests of the organization, whereas in the not-for-profit sector there is no readily identified owner to fulfil this oversight role. Sasso (2003) states, "...the not-for-profit does not have readily identifiable equity holders equivalent to the for-profit shareholder. Consequently the question of who should have standing to enforce a particular not-for-profit fiduciary duty is a complex issue..."(p. 1530).

Much of the nomenclature related to the not-for-profit governing board is drawn from the American corporate governance literature and as a result there are many terms that are common to both models of governance. While for the most part this phenomenon of overlapping terminology is inconsequential, there is one area that I feel is problematic and worthy of clarification. In my view the concept of "ownership", as it relates to the not-for-profit organization, is not well addressed in the literature. "Ownership" is a term that has been adopted in the governance literature to apply to both for-profit and not-for-profit
organizations and this in turn affects our understanding of the duty of obedience and the
potential remedies for holding trustees accountable for their actions. Sasso (2003)
summarizes the conundrum of ownership of not-for-profit organizations:

While it is debatable who, if anyone, actually owns the for-profit corporation,
the issue becomes even more clouded in the not-for-profit context where — 
by definition — there can be no alienable claims to institutional profits. Thus
the notion of ownership is ultimately a distraction (p. 1497).

The pivotal question in my view is not "Who are the owners?" but rather the more
important question is, "To whom are the boards accountable?" In the Canadian publicly
funded, not-for-profit health system the answer to this question is not entirely clear.
Certainly, the legislation, at least in Nova Scotia, is unequivocal: the DHA Boards are directly
accountable to the Minister of Health (Sec.19, 20 Health Authorities Act). There is however,
an unwritten assumption that the boards (by virtue of the fact that they are appointed to
serve as citizen volunteers to hold the public's interest in trust) are accountable in some
fashion to the public. Many organizations, such as Capital District Health Authority have
managed to circumvent this ambiguity by stating in their Mission Statement that the Board
"...is accountable to the public through the Minister of Health."

In place of the term "ownership" I would argue that it may be more appropriate to
use the phrase, "community(s) or individual(s) to whom the board is legally, financially and
morally accountable." The boards are legally and financially accountable to the Minister of
Health because, as stated above, this is clearly outlined in the Health Authorities Act. The
issue of moral accountability, i.e. serving the public's interest (fiduciary role) is more open to
interpretation and is grounded in common understandings of accountability.
4.1.3 Accountability

In recent years accountability has become the new 'buzz word' in health care circles. Indeed, in the past ten years, most of the major reports on the Canadian health system have highlighted the need to focus on, and improve accountability as a means to achieve a sustainable, citizen oriented, universal model of health care (Fyke, 2001; Kirby, 2002; Mazankowski; 2001; Romanow, 2002).

Cathy Fooks and Lisa Maslove (2004) quote the 1979 Royal Commission on Financial Management and Accountability (Royal Commission, 1979) when they state, "Accountability, like electricity, is difficult to define, but it possesses qualities that make its presence in a system immediately detectable" (p. 13). The literature on accountability is diverse and spans many disciplines and sectors. While there are many general definitions of "accountability", few apply specifically to the health care setting. For the purposes of this thesis I have chosen to adopt the definition of accountability developed by the Auditor General of Canada (2002): "Accountability is a relationship based on the obligation to demonstrate and take responsibility for performance in light of agreed upon expectations."  

The Auditor General of Canada (2002) identifies five principles that demonstrate effective accountability and form the basis for an integrated accountability framework: clear roles and responsibilities, clear performance expectations, a balance of expectations with capacities, credible reporting, and mechanisms for review of performance and adjustments. I will discuss each one briefly.

**Clear roles and responsibilities.** There is a need to clearly define the responsibilities (duties, obligations and related authorities) of, for example, a District Health Authority and its partners. Inherent in this process is a need to determine how those responsibilities will be fulfilled, and if in fact other partners are required to enable the DHA
to fulfil its responsibilities (for example, Community Health Boards, professional groups, trade unions, or the Department of Health). The Auditor General of Canada (2002) states that without a clear understanding of the partners' roles and responsibilities the basic requirement for an effective relationship are not present.

**Clear Performance Expectations.** It is important that clear performance expectations for each party in the relationship be established. In the absence of clearly stated performance expectations it is difficult to determine if success has been achieved and it is difficult to attribute accountability for performance (or non-performance). In the case of DHAs there is a need to agree upon and establish clear performance expectations regarding financial management, service provision, etc. among the DHA, government and other stakeholders.

*A balance of expectations with capacities.* In an effective accountability relationship the expectations must be known, realistic and achievable. This is an ongoing problem for DHAs because public and government expectations for performance usually far outweigh financial and human resource capacity.

**Credible reporting.** In an effective accountability relationship there is a requirement for clarity regarding what information is required, for example, financial, non-financial, management, health service utilization, or health status etc. Credibility is enhanced when information needs and reporting requirements are established in a manner that is open and transparent and agreed upon by all parties in the accountability relationship. In the case of District Health Authorities there is a need to clearly establish what parties are involved in their accountability relationship (e.g. public, government, stakeholders) and more important, the information needs and reporting requirements. While DHAs report on several financial
indicators to government, DHAs currently have limited reporting requirements to the public on finances and service provision.

**Mechanisms for review and adjustment.** Finally, there needs to be a process whereby performance of the organization (and its partners) will be evaluated and guidance regarding specifying how remedial action, if required, will be implemented.

Based on this framework it is easy to see that there are many opportunities for the accountability relationship to break down and become dysfunctional. For the most part, the accountability framework for District Health Authorities is not well articulated. In the case of District Health Authorities there are limited avenues available to communities to hold the government (or the DHA) accountable for the allocation of resources to meet their health needs.

In the case of the DHAs the Board is directly accountable to the Minister of Health. There are other mechanisms, through various governmental processes, to hold the Minister of Health accountable, though I will not attempt to elaborate on these mechanisms. Moral accountability requires that the Board be accountable in some fashion to the community it is supposed to be representing to ensure that it is fulfilling its stewardship mandate i.e., "holding the public's interests in trust." In my view this issue has not been adequately addressed in the literature.

This raises an interesting question: Do Board members serve as trustees or representatives (or delegates)? This is an important distinction from the perspective of developing accountability frameworks, because if a board member is serving as a trustee they are by definition authorized to make decisions based on what *they* think is best for the population, irrespective of the views the public (or stakeholders) may hold (Young, 2002). This is problematic when boards are asked to be accountable for their decisions. If one
serves as a trustee they are then accountable to the entity (in the case of DHAs it would be the Minister of Health) that authorized them to hold the public's interest in trust. If, however, one serves on the board as a delegate/representative then the accountability relationship changes; a board member who is a delegate is expected to bring forward the views and perspectives of their constituency and vote on matters in accordance with the "will of the people." The delegate is accountable to the individuals who appointed (or voted) for them to serve as their representative. These are distinctly different demands and the potential for conflict is obvious.

In reality, however, the distinction between delegate and trustee is not so clear-cut. Adhering to the rhetoric of health reform, Board members should serve not as representatives for the Minister of Health, but rather as representatives for the public as a whole. The DHA board, therefore, in its role of intermediary between the community's interests and government, has a pivotal role to play in advocating for the interests of the public and, more importantly, they have a special role to play in attending to vulnerable populations.

To return once again to the problem of the duty of obedience and its relationship to the concept of ownership in the not-for-profit sector, the literature is less than helpful in determining how this duty can be monitored and enforced. There are several potential agents available to monitor the duty of obedience: The Minister of Health, the public, the board itself, and the CEO (Sasso, 2003).

The individual who serves as the public's representative to ensure the duty of obedience — adherence to mission — is the Minister of Health. Because boards are financially and legally accountable to the Minister of Health it may be reasonable to assume that the Minister should therefore enforce the duty of obedience. While in a general sense this
monitoring duty is fulfilled by the Minister of Health (or more accurately the Minister's bureaucracy), this Ministerial oversight role is also problematic because there is a risk of the Minister serving political interests as opposed to the well-being of the organization and the health needs of the population. The likelihood of this occurring is not far-fetched.

Speaking from personal experience in this regard, I can recall many instances when government imposed directives on the Regional Health Boards that were contrary to acceptable management practices, sound evidence and in some instances contrary to the mission of the organization. Often the directives were informed and motivated by political interests as opposed to serving the interests of the organization or the well-being of the public. For example, it was a common occurrence during pre-election periods to be told by Department of Health officials to defer laying-off staff or making service changes or program modifications. While the lay-offs or program cuts were necessary to stay on budget, promote fiscal stability, or improve efficiency political interests would dictate that the implementation of the changes be delayed to not embarrass the government in power.

Another example of this kind of political interference occurred when political interests and public lobbying motivated the implementation of a particular service (for example bone densitometry or mobile breast screening) when available evidence and advice from the Medical Advisory Committee found the treatments to be of minimal or marginal value when compared to other diagnostic or treatment modalities. This type of political interference in administrative and governance matters tended to occur more frequently around the time of elections, when the issue of concern was controversial for the government, or if the issue had the potential to become a focus of media attention. This conflict between balancing political concerns with the concerns and interests of the public
continues to create significant challenges for governing boards in health care (Roberts, 1992).

Opinion polls consistently rate health care as the number one concern of Canadians. Thus it comes as no surprise that politicians face considerable pressure to intervene and "do the right thing" when it comes to addressing public concerns irrespective of what the community is demanding or what the evidence is suggesting (Chyna, 2000).

There are few specific measures in place in the Nova Scotia health care system for the public to hold the DHA boards accountable for their actions. Typical avenues to enhance accountability may include for example, open board meetings, transparency of decision-making, and access to information. In Nova Scotia regular meetings of the DHA board and its sub-committees are closed to the public and access to CDHA Board and committee minutes are subject to certain conditions. Public measures of accountability such as direct reporting and transparency of decision making are limited to two public forums per year. The Health Authorities Act (2000) states:

A board of directors shall conduct at least two public forums in the health district in each year for the purpose of providing information on the operations and activities of the district health authority and seeking input from the public. (Section 18)

This, in my view, is inadequate to permit a reasonable public assessment of the Board's decision-making activities.

Accountability can also be partially achieved through board evaluation processes. Board evaluation is generally accomplished in two ways: boards either self-evaluate their performance or they are evaluated by external agencies such as the Canadian Council on Health Services Accreditation (CCHSA, 1998). Regarding self-evaluation, it is acknowledged that there is an inherent conflict in this arrangement and there are many challenges associated with effective board self-evaluation including a lack of normative standards,
intrinsic bias on the part of the board members and differing opinions on gold standards of performance (CCAF~FCVI 1998; Dobb, 2002; Kovner, 1990; Orlikoff, 1992; Nelson, 2000).

External evaluation of the board, such as the standard accreditation survey performed by the Canadian Council on Health Services Accreditation merely ensures that the basic governance structures and processes are in place to facilitate effective performance and to permit effective self-evaluation. It is beyond the mandate of the Council to engage in a critical evaluation of the board's performance (CCHSA, 1998). Moreover, in both cases board self-evaluation and external evaluation reports are normally not accessible to the general public.

Sasso (2003) proposes that the only other available means to monitor and enforce the board's duty of obedience is to assign this task to the Chief Executive Officer. There are problems with this approach however, not the least of which is the conflict of interest the CEO would be in to hold her/his employer accountable for their fidelity to the mission of the organization (Sasso, 2003).

In the next section of this chapter I discuss the history and evolution of citizen involvement in health care decision-making with a particular focus on the Nova Scotia health system. I describe how the call for greater public participation in decision-making continues to shape our conception of a reformed health care system. Nova Scotia is keeping pace with the rest of the country in terms of its efforts to involve the citizenry in decision-making. There are positive and negative aspects of the current health reforms that need to be examined more closely to determine whether they will better position the District Health Authorities to attend to the health needs of African Nova Scotians. As a preface to the discussion on history and evolution of Nova Scotia's District Health Authorities it is useful
to clarify what is meant by the term "public participation" to understand why this concept is an important feature of organizational governance.

4.2 Public Participation and Governance

One of the recurring themes of provincial health reform initiatives in Canada has been a trend toward increased citizen participation and experimentation with deliberative processes in the health care system. The majority of recent task forces, commissions and reviews of the health system in Canada have highlighted the need to create avenues for increased citizen participation – or citizen engagement – in decision-making, policy development and priority-setting as a means of attending to the health needs of the population (Fyke, 2001; Kirby, 2002; Mazankowski, 2001; Romanow, 2002).

Recommendations arising from these commissions to reform the health care system support the view that decision-makers have to be held accountable for the decisions they make and this can be accomplished at least in part through greater involvement of citizens in the deliberative process (Kirby, 2002; Romanow, 2002). Moreover, there is a growing belief that decision-making in health care needs to conform to a new paradigm that is supportive of citizen involvement in processes that are open, transparent and meaningful for citizen participants, stakeholders and policy-makers.

There are several good definitions of citizen participation available and most are very similar (Abelson & Eyles, 2002; Arnstein, 1969; Lilley, 1993; Pivik, 2002). I have chosen to adopt the definition proposed by Julia Abelson and John Eyles (2002). They define "public participation" as

...a broad set of practices that includes passive forms of citizen involvement, where the public's views are sought as an input to a planning or decision-making process, and more active involvement through direct participation in
decision-making processes, and structures. Public participation also encompasses citizen engagement and deliberative democracy (p. 1).

Pivik (2002) categorizes the processes of citizen participation in decision-making and health planning into two general categories: consultation strategies and involvement strategies. With consultation strategies citizens take on a more passive and consultative role. These approaches usually provide an opportunity for the public to voice opinions but not involvement in actual decision-making (Pivik, 2000). Consultation strategies include surveys, community forums, focus groups, public meetings, citizen juries, policy juries, deliberative polling, tele-voting, town hall sessions, and key informant interviews (Abelson et al, 2001; Abelson & Eyles, 2002; Graham, 2003; Kothari, 1999; Pivik, 2000; Slaton, 2001).

Involvement strategies are examples of more active participation and are characterized by "voice and choice" as opposed to being presented with opportunities to express opinions without promise of influencing decisions (Saltman, 1994). With involvement strategies citizen participation in planning, implementing and evaluating health services usually takes the form of membership on committees, boards or task forces or collaborative partnerships with health professionals or researchers (Pivik, 2000).

The strategies for public participation generally consist of a range of practices where various levels of power sharing fall on a continuum ranging from minimal involvement (consultation and information sharing) to complete involvement (direct participation in decision-making). The range or continuum of public participation options can be visualized as a process where power-holders share their power on a scale ranging from no sharing at all to full sharing of power.
Bruce Smith (2003) proposes a model of public participation on a continuum that ranges from information exchange at one end of the spectrum, to shared jurisdiction at the other. (See Figure 1 – Public Participation Continuum)

**Figure 1**

**Public Participation Continuum**

<table>
<thead>
<tr>
<th>Information Exchange</th>
<th>Consultation</th>
<th>Engagement / Dialogue</th>
<th>Shared Decisions</th>
<th>Shared Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Info in / info out</td>
<td>I listen and speak / you listen and speak</td>
<td>We talk and understand each other</td>
<td>We decide</td>
<td>We are responsible and accountable</td>
</tr>
</tbody>
</table>

(Source: Smith, 2003, p. 36)

In this model Information Exchange refers to the process of increasing awareness through education and dialogue. Consultation and Engagement/Dialogue are similar in that the objective is to engage in meaningful dialogue through an open two-way process of exchanging information between or among parties. Examples of this would include seeking stakeholder input, discussions of tradeoffs and priorities, in-depth exploration of views or concerns, etc. (Smith, 2003). At the higher end of the continuum, Shared Decisions and Shared Jurisdiction seek to forge power sharing arrangements where notions of shared responsibility, decentralized decision-making, and accountability frameworks are prominent features (Smith, 2003).

At the lower level of the public participation continuum (Information Exchange and Consultation) citizens have an opportunity to "participate in participating" but their involvement and influence on decision-making is limited, if not completely non-existent. Informing citizens of decisions that have already been made, and consulting them on matters
with no assurance their suggestions will be taken into consideration are examples of tokenism (Amstein, 1969).

Tokenism can be a very deceptive and destructive element in public participation initiatives. Tokenism can also serve to undermine efforts to bring meaningful opportunities for majority and minority voices to come to the decision-making table (Taylor et al., 2000). There are two kinds of tokenism, the first being a form of low level participation where groups or individuals are consulted or engaged in dialogue with no intention of attending to their concerns.

The second kind of tokenism involves circumstances where a small number of "representatives" of minority or oppressed groups are invited to participate in the power structure. In this sense, tokenism tends to serve the needs and interests of those in power and not necessarily the interests of the "have-nots". Taylor and colleagues (2000) describe this form of tokenism as

...a structural reality that may be encountered by members of virtually every disadvantaged group, including immigrants and refugees, women, the disabled, and every racial, ethnic and language minority. Tokenism is a strategy whereby a few capable members of a disadvantaged group are accepted into positions usually reserved for members of the advantaged group, while access is systematically denied to the vast majority of qualified disadvantaged group members (p. 188).

Tokenism in the second sense occurs when particular individuals of have-not groups are chosen to serve on boards often as a means for the organization to demonstrate "diversity" in its membership. In these instances their single voice cannot hope to compete against the traditional, majority voices (Amstein, 1969). bell hooks (1995) refers to this phenomenon (where individuals from racialized minority communities are accepted into white power structures) as a form of assimilation and an attempt to make Blacks or other
minorities into "Honorary Whites" (p.189). In reality however, many "advantaged groups" as well as disadvantaged groups are also excluded from decision-making in health care.

While Smith's typology of public participation is a helpful way to visualize and categorize opportunities for public participation, his typology is limited in that it makes the assumption that those who hold power and those who are seeking power are homogeneous and that their groupings are clearly delineated. In reality there may be many fine gradations of participation and these may vary depending on the circumstances (Arnstein, 1969).

Participation strategies can be more succinctly categorized into two basic categories: token participation and meaningful participation. In this regard, meaningful participation would be defined as being able to significantly influence decisions regardless of the strategy employed. It is possible that a public protest, or recommendations from an advisory committee, which on Smith's continuum would be categorized as Information Exchange or Consultation, can be examples of meaningful participation if protesters' concerns or advice from the committee are acted upon and constructive change is implemented.

It may also be the case that a decision-making body may have their decisions overturned by a higher authority. Take the example of a DHA. On Smith's (2003) continuum they would fall into the category of Shared Jurisdiction (where decision-making authority is shared between government and the DHA); legislation permits the DHA authority to make decisions and meet the health needs of the district (Health Authorities Act, 2000). But if the Board's decisions are overturned as a result of government intervention (or more bluntly stated, political interference) then this, in effect, renders the presence of the DHA itself, on this particular issue at least, as token. As an alternative to delineating public participation strategies based on distinct categories, participation strategies
need to be evaluated based more on the outcomes of the participation and not just the rhetoric of the strategy's stated objectives.

The most significant advantage associated with fostering effective and meaningful citizen participation in decision-making is that the outcome of the process – the health services, policies or programs – can more closely reflect the specific needs, values, culture and attitudes of the community, enhance community "buy-in" of decisions and enhance social capital (Frankish, 2002; Pivik, 2000; Veenstra & Lomas, 1996). Also, citizen involvement in decision-making can result in increased community awareness of health services and an enhanced sense of community-control and self-determination, and this in turn can provide new avenues for dialogue between the health system and the community (Frankish, 2002; Pivik, 2002).

The goal of citizen participation is laudable and seemingly straightforward, yet there are many challenges and barriers associated with fostering effective citizen participation including for example, power differentials among and between government, professionals and citizens. Participation on governing boards in health care is a sophisticated, complex form of public participation and the processes and structures through which the public can play a meaningful role in decision-making is of key interest in this research.

Despite the rhetoric of health reform the ideal of citizen participation in health care governance is not always achieved. Abelson and Eyles (2002) outline several barriers to meaningful citizen participation including:

1. Citizen domination by powerful groups interested in involving the public when it suits their purpose;
2. Policymakers touting citizen governance as a critical element to achieve responsive decision-making while using these structures as instruments of cost cutting and restructuring;
3. The ability for only the most educated and sophisticated and arguably the most unrepresentative and biased "public" to participate as citizen governors; and,
4. An increasingly cynical public weary of pre-determined illegitimate public consultation processes, reluctant to take responsibility for decision making, seeking more accountable consultation. (p. 16).

Conflicting vested interests, resource constraints and tokenism further exacerbate the challenges of achieving effective citizen participation (Higgins, 1999; Pivik, 2000; Taylor et al, 2000). The gap that exists between power holders and those who want to hold or share power creates challenges for implementing effective strategies for citizen participation in decision-making processes. This is particularly evident when one considers the challenges faced by members of vulnerable groups and their desire to participate in decision-making, especially when the decisions in question may affect their well being. There are members of our society who, because they are discriminated against based on social class, racial or cultural background or socio-economic status face overwhelming barriers to meaningful participation in decision-making.

Finally in this chapter I examine the history and evolution of governing boards in health care and in this regard I focus specifically on Nova Scotia’s foray into health reform. Provincial reform initiatives have made significant strides to enhance greater public participation in decision-making, yet governing boards in health care continue to struggle to achieve the lofty goals of a health system that is responsive to the health needs of the citizenry. In Nova Scotia much progress has been made in involving the lay citizenry in decision-making at the level of District Health Authority and local Community Health Boards. This increase in citizen involvement in health care has been beneficial in some ways and at the same time it has been fraught with many pitfalls.
4.3 History of Governing Boards in Health Care

Initially, the majority of hospitals were built and maintained by philanthropic or religious organizations (Johnson, 1994; MacEachern 1962). The first historical references to hospitals were in ancient India where Hindu documents record the existence of hospitals in the 6th century before Christ when Buddha appointed physicians to serve groups of villages and hospitals were built to serve the indigent (MacEachern, 1962).

In Canada during the pre-World War II period, hospitals were autonomous agencies that competed against one another for patients and limited financial and human resources. Because hospitals were not publicly funded in Canada until the early 1960's, religious organizations and community groups that owned hospitals established boards of directors, or boards of management to operate their facilities. In the absence of government funding and regulation, hospitals were run in a similar fashion to independent businesses. They were responsible for generating revenue from patient visits, charitable donations and grants from local governments and budget deficits were the responsibility of individual hospitals (Sutherland & Fulton, 1992).

The primary responsibility of hospital boards was to fundraise for capital and operating funds, recruit and train staff (for example nursing and medical staff), oversee management decision-making and maintain the financial viability of the organization (Sutherland & Fulton, 1992). During the pre-WWII period the role of the Board – in the absence of government regulation and funding – evolved to become one of serving the health needs of the community both in the capacity of fundraiser and acting as a formal steward and manager of the community's resource (Sutherland & Fulton, 1992; Taylor, 1990).
Following World War II, Canada embarked on a major hospital construction initiative and since that time there have been significant changes in the ownership, delivery, organization and management of health services. In Canada, the federal government, following the lead of Saskatchewan, passed the Hospital Insurance and Diagnostic Services Act (HIDSA) in 1957 in an attempt to encourage the development of a pan-Canadian hospital insurance program (Taylor, 1990). As an incentive to participate the Federal government offered the provinces a 50-50 cost sharing plan on insurance premiums that provided universal coverage for hospital services. By 1961 all the provinces and territories developed similar universal coverage programs for hospital services. The HIDSA Act facilitated the rapid growth and development of the hospital sector throughout the 1960s and 1970s (Taylor, 1990).

In the period from the early 1960s to the present, provincial governments increasingly assumed responsibility for the ownership, funding and regulation of hospital services. When governments took over the role of funding hospitals, annual budget exercises consisted of line-by-line reviews by the Department of Health thereby diminishing the role of the governing board as financial manager. It was not until the early 1990s that governments reintroduced global budgeting for hospitals and as a result boards and their management staff could once again engage in independent financial management of their organizations (Sutherland and Fulton, 1992; Taylor, 1990).

During the same time governing boards struggled to keep pace with rapid technological changes in the delivery of health services, changes in government regulation, increased "professionalization" of health human resources, and dramatic increases in the costs of delivering services (Sutherland & Fulton, 1992). As recently as the early 1990s, many hospitals in Nova Scotia were still owned by religious organizations and community
corporations. This independent ownership of hospitals came to an end when in 1994 the government of Nova Scotia introduced regionalization and assumed the ownership of all hospitals in the province.

In the pre-regionalization period early governing boards characteristically fulfilled their role as managerial stewards of hospitals, concerning themselves primarily with developing new "state of the art" health services, managing budgets, and seeking partners to assist in growing their organizations. It is only in recent times, since the advent of health reform initiatives of the 1990s, that the role of the governing board undertook a perceptible shift in emphasis from managerial stewards of hospital services to citizen governing boards concerned with the health of populations.

Increasingly, citizen participation in decision-making in health care is being viewed as an essential feature of an effective and responsive health care system (Abelson et al, 2001; Abelson & Eyles, 2002; Crawford et al, 2002; Eyles, 1993; Frankish et al, 2002; Mhatre & Deber, 1992; NSRCHC, 1989; Pivik, 2002; Redden, 1999; WHO, 1978; WHO, 1986). With this change in emphasis however, comes the challenge for governing boards to manage the process of citizen involvement in decision-making. As noted in the previous section, it is hard to argue against the intuitive benefits of fostering active citizen participation in decision-making in a field such as health care. Yet, not all forms of citizen participation are viewed as equally effective or constructive, nor are all forms of participation viewed as being able to contribute to constructive change (Abelson & Eyles, 2002; Arnstein, 1969; Florin & Dixon, 2004; Frankish et al, 2002; Smith, 2003; Taylor, 2000).

This trend towards citizen participation in policy making in health care has been accomplished in part through the devolution of decision-making authority from central agencies such as Departments of Health to regionalized systems of governance, for example
Regional Health Boards. In theory, at least, the objective of regionalized governance is to increase local citizen participation in priority setting so that decision-making processes can reflect the needs and values of local communities (Bickerton, 1999; Redden, 1999). In reality, however, the ideal of a citizen led governance model in health care that is characterized by open democratic processes, meaningful participation, responsibility for priority setting, and accountability for their decisions – especially for minority or vulnerable populations – often exists more in rhetoric than in reality and in this regard Nova Scotia is no exception (Abelson & Eyles, 2002; Jewkes & Murcott, 1998; Pivik, 2002).

4.4 Evolution of District Health Authorities in Nova Scotia

In the period from the mid-1980s to the early 1990s, Nova Scotia and six other provinces in Canada established independent Commissions to review their health care systems in an effort to contain spiralling costs and to preserve the principles of Medicare (Hurley, Lomas & Bhatia; 1994; Mhatre & Deber, 1992). In addition to making recommendations to remedy the growing problem of escalating costs and increases in the utilization of services, most of these reports concluded that existing governance structures and management processes were outdated and in need of fundamental reform (Hurley, Lomas & Bhatia, 1994). The majority of the provincial reviews – with the exception of Ontario – recommended the adoption of regionalized governance systems for health services and increased citizen participation in decision-making as a means to improve the health of the public.

On August 25, 1987 the Governor in Council established the Nova Scotia Royal Commission on Health Care. The Commission’s mandate was to examine every dimension of the health care system in Nova Scotia and to make recommendations regarding future
directions. The Commission examined various aspects of the health system including funding and costs, utilization and duplication of services, supply and education of health professionals, organization of services and efficiency of the system (NSRCHC, 1989).

In December 1989 the Commission released its final report entitled, "The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy." The Commission recommended sweeping changes to every level of the health care system. The recommendations focused on several areas including: the need to develop health policy that is oriented to healthy outcomes, enhancement of citizen participation in decision-making, decentralization and regionalization of health services, development of mechanisms to promote the accountability for expenditures of limited resources and a shift in resource allocation policy so that available resources are matched to health needs (NSRCHC, 1989).

