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Authority Migration and Accountability in Canadian Type II Multilevel Governance

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Abstract

In advanced industrial democracies, including Canada, elections act as important mechanisms of democratic accountability. However, the migration of public decision-making responsibility away from elected representatives and toward new governance models may alter accountability relationships. As authority is dispersed horizontally to new governance actors that exist beyond the reach of the ballot box, questions of public input and accountability within the democratic governance process arise.

The objectives of the dissertation are: 1) to evaluate the extent to which Canadian provinces have opted to migrate decision-making authority horizontally in response to policy issues and why; and 2) to evaluate the existence and relative strength of the accountability relationships that emerge between new governance actors and both government and society once authority has migrated. It is hypothesized that period in time, political ideology, and government fiscal capacity are predictors of authority migration as a policy tool. Like wise, it is hypothesized that period in time, political ideology, and the geographic scale of the new governance jurisdictions, are predictors of the strength of both government and societal accountability relationships.

To test the hypotheses, both quantitative and qualitative approaches are utilized. First, the incidence of decision-making authority migration and strength of accountability relationships are evaluated using regression analysis. This analysis considers these relationships using an original dataset of cases of horizontal authority migration in the provinces of Alberta, British Columbia, Nova Scotia and Ontario, between the years of 1946 and 2005. Second, case studies and qualitative interviews are leveraged to gain greater contextual understanding of the causes and implications of migration of decision-making authority to regional healthcare bodies in the provinces selected.

While horizontal governance arrangements may raise questions over public input and accountability, findings support the hypothesis that their use is not new having existed for the entire post-war period. Furthermore, while the accountability relationship between government and new governance actors has remained dominant, the accountability relationship with society is strengthening as predicted. Perception of accountability

relationships by interviewees, however, suggests that a lack of clarity in decision-making responsibility has weakened the ability for citizens to hold decision-makers accountable.

Keywords

Accountability, Multilevel Governance, Type II Multilevel Governance, Authority Migration, Democratic Accountability, Public Accountability, Democracy.

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Table of Contents

List of Tables

List of Figures

List of Appendices

Chapter 1

1 Introduction: The Migration of Authority

On December 27th 2009 Reilly Anzovino died as the ambulance carrying her reached the Welland hospital. Anzovino was taken to the Welland hospital, approximately twenty kilometers from the scene of the car accident that caused her injuries. The Fort Erie Douglas Memorial hospital, which was only five kilometers from the accident scene, had recently had its emergency room closed (Hamilton Spectator, 2010).

The decision to close the emergency room in Fort Erie was made by the Haldimand Brant Local Health Integration Network (HNHM LHIN). The HNHB HLIN is one of fourteen not-for-profit corporations in Ontario that work with local health providers and community members to determine the health service priorities for their regions. The Local Health Integration Networks were created in 2006 with the stated purpose of planning, integrating, and funding local health services, including: Hospitals, Community Care Access Centres, Community Support Services, Long-term Care, Mental Health and Addictions Services and Community Health Centres (Ontario Local Health Integration Network, 2006). At its January 27th 2009 meeting the HNHB LHIN passed a motion requiring the Niagara Health System to make changes at its hospital site in Fort Erie. Among the changes was the order to close the emergency room at the Fort Erie Douglas Memorial hospital (Hamilton Niagara Haldimand Brant LHIN, 2009).

Like many public policy decisions, the decision to close the emergency room at the Fort Erie Douglas Memorial hospital was made neither by an elected representative nor by a member of the public service for whom our elective representatives are accountable. Instead a not-for-profit corporation to which the Ontario government migrated decision-making authority over fundamental aspects of the Ontario public healthcare system made the decision. Using the language of multilevel governance, decision-making responsibility had shifted horizontally from a general-purpose jurisdiction, the province of Ontario, to a task-specific jurisdiction, the HNHB LHIN. It is in this environment, where actors from outside of traditional government are engaged in the act of public

governance, that this research is focused. As public decision-making authority migrates beyond the traditional confines of government, questions must be asked as to the resulting implications for public input and democratic accountability. How are such decision-makers held accountable for their actions?