The dominant theme in the Report was the need to decentralize decision-making authority away from the Department of Health to a regionalized system of governance for health services, in short, to put decision-making in the hands of communities. Until that time hospitals in Nova Scotia were governed by separate hospital Boards of Directors that were directly accountable to the Department of Health. At that time, local hospital boards and private physicians worked in a "collegiality model", that is, they worked closely as a team to achieve mutually beneficial goals. While the collegiality model was common within organizations, there was intense competition among organizations to promote the financial interests of their own hospital (Bickerton, 1999).

The Commission envisioned that Regional Health Authorities would become the focal point for citizen participation in planning, managing and delivering health care services. The Commission believed that the delegation of authority to specified health regions would create a dynamic governance system that was flexible and responsive to the local needs of
consumers. The new Regional Authorities would serve as vehicles for increased community empowerment and would be held accountable for the expenditure of limited resources and they would increase efficiency through service integration and elimination of duplication at the level of local hospitals (NSRCHC, 1989).

In April of 1990 the Minister of Health's Implementation Committee was formed to develop a response to the Royal Commission's recommendations. In November 1990 the Implementation Committee released its final report entitled, "Health Strategies for the Nineties: Managing Better Health." In addition to other recommendations regarding health system performance, the Minister's Implementation Committee also supported the recommendation to form a regionalized system of governance for Nova Scotia's health care system.

In 1990 I was working as a Policy Analyst in the Nova Scotia Department of Health and I was seconded to serve on the Minister's Implementation Committee. My recollection of this experience was that there was a steadfast resistance within the senior ranks of the Department of Health, and among health professionals and hospital administrators in the field, to the concept of regionalization and other efforts to decentralize decision-making power to citizen dominated community boards. There was also an unwillingness on the part of local hospital administrators and Department of Health bureaucrats to acknowledge that the "community" had the capacity to make responsible decisions regarding the delivery of health care. Yet, at the community level, there was considerable support for decentralization of power and decision-making authority. The perception from communities was that the "bureaucrats in downtown Halifax" did not have the indepth knowledge or internal capacity to make decisions on behalf of communities regarding their well-being. This difference of opinion between those that held power, namely government bureaucrats and health system
administrators, and those at the community level that wanted decentralized decision-making lasted well into the period that saw the actual creation of the regional health boards.

The political will to actually devolve decision-making authority to functional regional health authorities was not present until 1993 when the Liberal government of John Savage created the "The Minister's Action Committee on Health System Reform" – dubbed the "Blueprint Committee." The Regional Health Boards were formally created in September 1994 after the Committee's recommendations contained in the Report entitled, "Nova Scotia's Blueprint for Health System Reform (1994)" were adopted. At the time, Nova Scotia was the last province in Canada – with the exception of Ontario – to adopt a regional system of governance in health care (Regionalization of Health Care Systems in Canada, 1997).

As stated previously, prior to the creation of a regionalized model of governance of health services, municipal or Crown corporations or religious orders owned the province's hospitals. In each case a separate board of directors governed hospitals in accordance with the *Hospitals Act* and these boards were directly accountable to the Minister of Health. These individual hospital boards were disbanded and the assets of the separate corporations were transferred to the newly created Regional Health Boards. This was a period of anguish for all players in Nova Scotia's health system. While it was generally acknowledged that change was needed, there was considerable anxiety and uncertainties associated with implementing wholesale changes to the existing structures.

Under the "Act to Establish Regional and Community Health Boards" (1994) also known as the "Regional Health Boards Act", the province's health system was divided into four Regional Health Boards (RHBs) and four "non-designated hospitals." The Non-Designated Hospitals included the Cape Breton Health Care Complex, the IWK Grace
Health Centre for Children, Women and Families, the Queen Elizabeth II Health Sciences Centre, and the Nova Scotia Hospital. Each of these non-designated hospitals operated under a separate Board of Directors that was independent of the Regions within which they were situated. The RHBs and the Non-Designated hospital Boards were comprised of volunteer members appointed by the Minister of Health. These Boards were given the responsibility and accountability for managing hospitals, community health centres, addiction services, and public and mental health services. Devolution of hospitals, mental health, public health and addiction services was completed by April 1, 1997 (Regionalization of Health Care Systems in Canada, 1997).

The Blueprint Committee Report originally recommended that Community Health Boards be given the majority of responsibility and decision-making power and the Regional Health Boards would play the secondary role of planning and coordination (Bickerton, 1999). It was envisioned that the RHBs would, "... plan, fund, rationalize, coordinate and evaluate programs and services (rather than facilities) that would serve the whole region and allocate funds for community boards consistent with provincial guidelines" (Bickerton, 1999, p.172).

It was anticipated that the dissolution of existing hospital boards – and their associated financial inefficiencies – would provide necessary funding for community programs and services (Bickerton, 1999). In the end however, the Regional Health Boards were designated as the primary governing boards with ultimate accountability and responsibility for health care services and local Community Health Boards were relegated to an advisory capacity, much to the chagrin of community participation advocates.

Considerable effort was put into integrating the work of the Community Health Boards into
the regional governance process and there was a genuine interest in making the most of the advice the CHBs had to offer.

In August 1995 I was hired as the first Chief Executive Officer for the Western Regional Health Board and I served in that role until August 2000. There was, at least from my experience in the Western Region, considerable interest and enthusiasm from community members to participate in the work of the RHB and CHBs and to make the new regionalized system of governance reach its potential.

In the early days of regionalization the RHBs operated as "hospital boards without a hospital," i.e. while the Board existed in legislation, they did not have designated responsibility for providing health services. This served to promote a strong sentiment (or hope) among traditional power brokers – community hospital boards, hospital administrators and physicians – in the health system that the government would not follow through with their commitment to regionalize health services. This sentiment was short lived because in April of 1996 Valley Regional Hospital in Kentville was the first hospital in Nova Scotia to be "designated" as a Regional Health Board facility. The transfer of assets and authority for the remaining hospitals and health services from local boards to the RHBs followed over the coming months. The decision to designate the Valley Regional Hospital as an RHB facility was a landmark decision in that it signalled a firm commitment to follow through with regionalization. I recall naysayers of regionalization expressing shock and dismay that the government had finally acted on their support of citizen decision-making and their commitment to regionalization.

However, persistent and ongoing opposition to regionalization was mounted early in the process of regionalization. The newly formed Regional Health Boards were being asked to re-design the health system during a time when government was attempting to eliminate a
significant and longstanding budgetary deficit. As a result, the RHBS were mandated to initiate financial restraint in the form of expenditure reduction. In the first year of the WRHB's mandate the board was asked to make significant budget cuts which resulted in staff layoffs, bed closures and service reductions and this was in addition to the challenges associated with amalgamating ten hospitals and three major service portfolios (public health, addiction services and mental health services). Not surprisingly the general public and the health community began to associate health reform with budget and service cuts – a persistent albatross that arguably led to the demise of the RHB system of governance.

In October 1998 the minority Liberal government of Russell MacLellan appointed Dr. Richard Goldbloom to Chair the Minster's Task Force on Regionalized Health Care in Nova Scotia (Minister's Task Force, 1999) as a response to ongoing criticism of the Regional Health Board system. The mandate of the Task force was to review the status of regionalized health care in Nova Scotia and to make recommendations for improving the health system. In July of 1999 the Task Force issued its final report entitled, "Minister's Task Force on Regionalized Health Care in Nova Scotia: Final Report and Recommendations." The Report concluded that the government should – despite ongoing criticism of the RHBS – continue with the process of regionalization and strengthen the existing Regional Health Boards to ensure that the initial goals of regionalized health care were achieved. This included bringing the non-designated hospitals under RHB jurisdiction, improving the funding model for RHBS, formally recognizing Community Health Boards through legislation and improving community representation on the Regional Health Boards (Minister's Task Force, 1999).

In the provincial election in the summer of 1999 the Progressive Conservatives, under the leadership of John Hamm, won a majority government. One of Premier Hamm's
election promises was the dissolution of Regional Health Boards and the creation of smaller District Health Authorities that would be centered around the Level 2 hospitals, previously known as Regional Hospitals. In October of 1999 – despite the recommendations contained in the Goldbloom Report to support the ongoing development of the RHBs – the Hamm government announced the future dissolution of the Regional Health Boards.

In November 1999 the Department of Health released a report entitled, "Future Directions of the Health Care System: Establishing District Health Authorities." This Report detailed the transition to, and formation of, nine new District Health Authorities. The stated rationale for dissolving the four RHBs and creating nine DHAs was the need to bring decision-making closer to the community level, even though it was acknowledged that this increase in the number of administrative units, i.e. Districts, would result in a significant increase in administrative costs. To date, Nova Scotia is the only province in Canada to increase the number of health regions, whereas the trend has been towards decreasing the number of regions to increase administrative efficiency and promote the integration of service delivery (CCARH, 2003).

On December 21, 2000 "An Act to Provide for Community Health Boards and District Health Authorities and Respecting Provincial Health-Care Centres" also known as the "Health Authorities Act" was proclaimed. In January 2001 the nine District Health Authorities (DHAs) were formally mandated to manage and govern the province's publicly funded health care programs, including hospitals, community health centres, public health services, addiction services and mental health programming. The IWK Health Centre is the only health organization to remain outside the District Health Authorities Act. While the IWK Health Centre works closely with the Capital District Health Authority, it maintains a separate Board of Directors that is directly accountable to the Minister of Health.
It is envisioned that DHAs will eventually be given the responsibility to govern Home Care services and Long Term Care facilities. The DHA Boards, made up of volunteer trustees appointed by the Minister of Health, are the primary governing bodies for the health services under their jurisdiction. In Nova Scotia the Minister of Health appoints all members of the Board of Directors to the District Health Authorities. Section 11 of the District Health Authorities Act (2000) specifies that:

A board of directors consists of:
   a) the number of voting members specified in the regulations respecting the district health authority;
      i) one third of whom shall be appointed by the Minister, and
      ii) two thirds of whom shall be appointed by the Minister from among persons nominated by community health boards pursuant to Section 54; and
   b) such number of non-voting members as the Minister may appoint.

Furthermore the Act specifies that no more than three of the maximum number of voting members of a board of directors can be staff or physicians who work for, or in, the District (Section 13(2)). The Act states that the objectives of the DHAs are:

   (a) to govern, plan, manage, monitor, evaluate and deliver health services in a health district in accordance with this Act and any other enactment in order to:
      i) maintain the most beneficial allocation of health-care resources,
      ii) avoid duplication of health services, and
      iii) meet the needs of the health district
   (b) to endeavour to maintain and improve the health of the residents of the health district. (Section 19).

The Health Authorities Act provides the District Health Authorities with the authority to create Community Health Boards (CHB). The legislation states that the role of the CHB is to, "...foster community development that encourages the public to actively participate in health planning and service delivery." Section 50 (a).
The CHBs also engage in assessing community health needs and the CHBs routinely make recommendations, and report to, the DHA in the form of an annual Community Health Plan. The primary role of CHBs is to advise the local DHA on health matters. A CHB is not a body corporate, nor does it have the authority to manage or govern the delivery of health services and it does not have the capacity to enter into contracts of any kind (Section 46, 47, 48). The process of appointing individuals to the CHBs is outlined in the individual By-Laws of the District and the selection of membership varies among the 37 CHBs in the province. Most of the CHBs existed prior to the formation of the DHAs, the majority having been formed during the time when RHBs were responsible for governing health services in the province. The role of CHBs has not changed significantly from the time of their creation under the RHB system.

The newly formed DHAs have made progress encouraging public participation through their Community Health Boards but at the same time the efforts of the CHBs have been frustrated by a number of factors including the continued dominance of the acute care system to demand more resources at the expense of community initiatives. This in turn has led to frustration on the part of CHB volunteers. Christopher Dawson and colleagues (2004) state

It was expected and mandated by legislation that the community health plan recommendations would be important considerations within the DHAs' strategic planning process and be reflected in their action plan. This did not appear to be the case, as the recommendations were viewed with "suspicion" and considered extraneous to the DHAs focus. Part of the reason for this disconnection is that the CHB goals highlighted matters of health promotion and population health while the DHAs were more focused on acute care/hospital-based services. Many CHBs feel that they lack the support of the DHA, which they think is not buying, wholeheartedly, into the population health concept (p.3).
This frustration on the part of CHBs has led to a chronic problem with recruitment of new members and retention of existing members. The continual turnover of CHB members and the sense that their recommendations are not being heeded by the DHA create challenges with keeping the boards motivated to prepare annual community health plans (Dawson et al., 2004).

One of the problems facing health care—and more specifically, District Health Authorities—is that, for the most part, there are a very limited number of opportunities for citizens to engage in broad-based deliberation on issues relating to their health. Moreover, there are very few opportunities for the public to be involved in policy-making in health care generally. This is probably due in large part to a historical culture that has been created in the health industry that limits decision-making to professionals, political and social elites (Porter, 1965; Minow, 1991; Otten, 1992). This culture of exclusion is fostered by a legislative framework that limits access to information and creates barriers to public access to decision-making processes. While health reform rhetoric promoted greater citizen involvement in decision making—Shared Decision, Shared Jurisdiction (Smith, 2003)—the organizational culture of District Health Authorities does not always support or promote deliberative democratic decision-making.

The District Health Authorities Act (2000) assigns considerable authority to DHA Boards of Directors to address health needs, but in reality their power is not unlimited. The authority of DHAs is contingent on a range of internal and external forces that influence and constrain their decision-making. Many of the factors that influence the health of populations are outside the jurisdiction of DHAs. For example, it is widely acknowledged that the primary social and economic determinants of health include such factors as employment levels, education levels, income and social status, genetic endowment, personal
health practices, culture and gender (Evans et al, 1994; Raphael, 2004). The delivery of illness-focused "health" services is recognized to play a relatively minor role in promoting health (Evans et al. 1994). There has been a perceptible shift in emphasis from the time when hospital boards were concerned only with treating illness by delivering health services to the present day where regional boards are being asked to address "population health issues" in their broadest sense. Yet, DHAs remain, for the most part, focused on the delivery of acute care services.

In terms of developing strategies to address the broader determinants of health the DHAs are very much in their infancy, relying primarily on the Community Health Boards to assess and attend to community health issues, while the bulk of the work of the DHAs is still primarily concerned with the delivery of primary, secondary, and tertiary hospital-based health care services (Bickerton, 1999; Dawson et al, 2004; Redden, 2002). In many ways the DHAs lack the internal capacity and are under-resourced to address the broad determinants of health (Dawson et al., 2004).

There are many extraneous pressures that also influence, limit and enable the decision-making capabilities of DHA boards. For example government (in particular the Department of Health) continues to exercise considerable power that limits and constrains the activities of the DHA through provincial health policy, including assigning budgetary allocations for health care organizations and determining provincial health service menus.

The Health Authorities Act explicitly limits the autonomy and independence of DHAs and CHBs. For example, the Act requires that the Business Plans of the DHAs must be approved by government before they can be implemented (Health Authorities Act, 2000 Sec. 56(2)). The Health Authorities Act also empowers the Minister of Health to dismiss the Board of Directors (Sec. 63) and determine the organizational structure and management
responsibilities of the DHA (Sec. 61). Recently, legislation was tabled in the Provincial Legislature that permits the Governor in Council to dismiss the CEO (the Board's only executive employee) of the DHAs. The proposed legislation stipulates that the decision to terminate the CEO is "binding on the government agency and its governing board" (Amendment to the Public Services Act, 2004 Sec. 2). While these measures are intended to enable the Minister to intervene and initiate remedial action in the case of non-compliance with government directives, these measures have the potential to undermine the authority of the governing boards in fulfilling their mandate.

The media, trade unions, professional associations (for example the Nova Scotia Medical Association or the College of Registered Nurses), pharmaceutical and medical technology companies, consumer and patient advocacy groups and a range of other special interest groups seek to influence the board's decision making (Chyna, 2000; Murray et. al., 1998/99; Otten, 1992; Stanbury, 1995). The governing board's ability to make decisions is also influenced by broader social and world events such as the timing of provincial and federal elections, public expectation, disasters, terrorism, and disease outbreaks that threaten human populations such as pandemic influenza, AIDS, West Nile Virus, and SARS.

There are a range of internal factors that also limit the board's ability to make decisions including for example, the organizational culture, funding levels, labour disruptions, internal politics, staff shortages (for example nursing or other professional staff shortages), equipment failure, deteriorating infrastructure, limited access to necessary data and relevant information, policies and procedures, budgetary constraints, and the complex interpersonal and professional relationships that exist among the board, senior management, staff, ancillary organizations and volunteers. Within this environment of limitation and
restraint the DHAs are given considerable authority and power to make decisions and allocate resources to attend to the health needs of the catchment population.

The DHAs have a responsibility to provide for the health and illness needs of the population generally, and more specifically, the DHAs need to understand and attend to disadvantaged social groups, such as African Nova Scotians. Any discussion regarding the role of DHAs in attending to the health needs of populations generally, or more specifically, African Nova Scotians, needs to be tempered with the realization that the DHAs are just one of many social institutions that contribute to the health of communities. Having said that however, the DHAs do have the potential to begin to address community health issues and they do have the authority to address the "illness care" needs of this population in a manner that is more fair and equitable.

4.5 Summary

The lofty goal of fostering increased public participation in decision-making has been a prominent feature of recent health reform initiatives in Nova Scotia and Canada. Yet, at the same time, there are tensions that exist within the regionalized structure of health service delivery. Continued public and political emphasis on the maintenance of the acute care system, limited resources to devote to "population health" and internal and external constraints that serve to limit the capacity for health boards to make independent decisions pose significant challenges for DHAs as they seek to fulfil their legislated mandate to improve the health of their catchment population. Nova Scotia has made significant progress in engaging the public to participate in the work of the Community Health Boards. Yet at the same time many of the CHBs are feeling disaffected because the recommendations put forth by CHBs to promote community interests, are not being
implemented in the District Health Authority service plans (Dawson et al., 2004). This raises the question whether the very structures that are supposed to promote health, i.e. the governing boards and their inability to implement change, may in fact contribute negatively to the health of African Nova Scotians.

Health reform initiatives of the past 15 years have consistently promoted the need to increase the involvement of lay citizens in decision-making as a solution to a centralized model of decision-making dominated by political and professional elites. In this regard the role of the citizen in decision-making in health care has evolved over time and the composition of governing boards have also changed to reflect this shift in emphasis. Searching for the ideal mix of backgrounds, skills, cultural background, gender, and community knowledge to ensure citizen governors represent the community continues to be a subject of debate. In a reformed health care system the question of whether a board member is serving as a "trustee" (making decisions on behalf of the community) or as a "representative" (implying the presence of some process to seek the views of the community) becomes an issue for debate. It is likely that it is not simply a case of one at the exclusion of the other. Rather as Young (2002) states

Both sides are correct in their way; the specific function of legitimate representation consists in exercising independent judgement but in knowing and anticipating what constituents want (p. 128).

Therefore, the question of knowing "what constituents want" is dependent in part on the composition of the boards and the processes in place to seek public input on decision-making. Thus the demographic profile of the DHAs and CHBs and consultative processes become important questions of interest. I will address these two issues in the next two chapters, beginning with the demographic profile of health boards in Nova Scotia.
Results from demographic surveys of health boards in Canada and the United States (public, not-for-profit) show that governing boards tend to be comprised of individuals who are predominately white, middle-aged, well-educated, affluent, married or widowed, and retired or employed (Frankish et al., 1998; Alexander et al., 2001). The question then arises whether the demographic composition of governing boards and the processes of selection of board members contributes in some way to the exclusion of minority groups in general and African Nova Scotians specifically. While the literature in this area is limited, there is a concern that a lack of cultural diversity (and other dimensions of diversity) on governing boards may impact on the board's ability to attend to various minority group interests (Brown, 2002; Carver & Carver, 1997; Guterbock & London, 1983; Kouri, Chessie & Lewis, 2003). The process by which board members represent various group or community interests – including the health needs of vulnerable populations or racialized minorities – is also not well addressed in the governance literature.

In the next chapter I examine the demographic composition of governing boards in Nova Scotia and answer the following questions: What is the demographic profile of District Health Authorities and Community Health Boards in Nova Scotia? How does Nova Scotia compare with other jurisdictions that have conducted similar demographic surveys? Is there a difference in demographic profiles between District Health Authorities and Community Health Boards? How do DHA and CHB demographics compare with population demographics for Nova Scotia? To what extent are minority communities, particularly African Nova Scotians, represented on DHAs and CHBs?
Chapter 5: Demographic Survey

Because if you were to sit in this room with the exception of gender, all Board members look like I do...and that's not pretty, but they all basically bring the same demographic, if you will, to the table. (Board Member, CDHA)

5.0 Introduction

This chapter presents the results of a demographic survey of board members of Nova Scotia’s District Health Authorities (DHA) and Community Health Boards (CHB) that was conducted during the summer of 2003. The primary reason for conducting the Demographic Survey was to determine the level of diversity that exists on governing Boards responsible for health care in Nova Scotia.

My interest in knowing the demographic characteristics of Board members was motivated by the potential relationship between board composition and members' understandings of the health needs of minority groups. My assumption was that if there was a significant degree of diversity on the boards then there is a greater likelihood that members would demonstrate a greater understanding of the lives of oppressed and vulnerable groups, and conversely, the greater the homogeneity of the boards, the less likely this would be so.

In the first section of this chapter I present a review of previous research in Canada and the United States regarding demographic profiles of governing boards in health care. The second section of this chapter examines the results of the survey. A discussion on survey design and data collection methods is included in Chapter Two. The data compiled from the survey is used to compare Nova Scotia to other provinces that have conducted similar surveys, and to determine if there are differences in the composition of DHAs and CHBs. Finally, I present ideas for further research and offer some conclusions. This demographic survey represents the first comprehensive survey of its kind in Nova Scotia.
5.1 Previous Research

A number of national and provincial surveys of governing boards have been undertaken in the past ten years that have examined demographics and attitudes of board members and senior managers. There have been two provincial studies: one in British Columbia (Frankish et al. 1998) and the second in Saskatchewan (Lewis et al. 2001). On a national level there have been surveys that have examined attitudes and opinions – demographics were of secondary concern – of governing boards and managers in regionalized health systems in Canada (Kouri et al., 1997, 2002; Brunelle et al., 1998/99; Lomas et al. 1995, 1997). In general these surveys found that among regionalized health systems, multi-hospital systems and individual, stand-alone hospitals, boards of these organizations tend to be made up of individuals who are primarily Caucasian, middle-aged, well educated and affluent.

Frankish and colleagues (November 1998) conducted two surveys in British Columbia, one in May of 1996 and one in May of 1998. In the early 1990s British Columbia, like most provinces in Canada, regionalized its health care system. These newly formed regional boards were comprised of community members that were either appointed or elected. In the first survey Caucasians made up 94.6% of the boards followed by First Nations 3.1%, East Indian 1.5% and Asian 0.8%. In the 1998 survey the numbers had changed and Caucasians made up 88.5% of the health boards, followed by 6.1% for First Nations, Other 4.6%, East Indian 2.3%, Asian 1.5% and Black 0.4%. It is interesting to note that in British Columbia, visible minorities, as a percentage of the population, is the highest in Canada at 21.6% (Statistics Canada 2001).
There are at least two possible explanations for the change in demographics from the survey in 1996 to the survey conducted in 1998. First, in the period between surveys the British Columbia government decreased the number of RHBs from 20 to 12. In the absence of reviewing the actual numbers of representatives – versus percentages – it is difficult to tell if the percentages of minority representatives changed as a result of the decrease in numbers of Board members or if it occurred as a result of an increase in the total number of minority representatives. Second, in British Columbia the Minister of Health Services Planning appoints all Board members. It is possible that the increase in minority representation may be a result of the Ministry responding to the need for greater diversity on governing boards. It is also possible that the earlier survey helped to raise awareness of the lack of diversity on the boards and the Minister acted to correct this problem.

In the United States similar demographic research has been conducted. While governance structures vary between private and not-for-profit health care organizations, the research has found that, particularly in the not-for-profit hospital sector, boards tend to be made up of individuals who are primarily Caucasian, middle or upper middle class, well-educated professionals (Alexander et al., 2001; Berman & Salant, 1998; Grady, 2001; Feldman & Khademian, 2000; Shinkman, 2001; Widmer, 1987).

There is a growing consensus that there is a need to increase the diversity of membership on governing boards in health care (Carver & Carver 1997; Brunelle et al. 1998/99; Shinkman, 2001; Widmer, 1987; Marschall, 2001; Brown, 2002). The rationale for this view is summarized well by Widmer (1987) who states, "Some organizations recognize the need for diversity, particularly racial diversity, in order to make effective decisions, to design and deliver appropriate services to minority clients, to compete, and to survive" (p.33).
In this thesis I argue that there is a moral imperative for boards to increase their sensitivity to issues of diversity in a broader sense to enable boards to be more attentive to health needs in vulnerable or disadvantaged communities. This needs to happen at many levels within the processes and structures of governance and management in health organizations. Boards need to demonstrate an awareness of their duty to serve diverse populations and to see the benefits of embracing diversity as a way of doing business and a way of adding value to their work in a field that is supposed to be concerned with health (Brach & Fraser, 2000). Because boards act on behalf of a broader community of interests, sensitivity to the diversity in the community – in theory at least – should be reflected in some fashion in how the board evaluates and sets priorities and makes decisions. Having a diverse membership is generally believed to be an important way of increasing knowledge of various community needs.

Diversity, or the lack of diversity on governing boards, and the impact this has on the ability of governing boards to address health needs, is a central theme of interest in this thesis. In this regard it is acknowledged that diversity is more than just cultural or racial diversity. Hopkins (1997) identifies eight major categories of diversity including geographical, cultural, gender, spiritual, language, disability, sexuality and age. Other categories of diversity can include socio-economic status and membership in a particular group for example, a professional classification, single parents, or membership in an interest group. In addition, one can also conceive of board members bringing a diversity of values or life experience to the table regardless of other demographic characteristics that they may possess (Golembiewski, 1995; Hopkins, 1997). In each instance an organization, or in the case of this research, the governing boards of organizations, can be evaluated in terms of their diversity at many levels, some more easily identifiable than others.
At this point it is worthwhile examining the issue of health professionals serving as members of governing boards. It is not uncommon for health professionals to serve on governing boards in healthcare and their presence contributes to the range of skills and points of view present in the board's membership. Yet, some writers have raised concerns regarding the presence of healthcare providers (physicians, nurses, etc.) as voting members on governing boards in health care (Frankish et al, 2002; Reinersten, 1998). There is the potential for health professionals or staff of health organizations to be in a real or perceived conflict of interest position as boards engage in decision-making and priority setting. The potential conflict in question is: do health professionals serve on boards to represent the interests of the community, or are they — in their privileged position as "insiders" — seeking to represent professional self-interests? (Frankish et al, 2002; Reinersten, 1998).

Input from staff and professional interests is part of the normal process of board meetings. At any routine meeting of the Board, there are usually several organizational staff present, including for example, the CEO, Senior Managers and clerical staff who provide the Board with information, advice and management support. This situation is necessary because Boards by themselves can do little to manage an organization. This interaction between the board and management staff is an essential feature that contributes to the smooth operation of an organization.

The counter argument to the view that health professionals should not be voting members of the Board is that they bring a unique viewpoint — as knowledgeable insiders — and thus add value, to the board's deliberations (Checkoway, et al. 1981). As stated earlier, the Nova Scotia DHA Act limits the number of staff or physicians serving on DHA boards to a maximum of three. There is no such limitation imposed on the Community Health
Boards. The potential benefit or detriment to having staff from the organization serve on the Board is a subject worthy of further research.

Based on my experience I argue against the presence of heath professional staff on the board, especially if they are employed by the organization. In this instance their conflict of interest is real and not just a perception. It is difficult for board members that are also employed as professional staff to separate their self-interested role as staff from their role as public trustee. I recall several instances where this dual role was problematic for the board member/employee (and the Board) because they were unable to clearly separate the two distinctly different role requirements. On a similar vein, it can be argued that the predominance (or absence) of any one group on a board, (for example groupings based on age, gender, socio-economic status, professional status) can lead to an imbalance of viewpoints in the decision-making process.

5.2 Some Features of the Population

Among the Atlantic Provinces, Nova Scotia has the highest proportion of Visible Minorities as a percentage of its total population at 3.8% (See Table 3). By comparison the Canadian proportion of Visible Minorities as a percentage of the population is 13.4%. British Columbia has the highest percentage of Visible Minorities at 21.6%, followed by Ontario 19.1% and Alberta 11.2% (Statistics Canada 2001).

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<th>Table 3</th>
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<tr>
<td>Proportion of Visible Minorities: Canada, Atlantic Provinces</td>
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<tr>
<td>2001 Census – Statistics Canada</td>
</tr>
<tr>
<td>Canada</td>
</tr>
<tr>
<td>Nova Scotia</td>
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<tr>
<td>New Brunswick</td>
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The focus of this research project is the Capital District Health Authority – the DHA for greater metropolitan Halifax – and in this regard the Census data show that Halifax County was home to 25,100 Visible Minorities in 2001, representing 7% of the total population of 355,900. This proportion was higher than the average for Nova Scotia (4%), but lower than the national average (13%) (Statistics Canada 2001). Census data indicate that metro Halifax has the highest proportion of Canadian-born Blacks among major urban areas in Canada: African Canadians accounted for 4% of the total population in Halifax (91% of whom were born in Canada) (Statistics Canada 2001).

Census data indicate that 66% of Nova Scotia's Black population lives in Halifax (13,100) representing approximately 0.4% of all Blacks in Canada (Statistics Canada, 2001). Furthermore, African Nova Scotians account for more than half (52%) of Nova Scotia's Visible Minorities (19,670). By comparison, the remainder of Visible Minority groups in Nova Scotia included Arabs and West Asians (3,400), Chinese (2,400) and South Asians (2,300), each representing less than 1% of the population (Statistics Canada, 2001).

5.3 Demographic Information/Analysis of Results

Response Rate

A total of 527 surveys were mailed to members of all DHAs and CHBs in Nova Scotia (DHA= 103, CHB=424). The number of surveys received was 315 (DHA= 70, CHB= 245) for a total response rate of 60%. The response rate for DHAs was 68% and the response rate for CHBs was 57.8%. There is no way to determine if there was response bias, i.e. if those who responded to the survey were systematically different from those who did not respond. The results of this survey can only reflect the demographic composition of those Board members that participated in the survey.
Question 8 in the Survey, "Do you do any paid work for your DHA or CHB?" was discarded from the analysis because a significant number of respondents interpreted this question to mean, "Are you paid for your work as a board member?" In Nova Scotia all Board members serve as volunteers; only the Board's staff are paid. The intent of the question was to determine how many people serving on Boards are also employees or physicians practising in their District.

How long have you been a board member?

The District Health Authorities have been in existence since January of 2001 and therefore the longest possible length of service on the District and Community Health Boards is 30 months (using the date of June of 2003 as the reference point for the Demographic Survey). Survey data indicate that 79.2% of DHA members have served between 24 and 30 months thus indicating that the majority of the respondents were original members of their DHA and that there has been minimal turnover of members on the District Boards (See Appendix L, Table One). The percentage may have been even higher but some of the initial appointments of Board members were pre-established by the Health Authorities Act for a term of one and two years.

Regarding CHBs there is more variation in length of service, though there is still a high percentage (51.7%) that have served for between 24-30 months. In Nova Scotia two thirds of the membership of DHAs are appointed by the Minister of Health from a list of names recommended by the CHBs with the remaining one third appointed by the Minister of Health. Some of those recommended by the CHBs to serve on the DHAs may have served as members on the CHBs or the individuals may have been selected from the broader
community. Given this, it is not unreasonable to propose that the CHBs may be viewed as the training and selection grounds for community representatives to serve on the DHAs.

How old are you?

Two trends emerge from the survey data: first, there is a more equal distribution of age groupings of board members who serve on CHBs than those who serve on DHAs. Second, there is a larger proportion of DHA members who are over the age of 55 (67.1%) as compared with CHBs (49.4%) and there is a larger percentage of members over the age of 65 on DHAs than CHBs (21.4% for DHAs and 16.7% on CHBs) (See Appendix L, Table Two). The higher percentage of members on CHBs in the under-35 age grouping (13.5%) as compared with DHAs (7.1%) is likely the result of many of the CHBs having created positions for youth representatives on their boards. Census 2001 data indicate that 13.4% of Nova Scotia’s population is over the age of 65 and 23.3% of the population is over the age of 55 (Nova Scotia Department of Finance, 2002).

Gender

As with age distribution there is a notable gender difference between DHAs and CHBs. Women are in the majority on the Community Health Boards (68.6%) and men are in the majority on the District Health Authority Boards (61.4%). (See Appendix L, Table Three)

Ethnic/Cultural Background

The data indicate that DHA and CHB boards in Nova Scotia are overwhelmingly Caucasian (97.1% for DHAs and 89.6% for CHBs) (See Appendix L, Table Four). Because Acadians self-identify as a cultural group, but are European in origin, the percentages rise
significantly if the Caucasian and Acadian figures are combined (98.5% for DHAs and 95% for CHBs). In the CHB category, the second most represented cultural/ethnic group is made up of those that self-identified as multiple (2.9%). In all but one instance those individuals that identified as multiple, identified themselves as both Caucasian and Acadian. Adjusting for these factors the actual total figure for Caucasians (including Acadian and Multiple) on CHBs is 97.9%. The majority of those that self-identified as Acadian were located in areas of the province where Acadian communities exist, namely North Inverness CHB and Clare CHB. The third most represented ethnic cultural background on the CHBs was East Indian on the CHBs (N=4 or 1.7%). There was only one individual in the survey that self-identified as Black and this individual served on one of the DHAs. In short, the DHA and CHB boards do not reflect significant diversity along cultural/ethnic lines.

**Highest level of Education Attended or Completed**

The data obtained in the survey show that, once again, regarding educational attainment, there is more diversity on CHBs than on DHAs. Approximately 73% of DHA members have a university degree compared with only 62.2% of members who serve on CHBs. In general, DHAs members have higher levels of education attended or completed than CHB members. Census 2001 indicates that 9.8% of Nova Scotia’s population (ages 15-65+) have a Bachelors degree, 2.4% have a Masters degree and 0.5% have a Doctorate (Department of Finance 2003). Census data for Nova Scotia also indicate that 9.7% of the population indicated that their highest level of education attained was a high school certificate. (See Appendix L, Table Five)
Marital Status

For both DHAs and CHBs the majority of their members are married (81% for DHAs and 75.7% for CHBs) (See Appendix L, Table Six).

Total Household Income Before Taxes

The data indicate that of those surveyed, there is a greater proportion of individuals serving on District Health Authorities that have a total household income, before taxes, in excess of $75,001 per year (55.1%) when compared with Community Health Boards (30.4%) (See Appendix L, Table Seven). Also, there is a greater proportion of members of District Health Authorities with total household incomes of greater than $100,000 (24.1%) compared with Community Health Boards (10.1%). Similarly, there is a greater proportion of Community Health Board members (42.3%) who have total household incomes that fall below $50,000 when compared with District Health Authorities (20.7%). In Nova Scotia the average household income before taxes is $49,048 (Nova Scotia Department of Finance 2003).

Work/Employment Status

The data collected indicate that there are differences in the percentages of members who are retired (45.7% for DHAs and 36.2% for CHB), and for those who are employed full time (30% for DHAs and 38.7% for CHBs). (See Appendix L, Table Eight)

In What Field Did/Do You Work?

For both the DHA and CHB boards there was a high percentage of individuals who either currently work, or have worked previously in the health field (35.7% for DHAs and 38.9% for CHBs). (See Appendix L, Table Nine). There are limitations in the Health
Authorities Act that stipulate that no more than 3 members of the DHAs boards can be currently employed by the DHA. This does not, however, limit the number of individuals who can serve who are – or have been – health professionals, or who work in other districts or those not employed by the Health District. Many of the respondents wrote in the margins of the survey their profession and these included for example, pharmacist, naturopath, nurse, retired nurse, counsellors, and physicians.

There are several possible explanations for the high rate of participation of health professionals on governing boards. First, individuals that have retired from professional practice, or who work as a health professional (but are not employees of the DHA) – or those who nominate or appoint them – may hold the view that their "insider" knowledge and experience in the health system will, in some way, contribute to their ability to be an effective board member. Second, people who are working or who have worked in the health system may participate because they have personal interests in the health field. Third, some individuals may want to serve on governing boards because they have a particular personal or professional vested interest and they may see their participation as a means to influence decision-making or to advance certain agendas (Frankish et al, 2002; Reinersten, 1998).

Do You Have a Disability?

The number of respondents that indicated they had a disability was 5.7% for DHAs compared with 11.5% for CHBs. (See Appendix L, Table Ten). The survey asked for a description of the disability and the types of disabilities listed included cardiac disease, Multiple Sclerosis, hearing loss, deafness, diabetes, Parkinson's Disease, Muscular Dystrophy, and "old age". The survey did not attempt to determine the degree or extent of the disability.
The 2001 Census indicates that 20.1\% of individuals age 15 and over in Nova Scotia reported having a disability compared with 14\% for Canada as a whole. Census 2001 defines a disability as "...those who reported difficulties with daily living activities, or who indicated that a physical, mental condition or health problem reduced the kind or amount of activities they could do. Types of disabilities of adults include hearing, seeing, speech, mobility, agility, pain, learning, memory, developmental and psychological" (Department of Finance, 2003).

5.4 Summary of Results

5.4.1 What is the level of diversity on health boards in Nova Scotia?

Survey data indicate that there is more diversity (across the majority of demographic indicators) on the CHBs than on the DHAs. Regarding the level of diversity on governing boards in Nova Scotia the data show that while there is more diversity on Community Health Boards than District Health Authorities, the boards in general do not display significant diversity in their composition. Based on most of the indicators, the Boards do not reflect the same level of diversity found in the general population.

The survey data suggests the presence of a general "streaming process" that occurs between the CHBs and DHAs, i.e. there is more diversity on the CHB – across most categories – and the individuals who are selected for appointment on the DHAs display a more limited demographic profile.

The data from this survey suggests a tendency to appoint board members to the DHA boards who are older, male, Caucasian, well educated, able-bodied and affluent. As mentioned earlier, it is important to note that two thirds of the membership of the DHAs are selected from a list of recommended names from the CHBs and these individuals may or may not be appointed by the Minister of Health, though in most cases the list is approved
without question. The remaining one third of the members are appointed by the Minister of Health through the public appointment process. The Ministerial appointments are intended to remedy any imbalances in the composition of the boards in terms of gender, geographic location, ethnicity and skill mix.

There are various ways that the demographic composition of governing boards in health care can be viewed. One possible interpretation is that the homogeneity of District level governing boards may provide a foundation upon which boards can maintain stability in a healthcare system that works in an environment of constant change (Alexander et al., 2001). In a study of demographic trends of governing boards in the United States Alexander and colleagues (2001) suggest that

> Taken as a whole our findings suggest that hospital boards act more as a source of continuity than as the leading edge of change. Despite the tremendous shifts that have occurred in health care financing, organization, and delivery over the past decade, change in hospital governance has been modest (p. 273).

In an environment where health care organizations are increasingly facing changes in financing, structure and delivery of health services, the stability in the composition of boards may indicate that they are successfully fulfilling their role of representing the community's interests by resisting these changes (Alexander et al. 2001).

The lack of diversity and the "streaming effect" noted above may be due in part to the type of individuals who volunteer – or are recruited – to serve on boards. Individuals may volunteer to serve on DHAs because they possess the socio-economic means, time, expertise and life skills that are required to serve on a DHA board (Berman & Salant, 1998; Guterbock & London, 1983). It is noteworthy that these skills are disproportionately found in specific social groups, namely elite classes, and is possibly an indirect reflection of institutionalized racism, classism and sexism. It may also be the case that individuals may be
recruited or encouraged by their local community to stand for appointment on the DHA board because they are perceived as having the suitable attributes – socio-economic means, time, expertise, life skills, and social status – that would make them a good representative and advocate for their community.

Canada's population is ageing and this trend may also be reflected in the age demographic of governing boards. That board members are older may also reflect the board's desire to recruit individuals with extensive life experience, and a potential for leadership (Alexander et al. 2001). In addition it has been proposed that socio-economic factors play a significant role in determining whether people volunteer to serve on boards (Marschall, 2001; Leighley & Vedlitz, 1999; Widmer 1987).

An alternative interpretation of the demographic data, particularly the streaming effect described above, is that the selection process favours certain demographic characteristics, i.e. those viewed as more closely reflecting the values of the majority. Conversely, there are some attributes that are viewed as being not reflective of mainstream values and are thus viewed as less desirable.

The inclusion of some groups of people with particular demographic characteristics to the key decision-making bodies in health care demands an alternative view of the process of selection and appointment of board members. Governing boards, by virtue of an appointment and selection process that limits power to a privileged few – affluent, Caucasian, well-educated, predominately male and able-bodied – represents a form of institutionalized racism/classism by failing to acknowledge that the views expressed by homogeneous boards may not represent the views of the entire community, especially minority groups.
It is also important to bear in mind that diversity is a concept that includes more than the categories measured in this survey but also may refer to values and beliefs. In the absence of further research it is not possible to draw the conclusion that because the demographic indicators used in this survey do not reflect a significant degree of diversity on governing boards, this does not mean the boards are homogeneous in their opinions or values.

The literature on the subject of community representation on governing boards is unclear as to whether boards that are homogeneous in their composition lack the appropriate skills, understanding and insights to effectively represent their community, especially the interests of minority or vulnerable social groups.

5.4.2 How does Nova Scotia compare with other jurisdictions that have conducted similar surveys?

It is difficult to draw a direct comparison with the results of other surveys because of differences in survey questions, methods, organizational structures and context. The general conclusion of all the demographic surveys reviewed is that boards tend to be homogeneous in their composition on a variety of indicators, including age, gender, ethnic, racial and cultural background, levels of education marital status, income levels, and work/employment status. In general, District Health Authority Boards in Nova Scotia tend to exhibit a similar demographic profile to boards elsewhere in North America. A typical board is comprised of members who are members of social elites, i.e. predominately Caucasian, male, middle-class, well-educated, affluent, married or widow/ed and retired or employed full time.
5.5 Elites and Participation in Decision-Making

A chapter on the demographic composition of governing boards would be incomplete without some mention of the literature examining the role of political, corporate and social elites and their influence on decision-making in society (Gutmann & Thompson, 1996; Lavis, 2002; Porter, 1965). John Porter's (1965) landmark study, "The Vertical Mosaic: An Analysis of Class and Power in Canada" was the first to document that Canadian society was not homogeneous and egalitarian but rather social and political power and influence were stratified along the lines of distinct classes, language and cultural/ethnic groupings. Furthermore, Porter identified groupings of individuals — "elites" — that had significant influence over decision-making in many spheres of social life.

Porter (1965) defines elites as "...those who have the power to make decisions for the society" (p. 25) and this power can be obtained by birthright, socio-economic status, educational preparation, cultural heritage, professional designation, financial status, or membership in a particular group. It was Porter's view that elites have an important role to play in our society because those who are in a position of power make decisions on behalf of society as a whole. While the concept of "elites" carries a negative, oppressive countenance, Porter observed that elites have a valuable role to play in our society by providing stability and order in the mechanisms of change. He states,

Elites govern institutions which have, in the complex world, functional tasks. The economy must produce, governmental bureaucracies must administer, governments must govern, the military must maintain the defenses, and the churches or some counterpart in the epoch of the mass media, must continue to provide a view of the world in which the whole process is legitimate and good and in conformity with dominant social values. (p.27).

Stratification of power — and the benefits accruing from this power — based on membership in social grouping such as class, political affiliation, gender and ethnicity is well documented (Armstrong, 1998; Breton, 1998; Clement, 1998; Lavis, 2002; Porter, 1965). It
comes as no surprise then, that elites exist and dominate the positions of power and influence decision making in the health care field (Lavis, 2002). As health care has become a more complex and financially lucrative industry the number of groups involved in the decision-making process has increased and include the traditional social and political elites, the medical profession and a range of new, well-organized interest groups including health professional groups, trade unions, the pharmaceutical and technology industries, the media and more recently, the consumer (Chyna, 2000; Minow, 1991; Otten; 1992; Stanbury, 1995).

There is a significant body of literature that has examined the reasons why people participate in political and civic affairs. Socio-economic status is generally recognized to be the most influential factor associated with an individual's decision to become engaged in civic activity. In this theory those with the socio-economic means – higher levels of education, higher income and occupational status (and time) – are more likely to become involved in civic activities than are individuals with lower socio-economic status (Leighley & Vedlitz, 1999; Marschall, 2001; Verba & Nie, 1972). Individuals from this cohort participate because they have the social means, preparation and interest in civic matters (Leighley & Vedlitz, 1999). Other theories include the Psychological Resources theory (those with a particular interest or sense of civic duty are more likely to participate); Social Connectedness theory (individuals who have a sense of interconnectness with their community are more likely to participate in civic affairs) and Group Identity theory (identification with a particular group as motivation for becoming involved in civic affairs) (Leighley & Vedlitz, 1999; Marschall, 2001; Verba & Nie, 1972).

Widmer (1987) examined the participation of individuals who were Black and who were serving on boards of directors of human services agencies. She found that many of the board members who were Black felt that they were expected to represent the interests of the
entire Black community. Some saw this as a positive feature of their participation while others resented the assumption that they knew how other Black people felt and considered this expectation to be unrealistic. Widmer also found that, "Research into incentives for participation indicates that very few board members, black or white, serve in order to represent their interests as clients or the interests of their class, ethnic, or racial group" (p.37).

There are other challenges associated with creating designated representation for minority groups on governing boards. In 1997 British Columbia established designated seats for Aboriginals on the District Health Authorities as part of a wider health reform initiative. Ongoing dissatisfaction among the Aboriginal community, and in particular Aboriginal Board members, led many to believe that Aboriginal health issues were not being adequately addressed through designated representation.

...Aboriginal governors expressed concerns that representation was not consistent – that it was often felt or seen to be tokenism, and they were frequently confused about their role and the role of the board or council. There was also a lack of clarity about their accountability to, and relationship with, the Aboriginal community. Generally they did not feel their participation was significantly valued by health authorities or understood by Aboriginal communities (p. 4).

Many Aboriginal governors felt that the expectations of them as representatives of Aboriginal communities was onerous and that it was unrealistic to assume that one individual could represent the interests of such diverse communities. Aboriginal governors felt that developing consultation strategies and seeking input from Aboriginal communities was a responsibility that needed to be shared among all board members and not just the one appointed representative from the Aboriginal community (Aboriginal Governors Forum, 1999, p.4).
Designated representation was abandoned and in 2001 the province of British Columbia required that each of the Regional Health Authorities create a minimum of one Aboriginal Community Health Advisory Committee (ACHAC). While each of the ACHACs are unique in their composition and mandate (depending on the Aboriginal communities they serve) the general terms of reference are similar. Their responsibility is to provide advice to the Board and senior management and to engage the Aboriginal community in discussion related to their health and well-being. One of the primary goals of the ACHACs is to build and nurture trusting relationships between the regional health authorities and the Aboriginal communities and to ensure that there is both meaningful dialogue and action on identified issues of concern (Aboriginal Governors Forum, 1999). This example serves to illustrate the different perspectives that can be taken on representation and motivation to serve on boards.

Based on my experience working with Board members, individuals are motivated to serve on Boards for different reasons including, perceived power and status, vested personal or professional interest, a desire to apply life experience and knowledge and simple good will and a desire to serve the community.

Personal motivation is only one aspect that determines participation on boards. A person may be highly motivated to serve on a board but there may be structural or procedural barriers that prevent their participation. In this regard there are policy options available to organizations that can encourage individuals to serve on boards by removing barriers that inhibit their participation. Examples include providing: orientation programs, timely and appropriate information, child care or personal care support (if the board member is disabled), alternative forms of communication to address literacy issues, moral
support, and engaging board members in meaningful activity, (Kovner, 2001; Orlikoff et al, 1996; Orlikoff et al, 1997(a)(b); Rutledge, 1994).

The process to determine Board member selection can also influence an individual's decision to participate on governing boards. Most board members in health care in Canada are chosen by one of four different means: elected, board-appointed, Ministerial appointment, or a combination of the three other methods. (See Table 4 – Provincial and Territorial Board Member Selection Methods).

Table 4
Provincial and Territorial Board Member Selection Methods

<table>
<thead>
<tr>
<th>Province / Territory</th>
<th>Board Member Selection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Government appointed</td>
</tr>
<tr>
<td>Alberta</td>
<td>Government appointed</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>2/3 elected and 1/3 appointed</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Government appointed</td>
</tr>
<tr>
<td>Ontario</td>
<td>Not Regionalized (Mixed methods)</td>
</tr>
<tr>
<td>Quebec</td>
<td>Elected by a representative caucus of stakeholders</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Government appointed</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>8 elected members and 7 appointed members.</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Mixed elected and appointed</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>Government appointed</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>Government appointed</td>
</tr>
<tr>
<td>Yukon Territory</td>
<td>Not regionalized</td>
</tr>
<tr>
<td>Nunavut</td>
<td>Not regionalized</td>
</tr>
</tbody>
</table>

(Source: Kouri et al, 2002)

The constituency representational model of board member selection generally divides a catchment area into electoral wards, within which individuals (above the age of majority) can run for office. Examples of this model include school boards, municipalities, provincial and federal governments. Elections are held on a periodic basis and if elected, board members are expected to represent the interests of the constituency they serve.
Constituency representational (elected) boards in health care have been employed in other jurisdictions in Canada (or a hybrid of elected and appointed (Kouri et al, 1997)) with varying degrees of success.

At one time, it was envisioned that the majority of provinces in Canada would adopt a completely elected model of board member selection (Lomas, 1997). However, in recent years, the use of elected boards has fallen out of favour. There are several reasons for this including factionalism (special interests groups capitalizing on low voter turnouts to elect single-issue representatives), low voter turnouts, and the politicization of health care boards (Church & Baker, 1998; Lewis et al. 2001; Lomas et al. 1997).

Board-appointed membership is a process that was at one time very common among single-site hospital Boards in Nova Scotia. Since the advent of regionalized health systems the board-appointed method of selection is not commonly used. Briefly, with this method of selection a board would establish a Selections Committee, or Recruitment Committee to search for new members in accordance with provisions outlined in their By-laws. Interested individuals were at liberty to put their names forward, or the Committee actively searched for suitable members for the Board. This model was often criticized as being a "closed-shop approach" and "elitist." Opponents of this method believed that the Board self-perpetuated their own values and agendas by appointing similar-minded individuals, rather than appointing individuals that would hold contrary views.

In recent years the healthcare system in Nova Scotia and elsewhere has become highly politicized. It is a commonly held belief that serving on a Board of Directors of a health organization is a position of power and the control over who appoints Board members is an issue of concern for politicians, stakeholders and the community. This preoccupation with political control over the composition of governing boards in health care
has led to most governments in Canada appointing board members. In Nova Scotia for example, the power to appoint Board members has become the exclusive domain of the Minister of Health.

While the literature on the subject is limited, the method of selection does have an impact on the composition of the board. In the United States, the debate around minority populations and participation on democratic institutions such as school boards has existed for some time (Robinson et al, 1985; Robinson & England, 1981; Meier & England, 1984; Taylor, 2001; Underwood, 1992). One of the concerns has been how to ensure adequate minority group representation in an electoral model where low population numbers usually preclude minority group candidates from being elected (Underwood, 1992).

One study that examined the representation of Blacks in communities where electoral models have been employed found that Blacks received less than 60% of the representation that would be expected based on their proportional share of the general population (Robinson & England 1981). This inequitable representation however, diminished when the percentage of Blacks approached 40% of the total population (Robinson & England 1981). In the case of school boards, the research conducted in this area generally supports the view that Blacks and other minorities fare better when they are appointed rather than when they seek election (Taylor 2001; Robinson & England, 1981).

The challenge of achieving effective minority representation on governing boards in health care is complex. Based on the limited research available it would appear there is no guarantee that the adoption of an electoral model would increase minority representation on governing boards. Based on the experience of other jurisdictions the relatively low population numbers in the Black community relative to the non-Black population would make the election of a Black representative unlikely. Furthermore, the Minister of Health in
Nova Scotia appoints all DHA board members and thus he or she has the authority to ensure balance on the boards in terms of gender, age, culture, skills, race, ethnicity, geographic location, etc. The current demographic profile of the boards in health care, however, suggests that the objectives of balance and diversity are not being met.

5.6 Ideas for Further Research

Several questions arise from this Demographic Survey that are worthy of further research and exploration. First, there is a need to determine if the composition of governing boards actually influences the decisions Boards make and whether those decisions reflect systemic biases based on the homogeneity – or diversity – of the board members. The question then arises: is it necessary for governing boards to reflect the cultural mosaic of our communities to ensure they adequately represent their interests? And if this is so, then what is the most effective way to represent "groups of interest" on governing boards to ensure effective participation?

Second, there is a need to examine more closely the "streaming effect" described above to determine what factors lead to the selection of Caucasian, middle-class, educated, affluent, able-bodied males to make decisions on behalf of a much more diverse community of interests.

Third, there is merit in examining the enabling factors and motivations (and barriers) that may explain why some people choose to serve (or why some may choose not to serve) on governing boards in health care. This may provide insight into why boards have similar demographic profiles.

Fourth, while DHA boards are very similar in terms of their roles and responsibilities (and composition) not all boards serve similar catchment populations. There is a need to
examine how health boards understand and attend to the health needs of minority groups if they are located in rural or remote areas. For example, there are approximately 30 recognized Black communities in Nova Scotia, and while more than half of the Black population lives in Halifax County, most Black communities in the province are very small and the majority are located in rural areas, outside of existing towns. Given that low population numbers are common for many vulnerable groups in rural areas there is a need to explore innovative strategies to conduct research to understand how to identify, engage and attend to the needs of these populations.

Fifth, in Nova Scotia the Minister of Health appoints all members to the District Health Authority. This raises the question of whether a different method of selection of board members – e.g. election, community appointment, or some other means of selection – would influence individual decisions to serve on health boards and would this potentially change the demographic profile of boards.

Sixth, there is a need to explore the impact of having professional staff and physicians employed by an organization serving on health boards. Overall, is their presence helpful or detrimental to the aims and objectives of the board?

Finally, in an attempt to address the lack of Black representation on school boards the province created designated seats for African Canadians on every School board in the province. In October 1999 the Council on African Canadian Education (CACE), an Advisory Council of the Province of Nova Scotia, submitted a Position Paper to the Minister of Education, the Honourable Jane Purves (CACE 1999). The Position Paper recommended the creation of designated African Canadian seats that would permit the election of African Nova Scotians – by African Nova Scotians – to represent their interests on English speaking School Boards. On April 27th 2000 the Department of Education announced the creation of
designated African Canadian seats (only African Canadians can run for office and only African Canadians can vote for candidates) on Nova Scotia School Boards (Bill 47). This was the first legislation of its kind in Canada. Other jurisdictions have also experimented with the concept of designated representation, with varying degrees of success (Aboriginal Governors Forum, 1999; Maori Health Strategy, 2002: New Zealand Ministry of Health 2002). The use of designated representation should be subjected to formal evaluation to determine if this is an effective way of identifying and addressing the concerns of minority groups in the health care setting.