In assessing the implication of authority migration for democratic accountability the proceeding chapters focus on the following: 1) the extent to which Canadian provinces have opted to migrate decision-making authority horizontally in response to policy issues and what factors explain the migration of authority; and 2) the existence and relative strength of the accountability relationships that emerge once authority has been migrated, especially the accountability relationship between the new governance actors and both government and society. In other words, how often is decision-making authority migrated and why? When authority is migrated, who are the new decision-makers accountable to? And, how strong are the new accountability relationships? Expressed in terms of the decision to close of the emergency room at the Fort Erie Douglas Memorial hospital, the questions being asked would be: 1) What factors explain the migration of healthcare decision-making authority? And 2) How can citizens hold LHINs accountable for the decisions made that shape public healthcare within their community?

1.1 Authority Migration and the Changing Face of Governance

As stated by David Adamany in his introduction to 1975 edition of Schattschneier's *The Semisovereign People,* the most legitimate question for political scientists in a democracy is how can the people control government (Adamany, 1975: xiii). In the case of authority migration, the question can be expanded to how can the people control the range of actors engaged in the governance process. As the governance structure has changed, what is the effect on the ability of citizens to hold decision-makers accountable?

While the word governance has become omnipresent, it remains a contested term with people ascribing varied meanings to the concept of governance based upon their own theories and values (Bevir, 2010: 1-2; Pierre and Peters, 2005: 1; Torfing, et al., 2012: 2). The interest in governance reflects concerns over how to understand the changing role of

public leadership and the changing institutional and social patterns in society (Torfing, et al., 2012: 2). As a concept, governance is not constant, but shifts in step with changes in the needs and values of society (Pierre and Peters, 2005: 49). At one time governance simply referred to statecraft, or the exercise of governmental responsibility (Stivers, 2008: 5), however, as societal needs and values changed, the meaning of governance has changed to include a broader range of actors in the governance process. The current use of government and governance now convey different meanings and can no longer be used interchangeably (Hughs, 2010: 89; Rhodes, 1997: 46). The modern conceptualization of governance can be broadly defined as collective problem solving in the public realm (Caporaso, 1996: 32). Another account suggests that governance is the pursuit of collective interests and the steering and coordination of society (Peters and Pierre, 2006: 209). Bell and Hindmoor provide a more fleshed out definition, defining governance as shaping, regulating, or attempting to control human behaviour in order to achieve collective ends (2009: 2).

While for the majority of the past three centuries we have associated the act of governance with the state and a dominant pattern of hierarchical governing in which governments decide the laws and policies to be adopted, this traditional view of governance is being challenged as networks and other social actors seek greater autonomy (Peters and Pierre, 2006: 209-210). Challenges to the traditional structure of governance have also emerged in the form of high demand for governance. The demand for governance has expanded beyond the capacity of the state to the point where governance requirements cannot be fulfilled without widespread delegation (Flinders, 2006: 223). The result is an increased interest in partnerships between government and societal actors and the dispersal of political authority across multiple layers (Peters and Pierre, 2006: 209). The state is no longer seen to monopolize the governance process, and governments are now subject to negotiations with a wide range of public, semi-public, and private actors when engaged in policy formation (Sørensen and Torfing, 2007: 3-4). This dispersal of authority has reshaped the governance landscape and brought about questions of democratic input and accountability within the governance process (Peters and Pierre, 2006: 209).

At the heart of the question over public input and democratic accountability is the movement of decision-making out of the hands of elected representatives. A central premise of democracy is that decision-makers are legitimate and accountable. In the democratic tradition the election process has fulfilled these roles at it provides a mechanism by which to identify the legitimate representatives of the people and a means through which to hold the same representatives accountable. As stated by James Fearon, in elections have been seen as an important mechanism of accountability through which the policy preferences of the citizens can induce government action (1999: 57). However, the new forms of governance that have emerged as decision-making authority has been migrated rarely call for the popular election of board members and decision-makers. In the absence of elections, it is essential to examine whether mechanisms are being put in place to ensure the continued legitimacy and accountability of decision-makers.

When authority migrates beyond the boundaries of elected government, the nature of the ensuing accountability relationships must be considered. In the chapters that follow two potential accountability relationships are investigated: 1) the relationship with government through which government holds decision-makers directly accountable and citizens hold decision-makers indirectly accountable through government; and 2) the relationship with society in which citizens hold decision-makers directly accountable. In addition to the two possible accountability relationships, a third outcome exists where decision-makers are neither accountable to government nor citizens. Through the evaluation of both potential accountability relationships a better understanding can be gained of if and how decision-makers that exist outside of traditional government are held accountable.

Up until now, the goal of this chapter has been to provide context and to instill a sense of importance in studying the migration of decision-making authority away from elected our elected representatives. In the next section the focus shifts to outlining each of the following chapters and how each of the two accountability relationships discussed above are evaluated using both qualitative and quantitative means.

1.2 Assessing the Migration of Authority and Accountability: A Chapter Outline

In investigating the changes in the governance environment and the implications for democratic accountability, this research project assesses both the extent to which governments have opted to migrate authority and the subsequent accountability relations that emerge. To accomplish these ends instances of authority migration in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946 and 2005 are considered. Provincial politics was selected as it provides a larger sample sizes than using national level data alone. The specific provinces were selected based on regional diversity and political ideology. The sixty-year timeframe was selected as it provided an observation window that began with the emergence of Keynesianism after World War II and continuing through the shift to neoliberalism.

The necessary theoretical constructs that underpin this research endeavour are put forward in Chapter 2. Using the construct of multilevel governance, authority migration and the potential accountability relationships are discussed. The concept of accountability is then elaborated upon, followed by the challenges to accountability that authority migration is seen to cause. Chapter 2 concludes with a preview of the hypotheses to be discussed and evaluated in subsequent chapters.

Chapter 3 provides a detailed description of the methodology and the data used throughout the research project, including the rational for the timeframe, provinces, and specific case studies selected for study. Moreover, as the project realizes upon datasets compiled specifically for the purpose of this study, Chapter 3 provides a detailed account of the compilation criteria and process. The methodology used to conduct both large-n quantitative analysis and the ensuing case studies is also discussed in Chapter 3.

In Chapter 4 the ‘newness’ of authority migration and the ensuing governance arrangements are first evaluated. Taking a historical perspective, the rate at which the provincial government of Alberta, British Columbia, Nova Scotia, and Ontario migrate authority is evaluated across time. If authority migration is a recent trend, then the rate of authority migration should increase over time. If authority migration is nothing new,

however, and what is being witnessed is the accumulation of decisions to migrate authority then the rate of authority migration should remain relatively stable, while the number of decision-making bodies that exist beyond the confines of the traditional state should increase.

Beyond the newness of authority migration, Chapter 4 explores two hypotheses regarding the rate of authority migration. First, that as the capacity of government to respond to policy demands decreases the rate at which authority is migrated increases. Second, that governments further to the left on the political spectrum will be less likely to migrate authority than governments on the right. In Chapter 4 a quantitative approach is employed, which uses both descriptive statistics and regression analysis.

While Chapter 4 assesses the extent to which authority has migrated, Chapter 5 assesses the strength of the subsequent accountability relationships. To do so a quantitative approach is again used. A dataset containing all cases of authority migration in the provinces of Alberta, British Columbia, Nova Scotia and Ontario between the years of 1946 and 2005 is again used. For all cases, the accountability relationship with both government and society is coded based upon Mark Bovens's definition of accountability, which states that "accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences" (2007: 450).

In Chapter 5 the effect of time, political ideology and the geographic scale on the strength of the accountability relationship between both Type II bodies and government and society are tested. In evaluating the effect of political ideology it is expected that governments further to the left will build stronger accountability relationships with government than governments further to the right. When considering accountability relationships over time, Chapter 5 assesses whether the accountability relationships, both with government, and society, have been strengthening or weakening over time. Lastly, Chapter 5 explorers the effect of geographic size as the strength of each accountability relationships is compared across jurisdictions that are municipal, regional, provincial, or interprovincial in size.