5.7 Conclusions

This Demographic Survey represents an attempt to create a demographic profile of District and Community Health Boards in Nova Scotia. Based on the DHA and CHB members that participated in the survey, boards in Nova Scotia closely resemble the composition of health boards in other jurisdictions across Canada and the United States (Alexander et al., 2001; Berman & Salant, 1998; Brunelle et al., 1998/99; Feldman & Khademian, 2000; Frankish et al. 1998; Grady, 2001; Kouri et al., 1997, 2002; Lewis et al. 2001; Lomas et al. 1995, 1997; Shinkman, 2001; Widmer, 1987). The data indicate that there is more diversity across all survey categories on the Community Health Boards as compared with the District Health Authorities where the trend reflects a narrower demographic profile.

The demographic survey of Nova Scotia’s health boards raises as many questions as it answers regarding the decision making practices of governing boards as they pertain to addressing the health needs of minority groups. Hence, in the next chapter I examine the case study of Capital District Health Authority as a more indepth means to answer the
question of how board members understand and attend to the health needs of African Nova Scotians.
Chapter 6: Case Study of Capital District Health Authority (CDHA)

[T]here is, at least at a theoretical level, certainly a willingness and a growing recognition that we need to do things differently, but right now the opportunities, the forums, the ways we have available for those voices to be heard are fairly limited...and not focused on being sensitive to the needs of minority groups. (Senior Manager, CDHA)

6.0 Introduction

In Chapter 5 I presented the results of the Demographic Survey of Nova Scotia's District Health Authorities and Community Health Boards. The results of the survey showed that Nova Scotia's health boards are comprised of individuals who are predominately Caucasian, middle age, middle-class and well educated. Moreover, people from minority communities are either under-represented or not represented at all on health boards in Nova Scotia. While the demographic survey sheds light on the composition of governing boards, it did not help to answer important questions about the ways that governing board members understand their responsibilities to attend to the health needs of the population they are mandated to serve. The principal aim of this chapter is to present a case study of Capital District Health Authority (CDHA) to further explore answers to my primary research question: How do Board members and Senior managers assess, understand and attend to the health needs of African Nova Scotians?

A description of research methods and modes of analyses are provided in Chapter 2. This chapter centres on the data from interviews with Board members and Senior Managers from CDHA. Occasionally, I shall also bring in data from the interviews with key informants from the Health Association of African Canadians as reviewed in Chapter Four. At the end of each quotation the status of each participant is identified as either Board Member (BM), Senior Manager (SM) or a representative from the Health Association of African Canadians (HAAC). I use the generic "s/he" for all speakers.
6.1 Capital District Health Authority (CDHA)

CDHA (also referred to as "Capital District" or "Capital Health") was established in 2000 as part of Nova Scotia's most recent health reform initiative. Capital Health is the largest of nine health regions in Nova Scotia (as defined by budget and population served) and is the largest academic health region in Atlantic Canada. The geographic area served by CDHA is comprised of Halifax County and the western portion of Hants County. Capital Health is responsible for operating nine health facilities ranging in size from small community health centres in rural communities to the largest tertiary health facility in the province. In addition, Capital Health operates several programs including mental health (and forensic services), public health, and addictions services.

While the CDHA is the largest health organization in Nova Scotia, the Board of Directors is similar in size and composition to other health boards in the province; the DHA legislation does not differentiate among DHAs based on size, budget, or geographical area served. The Board is comprised of fifteen individuals, ten of whom are recommended by the District's CHBs, the remaining five are selected by the Minister of Health. The Minister of Health appoints all Board members. There are two ex officio Board appointments: the Dean of the Faculty of Medicine at Dalhousie University and the Chair of the District Medical Advisory Committee. The Senior Management team is comprised of a Chief Executive Officer and ten Vice-Presidents. CDHA employs 8,500 staff and the annual operating budget for 2004/05 was $593,366,758. Capital Health serves a local, provincial and regional catchment. In this regard the CDHA website describes the District's provision of services to its constituency in the following manner,

Capital Health provides core health services to 395,000 residents, or 40 per cent of the population of the Nova Scotia and tertiary and quaternary acute
care services to residents of Atlantic Canada. Specialized adult health services are provided to a referral population from the rest of the province of 550,000, and to residents of New Brunswick and Prince Edward Island. (www.chda.nshealth.ca)

There are seven Community Health Boards affiliated with CDHA: Chebucto-West, Cobequid, Dartmouth, Eastern Shore-Musquodoboit, Halifax Peninsula, Southeastern and West Hants.

6.2 Prevalent Understandings of the Health Needs of African Nova Scotians

The first document I turned to in my examination of CDHA was the organization’s Strategic Plan. One of the Board's primary responsibilities is to establish the Mission, Vision and Values for the organization and to develop the Strategic Plan (Carver, 1997; Houle, 1989). The Strategic Plan is the organization’s single most important policy document because, in theory, it best reflects the values and beliefs of the governing board and hence the organization as a whole. It is widely recognized that the Strategic Plan of an organization should serve to "...shape and guide what an organization is, what it does and why it does it" (Bryson, 1995, p.5). This textual representation of the organization's values represents the ideal. While the Strategic Plan is the "public face" of the organization it often does not reflect many of the inner tensions and conflicts that exist.

Much of the language in the strategic plan that refers to the organization's responsibility to serve the public's health needs focuses on the concepts of "patients" and "community." This duality of the Board's mandate – the medical model focus on "patient" and the population health focus on "community" – are recurring themes that shape much of the Board's activities as they pertain to serving the needs of the general public and how it shapes their understandings of social groups such as African Nova Scotians.
Prior to the health reform movement of the 1990s, the dominant focus of the health care system was the delivery of acute care medical services and attending to the illness needs of the "patient" or "client." With the advent of regionalized governance, there has been a shift in emphasis to a population health model where the central feature of interest has been "community" and preventing illness and promoting health. In this instance population health is defined by its focus on disease, disability and mortality in human populations with particular attention being given to the social and economic determinants of health. (Evans et al., 1994; Spasoff, 1999). The tension that exists between these two paradigms or approaches to achieving health and the imbalance of resource allocation and organizational capacity (heavily favouring the medical model) creates particular challenges for the Board as it contemplates its responsibility to serve the needs of minority groups including the Black community. This is a theme that I address at various points in this chapter.

It is worthwhile noting that the 2002-2006 Strategic Plan for CDHA does not specifically mention diversity, culture, race/ethnicity or the need to be culturally sensitive to the needs of patients. Rather the "patient" in this document is generic. This lack of express commitment to cultural diversity at the highest level of organizational policy is significant and problematic. The absence of a statement acknowledging the presence and importance of a diverse cultural community communicates the view that the catchment population can be treated as homogeneous, when in fact the population demographics indicate a more diverse composition.

Furthermore, as I show later in this analysis, it is important for minority groups to see themselves reflected in the organization (either in the diversity of the employees or in public domain texts in the form of pictures or language). This is an important feature that
often determines how (and whether) visible minorities or cultural groups access and interact with the system in terms of receiving care.

When I started my data collection in the spring/summer of 2003 there were no specific programs or policy statements at the Board level, or in its human resource management department, that pertain specifically to diversity management, affirmative action or cultural sensitivity. The absence of statements or policies that acknowledge the presence of a diversity of communities served by the organization and the use of a generic person, patient or employee can have the unintended effect of rendering the unique concerns of minority groups as being invisible or unimportant.

Since that time, the province of Nova Scotia, specifically the Department of Health, initiated the Diversity and Social Inclusion Project. This initiative receives temporary funding from the Primary Health Care Transition Fund, a program of funding established through one of the many Federal/ Provincial/ Territorial negotiations on health care funding transfers to the provinces. The purpose of the Diversity and Social Inclusion Project was to begin a dialogue on the need to provide culturally competent care to the public. The CDHA (and all DHAs in Nova Scotia) have been a part of this initiative since April of 2004 and progress is being made in the development of programs and forums to facilitate dialogue and education among staff and cultural communities. I make reference to several of these initiatives throughout the chapter.

This raises an issue that is worthy of mention. The data collection (in particular the interviews and document review) was initiated in the spring/summer of 2003. The writing of the thesis took place primarily during the time period from the fall of 2004 until July 2005. There have been several important changes in the organization as regards attention to culture and diversity during that time period. The presentation of the interview data reflects
the understandings of Board members and Senior Managers and HAAC representatives prior to the implementation of many initiatives. From time to time, in this chapter in particular, I make specific note of more recent developments to contrast the changes over time. While this research is not actually a longitudinal study, I do portray changes over time, specifically, during the process of conducting a doctoral research project.

Before I begin a more general exploration of the interview data, there is one interesting feature of the interviews that is worthy of mention. African Nova Scotians were the subject of discussion during a significant portion of the interviews and yet I was surprised how infrequently Board members and Senior Managers referred to them using appropriate nomenclature. Rather than referring to "African Nova Scotians" or "African Canadians" or "Blacks" Board members and Senior Managers tended to use the terms "them" or "they." In six of the nine interviews – in most cases lasting more than an hour – the term "African Nova Scotian" or "Black" was used fewer than five times and in three of those six interviews those terms were used by participants fewer than three times. Contrast this with other interviews where participants used the terms "Black" or "African Nova Scotian" frequently and with ease; one Board member of the four interviewed and one Senior Manager of the five interviewed used appropriate nomenclature 18 times and 29 times respectively during the course of the interviews. I believe this unease or discomfort with language and nomenclature related to African Nova Scotians may be due in part to a lack of exposure to Black culture and a concern that inappropriate language may be seen to be offensive. A Senior Manager spoke openly of this discomfort with nomenclature.

One of the things we don't have a good handle on is language. So we talk about the Black community but many of us aren't even sure what words to use because as time passes certain language is more acceptable or not...and we are not always sure about that and certainly not terribly comfortable with that. (SM).
Prior to engaging in this research my exposure to Black culture was limited and I, too, experienced a period of time when I had to learn appropriate nomenclature and be educated on the history and culture of African Nova Scotians.

The interviews with Board members and Senior Managers explored many dimensions of the Board's work as it relates to attending to health needs of the catchment population. One of the main discussion points during the interviews was an exploration of Board members' and Senior Managers' perceptions of health issues in the Black community and whether (and/or how) the CDHA was attending to their health needs. I have chosen to present this material in three general categories. First, there was an open acknowledgement that the Board was — generally speaking — not attending to this community's health needs (inaction). Second, participants claimed that the Board was attending to health needs in the African Nova Scotian community but in focused or limited ways (action). The third topic area, also related to how organizational leaders understand health issues in the Black community, was associated with the Board's approach to improving health, i.e. the medical model and the population health model. There is some obvious overlap among these three topic areas.

6.2.1 Inaction

The majority of those interviewed stated that the Board is not attending to the specific health needs of African Nova Scotians and of other cultural/minority communities. Three main reasons were offered for this inaction. First, there is a general acknowledgement that Board members and Senior Managers lacked knowledge of many of the health and social issues in the Black community, and, furthermore, there is no pre-existing relationship between the Board and the Black community upon which to build an understanding of their
concerns. Second, the "slippery slope" argument, that is, 'If we serve the needs of African Nova Scotian in a special way what about all the other vulnerable groups out there that also demand attention?' And finally, there were several structural and organizational barriers identified that prevented the Board from attending to the needs of the Black community, for example, an overwhelming workload, limited financial resources, the newness of the organization, a lack of data and research, and a lack of appropriate processes and infrastructure to facilitate dialogue. Some interview participants cited all of the above as reasons for inaction while others focused on one or two particular reasons. In some cases there is overlap, for example, the lack of knowledge of issues in the Black community was also related to an absence of data and research.

All Board members and Senior Managers acknowledge that the organization has not engaged in any particular or comprehensive assessment of general health needs in the Black community. Furthermore, participants' own understandings of African Nova Scotian culture and health related issues were very limited.

I think I have a pretty good understanding broadly speaking...you don't have to drive around very far to know that if you are living in this environment you are probably not as healthy as you would be if you were living in this [other] environment. You don't have to be a brain surgeon to do the math. So what is it that is going on in this environment that creates a less healthy population than here? I like to think I have a reasonable idea, but the reality is I really don't. My opinions are all biased by the kind of life I have lived. So I would probably be appalled if I were to experience that piece of it. Probably appalled and scared to death quite frankly. I don't know how you take a Board that is primarily a mirror of myself and educate them and say, do you know what's going on there? (BM)

In this instance the Board member reflects on their lack of first-hand knowledge of minority communities and expresses the view that s/he would be "appalled and scared to death" if s/he really understood the circumstances and deprivation that African Nova Scotians experience. Moreover, s/he extrapolates this sentiment to the Board as a whole because
s/he sees the Board as "primarily a mirror of myself" and acknowledges the challenges
associated with having a board with limited diversity and educating the Board on health
issues in the Black community. This was a common sentiment expressed by Board members
and Senior Managers.

Board members also acknowledge a lack of personal and organizational capacity to
address the problem because there is a lack of demographic and health related information
specific to the Black community to inform decision-making. This lack of awareness of
health issues was also attributed to a lack of diversity among Board members.

...but we tend to be a bit clones of each other, we tend to be primarily
upper-socioeconomic class, we tend to be grey haired or retired, we tend to
be White, we used to have somebody with a visible health problem, that was
very helpful on the board to ask questions from a different perspective. We
do not have any minorities, any visible minorities on the board at all, of any
kind. (BM)

This is a concern that I raised in Chapter Five, namely, how can members of a Board
that reflects a narrow (affluent) demographic profile understand people who live very
different experiences within that same society? This was a prevalent sentiment that was
raised at many points during the interviews by both Board member and Senior Managers.
They expressed a general understanding that there were needs in the Black community, but
they lacked specific knowledge – evidence – and moreover, they lack a clear understanding
of how to begin to approach the problem.

Board members and Senior Managers also raised the "slippery slope" concern i.e.,
how to manage the Board's existing responsibilities (which are considerable) and engage in
addressing the health needs of one cultural group without neglecting other, equally needy
groups. In particular, concern was expressed regarding the potential for one minority group
or special interest group to dominate the Board’s time and the challenges this may bring in terms of balancing competing interests.

For us to identify other than in a cursory way a specific population base and try then to channel resources into that specific population base without knowing what the outcomes are going to be is again a slippery slope, because once you start where do you stop? You look at visible minorities, you look at the handicapped and this group and that group. It would be really difficult for the Board to develop policies for one group when there are 25, 30, 50 or a hundred other groups out there that we could target as well. (BM)

The workload of the board is considerable. Other Board members and Senior Managers also shared this concern. It is not so much that they do not want to attend to the needs of those groups, but rather they feel they are already challenged by managing the services they currently provide to the general public and they lack the capacity to assume additional responsibilities.

The participant above also raises the concern that the allocation of resources should not occur without knowing the potential outcomes of those decisions. The CDHA, not unlike other DHAs across Canada, is cash-strapped and it faces a constant struggle to maintain existing service levels. The implementation of new programs is always a contentious issue and fraught with political and financial wrangling. In this regard the mantra of "evidence-based decision-making" has become a central feature in the priority setting process in health organizations. It has been my experience that this axiom is often used as a reason — bluntly stated, an excuse — for inaction as much as it is used to support a particular course of action. When the decision under consideration is unpalatable, for whatever reason, the available evidence to support a particular course of action is often considered insufficient, or it lacks the requisite authority. It is interesting to note that many decisions have been made in health care with only scant or incomplete evidence when it is deemed politically favourable. Alternatively, when a particular course of action is seen to be
desirable, evidence is generated or found, often after the fact to support the decision. In administrative circles this is commonly (humorously) referred to as "decision-based evidence-making." In short, what is considered as a sufficient rationale to support (or not support) a course of action is a flexible standard. It is important to ask who benefits or who is disadvantaged by the possible outcome of the Board's decisions.

For some, the issue of not attending to the needs of groups such as African Nova Scotians is framed in terms of Board's role as stewards for a community resource, balancing competing interests and safeguarding inappropriate allocation of resources, a task that Board members take very seriously.

[We] have not focused on high-risk sub-populations who may not be getting their needs met as particularly as they could be. I think there is always a push-pull on those things. If you focus all your attention on a group or a good chunk of your attention on a group, it means that there is less attention spent on others. And you need to get that balance right. We've all seen populations who hijack health agendas and who have taken a fair amount of resources...often needed to work with their problems, but it meant that others didn't get those resources. This is always a complicated thing. And I see one of the issues of the Board as being necessary to think that through as representatives of, the guardians of, how the system is going to work in that sense. (BM)

The Board's responsibility is to serve the health needs of its catchment population. There is a danger, however, when considering the catchment population as a whole, to neglect the specific concerns of the many sub-populations, or distinct social groups, that exist within the District. This Board member's use of the word "guardian" is, I believe, an accurate term to describe one of ways that the Board views its responsibilities. In this discussion s/he is referring to the issue of groups seeking to influence the Board's decision-making processes, with the particular aim of serving their own interests. I recall from my experience as a CEO, that various individuals or groups are constantly lobbying and challenging the Board to focus on the needs of sub-groups as opposed to the population as a
whole. This is a constant source of tension for Boards. Plainly stated, when a Board like CDHA is responsible for allocating in excess of $500 million annually, there are many people and groups seeking to have a portion of these resources directed to serve their interests. Acting as a "guardian" of the system is often another way that Board members understand their stewardship role.

When an individual or group seeks to convince, lobby, threaten, force, or coerce the Board (a variety of words can be used to describe approaches to advocating for individual or group interests) to address their particular concerns this is referred to, in Boardroom parlance, as trying to "hijack the agenda." The concern of having a single group hijack the Board's agenda was raised several times during the interviews.

Beyond the obvious connotation that the term "hijacking" implies, there is a fear among Boards generally, that their mandate or agenda will be determined by forces — for example concerted lobbying efforts, media campaigns, or political activism — that are beyond their ability to control. When this occurs, the Board loses control of the objectives it has established through its strategic and business planning efforts. As a result, much of the work of an administrator is spent managing unwarranted access to the Board's decision-making processes to prevent such occurrences.

If every interest group was granted access to the Board the organization would indeed be paralyzed with inaction. As a result priorities must be set and the Board is given the responsibility to set those priorities within certain parameters (legislative, financial and social). A Board member puts the slippery slope concern in the context of managing an overwhelming workload.

This is going to sound really hard nosed and crass but it's [the health of African Nova Scotians] one issue among so many that you are trying to deal with. I guess you...try to keep the balls in the air and try to keep a focus on that kind of issue, but if you put that front and center all the time you're going to
let fall off a lot of other issues. And I guess if we're going to do service properly to the folks that we try to provide service for ...if we can focus on the fact that we are patient-centered with all that that implies and patients come in all shapes sizes, colours, conditions and their capacities we will have done an awful lot. (BM)

This Board member uses the metaphor of juggling balls as a way to express the challenge and anxiety associated with managing the Board's workload. The concern is that when the organization tries to manage too many issues — juggle too many balls — there is a risk that other issues will fall aside, that some of the balls may be dropped. This is a good analogy because at any one time the Board is managing a myriad of complex issues and choices must be made to act on some issues and not others.

The health care system has traditionally adopted a general utilitarian approach in their allocation of health services, that is, services are allocated in such a way as to maximize the greatest overall benefit for the majority of the population. This approach, however, has the effect of perpetuating an unjust social distribution by not attending to the needs of vulnerable populations whose needs may differ from those of the majority (Beauchamp & Childress, 1994). While the health system is "patient-centered" (i.e. serving patient needs on an individualized basis) this does not account for the many people who, for whatever reason, do not access the health system.

These comments regarding the complexity of the Board's workload provide a useful segue into the next reason for inaction cited by participants, namely, structural and organizational barriers. Board members and Senior Managers frequently expressed feelings of being overwhelmed by the sheer enormity of the Board's mandate and the problems faced by the health care system generally. The complexity of the issues facing the Board, the newness of the organization, a lack of adequate funding, a lack of data and research, and having to deal with emergent day-to-day issues in the health care system were often cited as
barriers to accomplishing even their most basic responsibilities. Many of the Board members also expressed the view that they felt unprepared and under-resourced to fulfil their role as Board members.

Now you need to understand that Capital Health is a very new organization and this started with a Board with zero experience. I don't think there was anybody who had managed such a large organization being on the Board before. So that's very complex...(BM)

When one considers that Board members are predominately lay people (and volunteers) many of whom do not have a professional background in the health industry, the issues the Board deals with on a regular basis are complicated. For most Board members the learning curve on many issues is steep.

It has been a tremendous, tremendous learning curve. I sat on Boards before and was President of this organization and that organization but Capital Health is just a monster. It is a very large, complex organization and very few people in their lifetime have an opportunity to sit on a board that large and that complex. There are times of the year when it takes up an inordinate amount of your time...(BM)

All of the Board members interviewed described their time commitment to the work of the Board as being significant, demanding and often overwhelming. Board members attend two regular meetings of the Board (one for business and one for education) on a monthly basis. In addition, most Board members also serve on one or more sub-Committees.

...last year I attended 63 meetings or functions on behalf of the board. This past year I think it was 57. And there are certainly a lot more that I could attend...(BM)

This pressing demand on the personal time of Board members is significant; they are, after all, only human and as volunteers, they, too, have their limits. Board members and Senior Managers also cited a lack of financial resources, a lack of avenues for dialogue and processes to engage the Black community as other structural barriers for inaction. The other significant structural barrier that was cited by organizational leaders was the lack of
information (for example, demographic data, health research) on the Black community. I address this in more depth in a later section of this chapter.

As I reflect on the reasons cited by interview participants for inaction I feel the particular concern expressed regarding interest groups seeking to "hijack the agenda" needs to be put in its proper perspective. It is often the powerful groups (professional groups, trade unions, pharmaceutical and technology companies, politicians, not to mention the day-to-day health concerns of the mainstream Nova Scotians) that have the economic means and political savvy to successfully "hijack" the Board's deliberations. Indeed it is those issues that generally dominate the Board's deliberations. These groups are not seen as hijacking the process because they represent the dominant powers in the hierarchy of health care. Rather, they are viewed as conducting normal business; this pattern of influence has become naturalized and hence 'normal' and invisible. Oppressed groups, by virtue of their relative powerlessness, are rarely in a position to hijack the Board and this is a situation that is perpetuated through the allocation of power in the hierarchy of health care. In short, certain forms of social, political and professional influence carry privilege and others do not.

Based on my own experience I am aware that Boards are not just concerned about individuals or groups hijacking their agenda. Boards also fear unpredictable events such as internal scandal, budget reductions, staffing shortages, equipment failure, disease outbreaks, and natural disasters because these kinds of events force the Board to deviate from what they perceive to be their primary goals. In addition to managing special interests and routine agenda items, Board members are also keenly aware of emerging health problems such as rising rates of diabetes, heart disease, cancer, SARS, and pandemic flu and they express uncertainty regarding how these problems will potentially impact on the organization.
These, too, have the potential to "hijack" the Board's agenda and render their strategic goals redundant.

From a feminist ethics perspective this exclusion from influencing the decision-making process is problematic. As Sherwin (1992) states, "The organization of the health care system does not, however, merely mirror the power and privilege structures of the larger society; it also perpetuates them" (p.228). The 'gate keeping' and 'guardian' role that governing boards view as part of their mandate is an expression of the distribution of formal power in the health system and this has a significant influence on the Board's deliberations and decisions. While on the one hand Boards require some process to manage the lobbying efforts of individuals and groups there is, on the other hand, a need to be aware that there are some groups who, because of their relative powerlessness, lack the capacity to participate or influence the governance process altogether.

If the mandate of governing boards in health care is to serve the health needs of their catchment population – including vulnerable groups – then having senior organizational leaders expressing concerns about not wanting a group comprised of relatively powerless individuals to gain access to their priority setting process is a significant concern. Actively preventing the powerless from gaining access to the governance process for example, by not addressing issues of institutionalized racism and issues related to cultural competency are forms of marginalization (Young, 1990).

Young (1990) believes that marginalization is the most dangerous form of oppression and as a result of being excluded from useful participation in governance processes racialized groups such as African Nova Scotians are potentially subjected to material deprivation and an increased susceptibility to poor health outcomes. A more
egalitarian system of governance would seek to create a space where a wide range of diverse populations can have a voice to inform the Board and seek to have their interests promoted.

6.2.2 Action

The second general category of responses regarding how organizational leaders understand and attend to health issues in the Black community is that the Board was acting on some health concerns in the Black community, not in an all encompassing manner, but rather in the form of specific initiatives. For example, during an interview with one of the Senior Managers it was indicated that a new position (Manager – Spiritual and Religious Care) had been created and that it would be the responsibility of this new manager to attend to issues of diversity in the Capital District. The responsibilities of this Manager include spiritual and religious care delivery, human resource and professional development, financial planning and analysis, program service development and finally, maintaining a "multicultural focus." Regarding the multicultural focus the job description lists the following responsibilities:

- Develops a strategy in partnership with other stakeholders to respond to the need of CDHA to show sensitivity to the multicultural diversity of our society, especially on how this impacts on the quality of our patient care.
- Facilitates the development of programs to educate CDHA personnel at all levels and promote sensitivity on multicultural and minority issues.
- Maintains an effective working relationship with the multi-faith and multi-cultural communities of the region exercising leadership within CDHA in the development of a multicultural/diversity strategy and focus.

During the data collection process (summer/fall 2003) the position was vacant and under review. At the time of writing, there are plans to hire an individual to attend to diversity issues in the summer of 2005.
In the following passage a Senior Manager acknowledges that CDHA is not attending to African Nova Scotians in a concerted fashion, but that they are making progress on specific initiatives.

For example when we were looking at how do we increase our rates of mammography screening in Preston we actually went out into that community and worked with community leaders and came up with some different solutions that were actually very successful. So we have at least made some effort and made some progress in better understanding the needs of sub-groups of our populations. But...its one area where we have not put a lot of focus on and its one that we need to figure out how to do better. (SM)

In this instance the Senior Manager cites an example where CDHA was successful in partnering with the Black community to meet an identified need. At the same time s/he acknowledges that the Board has not attended to "sub-groups" and this is an area for improvement. S/he describes how women in the community of North Preston were identified as having low participation rates in the Nova Scotia Breast Screening Program (NSBSP). Also, s/he indicates that when women from Preston did utilize breast screening many were at advanced stages of disease, signalling again, low participation rates in the provincial screening program. This is an interesting example, because in this instance there was statistical evidence available through the NSBSP to support their concern that participation rates in the NSBSP were low from the Preston area. The availability of evidence enabled concrete action.

Another example occurred in the Southeastern CHB (SECHB) that serves the predominately Black communities of North and East Preston and Cherry Brook/Lake Loon in addition to other non-Black communities. The Southeastern CHB in their 2001 Annual Report to the CDHA Board highlighted a concern that arose from consultations with the community regarding racism and the detrimental impact of racism on the issue of accessing health services. In their Report they state,
Racism is a barrier for many African Nova Scotians needing to access available health services. The health care system as a whole must be sensitive to the distinct physiological and cultural differences when providing services to Black communities if we are to positively achieve health gains in these areas. Our residents would feel more comfortable receiving primary care in their own community and either cannot or prefer not to travel into the city to access services there (p.17).

As a response to the concerns raised regarding racism and access to primary care the Capital District, in 2004, entered into a lease agreement with the newly constructed North Preston Recreation Centre with the objective of establishing a health clinic. The clinic came about largely at the initiative of the Black community who approached the CHB with the goal of establishing a clinic as a means to improve access to primary care services.¹²

My primary interest in the breast screening example and the North Preston Community Clinic initiative is related to how health organizations come to understand that there are health needs that require attention and the means by which they choose to attend to those needs. The Nova Scotia Breast Screening Program has a sophisticated database that permits the tracking of utilization trends and incidence of cancer. In this instance data from the NSBSP served to facilitate the identification of a health issue and remedial action was taken by engaging leaders in the community to find solutions.

6.2.3 Approaches to Improving Health

I have observed in my professional career that the health system tends to respond to health problems by providing services delivered by trained professionals rather than attempting to resolve the root causes of disease, many of which are grounded in the broad social and economic determinants of health. As described in Chapter Four (Governance) the health reform movement of the 1990s emphasized the importance of adopting the population health approach as a means to improving health. Regionalized health boards
experience many challenges associated with balancing the need to adopt a population health approach while still providing illness care services associated with the traditional medical model.

The important distinction between the two models of health care is that the medical model tends to focus on the diagnosis and treatment of disease in individuals whereas the population health model focuses on disease and disability trends in human populations. Moreover, the population health model is also attentive to the role of the broad social and economic determinants of health (Evans et al., 1994; Raphael, 2004). In this regard, the population health approach harmonizes well with a feminist interpretation of empowering oppressed groups. Sherwin (1992) states,

The current healthcare system is organized around the central ideal of pursuing a "cure" in the face of illness, wherein "cure" is interpreted with most of the requisite agency belonging to the health care providers. A feminist alternative would recommend that the health care system be principally concerned with empowering consumers in their own health by providing them with the relevant information and the means necessary to bring about the changes that would contribute to their health. The existing health care system, modeled as it is on the dominance structures of an oppressive society, is closed to many innovative health strategies that would increase the power of patients; a feminist model would be user controlled and responsive to patient concerns (p. 239).

While providing primary care services is an important dimension of attending to health needs of African Nova Scotians, it is only one dimension of addressing health problems facing the Black community. Many of the health issues in Black communities are the results of – or are exacerbated by – racism, poverty, low education levels, low literacy skills, unemployment and are not just the result of limited access to medical care services. As Sherwin (1992) states, "Medical care per se will not always be the most effective means of restoring or preserving the health of oppressed persons" (p. 228). The benefits of improving
access to culturally appropriate care are obvious, but will not necessarily improve the overall health status in the Black community.

Racism was identified by key informants of HAAC as being a determinant of health in the Black community. Yet, the detrimental effects of various forms of racism and social exclusion remain, for the most part, unresolved and continue to contribute to the poor health status of African Nova Scotians. In this regard the District Health Authorities are ill equipped and lack the capacity to address many of the broad social and economic determinants of health. Governing boards such as CDHA find themselves caught in a familiar conundrum: trying to resolve health problems by providing professional health services and yet failing to attend (or not having the resources or capacity to attend) to the broader determinants of health that are the genesis of many health problems in the first instance.

Interview data suggest that Board members and Senior Managers demonstrate a good understanding of the need to consider the broader determinants of health in their deliberations.

I think there is a general awareness in the Board that the prevalence of disease in a population is in many ways tied to socio-economic dynamics (BM)

In keeping with the rhetoric of health reform, the CDHA Board closely aligns itself with the population health agenda. Organizational leaders believe that the population health mandate of promoting health and moving beyond a strictly illness/medical model focus serve as defining characteristics of the Board. Yet at the same time this remains new and unfamiliar territory for most regionalized health organizations. Board members expressed concern that there are several barriers to achieving this mandate, including a lack of funding devoted to population health, a lack of knowledge (and information systems) and capacity to develop
healthy public policy, and the dominance of the medical paradigm of health in the resource allocation process.

To treat people when they come in through the door, we've been doing that since time began...we've got excellent, excellent staff, good facilities, good equipment...mind you both of the latter two are outdated and we need a lot of money to fix that, but step outside of the structure and get back into the population and try to identify how are we going to fix that so they don't need to come to the hospital as often and less of them need to come to the hospital, or our hospitals or clinics. That's just a hugely complex thing...and as a Board we are just trying to get our heads around that. The CHBs form a good part of trying to help us identify that. Trying to get the people who ultimately write the cheque which is the province, to understand that we have a responsibility in that regard and we need to find a way to dedicate resources to population health ... [It] is a difficult undertaking. (BM)

This Board member summarized many of the perennial problems faced by health boards everywhere; ageing infrastructure, lack of personnel and outdated equipment to maintain the "illness care system" consume a lot of the Board's time and attention. S/he also acknowledges that the Board is trying to understand how to accomplish this new population health mandate. Health care leaders recognize the importance of investing in population health and yet the acute care mandate of the Board is demanding that the majority of the time and resources be allocated to perpetuate the medical model of care.

Every health organization...has recognized for some time that population health is absolutely crucial in order to take some of the down the road burden off the acute care system. (BM)

Throughout much of the interview data there is a palpable tension between the rhetoric of the Board's stated "population health mandate" and the powerful forces of the acute care system to dominate the allocation of resources and the energies of the Board. It is also important to remember that while CHBs are viewed as playing an important role in achieving the Board's population health mandate, their role, defined in legislation, is advisory and their formal authority is very limited. And even once the CHBs make their
recommendations the DHAs are then faced with the problem of how to respond to those recommendations.

I guess my frustration is that we have a pretty good understanding of what we need to do to improve the health of our population. We don't have the resources to do it, we don't have the tools yet developed, we don't have the technology that will allow us to do it, on the one hand, and on the other hand you've got politicians who are very, very frustrating to deal with because their agendas are different than ours. Anyway, there is a lot of things we could do better, and at the end of the day we probably will, but part of it is maturing as a board. (BM)

Board members and Senior Managers rely heavily on the CHBs to fulfil the population health mandate. While the CHBs serve primarily in an advisory capacity to the DHAs, much of their work at the community level involves assessing need, building partnerships with individuals and groups and fostering local initiatives. Organizational leaders see the CHBs as playing an important "information brokering" role that is central to achieving the DHA's population health mandate.

They are the folks day in and day out that are in touch with the communities and so we use them to know what's happening in the community and to hear what the key issues are in the minds and eyes of the communities and to understand where (we can) intervene and make a difference from the perspective of the things that are important to the communities (BM)

CHBs make recommendations to the DHAs on a wide range of health and social issues and it is the responsibility of the DHAs to prioritize and address identified needs. The process for incorporating the CHB recommendations into the organizations' strategic and business planning documents is not formalized. Rather, CHB recommendations form part of a large corpus of information that the Board considers as it develops its strategic plan.

Further complications arise from the concern that the empirical research evaluating the work of CHBs and their impact on the health of populations is scant. One study by Dawson and colleagues (2004) found that CHBs felt the DHAs generally did not take their
work seriously and that there have been significant impediments associated with achieving the population health mandate. Furthermore, Dawson et al (2004) they found that the CHBs generally felt that the DHAs were not fully supportive of the population health model. This is not a new problem. The same concerns existed during my time with the regional health board and it is likely to continue as long as the focus of the DHAs is divided between two distinctly different paradigms of health and as long as the bulk of funding is allocated to acute care services.

Despite the good intentions of volunteer board members who are trying to fulfil this new population health mandate there are challenges associated with fully integrating this approach into the health care system. An examination of Board documentation indicates that while population health issues form a significant portion of Board deliberations the powerful professional and political interests associated with institutional / medical model health care continue to demand attention (and resources), often at the expense of population health issues. CHB recommendations to improve health at the community level compete for limited resources with demands for increased funding from the acute care sector.

The CHBs form a good part of trying to help us identify (health needs). Trying to get the people who ultimately write the cheque, which is the province, to understand that we have a responsibility in that regard and we need to find a way to dedicate resources to a population health (approach) is a difficult undertaking. (BM)

While Board members may conceptualize their role in terms of population health and promote the value of CHBs in helping to achieve this mandate, the financial commitment to CHBs is negligible compared to the overall budget of CDHA. Budget figures for fiscal 2004/05 indicate that the total expenditure to support Capital Health’s seven CHBs was $1,322,000 out of a total budget of $593,366,758 or 0.22% ¹³. Part of the
CHB budget includes a block of funding that the CHBs allocate to community groups in the form of small grants to fund community projects.

It is important to remember that CHBs are advisory and thus they do not require significant resources to fulfil their advisory duties. Moreover, it is the responsibility of the DHAs to allocate sufficient resources to implement the CHB recommendations. An alternative interpretation of the low level of funding allocated to the CHBs might be that while they are touted as being central to accomplishing the organization’s population health mandate they are in fact of secondary importance to the dominant acute care mandate of the CDHA. Additional resources may permit the CHBs to undertake more sophisticated assessment techniques, build information systems, build an infrastructure to facilitate stronger ties with other agencies interested in social and economic determinants of health and continue to build capacity in the areas of community development and primary health care.

By citing this tension between two paradigms of improving health status I am not advocating that the population health model should supplant the concerns facing the acute care system. It is widely recognized that attending to illness and disease form an integral part of the CDHA's mandate. Rather, I merely highlight the challenges facing the Board as it tries to build organizational capacity (and devote time and resources) to attend to the broad social and economic determinants of health. Attending to "population health" issues can be a "hard sell" in the politically charged health care environment when the public and health professional groups are also demanding reduced wait times, access to new technologies and improved access to basic medically necessary services. Furthermore, vulnerable minorities, including African Nova Scotians suffer more from this imbalance of focus than do more privileged groups.
The medical model of health care remains the dominant discourse of the public, politicians and the health service industry. This is significant because many of the health issues facing the Black community are rooted in the broader social and economic determinants of health. The regionalization of health care delivery is attempting to introduce a new discourse on health – one focused on population health and the broad determinants of health – yet the decision-making capabilities of the Board continue to be influenced by the dominant forces of institutionalized, medical care. The privileged position of the medical model of care has become "naturalized" (Fairclough, 1989). Fairclough (1989) states,

Naturalization is the royal road to common sense. Ideologies come to be ideologically common sense to the extent that the discourse types which embody them become naturalized. This depends on the power of the social groupings whose ideologies and whose discourse types are at issue. In this sense, common sense in its ideological dimension is itself an effect of power. What comes to be common sense is thus in large measure determined by who exercises power and domination in a society or a social institution" (p. 92).

Shifting to a new paradigm of health creates special challenges for regionalized health care systems in Canada. It is recognized that the major determinants of a population's health are often beyond the purview of the "health system" and include such factors as income and working conditions, social status, education levels, healthy child development, physical environment, social support networks, personal health practices, and genetics (Evans et al. 1994; Raphael, 2004). The provision of illness care services is recognized as having a limited impact on the overall health status of populations yet it consumes a large portion of public spending (Evans et al., 1994).

Board members and Senior Managers report that they face multiple competing demands from inside and outside of the organization as they attempt to fulfil their fiduciary
responsibilities. This resonates very well with my own experience managing a large health care organization. Board meeting agendas are full, the issues they face are complex and the demands on Board members' and managers' time are significant. As volunteers, Board members face many personal challenges including considerable demands on their time and steep learning curves on many issues encountered by the Board. These myriad circumstances conspire to challenge the Board's ability to manage routine and unusual events.

I noted very little difference between Board members and Senior Managers in their prevalent understandings of the need to attend to the health concerns of African Nova Scotians and the barriers and challenges they face in managing this agenda. This comes as no surprise since the governance process requires a close working relationship between the volunteer board members and the executive management staff.

Throughout the interviews lack of access to timely, reliable and relevant information was cited repeatedly by participants as one of the structural barriers to attending to the health needs of African Nova Scotians. Information generally plays an important role in the decision-making processes of the Board, in particular decisions regarding the allocation of scarce resources. In the next section of this chapter I examine data that describe the challenges the Board faces regarding the management of information.

6.3 Availability of Information to Support Decision-Making

In the health field there is a plethora of health information (including health status, morbidity, mortality, utilization and financial/administrative data) available to organizations to use for planning purposes. As regards the management of information, the Board faces two significant challenges. First, the volume of readily accessible health related data is so
large that the problem for Board members and administrators becomes one of selectively narrowing their subject of interest and then gathering, collating, filtering and presenting relevant information in a meaningful way so that it can be used to support decision-making. The general workload of the Board and the complexity of the issues faced by the Board compound the challenges associated with information management. The second problem (more closely related to my research) that arises is that there is a very limited amount of data that are specific to the health status of African Nova Scotians. I address each of these concerns in more depth.

6.3.1 Managing Health Information

One of the central requirements for effective health service and business planning is accessing relevant, accurate and timely data (Bryson, 1995; Kibbe, 1999; Posavac & Carey, 2003). It is difficult to articulate and find solutions to a problem when there is a lack of relevant data to assist in understanding the extent and dimensions of that problem. Much of the data required for planning purposes are collected from sources external to the CDHA, for example, Statistics Canada, the Canadian Institute for Health Information, and provincial and federal health databases. The Board also has access to large volumes of health, financial and utilization data that are generated internal to the organization. In addition, the District’s affiliation with the university research community permits access to the results of primary data collection through sponsored research projects and internally managed databases.

Board members and management staff often do not have the luxury of time to engage in extensive data collection or research on any given subject. As a result, they often rely on easily accessible data or research conducted by others to meet their information needs.
From the perspective of volunteer Board members the challenges associated with understanding and managing health information are formidable. To put this in perspective it may be helpful to understand the kinds of information Board members would receive for a routine meeting of the Board. A typical "Board package" consists of two basic types of information (in addition to standard items such as the minutes of the previous meeting, meeting agenda, routine correspondence). First, there are data related to finances, utilization and quality monitoring. This information is generated internally (often by sub-committees) and it is usually provided to the Board in summary form. Second, there is information that is provided to the Board in the form of briefing notes, correspondence, ad hoc and standing sub-committee reports, reports from CHBs and management reports. This information comes from sources that are both internal and external to the organization and provide the Board with updates on such issues as labour negotiations, capital projects, accreditation reports, reports on unforeseen events, personnel issues, and items for information.

The size of a typical "Board package" can be significant. For a routine business meeting the Board package can range on average from between 50 and 100 pages of material to read. Board packages are usually sent in advance (usually at least one week) to allow time for Board members to read the material prior to the meeting. A typical Board meeting will last (depending on the issues and depending on the Board) between two to six hours in length. CDHA Board members also attend a second monthly meeting that is devoted to Board education. Reading material associated with these educational sessions can vary. In addition to written material contained in the Board packages there is a considerable amount of verbal information that is conveyed by management and clerical staff before, during and after Board meetings.
Board meetings require considerable organization and preparation. It is important to remember that volunteer Board members come together once a month to conduct their business and the Board package both shapes and informs the Board's deliberations. Board members rely on management staff to coordinate the flow of information associated with any given Board meeting. Most Board members do not have the information management and research skills to collect, interpret and present health information. Therefore it is the responsibility of management staff to prepare simplified, summarized versions of pertinent health, financial and utilization data for the Board to review. For example, a 100-page utilization or quality report may have a 1-page Briefing Note summarizing highlights and key points or recommendations for the Board's consideration. Boards generally work on a "need to know" basis.

Many issues that require a decision from the Board are dealt with through Briefing Notes or Memoranda or through the work of sub-committees. A typical Briefing Note will contain a summary of the issue of interest and background information, an exploration of available options and a recommended course of action proposed by management. The Board may deliberate briefly on the issue, but in most instances the recommendations put forth by management are approved without delay. More contentious issues may be deferred to permit time for additional information to be gathered or to permit the sub-committee or manager time to address issues of concern.

While this may appear at first glance to distance the Board from understanding the full extent of available information, this process actually serves the purpose of streamlining the Board's decision-making and saving time. In most instances it is not practical for Boards to be involved in information management and evaluation of options and it is likely that many of their decisions – depending on the level of importance – are based on limited or
incomplete data. Most of the information the Board deals with is used to facilitate and support mandatory monitoring and reporting requirements, to educate the Board on emergent issues, and to aid in short term and long term planning efforts.

The other major stream of information that the Board manages is related to their mandate of attending to "population health." This requires that the Board receive information on the health status of their community, though there is some ambiguity regarding what constitutes population health data. During the interviews the Board members and Senior Managers clearly indicated their reliance on the CHBs to provide them with information and serve as a link between the Board and health issues in the community.

The CHB connection has I think been vital to my understanding of how health, health care and the broad social determinants of health and the broad feeds into that whole health paradigm which has at the bottom is wellness, self-care, then primary care, then secondary and tertiary and the majority of the resources that we spend in the secondary and the tertiary part of health care…the huge connection to what goes on in the community and the social determinants of health. You know that becomes so much clearer when you have a foot in this camp…called the community health world. (SM)

This comes as no surprise, since the Nova Scotian DHA system is structured to have CHBs serve as the primary link to the community. Community Health Boards are viewed as a primary source of "community health" data. The CDHA web site provides the following description of the role of CHBs:

Community Health Boards represent an important link between citizens and the health care system. Legislated by the Health Authorities Act, the Boards are mandated to carry out key functions to ensure our health system is responsive to community health needs. Each year Community Health Boards are expected to develop a community health plan for their area. They do this by consulting with people and organizations about their views on how to improve the health of individuals and how to create social and physical environments that promote health. The Boards also consider information about their population’s health status and demographic profile. This information, along with community views, is used to develop recommendations for the community health plan. The District Health
Authority is mandated to consider these plans as yearly health-services business plans are developed (www.cdha.nshealth.ca).

It is important to note in this description that the CHBs are mandated to "improve the health of individuals" and to "create social and physical environments that promote health."

At an administrative level, each CHB is supported by paid staff to assist with the collection and organization of community related information. CHBs prepare an Annual Report that is submitted to the DHA to be included as part of the overall district-level health service and strategic planning process. Each CHB prepares its annual Community Health Plan (or an update of an existing plan) drawing on a variety of secondary data sources (for example, Statistics Canada) and through various community consultation strategies (for example, surveys, focus groups, and town hall sessions). Each CHB Annual Report includes a progress report on the activities of the CHB, local initiatives, and a list of prioritized recommendations requiring action. The DHA then compiles the information from the various CHB Reports in summary form to be considered by the District as it develops the organization's strategic and business plans. Also, on a monthly basis the Chairs of the CHBs meet with representatives of the DHA Board and Senior Management at the "Council of Chairs" to discuss relevant issues and share information.

At the community level the CHB plans serve as a "filter" through which a wide variety of health related issues are identified, prioritized and summarized for planning purposes. This reliance on the Community Health Boards to serve as the link between the citizenry and the formal health system, and as an important source of data, was very evident in the interviews with both Board members and Senior Management staff.

Our Community Health Boards...no question...powerful vehicle for us. They are of course volunteer structures, so people who work on them live in the communities, they relate to the various agencies in the course of their day to day existence. They've got good relationships established and in many
cases a history of working together. So I think in our organization the CHBs are the primary vehicle. (SM)

Board members acknowledge that there is a difference between the kind of information they receive regarding the operation of health facilities (statistically oriented financial and utilization data etc.) and the kind of indeterminate, qualititative, sometimes anecdotal, data they receive from CHBs.

The Community Health Boards are an invaluable source of information. Not perhaps that kind of technical, highly researched or footnoted kind of material...but what's important in their community and their access to health care and their needs for it. (BM)

DHA Board members recognize that there are challenges associated with collating, understanding, interpreting and translating the "community health" data into decisions and health policy. There is no agreed upon model or framework that Boards can adopt to help them through this maze. Instead, the Board, the CHBs and management staff rely on dialogue and consensus to resolve how CHB priorities will be acted upon. The CHB submits their annual plans containing priorities for funding to the DHA and it is the responsibility of the DHA to incorporate these priorities into their general strategic and business planning processes. There is a need for those in positions of authority to recognize that there are different sources of information available that can provide valuable insight into health needs in the Black community. As Sherwin (1992) states

One important step in that task would be to broaden the base of the network of "experts" who shape the definition of health needs in our society. We can assume that, by virtue of their very success in their roles, those currently recognized as authorities on health matters are removed from the perspectives of many of the members of society who face the most serious health risks. (p. 234)

I did not examine the processes associated with how CDHA constructs its strategic plans in any depth during my research, but incorporating CHB recommendations into DHA business and service plans has been and continues to be a concern. Qualitative data from the
interviews with Senior Managers indicate that the process is not formal, but rather the CHB plans are considered among many factors in the determination of strategic priorities and resource allocation.

Dawson and colleagues (2004) surveyed CHB members regarding this issue and they found that CHB members expressed dissatisfaction with the existing strategic and business planning processes. CHBs felt that there was a need to put in place a mechanism to hold DHAs accountable for their decision to include or not include CHB recommendations into their district level plans. Part of the problem is that CHBs are advisory bodies and they carry no formal authority. They tend to focus on health promotion and population health issues while the business plans and strategic plans of DHAs are more focused on acute care and institutional based services (Dawson et al., 2004).

This suggests that different kinds of information carry different levels of privilege, authority and influence in the decision-making and planning process. To begin, there is a significant infrastructure in place to support the collection and maintenance of financial and utilization information to support the acute care mandate of the district. Financial and utilization data related to the delivery of acute care services are highly developed and sophisticated in terms of determining and monitoring outcomes, cost-benefit, efficiency measures, etc. and this kind of information capacity plays a central role in decision-making. This "evidence-based" information is privileged in the decision-making process.

This is not the case however, with community health data. As noted earlier, there is a relatively small amount of funds allocated to support the collection of "community health" information. Processes to collect and analyze community health data among the CHBs are often ad hoc and in some instances limited in terms of their validity and reliability. The lack of research and information management infrastructure, the reliance on "soft" methods of
assessing community needs (consultation, focus groups, town hall sessions, etc.) and processes to interpret these data to support decisions conspire to diminish the formal authority of community health data. The use of data that are not "technical, highly researched or footnoted kind of material," as the Board member indicates above, must compete against the highly sophisticated information infrastructure supporting the acute care model. The privileged position of evidence – specifically scientific research – that dominates the medical model and the lack of available processes to support the collection of the same kind of data in the community health realm combine to diminish the formal authority of the CHB data to support and influence decision-making. This creates particular challenges in assessing need in the Black community.

In the following dialogue a Senior Manager was asked why there are difficulties in engaging and seeking the participation of African Nova Scotians in the work of the CHBs. The statement that the historical exclusion of Blacks is due in part to the fact that we "want them to fit into our structures" and we have disregarded the need to approach the Black communities in a manner that is culturally appropriate is significant. The perception in this instance is that the CHBs are a microcosm of society, that the structures of White society that make Blacks feel unwelcome are based on a mutual fear of each other, most likely as a result of a long-standing history of racism and fear of violence.

We want them to fit into our structure. I think there is also a kind of fear...I think there is a whole cultural issue, that if...you are a minority in society you are already at some disadvantage. At least that's my perception. So how then do you get over all of that to participate in a group where all of a sudden you are expected to be an equal? So your CHB is a microcosm of what is happening in the community, so just like the police are struggling to get the issues around the Black community and how do they make contact or the school system or whatever...I don't think it's any different at the CHB level. Now they do driving tours, they go out around, they try to make themselves be seen, as not an arm of administration, or seen as part of the establishment...not part of the White establishment. But it's tough...it's tough breaking into parts of Preston, our CHB members are afraid to go
into...the police are afraid to go into...so why...the teachers, even the Black teachers, even their own people are afraid to go into some of those areas...so to host the community event in a certain part of Preston in the evening, you don't want to do it because your car is going to be torched. So there are huge issues to try and overcome. (SM)

In Nova Scotia there is a prevalent mythology associated with Black communities; they are often characterized as being separate domains and places to avoid. This Senior Manager's use of hyperbole to express the concern that entering "certain parts of Preston in the evening" may result in having your "car torched" is indicative of the historical fear, mistrust and misunderstanding that White society has of Black communities. This kind of stereotyping of Black communities is characteristic of the underlying racism that is so prevalent in Nova Scotian society. If Senior Managers in leadership positions and CHB members unwittingly carry such misperceptions with them, it should come as no surprise that they are having difficulty "engaging" the Black community. While Board members may be well intentioned in their efforts, the insidious impact of racism on the behaviours and beliefs of CDHA leadership demand that a more concerted effort be undertaken to overcome the ongoing historical and structural divides of racism.

In terms of information management there are other examples of health status documents, in addition to the CHB Reports, that are produced by the CDHA. These include a wide range of internal quality reports and departmental and program related reports on disease prevalence and service utilization. For example, in 2003 the CDHA, in cooperation with the IWK, produced a public document entitled, "This is Our Life – Community Health Status Report 2002". This document was intended to provide a "user friendly" overview of health issues in the Capital District. While specific health issues among cultural groups were not identified in the Report, the document did portray health in
its broadest sense and there were references to the need to attend to the broad social and economic determinants of health.

6.3.2 Lack of Health Information Specific to African Nova Scotians

In some cases however, the data that are required to facilitate health service planning do not exist. While there is a plethora of sources of health related information available to the Board on the general population, there is very limited information on the health status (and demographic characteristics) of African Nova Scotians and other minority groups specifically. In the process of conducting the document review I did not find evidence of data or information regarding health issues specifically related to the Black community, nor was there any documentation that indicated that this lack of data was an issue of concern.

Data from the interviews with representatives of the Health Association of African Canadians (HAAC) also highlight a concern over the lack of credible research and information on demographics and health issues in the Black community (See Chapter 3). For HAAC participants, having access to credible data in the form of research-based evidence is equated with the power and authority to leverage change. By default, not having information leaves the Black community in a situation where they lack the power and authority (by virtue of not having "evidence" to support their claims) to convince those in positions of authority that their health concerns warrant attention. During the interviews with key informants from HAAC, concern was expressed regarding the dearth of several kinds of data including, for example, basic demographic data, disease-specific incidence and prevalence data (and culturally appropriate treatment options), and research that examines the impact of the broad social and economic determinants of health and the impact of racism on the health of the Black community.
From a feminist ethics perspective, this lack of data and research detailing health issues in the African Nova Scotian community is problematic and indirectly contributes to the poor health status of this community. Baylis and colleagues (1998) state,

As such, feminist ethics provides us with a framework for reviewing the norms that govern research involving and affecting women and members of other oppressed groups in a way that invites us to consider how research practices have harmed women and others (individually and collectively). By raising the familiar feminist questions, "Whose interests are served?" and "Whose interests are harmed?" the ways in which research has historically tended to serve the interests of privileged social groups and to subordinate those of oppressed groups is made visible. Further, feminist ethics' commitment to social change encourages us to consider how current research practices might be reformed to better serve the interests of those who have been disadvantaged, and thus improve their health status (p.236).

This problem is compounded by the fact that members of oppressed groups are often not represented in the power structures that set research agendas and make decisions regarding research funding and allocation (Sherwin, 1992). This serves to highlight the systemic nature of the problem. The lack of relevant research detailing health issues among African Nova Scotians serves as a barrier to addressing these health problems because, as stated earlier, problem identification, problem solving and effective resolution of health issues requires credible, meaningful and timely data that can be used for decision-making purposes.

The importance of relevant, timely data on health issues is an ongoing problem in the health industry and it is central to good decision-making. While there are myriad sources of financial, administrative and utilization data, often the sources of information that are most needed are not available. It is reasonable to conclude that one of the first steps in attending to the health needs of African Nova Scotians is a commitment on the part of decision-makers to acknowledge this void in information and the lack of pertinent and credible research. Policy-makers who establish and manage health databases, research agendas and fund health research need to work together with the Black community to
remedy this problem. A research agenda to support appropriate care for African Nova Scotians will require focusing on demographic data, disease and utilization specific data and most important, research that examines the relationship between the broad determinants of health and health status among Black Nova Scotians.

6.4 Future Directions

There are opportunities to build on the research findings of this study. For example, there is a need to further explore the relationship that exists between volunteer board members and their executive management staff. In particular there is a need to examine more closely the power that executive management has to influence the Board's decision-making processes.

There is a need to evaluate the ways that boards in health care fulfil their role as public trustees and examine the extent and capacity of Boards to fulfil this role. Regionalized health care systems have been given the mandate to attend to population health issues and yet, in may ways they lack the knowledge, capacity and information systems to fulfil this role. There is a need to develop the capacity (education, processes and information systems) to support Boards in attending to population health issues.