Having looked at the universe of cases of authority migrating in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946-2005, attention in Chapter 6 is turned to the migration of authority in a specific policy area – healthcare. Building on the results of previous chapters, Chapter 6 explores the process by which each of the four provinces legislated the migration of authority and the creation of health authorities in their health care systems. To continue to develop an understanding of why authority migrates, both the fiscal capacity and political ideology hypotheses put forward in Chapter 4 are evaluated against the migration of authority in the four health care systems. Moreover, additional factors that influenced the decision to migrate authority in each of the four cases are sought, such as increased capacity for citizen participation, through the exploration of how the changes in the healthcare system were framed.

Beyond examining the factors that led to the migration of authority, Chapter 6 looks at the consistency of the framing of the policy problem and solution with the eventual policy outcomes. In doing so both the initial migration of authority and the subsequent changes to the governance structure are considered.

Chapter 7 investigates the existence and functioning of the accountability relationships that emerged with creation of health authorities. An initial overview of the formal accountability mechanisms put in place by government through legislation and regulation as well as the accountability initiatives put in place by the health authorities are provided. Moving from how the accountability relationships appear on paper to how they are perceived in practice, interview responses from members of the health authorities, provincial public service employees, elected representatives, and members of interest groups active in the health care field are then assessed. In evaluating the accountability relationship between the provincial health authorities and both government and society, Chapter 7 considers the hypotheses put forward in Chapter 5. However, the main focus is on how the accountability of the health authorities is perceived. Interviews are used to gain greater understanding of whom regional health authorities are seen to be accountable to and whether the existing accountability structures are believed to be effective.

1.3 Implications

Through the use of both quantitative and qualitative approaches this research responds to concerns that the migration of authority outside of traditional government weakens the accountability relationships between the people and those who make decisions on their behalf. Significant academic literature exists on the vertical migration of authority to different levels of elected government and the migration of authority upward to the international sphere as a result of globalization. This project instead focuses on the understudied horizontal migration of authority outward from government toward special purpose bodies. The key contributions of this research are the illumination of the accountability relationships that emerge once decision-making authority shifts beyond the immediate responsibility of our elected representatives, and the relative effectiveness of these relationships.

In Democratic theory, elections have been an important mechanism of accountability through which the policy preferences of the citizens can induce government action (Fearon, 1999: 57). The migration of decision-making responsibility outside the boundaries of elected governments, however, necessitates a different conceptualization of accountability relationships. When decision-making authority is granted to an unelected body, what are the channels and processes available to citizens to hold decision-makers accountable? Through the evaluation of the existence and strength of accountability relationships between decision-makers, such as the HNHB LHIN, and both government and society, an understanding of if and how these decision-makers are held accountable can be gained.

Linked to concerns over accountability is the extent to which authority is migrated. The greater the tendency of government to resolve public policy issues through authority migration, the greater the implications for any associated loss of accountability. Through studying both the propensity for governments to migrate authority and the viability of resulting accountability relationships, both the validity of accountability concerns and risk to democratic accountability presented by the volume of instances of authority migration can be addressed.

Overall, in assessing both the frequency and the effect on democratic accountability of having decision-making authority migrated horizontally to special purpose bodies this research fills significant gaps in the academic literature on two levels. First, by focusing on the horizontal migration of authority at the provincial level, the research explores an area of authority migration that while common in practice is understudied in the academic literature. Second, backed by empirical findings, this research contributes to our broader understanding of roles and abilities that both government and citizens play in holding decision-makers accountable.

Chapter 2

2 Theoretical Background: Migration of Authority, Multilevel Governance, and Accountability

At its core, democracy can be described as self-governance though collective decision and action (Cohen and Sabel, 1997: 317; Warren, 2011: 687). The structure of representative democracy has remained relatively constant during the last two centuries: rulers are elected by citizens, citizens are free to discuss and demand at all times, but can give no legally binding instructions, and rulers are subject to periodic reelection (Manin, Przeworski and Stokes, 1999: 3). Within the structure of representative democracy, the dominant pattern of governance has been hierarchical, where government decides the laws and policies to be adopted (Peters and Pierre, 2006: 209).