There is also a need to evaluate the effectiveness of various models of identifying the particular health issues that are specific to African Nova Scotians and other cultural minorities.

Finally, there is a need to define and establish a research agenda that begins to elucidate the complexity of health issues facing minority and vulnerable communities in partnership with those social groups.
6.5 Study Limitations

There are several potential limitations associated with this research project. The first potential limitation of this research is the small number of interview participants from the Board. Four Board members of a potential fifteen, and five of a potential eleven Senior Managers agreed to participate in the research. This raises the possibility that those who agreed to participate in the research may represent a bias in the responses and that the remaining Board members or Senior Managers may have held views that were either contrary to, or supportive of, those expressed. There was, however, a general consistency in the responses of those that did participate and the data obtained in the interviews correlated well with the document review. The responses of organizational leaders were also consistent with my own knowledge and experiences of governance processes.

Regarding the interviews with the key informants from the Health Association of African Canadians it is important to note that the five individuals that agreed to participate in the interviews do not in any way constitute a representative sample of the Black community in Nova Scotia. HAAC participants acted in the capacity of key informants, sharing their experience and specialized knowledge of health issues in the Black community. A more in-depth research project would need to be conducted to determine prevalent health issues in Nova Scotia's Black community.

6.6 Summary

In this chapter I explored answers to my primary research question: "How does the Capital District Health Authority assess, understand and attend to the health needs of minority populations, in particular African Nova Scotians?" In particular I discuss the perceptions and understandings that Board members and members of the senior
management team hold regarding their responsibility to attend to the health needs of African Nova Scotians.

Capital Health is a large and complex health organization. Qualitative data obtained through interviews with organizational leaders and the document review suggest that, not unlike many health organizations across Canada, Capital Health Board Members face significant challenges in fulfilling their legislative mandate to attend to the health needs of their catchment population. Boards like CDHA function in a politically charged environment where constant scrutiny and lobbying from individuals and groups (internal and external to the organization), rising public expectations and the media diligently serving as "watchdog," have become the norm. In addition, Boards, while trying to serve and balance many competing interests, must conduct their affairs within a highly regulated environment that constrains and limits their decision-making authority.

The workload of the Board is significant and the demands on individual volunteer Board members and management staff are significant. The individuals who agree to serve as Board members assume considerable personal responsibility for keeping abreast of trends and developments in health care, changing social issues, new technologies, in addition to a wide range of issues related to the internal management of the organization.

During the interviews Board members and Senior Managers demonstrated a good understanding that the mandate of CDHA includes the need to attend to the health needs of vulnerable populations such as African Nova Scotians and not just the needs of the majority. For the most part however, organizational leaders expressed uncertainty regarding how to better understand and address the health needs of groups such as African Nova Scotians.

Organizational leaders identify several factors that limit their ability to attend to the health needs of African Nova Scotians including for example, their own personal lack of
knowledge, a lack of research and data on health issues in the Black community, a lack of resources, and a lack of organizational processes and structures to facilitate a meaningful dialogue with the Black community. While there have been efforts made to increase access to primary care and preventive services for African Nova Scotians, Capital Health has not undertaken a comprehensive examination of health issues specific to the Black community.

The lack of available research and data on demographics and health issues in the Black community is a significant impediment to the Board understanding both the problems and potential solutions to remedy prevalent health problems in the African Nova Scotian community. Furthermore, this lack of data contributes to the erroneous view that the problems do not exist. Bluntly stated, the lack of data on demographics and health issues affecting Blacks creates a situation where the problem of inadequate health services is invisible: out of sight, out of mind.

Qualitative data from the interviews with organizational leaders and the document review also suggests that the Board is trying to work within two, often conflicting, approaches to improving health status. The traditional focus on institutional medical care (and a sophisticated information and research infrastructure to support decision-making) and a new and emerging mandate to adopt a population health approach to improving health status are often at odds in terms of resource allocation and priority setting.

Board members expressed the view that while they believe that population health is their primary focus (in addition to providing institutionalized medical care) there is considerable uncertainty regarding how this mandate is achieved. Moreover, many aspects of the broader social and economic determinants of health remain for the most part outside the jurisdiction of the Board's formal authority.
Organizational leaders acknowledge that they are not a very culturally aware Board and that there is significant room for improvement in terms of how they assess and attend to the unique health needs of minority social groups. The Board, however, can do much to improve its delivery of preventive, primary, acute and chronic care services to the Black community as a means of dealing with illness related concerns. Addressing the sources of illness that are rooted in the broad determinants of health is a more complex problem.

Systemic problems require systemic solutions and the CDHA, as a significant player in health care in Nova Scotia, can play a leading role in this regard. There are different levels of policy alternatives that are available to the organization to more appropriately address health issues in the African Nova Scotian community. In the next chapter, I offer some conclusions and strategies to assist governing boards of health organizations to attend to health needs in the African Nova Scotian community and minority communities in general.
Chapter 7: Conclusions and Strategies

I guess my question is how are they going to do it? I don't know if they have been trying to do it because certainly the way we have been approaching the subject of systemic discrimination to involve and include has not worked, so clearly there needs to be a different approach. It's not that people haven't been told what the issues are...I just think they are not willing to go there because it's uncomfortable.

(Member, Health Association of African Canadians)

7.0 Introduction

In this thesis I have explored answers to my primary research question, "How does the Capital District Health Authority assess, understand and respond to the health needs of African Nova Scotians?" In particular, I was interested in identifying hidden institutional practices that create barriers and prevent boards from appropriately responding to the health needs of this population.

In this final chapter I take the lessons learned from Chapter Three (African Nova Scotians), Chapter Four (Governance), Chapter Five (the Demographic Survey) and Chapter Six (the Case Study of CDHA) and examine what these findings mean in terms of answering my research questions. I also explore various strategies by which changes can be incorporated into the work of CDHA to enable it to respond more effectively to the health needs of the Black community. I hope these suggestions will help guide CDHA to improve the delivery of health services to African Nova Scotians and will be of value to other regionalized boards in their efforts to attend to the needs of minority populations.

Feminist ethics provided the motivation for this research. My concern from the outset was to examine the connection between the structures and processes of governing boards in health care and patterns of oppression that may contribute to the Board's inability to understand and attend to the health needs of African Nova Scotians. In a health care system - and a society - that is fair and just, African Nova Scotians would have equitable
access to culturally appropriate health services and would experience levels of health status on par with non-Black members of society. Furthermore, the health care system (and other social organizations) would recognize the importance of group differences but these differences would not serve as a source of oppression (Young, 1990). Available evidence suggests, however, that this is not the case; African Nova Scotians have reduced access to culturally appropriate health services and poorer health status when compared to the non-Black population. My analysis of the case study of CDHA has led me to a better understanding of how governing boards in health care comprehend and attend to the health needs of African Nova Scotians and how hidden organizational practices contribute to the Board’s inability to effectively address health needs in this population. I will offer suggestions for remedial action that I hope will move us closer to the ideal.

The feminist ethics motivated Critical Discourse Analysis conducted in this study points to several features associated with the governance process that are fundamental to the Board’s failure to fully understand and attend to the health needs of African Nova Scotians. These include exclusionary features of membership on governing boards and limited avenues for involving the Black community in decision-making, challenges associated with implementing two paradigms of improving health status (i.e. the dominance of the medical model of health and a lack of attention to the social and economic determinants of health) and, difficulties in understanding the nature and extent of health issues in the Black community. In addition to a lack of personal knowledge of Black culture and a lack of data and research investigating the health needs of the Black community, the knowledge base that the Board does use to inform its decision-making is not well suited to responding to the health needs of African Nova Scotians.
7.1 Analysis

During my professional career as a Chief Executive Officer I observed that Boards tended to be homogeneous in their composition (Board members tended to be white, middle-aged, affluent and well educated) and there was minimal representation from Visible Minorities or from other groups that could typically be characterized as vulnerable. Because board members are selected to serve as trustees, i.e. holding the public's interest in trust, and not as representatives of particular segments of the community, there is good reason to question whether the composition (and selection methods) of governing board members influences how boards understand and attend to the health needs of African Nova Scotians.

My first question, then, was whether my own Board was typical of others. To answer this I conducted a demographic survey to determine the composition of Nova Scotia's District Health Authorities and Community Health Boards. My underlying assumption was that if Boards were diverse in their composition then there would be a greater likelihood that members would demonstrate an understanding of the circumstances of vulnerable groups, and conversely, the more homogeneous (and affluent) the composition of the boards, the less likely this would be so.

Data from the demographic survey indicate that the membership of governing boards in health care in Nova Scotia does indeed consist of individuals who are, primarily, Caucasian, middle-aged, affluent, well-educated, married or widowed and either working or retired. In short, boards are comprised of social elites. Moreover, in this survey, Visible Minorities are underrepresented and in the case of most DHAs and CHBs, sometimes not represented at all. This is consistent with the findings from other similar demographic surveys (Brunelle et al., 1998/99; Frankish et al., 1998; Lewis et al., 2001).
The survey data also showed a general "streaming" phenomenon, that is, there is a greater level of diversity on the CHBs across most survey categories than on the DHAs, indicating a progressive narrowing of demographic characteristics of Board members as they move from CHBs to DHAs. My question, then, was: "How are the concerns and voices of vulnerable groups being heard if members of these groups are not present at the decision-making table?" Or to view it another way, "Does the composition of governing boards influence how Boards make decisions and the kinds of decisions they make?" As Sherwin (1992) states, "When health decisions are made by predominately white, affluent, well-educated men, there is great danger that professionals will act on the basis of the familiar gender, social and class stereotypes of their society" (p. 321).

In Nova Scotia the Minister of Health appoints all board members to the DHA; thus, s/he has the power to determine the composition and level of diversity on each board. Failure to appoint more diverse boards probably reflects a lack of awareness of the problems created by appointing boards that do not reflect the diversity of the communities they serve. Limiting power in this way to a privileged few members often constitutes a form of institutionalized racism/classism by failing to acknowledge that the views expressed by homogeneous (elite) boards may not represent the views of the entire community, especially minority groups, and, may, therefore, lead to practices that are harmful to vulnerable minorities.

The demographic survey raises many questions regarding the barriers that keep individuals from minority or vulnerable populations from participating on boards. Moreover, it raises important questions regarding how the public interest is served by appointing social elites to serve as public trustees of health organizations.
The results of the demographic survey confirmed my original assumption that boards are comprised primarily of social elites and illustrated the outcome of exclusionary features of the trustee selection process. The results, however, provided little insight into the reasons why visible minorities are underrepresented on governing boards in health care and whether Boards with limited diversity are capable of understanding and attending to the health needs of vulnerable/disadvantaged populations. To understand this process more fully, the Case Study of Capital District Health Authority explored how Board members understand their role as it relates to serving the health needs of their catchment population.

Qualitative data obtained through interviews with organizational leaders and the document review suggest that Capital Health is a complex organization that faces many challenges as it fulfils a legislated mandate to deliver health services and attend to the health needs of its catchment population. Boards like Capital Health function in a politically charged and highly regulated environment that constrains and limits their decision-making capacity. Furthermore, the workload of the Board is considerable and the personal demands on volunteer Board members and management staff are significant. Board members assume responsibility for keeping abreast of developments in health care, changing social trends, new technologies, in addition to a wide range of issues related to the internal management of the organization. Board members' personal commitment to serve as volunteers in such a challenging environment is noteworthy.

Data from the case study of Capital District Health Authority indicate that Board members and Senior Managers demonstrate a good understanding of their role and responsibility to attend to the health needs of their catchment population generally. At the same time, however, they acknowledge that it is a challenge balancing and managing the many interests (internal and external to the organization) that compete for limited resources.
Nonetheless, there are some promising signs of change. Board members and Senior Managers expressed concern regarding the lack of diversity on the Board and the need to develop organization-wide diversity initiatives. During the early phases of the document review portion of the data collection process there was a dearth of organizational policy documents that addressed the issue of cultural sensitivity and cultural competence at the level of the Board or in human resource policy. At the time of writing this thesis — two years after initial documentary data collection started — several organization-wide diversity initiatives are in the early stages of development. For example, the Board established a Succession Planning Committee in 2003 to examine the composition of their board and make recommendations that addressed desired skills, backgrounds, etc. as a means to "strengthen the Board." In addition, Capital Health, in concert with the Department of Health's Diversity and Social Inclusion Project, has started several initiatives including working with the Metropolitan Immigrant Settlement Association, and the Acadian, First Nations and Black communities to promote dialogue, develop staff education modules and policies related to providing culturally competent patient care and, attend to issues related to access. A number of diversity workshops have been conducted in the District, committees are being established and there are plans to hire an individual dedicated to addressing issues of diversity within the organization (tentatively planned for 2005). This demonstrates that the organization is acknowledging and responding to the need to become a more culturally aware organization.

Board members and Senior Managers identified a number of barriers to attending to the health needs of African Nova Scotians including a lack of understanding and awareness of Black culture, a lack of data — and processes to collect and analyze data — on health issues in the Black community, a lack of formal processes to engage the Black community in
dialogue, an overwhelming and complex workload, and a lack of funding devoted to population health. Moreover, Board members and Senior Managers expressed concerns regarding the challenges associated with managing competing interests in the priority setting process as another reason why it is difficult to adequately attend to health needs in the Black community.

Board members and Senior Managers discussed their own personal lack of knowledge regarding the history and present day circumstances facing the Black community. This personal lack of knowledge, compounded by a lack of data and research on health issues, was cited as a significant barrier to adequately understanding and responding to health needs of African Nova Scotians. Organizational leaders from CDHA acknowledged the need to educate themselves on health issues affecting minority populations in general and to seek opportunities to open a dialogue with the Black community to begin identifying and resolving health issues.

As mentioned earlier, the Critical Discourse Analysis that was conducted in this study point to several aspects of the governance process that inhibit the Board's ability to adequately attend to the health needs of African Nova Scotians. Foremost among these is that the Board is faced with the challenge of implementing two different approaches to improving health status – the medical model and a new population health model. These two approaches are pursued in ways that often disadvantage the Black community.

While there is debate regarding the effectiveness of regionalized health services in Canada, there is no doubt that the expectations of this approach to governance include reducing costs, decentralizing decision-making and adopting a population health approach to improving health (Regionalization of Health Care Systems in Canada, 1997). The decentralization of decision-making to regionalized health boards was intended to increase
local community control in the areas of resource allocation and service provision and to expand the mandate of District Health Authorities beyond the provision of traditional hospital-based services (NSRCHC, 1989). In Nova Scotia, it was expected that regional boards, with the assistance of local community health boards, would begin to address the health status of their population by not only delivering institutionally-based medical services, but also by promoting health and preventing illness (NSRCHC, 1989; NSDOH, 1990, 1994, 1997).

The formation of new regionalized health boards thus represented two significant changes from their predecessors. First there was a shift from a distinctly (institutionalized) medical model of treating illness to a combined approach of the medical model and a new "population health" model. In this instance "population health" is defined by its focus on disease, disability and mortality in human populations with particular attention being given to the social and economic determinants of health. (Evans et al., 1994; Spasoff, 1999). The second significant change that accompanied this vision of health reform was the increased involvement of the community – as opposed to professionals – in the decision-making process.

This shift in emphasis from the medical model of health to the new population health paradigm has created challenges for regionalized models of governance. The transition to a population health model has been neither smooth nor as complete as was originally envisioned because District Health Authorities were largely unprepared and under-resourced to take on the challenges associated with implementing this combined approach to improving health. At the same time DHAs continue to face considerable pressure from the public and health professionals to allocate resources to promote services traditionally associated with the medical model of care. Furthermore, there are internal and external
constraints that serve to limit the autonomy of DHAs to make independent decisions regarding resource allocation and service provision. While the general mandate of the DHAs is to improve health, the opportunities for the DHAs to influence the major social and economic determinants of health – those factors that are recognized to have the greatest impact on the health status of populations – are limited.

Qualitative data from the interviews with organizational leaders and the document review support the concern that the Board is trying to work within two, often conflicting, paradigms of improving health status. Board members and Senior Managers readily identified population health as a central defining characteristic of their mandate, yet they expressed uncertainty regarding how this mandate is to be accomplished. This is partially due to the newness of the organization and a lack of infrastructure to support population health policy development. Furthermore, interview data indicate that Board members and Senior Managers are often uncertain of the types of health information required to support decision-making, and, more important, how population health data can be used to facilitate policy development.

Board members and Senior Managers identified the Community Health Boards as playing a lead role in achieving their population health mandate. The primary role of a CHB is to advise the DHA on the health needs of the community and to engage in community development initiatives. The recommendations put forth by the CHBs, however, must compete with other departments and programs in the organization for limited resources. The bulk of funding in organizations like CDHA is devoted to the provision of institutionally based medical services and only a relatively small amount is allocated to the promotion of health, illness prevention and the social and economic determinants of health. This continues to be a source of debate between the DHA and its CHBs. Such an imbalance
in the allocation of health care resources — favouring the delivery of illness care services — is not new, but rather reflects historical social values that favour the medical model of care versus other approaches to improving health status.

This tension between the two models of improving health status creates particular challenges for the Board as it seeks to attend to the health needs of vulnerable social groups, including African Nova Scotians. In this regard, it is widely accepted in the population health literature that the greatest improvements in health status are achieved by attending to the broader social and economic determinants of health including, for example, education, employment and working conditions, food security, housing, and an attention to justice in the development of social policy and not from the delivery of illness care services (Daniels, Kennedy & Kawachi, 2000; Evans et al.; 1994; Raphael, 2004). This is particularly true for vulnerable populations. While the DHAs are mandated to improve the health of their catchment population they are, for the most part, limited in their ability to influence those factors which have the greatest impact on health status.

Other health regions have openly acknowledged the limited role of the health system in improving the health of vulnerable populations and have taken steps to broaden the involvement of other sectors. For example, in Saskatchewan the Regina Qu'Appelle Health Region's "Working Together Towards Excellence Project" released a report entitled, "Improving First Nations and Metis Health Outcomes: A Call to Collaborative Action" (2002). In summary, the Report determined that if progress was to be made on addressing Aboriginal health issues there was a need for a new kind of relationship among Aboriginal communities and the non-Aboriginal community. The Report acknowledged that solutions that were externally imposed on Aboriginal communities from the outside (as has been the tradition) hold little hope for success, and that initiatives created through a community
development process — with the Aboriginal communities leading the process — will have a
greater likelihood of success.

The Saskatchewan Report also acknowledged that the best way to attend to the
health needs of Aboriginal communities is to address the broad social and economic
determinants of health and not just provide medical services. The authors conclude that
"...Aboriginal health outcomes largely result from social, economic, cultural and other
determinants of health' over which any one organization has quite limited control" (p.viii).
In this regard, the health care system is viewed as being one player, among many, that has a
role to play in improving the health status of Aboriginal communities. The Report
recommended establishing a collaborative framework among many partners (inside and
outside the formal health care system).

Key informants from the Health Association of African Canadians (HAAC) identify
four, inter-related, categories of concern regarding the health status of African Nova
Scotians: a lack of demographic data and health status research, limited access to culturally
appropriate primary, acute and chronic care services, attending to the broad determinants of
health and coming to grips with racism and its impact on health. I will discuss each one
briefly.

The lack of data and research on the demographic profile and health status of the
Black community was cited by HAAC participants as being a significant barrier to attending
to the health needs of African Nova Scotians. They felt that it is difficult to lobby for, and
implement, constructive change and identify priorities for action when there are no or
limited data to support decision-making. In a system where the mantra of "evidence based
decision-making" is axiomatic, lack of information on a particular health concern can serve
as a major impediment to change. Furthermore, the lack of health data about the Black
community contributes to the erroneous view that distinct health problems in this
community do not exist. Bluntly stated, the lack of data on demographics and health issues
affecting the Black community creates a situation where the problem is invisible: out of
sight, out of mind.

There are, however, positive examples that illustrate that when data that identify a
health problem are made available, strategies can be developed to improve the health of
African Nova Scotians. In a few notable cases the CDHA has partnered with the local
community to address specific concerns. Examples of this include increasing participation
in mammography screening, improving access to primary care services, prostate cancer
screening and diabetes care. This serves to highlight the importance and privileged status of
quantifiable data – "evidence" – and the health costs associated with the absence of relevant
information. CDHA organizational leaders also expressed uncertainty regarding the use of
more informal sources of knowledge as information upon which to base decisions and
formulate policy. In this regard it is important to acknowledge the need to develop
alternative means to identify sources of health information and to open avenues to promote
dialogue and community input in decision-making and not rely only on professionals to
identify health issues.

Key informants from HAAC also identified the lack of culturally appropriate
preventive, acute and chronic health care services and barriers to accessing health services as
areas of concern to the Black community. This includes the need to educate health
professionals in the diagnosis and treatment of diseases that are prevalent in the Black
population or the development of programs that take into consideration access concerns or
issues related to recruitment of patients. A positive example of this occurred when low
participation rates of Black women in the Nova Scotia Breast Screening Program were
determined to be related to lack of transportation, location of the mobile breast screening van in non-Black communities, and lack of knowledge of the benefits of the service. These issues were discussed with leaders in the Black community, and, in collaboration with the local churches, appropriate strategies were developed to address identified concerns. As a result the participation rate in the breast screening program among Black women has increased in some areas of Capital District. Recent initiatives to provide access to preventive and primary care services for the Black community indicate a progressive attempt to serve the primary health care needs of this community (e.g. the new health clinic in North Preston and the North End Community Clinic). But, there is a long way to go to address some of the concerns expressed.

Key informants from HAAC also highlighted the importance of attending to the broader determinants of health as a means to improve health status in the Black community. HAAC participants frequently cited issues such as inadequate housing, unemployment, low literacy skills, poverty, limited employment opportunities, low levels of educational attainment, and various forms of racism as being health problems that have both a short and long-term impact on health status and well-being of African Nova Scotians.

An example of the far reaching impact of how the broad determinants of health impact on the health of African Nova Scotians can be seen in the education system. The education system has not adequately supported young Black learners to help them gain access to training programs in the health professions and as a result there are few trained Black health professionals working in the health care system (BLAC, 1994). At a more basic level, there is a strong correlation between educational attainment and literacy skills and it is widely recognized that literacy is a major determinant of health (Ronson & Rootman, 2004).
Inadequate educational preparation can have far reaching implications on the health status of a community.

The overriding health concern that permeated all the interviews with HAAC representatives was that the poor health status experienced by African Nova Scotians (as a social group) was directly or indirectly related to various forms of racism. In this regard HAAC participants identified "racism" as being one of the broad social and economic determinants of health. HAAC participants expressed the general view that racism is endemic and part of the cultural fabric of Nova Scotian society and stems from a long history of prejudice, mistreatment, deprivation and exclusion from the benefits afforded to White society. HAAC participants felt that racism has a pervasive and detrimental impact on the health status of Blacks. Furthermore, institutionalized racism is experienced in every aspect of the lives of many African Nova Scotians and in their encounters with every system and sector in society, not just the health care system (Clairmont & Magill, 1970, 1987; Enang, 2002; Head & Clairmont, 1989). This finding is significant and problematic for several reasons, in particular, because the Board has limited ability to ameliorate the effects of institutionalized racism in all sectors of society. Again, the CDHA is one organization among many that have a role to play in improving the health of the Black community.

Racism – as a health problem – is endemic in Nova Scotian society and therefore it is important for the health care system to be aware of how health organizations attend (or do not attend) to "race." There are times when it is important for the health care system to be "race-aware" and there are times when it is important for the system to be "race-blind."

In the medical model of health care – with its particular focus on the "patient" – it is important that the health care system be attentive (patient centered) to the ways that disease manifests itself in the Black population. Examples include being aware of the influence of
skin pigment in certain skin disorders, the presence and characteristics of sickle cell disease or the need to modify the Apgar Score to assess newborn Black babies appropriately.

There are also times when it is important for the health care system to be "colour-blind", i.e. health organizations should ensure that all people have equal and equitable access to health services and equal opportunity to participate in decision-making regardless of race, culture, or ethnicity. The CDHA can play a leading role in addressing this complex issue within the organization by developing diversity management programs, introducing policies that promote inclusion, and offering culturally competent care. To promote this end the CDHA can also build on current initiatives that address racism, cultural sensitivity and diversity within its workforce, for example those currently being implemented as part of the Diversity and Social Inclusion Project described above.

In the population health model it is also important for the health system to be attentive to "race." With its particular focus on "populations" as opposed to "individuals" it is important to recognize that geographic or politically constructed populations (e.g. Capital Health) are not homogeneous and that specific social groups have unique or special needs that require particular attention. It is also important for a population focus to recognize that race should not serve as a dividing line that determines access to services; i.e. it is important to recognize that group differences exist, but these differences should not be a source of oppression (Young, 1990).

CDHA can play a leading role in developing new responses to address health concerns of African Nova Scotians and other vulnerable groups in the areas identified above. In the next section I draw on the qualitative interview data to develop recommendations for action.
7.2 Examining Policy Options

In my interviews with organizational leaders from CDHA and key informants from HAAC, I solicited their perceptions on potential solutions to address many of the concerns they identified. Proposed solutions and policy options can be broadly categorized into three main subject headings: 1) minority representation on governing boards, 2) raising awareness and education, and 3) building trusting relationships.

7.2.1 Representation

Qualitative data from the interviews provided mixed views regarding minority group representation on governing boards. Organizational leaders from CDHA and key informants from HAAC were in agreement that representation was important, and ideally, would be desirable. At the same time, however, participants agreed generally that appointing individuals to serve as representatives for the Black community for the sake of having an individual at the table may do more harm than good.

One approach to address this is through the use of "designated seats," i.e. appointing an individual from a particular group to serve as a representative on the Board. There is, however, no empirical evidence to suggest that "designated seats" are effective. In fact the limited information available on this approach would suggest that while designated seats give the illusion of representation, the use of designated seats places minority representatives in "no-win" situations and may serve to perpetuate racism in the form of tokenism (Aboriginal Governors Forum, 1999; Taylor et al. 2000; Widmer, 1987).

Both CDHA organizational leaders and key informants from HAAC expressed concern over the use of designated representation. First, some feared that designated seats would be merely tokenism. Second, there is an onus, or an unstated expectation, placed on
a designated member to represent an entire community. This responsibility can be overwhelming, and in some cases impossible. There is an implied expectation that designated members are to consult with and seek the views on issues within "their community." Unless there is an elaborate support system put in place to assist these members in their role as representatives, this expectation may be unrealistic. A similar expectation is not placed on the non-designated members, i.e. board members not sitting in designated seats are not expected to consult with and seek the views of their "community" (nor is it clear how "community" would be defined). Furthermore, an individual appointed to serve as a representative may or may not be viewed by the particular community as being credible or competent to represent their concerns. Third, having a designated representative implicitly relieves the remainder of the board from having to be seen to address issues related to the racialized community served by the designated representative. Fourth, there is the problem of determining which of the many vulnerable, minority, disadvantaged or racialized groups would be assigned a designated seat. The potential exists for many worthy groups to be left out of the process, which then serves to further marginalize their concerns. A fifth issue, not identified in the interviews, but a concern nonetheless, is that a designated representative is merely one vote among many and the traditional power holders can still outvote the views or Board motions put forward (Arnstein, 1969). In this respect, designated representatives are, for the most part, advisory and their power is limited since there is no requirement for the board to act upon the recommendations put forward by the designated representative.

There is little empirical evidence available to suggest that designated representation is an effective option as a means to ensure that the views of the Black community are heard and acted upon. Furthermore, approaches may vary depending on many factors, including the community of interest and historical and organizational context. Because there is little
guidance to be found in the literature, there is a need to conduct further research and
dialogue in this area to determine the most effective approach to ensure the concerns of the
Black community are heard at the Board table. In summary, having a "Black representative"
on the Board is not, by itself, a sufficient mechanism to overcome the many barriers and
institutional practices that prevent the Board from attending to needs in this community.

Data from the interviews with members of the Health Association of African
Canadians suggest that governing boards need to consider new approaches to seek advice,
input or participation from a community rather than from an individual. This requires for
example, revisiting the means by which input from the community is solicited, establishing
processes to ensure the views of the community are heard and considered, developing ways
to identify leaders in the community, and establishing ways to hold decision-makers
accountable.

Data from the interviews and the literature suggest that opportunities exist to address
health issues in the Black community and that the starting point for these alternative
approaches is grounded in raising organizational leaders' awareness of Black culture and
health issues in the Black community and building trusting relationships.

7.2.2 Education and Awareness

HAAC representatives and senior leaders in the CDHA agree on the need to raise
the awareness of Board Members and senior managers (and the organization generally) on
African Nova Scotian culture and more specifically, health issues in the Black community.
Furthermore, they agreed that education and raising awareness serves as a foundation upon
which to build avenues to participate in meaningful dialogue and build long-term trusting
relationships. Conversely, it is also important to educate leaders in the Black community
about the workings of the health care system and opportunities to participate. This two-way process of education must be viewed as a prerequisite to beginning a meaningful dialogue and collaboration between the organization and the Black community. With a visible willingness to inform and be informed about health issues in the Black community, including the mechanisms of racism and its impact on health, it is then possible to explore strategies related to representation and participation in decision-making processes especially on issues that impact on community members' health and well-being.

While the need to educate is an obvious starting point for understanding health needs in the Black community there are other organizational practices related to education and awareness that inhibit the Board's ability to understand racialized communities. For example, during the interviews Board members acknowledged the problem of being overwhelmed with information. Sorting through and understanding large volumes of information gives the illusion that the Board is being informed on all relevant and important issues. While the Senior Management staff provide the Board with financial, utilization and other kinds of data so that it can fulfil its organizational stewardship role, there are other important sources of information that are not collected or are not reported to the Board for consideration, for example, health issues affecting minority communities.

Educational opportunities for Board members should be expanded beyond "health system" issues. In particular, it is necessary to focus on understanding the composition and diversity of the communities they serve, how racism is manifested in minority communities, and how the social and economic determinants of health impact on the health of vulnerable communities.

Senior Management staff and the Board need to give higher priority to the different kinds of knowledge claims coming from the CHBs, in particular as they relate to identifying
health needs in the Black community. If, as was stated by organizational leaders, the CHBs serve as the cornerstone of the population health mandate of the Board, then privileging this information in the decision-making and priority setting process needs to be improved. It is ironic that the CHBs, who are closest to the African Nova Scotian communities, are also marginalized within the power structure of the organization. In this regard there is a need to create a mechanism that will allow the CHBs to hold the DHA accountable for their action or inaction on recommendations coming forth from the community. This process can serve as a valuable Board education tool.

Education and raising awareness requires information and research to inform discussions on health issues and approaches to resolving those issues affecting the Black community, particularly in the areas of the broader determinants of health and racism. There is also a need to broaden the Board's conception of what constitutes health and approaches to improving health beyond providing illness care. Current information management strategies utilized by the board to inform decision-making, especially in the realm of population health are insufficient. While there is a need to collect more information on demographics and health status in the Black community improving the collection of medically oriented epidemiological data alone is not enough. In this regard new and innovative strategies for seeking community input on health issues need to be explored so that 'community wisdom' can be considered in Board deliberations.

One of the responsibilities of the Board is to serve as gatekeeper and therefore the Board must be attentive to how it balances competing claims for limited resources. Thus there is a need for the Board to consider health concerns identified by the Black community as part of a comprehensive assessment of health needs. A constructive dialogue needs to be fostered between the organization, health professionals and the Black community to jointly
identify problems, collect data to justify decisions, and find workable solutions that are affordable and are culturally appropriate.

There is a need for the Black community, health organizations and researchers to collaboratively develop a common research agenda and information systems that will begin to fill the gap in knowledge around health issues, including incidence and prevalence of disease and factors influencing the broader determinants of health from the unique perspective of African Nova Scotians. Identifying a research agenda will also open new opportunities to explore the problems associated with collecting data and conducting research on the broad determinants of health and to examine ways that governing boards can influence social and economic policy in a broader sense.

Expressions of willingness to be educated on issues related to serving the needs of racialized communities can be reinforced by requiring that the Board re-evaluate the information that comes to the Board on a monthly basis. A concerted effort needs to be made on the part of senior managers – those that exercise considerable influence in steering the Board’s education agenda – to balance the need for organizational information (e.g. finance and utilization) and population health concerns, especially those of minority or vulnerable groups.

Further education on the causes and manifestations of racism – and other types of power relations – in society is also an important dimension to understanding the circumstances of racialized communities. It is through this re-assessment of educational needs of the Board (and the Black community) that can foster an informed debate on how to best understand and attend to health needs in the Black community.
7.2.3 Building Trusting Relationships

There is a legacy of poor relations between the Black community in Nova Scotia and the social and political establishment (BLAC, 1994; Clairmont & Magill, 1970, 1987; Head & Clairmont, 1989). During the interviews with organizational leaders and representatives of HAAC there was an acknowledgement of the need to build new, trusting relationships between the Black community and organizations such as Capital Health. As mentioned above, the starting point for this new relationship is to raise awareness and educate organizational leaders on the history and culture and current circumstances facing the Black community in Nova Scotia and the sources and manifestations of racism and classism. It is also important to help members of the Black community understand the organizational structure of DHAs and to learn how they can become more effective at making their needs known. A further prerequisite for building trusting relationship is to establish processes that facilitate open dialogue and provide venues for discussion with decision-makers. Furthermore, there is a need to ensure that the Board is held accountable to the public for their decisions, especially those decisions that impact directly on the Black community.

The literature on governance and accountability suggest that characteristics of open, trusting relationships include a transparent and deliberative framework for decision-making, opportunities for collaborative identification of problems and solutions in partnership with the Black community and adoption of an accountability framework that specifies roles, responsibilities, information exchange and expectations (Ableson et al, 2001; Abelson & Eyles, 2002; Auditor General of Canada, 2002; Young, 2000). Openness and transparency in decision-making, while laudable principles in their own right, are also a double-edged sword; the illusion of open processes that permit the powerless to exercise "voice" needs to be balanced with the need to conduct routine business. Opening Board meetings to the public
can have the undesirable effect of making Board meetings prone to factionalism, grandstanding and unwarranted delays in conducting routine business. It must also be understood that the voices of many invisible, vulnerable and unorganized groups with worthy needs may remain unheard. Nonetheless, the notion of governing Boards continuing to work in seclusion – closed to the public and the media – with no process for public accountability for their decisions, will serve to perpetuate the status quo and will not serve the interests of vulnerable populations who lack access to the power structures and decision-making.

The key point is that the structures and related processes to engage the Board and the African Nova Scotian community must be identified by, and be culturally appropriate to, the Black community and not a system of collaboration that is imposed by the DHA. Given the diversity among the Black communities in Nova Scotia this mechanism may vary from area to area. In addition, there is a need to recognize that one solution that may work for the Black community may not work for other vulnerable or disadvantaged groups. As well, it is important to remember that there is considerable diversity in the Black community and thus there is a need to recognize that health issues may vary from area to area.

HAAC key informants cited the importance of attending to the social and economic determinants of health. The privileged status granted to the medical model of health over the population health model is a source of disadvantage for the Black population. This bias is evident in the kinds of information that is considered valid and "actionable" by the Board in its decision-making processes and in the lack of health related data on the Black community generally. The Board acknowledges that it lacks the capacity to attend to the broad determinants of health and that a lack of appropriate information is a significant impediment. Addressing the sources of illness that are rooted in the broad determinants of
health and institutionalized racism are complex problems and must be addressed through multiple approaches. In particular this requires new approaches to collecting information and fostering participation from other sectors, for example, government departments and social agencies concerned with housing, environment, education and so forth.

Systemic problems require systemic solutions and the CDHA, as a significant player in health care in Nova Scotia, can play a leading role in facilitating this dialogue. It is important to recognize that CDHA, is one organization among many that can have an impact on the health and well-being of African Nova Scotians. Thus the membership of any multi-sector forum for dialogue should include various groups or agencies that have a material interest (or influence) on the issue at hand.

One possible alternative in this regard is to try and address the social and economic determinants of health within the existing health care system as opposed to implementing a parallel system. This can be accomplished, for example, by increasing the profile of the CHBs, increasing their influence in the decision-making process, providing additional resources for data collection and building community partnerships and, developing processes for CHBs to hold the DHAs accountable for their action or inaction on CHB recommendations.

Finally, the governing board has the opportunity to establish organizational policy and set goals that can elevate the importance of being attentive to the health concerns of minority groups generally. In this regard there is an opportunity for the organization to develop policy initiatives that are specifically designed to address the problems of discrimination and racism within organizations such as affirmative action programs, diversity management programs, race relations officers, multicultural committees and patient navigators.
Having served as a CEO in a health organization I recognize that the challenges facing governing boards (and the health care system generally) as they contemplate their role in attending the health needs of African Nova Scotians and other minority groups are significant. Creating a health care system that is built on the principles of equity and justice requires a radically different approach to understanding and attending to health needs of vulnerable and minority populations than has existed in the past. While it is laudable that organizations like CDHA are making inroads into understanding and attending to health needs in the Black community these are relatively recent developments and there is still much work to be done. Building awareness, building relationships and seeking ways to engage the Black community in decision-making as proposed by CDHA organizational leaders and HAAC representatives are the foundational building blocks to move this agenda forward.

There is also a need to acknowledge that the entrenched hierarchical power structure that characterizes health care organizations is itself problematic and in need of reform. The political, social and professional elites that have historically dominated decision-making in health care continue to exert considerable influence in the allocation of resources. Because of this fact, and based on my own experience as a health system administrator, I believe that the decision to attend to the health needs of vulnerable populations should not be left to individual boards and their management staff to decide. Priorities differ among boards and what is considered a top priority for one may be of minimal importance to another, depending on the personal interests and values of board members and senior managers, in particular the CEO.

Unfortunately, in our health care system, it is easy to create the illusion of change without really making a difference in the lives of the people we are supposed to be serving. It
is for this reason that I recommend that an evaluation and accountability framework be imposed on the governing boards to ensure that their actions, as they pertain to serving the interests of minority and vulnerable populations, are measurable and effective. This is not an unreasonable demand. Increasingly, health organizations are required to demonstrate the effectiveness and efficacy of the services they provide (Cutt & Murray, 2000; McLaughlin & Kaluzny, 1999).

In this regard, there is a role for the provincial government to play by ensuring that vulnerable and minority populations have equitable access to culturally appropriate health services and holding boards publicly accountable for the delivery of those services. The decision to attend or not attend to the health needs of vulnerable or minority group health needs should not be left to the whim of individual boards.

The powerful social forces that privilege the medical model of care as the dominant approach to improving health status are difficult to overcome. Shifting emphasis to more of a population health approach and diverting appropriate resources to fulfil this goal is, and will continue to be, a source of conflict in the health system.

In this regard, there is a need to broaden public debate about the factors that influence health status in human populations and in particular how these determinants of health affect vulnerable populations. Much of the public debate on health care in Canada has been focused on the publicly funded medical and hospital systems. The health care system is a reflection of social values and to change social values there is a need to engage the public in an informed debate about health and how it is achieved. In Chapter One I stated that feminist ethics demands that policies and practices in society need to be examined to determine whether the practice in question maintains, exacerbates, or lessens existing patterns of oppression (Sherwin, 1992, 1996). Broadening public debate on the macro-
allocation of scarce resources to improve health status is essential to bringing about systemic change.

The provincial government can also play a significant role in mandating that DHAs identify and attend to the health concerns of minority or vulnerable groups. The DHA Act gives the Minister of Health the power to set overall health policy and thus the Minister can require that all DHAs identify appropriate vulnerable populations and allocate resources and attend to health needs among these groups. The process to identify which vulnerable groups require attention will require informed public debate and considerable planning to ensure the outcomes are effective. DHAs should not be left to initiate this process; past experience has demonstrated that the risk of inaction, and the dominance of, for example, the medical model in successfully lobbying for health care resources at the expense of other social or economic initiatives, is significant.

7.3 Other Vulnerable Groups

While efforts to improve service delivery to the Black community are encouraging, my research raises important questions regarding how DHAs identify and serve the health needs of minority or vulnerable populations generally. Much of this thesis has documented the challenges associated with understanding and attending to Nova Scotia's Black community.

The Black community in Capital Health is relatively large and visible compared to many other minority groups. Furthermore, the Black communities of North and East Preston, Cherrybrook and Lake Loon and even sections of North End Halifax are geographical areas where there are large concentrations of African Nova Scotians. This makes identifying African Nova Scotians as a social group relatively easy compared to other
social groups that may also have unique health needs, but who, for various reasons, may be "invisible" in their community.

The current configuration of the structures and processes of the DHAs and CHBs serves to create a situation where there are significant challenges in identifying and attending to more dispersed — yet equally vulnerable — social groups. In this regard I am suggesting that social groups such as the disabled, recent immigrants, the homeless, members of other racialized groups, First Nation peoples, and others who may be especially vulnerable (i.e. at a higher risk for adverse health outcomes) remain, for the most part, invisible to the formal health system in terms of identifying and attending to their specific group needs.

Furthermore, avenues taken to assess and attend to the health needs of African Nova Scotians may not be appropriate for assessing and attending to the needs of other groups, for example, the deaf community.

Governining boards face challenges identifying which social groups have special needs, collecting data or conducting research and, developing appropriate strategies to respond to those identified needs. In many cases it is likely that data and research may not exist and hence problems may remain invisible or unknown. While the health care system's attention on delivering "patient centred care" may enable the system to attend to an individual's needs upon arrival at an emergency room, or the doctor's office, the health system needs to do more to address the underlying social or economic determinants of health that often precipitate the need for care in the first instance. Explicit awareness of this problem, and an openness to concerns presented by any vulnerable group, is an important step in meeting the health needs of the entire catchment population.
7.4 Future Directions for Research

This research raises many questions that warrant further examination. To begin, there is a need to explore, identify and document health issues from the unique perspective of the Black community. This requires a concerted effort on the part of researchers, leaders in the Black community and the CDHA to examine the meaning of "health," in its broadest sense, explore ways to collect various kinds of data that can be utilized by the Board in its decision-making processes and determine the most effective means to address the issues identified. If there are diseases that are more prevalent – or more serious – in the African Nova Scotian community than in the non-Black population then appropriate epidemiological research should be conducted and culturally appropriate interventions initiated.

In feminist ethics sources of oppression are a significant point of interest and include gender, class, disability, sexual orientation and race. In this research I have not focused on gender-specific patterns of harm (nor those attached to class, disability, sexuality, etc.) but rather on "race" as a source of group oppression in the Black community. Gender, along with the other categories of oppression, and the various ways each is manifested in the Black community and in the work of governing boards as they attend to health needs among vulnerable populations represents other areas worthy of further exploration.

There is a need to explore the effectiveness of the various approaches to providing representation of vulnerable or disadvantaged social groups on governing boards or in the governance process. The research literature in this area is scant. Various models that are currently being used in other jurisdictions should be identified and evaluated.\textsuperscript{14}

There is merit in conducting ethnographic research into "boardroom culture" in healthcare and examining the unique relationship that exists between the Board and its management staff, in particular, the CEO. This includes the socialization (for example,
formal education and orientation) of Chief Executive Officers and trustees. There are increasing pressures on both managers and volunteer trustees in healthcare as the environment within which they function becomes increasingly politicized and volatile. The governance structures and the power relationship that exist between the Board and CEO significantly influence the outcomes of resource allocation decisions.

There is a growing demand for accountability for the expenditure of public funds. At the same time, however, there is a danger that decision-making in health care is increasingly being dominated by powerful lobby groups rather than informed public debate. As a result of historical imbalances in power structures in health care the concerns of many vulnerable groups remain unheard.

There is also a need to broaden the notion of accountability to include the responsibility for use of public funds to promote social justice. Moreover, governing boards in healthcare in Nova Scotia continue to operate in relative seclusion and out of view from public scrutiny and there are few venues for public participation in the decision-making process. In this regard there is an opportunity to examine various mechanisms to increase public involvement in decision-making in healthcare and evaluate, for example, the impact of open board meetings on the deliberative processes of governing boards or other measures that promote transparency (and accountability) of decision-making.

One of the key messages that I heard in the interview with HAAC representatives was the need to address systemic problems (social and economic determinants of health and racism) as a means to improve the health status of African Nova Scotians. In this regard there is an opportunity to engage in further research that examines the kinds of health, social and economic data that would inform the decision-making process of governing boards (and other organizations) as it pertains to the broad determinants of health. There is a need to
determine the kinds of community health data (and other kinds of community knowledge) that give insight into the non-medical determinants of health and how these features are manifested in oppressed and vulnerable groups.

Finally, there is an opportunity to conduct research into processes and research methods that assist in the identification of vulnerable populations, in particular those that are often "invisible" in our communities and how to attend to their unique or special health needs.

7.5 Conclusions

I conclude with an excerpt from one of the interviews with a representative from the Health Association of African Canadians. She is responding to my question: "If you could talk to the CEOs and Chairs of these Boards what would be your key messages that you would want to communicate?"

I would say listen, listen, listen. I would say work with the community around the determinants of health because those are the very real issues that attribute to many of the health concerns. I would say really seek to develop an understanding of the history and the current (circumstances). People tend to think that history is history of the past, and not the present conditions and the very real impact that that has on prevention and treatment of health issues in the Black community. (HAAC)

Throughout this thesis I have been concerned with examining the role of governing boards in health care as it pertains to attending to the health needs of African Nova Scotians, a historically oppressed social group. The primary objectives of this research have been to determine the effectiveness of regionalized health boards at identifying and responding to the health needs of African Nova Scotians and to identify hidden organizational practices that act as sources of board failure to attend to the health needs of African Nova Scotians. These practices include exclusionary features of membership on governing boards and
limited opportunities for the Black community to participate in decision-making, an ongoing tension within the organization as it attempts to implement two paradigms of improving health status, namely the dominance of the medical model of health and a lack of attention to the social and economic determinants of health, difficulties in understanding the nature and extent of health issues in the Black community because of a lack of personal knowledge of Black culture and, a lack of data and research. While the Board does not have unlimited authority, the governing board is vested with the power to set priorities, establish policy and, through various internal processes, allocate resources to meet identified health needs.

It is acknowledged that the Board lacks the capacity to control the broad determinants of health. However, the Board can do much to improve its own delivery of preventive, primary, acute and chronic care services to the Black community (and remove barriers to access) as a means of dealing with illness related concerns. Furthermore, the Board can explore innovative and creative ways to integrate a health perspective that incorporates social and economic determinants of health within the medical model of care. The Board can give a higher profile to the work of the CHBs and processes can be put in place to develop strategies to hold the DHAs accountable for their action or inaction on CHB recommendations.

The organization can also continue to develop policies that promote diversity and culturally appropriate approaches to providing health care. For example it can support an organization-wide diversity management program, conduct cultural impact analysis of all new policies and programs, promote research agendas that take into consideration the health needs of cultural minorities, and create opportunities to increase the number of individuals from other cultures to participate as trainees in health professional programs. Identifying sources of knowledge that are available from within the Black community and
collaboratively developing research agendas offer opportunities to inform the Board's
decision making in a manner that will serve to promote the interests of African Nova
Scotians.

Organizational responses attending to health concerns in the Black community is a
step in the right direction; it does, however, raise the question of whether and how DHAs
attend to the health needs of other, vulnerable social groups in society that are less visible.
Different social groups will likely have different needs and require different strategies to
attend to their needs. Lessons learned from focusing on the Black community in Capital
District will increase the organization's capacity to attend to the needs of other equally
worthy groups by helping Board members to understand the importance of attending to
social groups as well as individuals.

Being attentive to the health needs of African Nova Scotians need not be a case of
attending to their needs at the expense of the needs of others. Policy development with the
stated intention of promoting a more culturally diverse and culturally sensitive organization
has the potential to serve the interests of many disadvantaged social groups and assist the
Board in exploring new opportunities to fulfilling its mandate.

A feminist approach would resist a hierarchical approach to delivering services to the
Black community, but instead search for ways to work together with and empower the Black
community to address identified issues (Sherwin 1992). New relationships among many
players need to be forged so that the definition of "health" is expanded beyond the medical
model and to genuinely include the broad determinants of health. All parties can work
together to identify and remove organizational barriers to accessing culturally appropriate
care and to develop a research agenda that will identify and answer relevant questions for the
Black community and other vulnerable groups in Nova Scotia.
Appendix A

List of DHAs and CHBs

<table>
<thead>
<tr>
<th>DHA 1 — South Shore DHA</th>
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<tbody>
<tr>
<td>1 Lunenburg County CHB</td>
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<td>2 Queen CHB</td>
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<tr>
<th>DHA 2 — Southwest Nova DHA</th>
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<tbody>
<tr>
<td>3 Shelburne County CHB</td>
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<tr>
<td>4 Yarmouth County CHB</td>
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<tr>
<td>5 Clare CHB</td>
</tr>
<tr>
<td>6 Digby and Area CHB</td>
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<tr>
<th>DHA 3 — Valley District Health Authority</th>
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<tbody>
<tr>
<td>7 Central Kings CHB</td>
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<tr>
<td>8 Western Kings CHB</td>
</tr>
<tr>
<td>9 Kingston -Greenwood CHB</td>
</tr>
<tr>
<td>10 Annapolis CHB</td>
</tr>
<tr>
<td>11 Eastern Kings CHB</td>
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<tr>
<th>DHA 4 — Colchester East Hants DHA</th>
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<tr>
<td>12 North Shore and Areas CHB</td>
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<tr>
<td>13 South Colchester CHB</td>
</tr>
<tr>
<td>14 East Hants CHB</td>
</tr>
<tr>
<td>15 Along the Shore CHB</td>
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<tr>
<td>16 Truro and Area CHB</td>
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<tr>
<th>DHA 5 — Cumberland DHA</th>
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<tbody>
<tr>
<td>17 Springhill, Oxford, Amherst and Region CHB</td>
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<tr>
<td>18 Pugwash and Area CHB</td>
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<td>19 Southampton Parrsboro Advocate and Region CHB</td>
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<tr>
<th>DHA 6 — Pictou County DHA</th>
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<tbody>
<tr>
<td>20 Pictou West CHB</td>
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<tr>
<td>21 Central/East Pictou CHB</td>
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<tr>
<th>DHA 7 — Guysborough Antigonish Strait DHA</th>
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<tbody>
<tr>
<td>22 Antigonish Town and County CHB</td>
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<tr>
<td>23 Guysborough County CHB</td>
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<tr>
<td>24 Strait Richmond CHB</td>
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<th>DHA 8 — Cape Breton DHA</th>
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<tr>
<td>25 Central Inverness CHB</td>
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<tr>
<td>26 North Inverness CHB</td>
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<tr>
<td>27 Victoria County CHB</td>
</tr>
<tr>
<td>28 East Cape Breton CHB</td>
</tr>
<tr>
<td>29 Central Cape Breton CHB</td>
</tr>
<tr>
<td>30 Northside the Lakes CHB</td>
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<tr>
<th>DHA 9 — Capital District Health Authority</th>
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<tbody>
<tr>
<td>31 Southeastern CHB</td>
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<tr>
<td>32 Halifax Peninsula CHB</td>
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<tr>
<td>33 Eastern Shore Musquodoboit CHB</td>
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Appendix B: Letter of Introduction to DHAs: Demographic Survey

Chair of DHA/CHB
CEO

Re: Demographic Survey of Nova Scotia's DHAs and CHBs.

Dear

I am a Ph.D. student in the Interdisciplinary Ph.D. Program at Dalhousie University. For the ten years prior to returning to study at Dalhousie I worked as a CEO of a small community hospital and as a Regional Health Board CEO. It was during this time that I became interested in exploring how governing boards in health care consider and attend to the health needs of increasingly diverse populations. Governing Boards in Nova Scotia face many challenges and based on my experience one of the primary challenges is how to continue to meet the health needs of their catchment population within limited financial resources.

Nova Scotia has made great strides in seeking community input into decision-making through the work of the Community Health Boards. District Health Authorities and Community Health Boards, as partners in promoting health, play an important role in informing the government regarding the health needs of their community. I am interested in documenting the complex work of DHAs and CHBs as they seek to understand and attend to the health needs of their community.

The title of my Doctoral Research project is, "Exploring the Role of DHAs and CHBs: Attending to the Health Needs of African Nova Scotians". My research project is being conducted in two phases. In Phase One I will be conducting a demographic survey of Nova Scotia's DHAs and CHBs. The purpose of this survey is to develop a better understanding of the composition of health Boards in terms of the age, gender, educational background, employment status, ethnic background, etc. In Phase Two of the research I will be conducting a case study of the Capital District Health Authority to explore the ways that they are attempting to understand and address the health needs of the African Nova Scotian population.

...2
The purpose of this demographic survey is to provide an overview of who is currently serving as Board members on Nova Scotia's District Health Authorities and Community Health Boards. The survey will provide information about the following characteristics of participants: length of service on the Board, age, gender, ethnic and cultural background, educational attainment, marital status, annual income, number of dependents, work/employment status, and ability/disability status.

The survey will be sent to every District Health Authority and Community Health Board member in Nova Scotia (approximately 650 people). The survey can be completed in approximately 15 minutes. Other provinces in Canada have conducted similar surveys of their health boards. This is the first time that such a survey will be undertaken in Nova Scotia and the results may assist in understanding how we can address the health needs of minority populations.

**Who Can Participate in this Study?**

You may participate if you currently serve as a board member on one of Nova Scotia’s District Health Authorities or Community Health Boards.

You may not participate if you are: a Board member whose term has expired, a non-Board member of a District Health Authority or Community Health Board.

**Proposed Use of the Information You Provide**

The information you provide on this survey will be used for research purposes only and the information you provide will not be distributed or sold to anyone. The information you provide will be presented in summary form only and will not be presented in any way that may lead to the identification of any individual who has participated in the survey. The results of this survey will be used in the Doctoral Dissertation of Victor Maddalena and the results may also be presented in scholarly journals.

**Possible Harms and Discomforts**

Because the information you provide will be presented in such a way that no individual can be personally identified the risks of harm of taking part in the survey are minimal to non-existent. You may find some of the survey questions upsetting or distressing. You may not like all the questions that you will be asked. You do not have to answer those questions you find too distressing.

There is no guarantee you will benefit personally by taking part in this study. I hope that the results will be of interest to you and that the outcomes of the study may benefit the public by enhancing our knowledge about the composition District Health Authorities and Community Health Boards.

*Page Two*

*File Number CDHA-RS/2003-047*

*March 12, 2003*
Compensation

No costs will be charged to you for being in this study, nor will you be paid for participating in the study.

Confidentiality

The following provisions have been put in place regarding confidentiality:

- You will not be identified by name as a study participant in any reports or publications of this research.

- Your completed survey will be kept in a secure area such as a locked file cabinet. The data obtained from the survey will be collected, analyzed and stored in a secure computer. In this instance the term "secure" means that the computer will be stored in the office of the Researcher and the data files will be password protected. The stored data files will not be identified by name, but by a unique identifier number. The data will be stored for a period of five years from the date of the Researcher’s thesis defense.

- The data from the survey will be used in the preparation of the researcher’s Doctoral thesis. Only the Researcher and his academic supervisors at Dalhousie will have access to the data that you provide.

- You will notice that the survey is numbered at the top right hand corner of the first page. The purpose of this number is to permit the researcher to determine how many of the surveys that were sent out have been returned and will serve as a unique marker in the database. The unique identifier will also allow for the researcher to send follow-up notices to those who have not responded to the Survey. The list of participants and their unique identifier will be securely stored in a locked file cabinet separate from the data files.

Withdrawal from the Study

Your participation in this survey is voluntary. If you choose to participate and later decide to change your mind you are free to withdraw from the study at any time up until when the doctoral thesis has been prepared. If you wish to have your survey results removed from the study after you send in the survey please contact the researcher and makes your wishes known.
CONSENT FORM AND DEMOGRAPHIC SURVEY

Research Title:  Exploring the Role of District Health Authorities (DHAs) and Community Health Boards (CHBs): Attending to the Health Needs of African Nova Scotians

Instructions:

1. PLEASE READ AND SIGN THE CONSENT FORM
2. COMPLETE THE SURVEY
3. PLACE THE SIGNED CONSENT FORM (PAGE FIVE) AND SURVEY IN THE ENCLOSED ENVELOPE AND MAIL.
4. KEEP THE INFORMATION SHEET (PAGES ONE TO FOUR) FOR YOUR OWN RECORDS.

CONSENT:

I have read the explanation about this study. I am aware that I may contact the Researcher to answer any questions I may have about the study.

I understand that I can keep a copy of the Information Sheet /Consent Form for my own records.

I understand that my participation in this study is entirely voluntary and if I choose not to participate this will not affect my position as a District Health Authority or Community Health Board member. I also understand that I may choose not to answer some of the questions.

I hereby I consent to participate in the Demographic Survey.

Participant's Signature: ______________  Date: ______________

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Page Five
District Health Authority and Community Health Board
Demographic Survey

Survey Number: ____

Check only one of the following:

I am a member of District Health Authority (Circle the appropriate number)

1  2  3  4  5  6  7  8  9

OR

I am a member of __________________ CHB. (Write name of CHB).

1. How long have you been a DHA/CHB member?
   1. 0-6 months [  ]
   2. 7-12 months [  ]
   3. 13-18 months [  ]
   4. 19-24 months [  ]
   5. 24-30 months [  ]

2. How old are you?
   1. 0-35 years [  ]
   2. 36-45 years [  ]
   3. 46-55 years [  ]
   4. 56-65 years [  ]
   5. over 65 [  ]

3. Gender
   1. Male [  ]
   2. Female [  ]
4. **Ethnic/ Cultural Background (Check all that apply)**
   1. Caucasian [ ]
   2. First Nations [ ]
   3. Acadian [ ]
   4. East Indian [ ]
   5. Asian [ ]
   6. Black [ ]
   7. Other [ ] Specify: __________

5. **Highest Level of Education Attended or Completed**
   1. Elementary School [ ]
   2. High School [ ]
   3. Trade/Technical [ ]
   4. College [ ]
   5. Undergraduate University [ ]
   6. Graduate University [ ]

6. **Marital Status**
   1. Married [ ]
   2. Widow (er) [ ]
   3. Common-Law /Partnered [ ]
   4. Divorced [ ]
   5. Separated [ ]
   6. Single [ ]
7. **Total Household Annual Income (Before Taxes)**
   1. $0-$25,000
   2. $25,001-$50,000
   3. $50,001-$75,000
   4. $75,001-$100,000
   5. Greater than $100,000

8. **Do you do any paid work for your DHA or CHB?**
   1. Yes
   2. No

9. **Number of Dependents**
   1. [ ]
   2. [ ]
   3. [ ]
   4. [ ]
   5. [ ]
   6. [ ]
   More than 6 [ ]

10. **Work/Employment Status (Check all that apply)**
    1. Retired
    2. Full-time Employed
    3. Self-Employed
    4. Part-Time Employed
    5. Full-time Homemaker
    6. Part-time Homemaker
    7. Student
    8. Unemployed
    8. Other [ ] Describe: __________________________
10. In what field did/do you work?

1. Health care [ ]
2. Education [ ]
3. Business [ ]
4. Service Industry [ ]
5. Government [ ]
6. Home Maker [ ]
7. Other: ____________________

11. Do you have a disability?

1. No [ ]
2. Yes [ ] If yes, please describe: ____________________

End of Survey --

THANK YOU FOR YOUR PARTICIPATION. PLEASE PLACE SURVEY AND SIGNED CONSENT FORM IN THE ENCLOSED ENVELOPE AND MAIL.
Appendix F: Interview Guide – CDHA

Interview Topics/Questions

The interview format is intended to be informal and will last approximately one hour. The following are questions and general topic areas and are intended to serve as a framework for the interview sessions.

**Trustees**

**A) History of Involvement**

1. Tell me a bit about your involvement with CDHA. (For Trustees -- Include brief personal history, length of service on Board, Committee participation etc. For Senior Managers - nature of position currently held, major responsibilities, length of service, etc.)
2. What are some of the reasons why you wanted to serve as Trustee on CDHA?
3. What would "doing a good job" mean to you personally in relation to your work on the Board of CDHA?
4. Can you describe your involvement with community health organizations other than CDHA? For example have you served on other community boards prior to your involvement with CDHA?

**B) Identifying the Health Needs of Local Nova Scotians**

1. What do you see as the role of CDHA in meeting the health needs of your catchment population?
2. How does the CDHA acquire information about health in the local population? (e.g. local health status, population composition, health services offered)?
3. How does the CDHA seek input from the community concerning the health needs of its catchment population?
4. What about specific minority populations? Specifically, African Nova Scotians?
5. How are factors like the broad determinants of health (employment, education, cultural background, race, poverty) taken into account within the work of the CDHA?
6. Can you describe how the CDHA attempts to identify the health needs of minority or marginalized populations? Can you give examples?
7. I’m particularly interested in how community health boards assess and address the health needs of the African Nova Scotian community. How has the CDHA worked with the distinctive health needs of this community? (probe: how have African Nova Scotians been able to give input? Has this happened? Why/why not? To what effect? Examples?)
C) Policy Options to Increase Awareness and Inclusive Governance and Management Practices

8. What kinds of information and education do you think would be helpful for Trustees of CDHA to increase their awareness of the health needs of minority populations, such as African Nova Scotians? (examples?)

9. In what ways do you think DHAs could increase the involvement of the Black Community (or other marginalized communities) in health decision-making?

10. If you were advising the local Black community about how to best make their voices heard in health care decision-making, what would you tell them, from your perspective as a Trustee of the CDHA?

11. If you could reorganize the entire DHA system so it would better meet the needs of groups whose members are not usually 'at the table', what would you do?

12. Do you have anything else you'd like to raise in relation to the work of the CDHA and the possibilities for serving the health needs of African Nova Scotians, and other marginalized groups?

13. Are there questions that I didn't ask that you feel I should have asked regarding the way Boards assess and address the health needs of African Nova Scotians?

Senior Managers

A) History of Involvement

1. Can you describe your involvement with community health organizations other than CDHA?

2. Can you tell me a bit about your role as a Senior Manager with CDHA. For example, title, how long have you served in this position, major responsibilities, etc.

3. What is your involvement (past or present) with other community service organizations and this could include personal or professional involvement.

B) Identifying the Health Needs of Local Nova Scotians

4. What do you see as the role of CDHA in meeting the health needs of your catchment population?

5. How does the CDHA acquire information about health in the local population? (e.g. local health status, population composition, health services offered)? How do you personally educate yourself regarding these issues?

6. Can you describe some of the ways that you strive to assess the health needs of the catchment population?

7. What about specific minority populations? Specifically, African Nova Scotians?

8. One of the most difficult tasks facing health decision-makers these days is dealing with competing – often conflicting – demands for health care resources. How are factors like the broad determinants of health (employment, education, cultural background, race, poverty) taken into account within the work of the CDHA?

9. How does the CDHA seek the input of the community when it comes to health related issues?
10. Can you describe how the CDHA attempts to identify the health needs of minority or marginalized populations? Can you give examples? Do you feel these methods have been effective?

11. I'm particularly interested in how community health boards assess and address the health needs of the African Nova Scotian community. How has the CDHA worked with the distinctive health needs of this community? (probe: how have African Nova Scotians been able to give input? Has this happened? Why/why not? To what effect? Examples?)

C) Policy Options to Increase Awareness and Inclusive Governance and Management Practices

12. What kinds of information and education would be helpful for Trustees and Senior Managers of CDHA to increase awareness of the health needs of minority populations, such as African Nova Scotians? (examples?)

13. What kinds of processes do you think could increase the involvement of the Black Community (or other marginalized communities) in health decision-making through the DHAs?

14. If you were advising the local Black community about how to best make their voices heard in health care decision-making, what would you tell them, from your perspective as a Trustee of the CDHA?

15. If you could reorganize the entire DHA system so it would better meet the needs of groups whose voices are not usually ‘at the table’, what would you do?

16. Do you have anything else you’d like to raise in relation to the work of the CDHA and the possibilities for serving the health needs of African Nova Scotians, and other marginalized groups?

17. Are there questions that I didn’t ask that you feel I should have asked regarding the way Boards assess and address the health needs of African Nova Scotians?
Appendix G: Interview Guide – HAAC

Interview Topics/Questions
Health Association of African Canadians and North End Community Clinic

The interview format is intended to be informal and will last approximately one hour. The following are questions and general topic areas and are intended to serve as a framework for the interview sessions.

1. Describe your position and role with the organization.
2. Describe the history of your involvement in the health care system.
3. Describe your involvement with the Black Community in Capital Health District. (Omit this question for African Nova Scotians)
4. What do you perceive as the top health concerns and needs in the Black Community?
5. What kinds of services are currently in place to meet the health needs that you have identified? Examples?
6. What kinds of services need to be developed to meet identified health needs? Examples?
7. What avenues are open for the African Nova Scotian Community to engage in a dialogue with the health system? Examples?
8. How responsive have you found the District Health Authority system to be in meeting the needs of the African Nova Scotian community?
9. What avenues for communication / input do you think need to be developed between the African Nova Scotian Community and the health care system? Examples?
10. If you could talk to the Chairs and CEOs of all the District Health Authorities in Nova Scotia what would your key messages be regarding how to better access and meet the health needs of African Nova Scotians?
11. Is there anything else you would like to add in relation to the health needs of African Nova Scotians and the structures that govern health services administration?
Specifically, the research will attempt to answer the following questions:

- What initiatives has the CDHA implemented to assess and address the specific health needs and concerns of African Nova Scotians that reside in their catchment?
- What are the attitudes and understandings of trustees and management staff regarding issues of cultural diversity and what is their level of knowledge regarding the relationship between culture, race and ethnicity on the health of minority populations?
- What educational opportunities are available for trustees and management staff to increase their knowledge of the interrelationship among the determinants of health and how culture, race, and ethnicity impact on the health of minority populations?
- What procedural options are available to increase participation of members of African Nova Scotians in the decision-making processes of the CHDA? More specifically, how can CDHA modify their governance and management structures to ensure the needs of African Nova Scotians are considered in their decision-making processes?

Who Can Participate in This Study

You may take part in the study if you are currently a Board Member or Senior Manager (Vice-President or CEO) in the CDHA.

You may not participate if you are: a Board member whose term has expired or a manager below the level of Vice-President or CEO.

Study Design

The research project is being conducted in two phases. The first phase is a Demographic Survey of Nova Scotia's nine District Health Authorities and 34 Community Health Boards. The second phase of the research is a more in-depth case study of the Capital District Health Authority.

The majority of the research information for this portion of the study will be obtained through in-depth interviews with Board Members and Senior Managers associated with the Capital District Health Authority and who agree to participate in this study. A portion of the analysis will be obtained from an examination of Board and Committee meeting minutes, government documents, newspaper articles, academic literature and from the Researcher's field notes.

The interview data will be analyzed to identify, categorize and examine the responses of the participants to determine what are the beliefs, understandings and views of Board members and Senior Managers regarding the health needs and concerns of African Nova Scotians. The study will attempt to identify policy mechanisms and continuing education programs for Trustees and Senior Managers.

Page Two

File Number CDHA-RS/2003-047

March 12, 2003
About the Interview

If you agree to participate in this study you will be asked to participate in an interview that will last approximately one hour. You may also be asked to participate in a follow-up interview after the initial round of interviews. The interview questions are open-ended and the interview will be informal.

The interviews will be audio-taped. The reason for this is to permit the interviews to be transcribed into print for the purpose of analysis.

The interview can take place at a time and location that is convenient for you. If, after the interview is over, you wish to speak with the researcher and add to, or change, any of your responses you may do so.

After the data from the interviews has been compiled the Researcher will invite you to attend a Feedback/Briefing Session to hear a presentation of the initial results of the research. Following this Feedback/Briefing Session you will be given the opportunity to communicate your reactions privately to the Researcher either by phone, e-mail or a private meeting. Your participation or attendance at this session is voluntary.

Possible Harms and Discomforts

Because the information you provide will be presented in such a way that no individual can be personally identified the risks of harm of taking part in the interviews are minimal to non-existent. You may find some of the survey questions upsetting or distressing. You may not like all the questions that you will be asked. You do not have to answer those questions you find too distressing.

A potential risk of participating in this research is that information you may disclose could possibly affect your career interests or personal relationships. If at any time during the interview you reveal something that you feel should be held in confidence then you should make this clear to the researcher and those specific comments will not be published in any form.

There is no guarantee you will benefit personally by taking part in this study. I hope that the results will be of interest to you and that the outcomes of the study may benefit the public by enhancing our knowledge about how District Health Authorities can understand and attend to the health needs of African Nova Scotians. Also, the information gained from this research may be of value in attending to the health needs of other minority populations.
The Research Outcomes

The results of this research project, including the Demographic Profile of District Health Authorities and Community Health Board members and the Case Study of CDHA will be published as a Doctoral Dissertation and will be available to the public in the Dalhousie University Library and other libraries through inter-library loan. It is also my intention to publish the results in academic and professional journals and to present the outcomes of the research at academic Conferences.

Compensation

No costs will be charged to you for being in this study, nor will you be paid for participating in the study. The main cost to you is the time that you will take to participate in the interview.

Confidentiality

You will not be identified by name as a study participant in any reports or publications of this research. The interview tapes will be transcribed and the tapes will be destroyed. The transcripts from the interviews will be kept in a secure area such as a locked file cabinet for a period of five years following the defense of the doctoral thesis. Following this period the transcripts will be destroyed.

At any time during the interview if there is any private, confidential or sensitive information that you provide I ask that you state whether this information may be quoted or cited in the research report. If the information is sensitive or if you do not wish the information to be quoted, it will be considered during the analysis, but it will not be quoted or cited in the report.

There are a limited number of participants in this research study. For this reason it is not possible to guarantee anonymity in all instances. Insofar as it is possible I will attempt to present results and analysis in an aggregate form without information that will reveal your identity.

In the event your comments are quoted directly or in such a manner that will disclose your identity you will have an opportunity to read and approve any such suggested quotation prior to the publication of the thesis.

Withdrawal from the Study

Your participation in this survey is voluntary. If you choose to participate and later decide to change your mind you are free to withdraw from the study at any time up until when the doctoral thesis has been prepared.
Research Title: Exploring the Role of District Health Authorities (DHAs) and Community Health Boards (CHBs): Attending to the Health Needs of African Nova Scotians

CONSENT:

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to satisfaction.

I understand that I can keep a copy of the Information Sheet and Consent Form for my own records.

I understand that my participation in this study is entirely voluntary and if I choose not to participate this will not affect my position as a Board member or Senior Manager in CDHA.

I also understand that I may choose not to answer some of the questions. I may withdraw from the interview at any time.

I hereby consent to participate in this study.

Participant’s Name: ________________ (print)

Participant’s Signature: ________________ Date: ________________

Signature of Witness ________________ Date: ________________

Signature of Researcher ________________ Date: ________________

Signature of Person Conducting Consent Discussion ________________ Date: ______
Specifically, the research will attempt to answer the following questions:

- What initiatives has the CDHA implemented to assess and address the specific health needs and concerns of African Nova Scotians that reside in their catchment?
- What are the attitudes and understandings of trustees and management staff regarding issues of cultural diversity and what is their level of knowledge regarding the relationship between culture, race and ethnicity on the health of minority populations?
- What educational opportunities are available for trustees and management staff to increase their knowledge of the interrelationship among the determinants of health and how culture, race, and ethnicity impact on the health of minority populations?
- What procedural options are available to increase participation of members of African Nova Scotians in the decision-making processes of the CHDA? More specifically, how can CDHA modify their governance and management structures to ensure the needs of African Nova Scotians are considered in their decision-making processes?

**Who Can Participate in This Study**

For this phase of the research you may take part in the study if you are a member of the Health Association of African Canadians or a member of staff or the Board at the North End Community Clinic.

You may not participate if you are not a member of the Health Association of African Canadians or the North End Community Clinic.

The purpose of these interviews is to:

a. Seek first-hand information regarding the perceptions of health problems that are specific to the African Nova Scotian community;

b. Determine if there are service needs that are not being met by the existing health care system from the perspective of those who work closely with African Nova Scotian health issues;

c. Determine the level and types of input from the Black Community that currently exist in the health system; and,

d. Determine if there are perceived barriers -- formal or informal -- that inhibit the participation of the Black Community in representing their health needs to the CDHA.

**Study Design**

The research project is being conducted in two phases. The first phase is a Demographic Survey of Nova Scotia's nine District Health Authorities and 34 Community Health Boards. The second phase of the research is a more in-depth case study of the Capital District Health Authority.
The majority of the research information for this portion of the study will be obtained through in-depth interviews with Board Members and Senior Managers associated with the Capital District Health Authority and who agree to participate in this study. A portion of the analysis will be obtained from an examination of Board and Committee meeting minutes, government documents, newspaper articles, academic literature and from the Researcher's field notes.

The interview data will be analyzed to identify, categorize and examine the responses of the participants to determine what are the beliefs, understandings and views of Board members and Senior Managers regarding the health needs and concerns of African Nova Scotians. The study will attempt to identify policy mechanisms and continuing education programs for Trustees and Senior Managers.

In addition, Key Informant interviews will be conducted with representatives from the Health Association of African Canadians and the North end Community Clinic to seek first-hand information regarding the perceptions of health problems that are specific to the Black community.

**About the Interview**

If you agree to participate in this study you will be asked to participate in an interview that will last approximately one hour. You may also be asked to participate in a follow-up interview after the initial round of interviews. The interview questions are open-ended and the interview will be informal.

The interviews will be audio-taped. The reason for this is to permit the interviews to be transcribed into print for the purpose of analysis.

The interview can take place at a time and location that is convenient for you. If, after the interview is over, you wish to speak with the researcher and add to, or change, any of your responses you may do so.

After the data from the interviews has been compiled the Researcher will invite you to attend a Feedback/Briefing Session to hear a presentation of the initial results of the research. Following this Feedback/Briefing Session you will be given the opportunity to communicate your reactions privately to the Researcher either by phone, e-mail or a private meeting. Your participation or attendance at this session is voluntary.

**Possible Harms and Discomforts**

Because the information you provide will be presented in such a way that no individual can be personally identified the risks of harm of taking part in the interviews are minimal to non-existent. You may find some of the survey questions upsetting or distressing. You may not
like all the questions that you will be asked. You do not have to answer those questions you find too distressing.

A potential risk of participating in this research is that information you may disclose could possibly affect your career interests or personal relationships. If at any time during the interview you reveal something that you feel should be held in confidence then you should make this clear to the researcher and those specific comments will not be published in any form.

There is no guarantee you will benefit personally by taking part in this study. I hope that the results will be of interest to you and that the outcomes of the study may benefit the public by enhancing our knowledge about how District Health Authorities can understand and attend to the health needs of African Nova Scotians. Also, the information gained from this research may be of value in attending to the health needs of other minority populations.

The Research Outcomes

The results of this research project, including the Demographic Profile of District Health Authorities and Community Health Board members and the Case Study of CDHA will be published as a Doctoral Dissertation and will be available to the public in the Dalhousie University Library and other libraries through inter-library loan. It is also my intention to publish the results in academic and professional journals and to present the outcomes of the research at academic conferences.

Compensation

No costs will be charged to you for being in this study, nor will you be paid for participating in the study. The main cost to you is the time that you will take to participate in the interview.

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You will not be identified by name as a study participant in any reports or publications of this research. The interview tapes will be transcribed and the tapes will be destroyed. The transcripts from the interviews will be kept in a secure area such as a locked file cabinet for a period of five years following the defense of the doctoral thesis. Following this period the transcripts will be destroyed.

At any time during the interview if there is any private, confidential or sensitive information that you provide I ask that you state whether this information may be quoted or cited in the research report. If the information is sensitive or if you do not wish the information to be quoted, it will be considered during the analysis, but it will not be quoted or cited in the report.
Research Title: Exploring the Role of District Health Authorities (DHAs) and Community Health Boards (CHBs): Attending to the Health Needs of African Nova Scotians

CONSENT:

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to satisfaction.

I understand that I can keep a copy of the Information Sheet and Consent Form for my own records.

I understand that my participation in this study is entirely voluntary and if I choose not to participate this will not affect my position as a member of the Health Association of African Canadians or the North End Community Clinic.

I also understand that I may choose not to answer some of the questions. I may withdraw from the interview at any time.

I hereby consent to participate in this study.

Participant's Name: ________________ (print)

Participant's Signature: ________________ Date: ________________

Signature of Witness ________________ Date: ________________

Signature of Researcher ________________ Date: ________________

Signature of Person Conducting Consent Discussion ________________ Date: ______

Page Six
File Number CDHA-RS/2003-047
June 16, 2003
Appendix L: Demographic Survey – Results

Table One
Length of Service of Board Members
District Health Authorities and Community Health Boards

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>District Health Authorities Members</th>
<th>Community Health Boards Members</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
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</tr>
<tr>
<td>0-6 months</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>7-12 months</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>13-18 months</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>19-24 months</td>
<td>10</td>
<td>14.3</td>
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<tr>
<td>24-30 months</td>
<td>51</td>
<td>72.9</td>
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<tr>
<td>Total</td>
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Table Two
Age of Board Members
District Health Authorities and Community Health Boards

<table>
<thead>
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<th>District Health Authorities</th>
<th>Community Health Boards</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0-35 years</td>
<td>5</td>
<td>7.1</td>
</tr>
<tr>
<td>36-45 years</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>46-55 years</td>
<td>14</td>
<td>20.0</td>
</tr>
<tr>
<td>56-65 years</td>
<td>32</td>
<td>45.7</td>
</tr>
<tr>
<td>Over 65 years</td>
<td>15</td>
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<tr>
<td>Total</td>
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Table Three
Gender
District Health Authorities and Community Health Boards

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<th>District Health Authorities</th>
<th>Community Health Boards</th>
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<tr>
<td></td>
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<tr>
<td>Male</td>
<td>43</td>
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<tr>
<td>Female</td>
<td>27</td>
<td>38.6</td>
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<td>Total</td>
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<td>100%</td>
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Table Four
Ethnic/Cultural Background
District Health Authorities and Community Health Boards

<table>
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<th>Ethnic/Cultural</th>
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<th>DHA</th>
<th>CHB</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
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<tr>
<td>Caucasian</td>
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<td>68</td>
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<tr>
<td>First Nations</td>
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<td>0</td>
<td>0</td>
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<td>Acadian</td>
<td>14</td>
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<td>East Indian</td>
<td>4</td>
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<td>0</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0.32</td>
<td>0</td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
<td>0.32</td>
<td>1</td>
</tr>
<tr>
<td>Multiple</td>
<td>7</td>
<td>2.3</td>
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<td>Total</td>
<td>311</td>
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Table Five
Highest level of Education Attended or Completed
District Health Authorities and Community Health Boards

<table>
<thead>
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<th>Education</th>
<th>DHA &amp; CHB</th>
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<th>CHB</th>
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<td></td>
<td>N</td>
<td>%</td>
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<tr>
<td>Elementary</td>
<td>3</td>
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<tr>
<td>High School</td>
<td>30</td>
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<tr>
<td>Trade/Tech.</td>
<td>38</td>
<td>12.1</td>
<td>8</td>
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<tr>
<td>College</td>
<td>40</td>
<td>12.8</td>
<td>6</td>
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<td>Grad. Univ.</td>
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Table Six
Marital Status
District Health Authorities and Community Health Boards

<table>
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<th>CHB</th>
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<td></td>
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<td>%</td>
<td>N</td>
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<tr>
<td>Married</td>
<td>241</td>
<td>77</td>
<td>57</td>
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<tr>
<td>Widow/er</td>
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<td>4</td>
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<tr>
<td>Common Law/Partnered</td>
<td>11</td>
<td>3.5</td>
<td>3</td>
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<tr>
<td>Divorced</td>
<td>20</td>
<td>6.4</td>
<td>2</td>
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<tr>
<td>Separated</td>
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<td>Single</td>
<td>23</td>
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<td>4</td>
</tr>
<tr>
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Table Seven
Total Household Income Before Taxes
District Health Authorities and Community Health Boards

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<th>CHB</th>
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<tr>
<td></td>
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<td>$0 - $25,000</td>
<td>29</td>
<td>10.2</td>
<td>1</td>
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<td>$25,001 - $50,000</td>
<td>79</td>
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<td>11</td>
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<td>76</td>
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<td>18</td>
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Table Eight
Work Employment Status
District Health Authorities and Community Health Boards

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<th>CHB</th>
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<td></td>
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<tr>
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<td>Full-Time Employed</td>
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<td>36.7</td>
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<tr>
<td>Self-Employed</td>
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<td>Part-Time Employed</td>
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<td>2</td>
</tr>
<tr>
<td>Full-Time Homemaker</td>
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<tr>
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<td>0.3</td>
<td>0</td>
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<tr>
<td>Student</td>
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<td>1.6</td>
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### Table Nine

Field of Work

District Health Authorities and Community Health Boards

<table>
<thead>
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<th>Field of Work</th>
<th>DHA/CHB</th>
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<td>%</td>
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<td>Education</td>
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<td>Government</td>
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<td>Other</td>
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<tr>
<td><strong>Total</strong></td>
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### Table Ten

Disabilities

District Health Authorities and Community Health Boards

<table>
<thead>
<tr>
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<td><strong>Total</strong></td>
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Endnotes

1 For the purposes of this thesis the terms "African Nova Scotian", "African Canadian" and "Black" will be used interchangeably.

2 E-mail correspondence with E. Mykhalovskiy.

3 In 1960 there were still seven formal Black school districts and three exclusively Black schools in Nova Scotia (BLAC 1994).

4 Source: www.cbc.ca/news/features/africville.html

5 (http://www.tbs-sct.gc.ca/rma/account/oagts02_e.asp#Principles)

6 Health Authorities Act 2000, Sec. 13(2)(a)(iii).


8 In this thesis I use the definition of Visible Minorities that is used in the 2001 Census. Census 2001 defines Visible Minorities as those individuals who self-identify as "...persons, other than Aboriginal people, who are non-Caucasian in race or non-white in colour". Source: http://www12.statcan.ca/english/census01/Products/Reference/dict/pop127.htm

9 Source: Correspondence from Finance Department, CDHA.


11 In this thesis I use the term "diversity management" to describe programs that assist organizations to promote employment equity. "Diversity management" is a term widely used in administration and generally refers to "the systemic and planned commitment by organizations to recruit, retain, reward, and promote a heterogeneous mix of employees" (Ivancevich & Gilbert, 2000, p. 75). I acknowledge that this is another term where the language is problematic. The term implies that diversity is something that needs to be "managed" rather than viewing diversity management as an opportunity to embrace the benefits that accrue to the organization by fostering a diverse workforce.

12 The Clinic provides the services of a full-time Registered Nurse funded by CDHA and a local physician who had been providing care in the community out of another location provides 3 hours of care in the clinic per week. Other services provided through the clinic include public health services, mental health and addictions. A Community Advisory Committee has been established with representation from the community and CDHA to oversee future development of the clinic. Long term, sustainable funding for the clinic services is currently under review. The "grand opening" of the clinic was scheduled for January 2005.

13 Source: Correspondence with Department of Finance, CDHA.