While the structure of representative democracy has remained relatively constant, the traditional pattern of governance has been challenged (Peters and Pierre, 2006: 209). An increasing number of public and private actors now have an effect on how society is governed (Sørensen, 2006: 98). Government has become just one of many actors, resulting in policy areas becoming more crowded and contested and the boundary between public and private less precise (Kennett, 2010: 20). New governance arrangements have emerged that do not align with conventional government hierarchy and new actors in public governance may operate autonomously from the dictates of legislatures and public agencies (Cohen and Sabel, 1997: 316). As stated in the November 1999 report by the Auditor General of Canada, changes have occurred in how we are governed with some policy initiatives moving beyond traditional forms of governance as responsibility is shifted to entities outside of government (1999: 23-27).

The transformation in public governance has been met with both optimism and concern. From a positive perspective, the migration of authority to special purpose bodies holds the potential for more responsive governance than a single area-wide political monopoly (Bollens, 1986: 119; Lowndes and Wilson, 2001: 633). The migration of authority to task specific bodies may allow greater efforts and resources to be effectively concentrated on specific problems than would otherwise be the case (Andrew and Goldsmith, 1998: 107).

Moreover, expanding the number of decision-making bodies in the public realm may also increase the opportunity for public participation in the decision-making process (Lowndes and Wilson, 2001: 633; Sørensen, 2006: 104). Government may even find that the use of nongovernmental actors in certain circumstances is better suited to achieving the state's goals than government itself (Peters and Pierre, 1998: 226; Bell and Hindmoor, 2009: 99).

From a critical perspective, the transformation of the role of government in governance has been seen to undermine representative democracy. The legitimacy of representative democracy is threatened as elected governments struggle to direct the policy process (Bevir, 2010: 2). The dispersal of authority away from government can limit the ability of politicians to translate the public's demands into effective political action (Andrew and Goldsmith, 1998: 104; Peters, 2004: 132) as well as weaken legitimacy and create disillusionment with the political process (Andrew and Goldsmith, 1998: 104). The potential also exists that public accountability will be lost as decision-making is removed from the political arena (Bollens, 1986: 118-119; Peters and Pierre, 2006: 209; Skelcher, 2007: 63). Even if the state maintains a preeminent position in the governance process, the involvement of nongovernment actors runs the risk of separating elected politicians from decisions (Bell and Hindmoor, 2009: 50). As the role of government in the governance structure is transformed there is the possibility that policy processes and decisions will become closed to public influence, while at the same time open to corruption (Andrew and Goldsmith, 1998: 104; Peters, 2004: 133).

The changing role of government in governance and the increased inclusion of new actors in the governance process have given rise to multiple concerns over democratic input and accountability (Pierre and Peters, 2005: 5; Peters and Pierre, 2006: 209; Flinders, 2011: 2; Gotham, 2012: 644). Taking into account both state-centric and society-centric perspectives on modern governance arrangements, the remainder of this chapter will provide a theoretical background for authority migration, state vs. society control of the governance process, and the prognosis for accountability. The concept of accountability will be explored as well as the possible accountability relationships that may emerge as authority is migrated outside the boundaries of traditional government

institutions. The chapter will conclude with an overview of the hypotheses that will be explored and tested in the following chapters.

2.1 Authority Migration and Multilevel Governance

One dimension along which governance can vary is centralization of authority. Authority can be highly concentrated in a single hierarchical entity that claims exclusive jurisdiction or dispersed among various nodes, each exercising only limited jurisdiction (Kahler and Lake, 2004: 409). Furthermore, the dispersal of authority may result in broad authority over a limited geographic jurisdiction, or concentrated authority in specific policy areas (Richardson, 2011: 671). The migration of authority can then be thought of as occurring along both a vertical and horizontal axis. Along the vertical axis authority can be distributed to successively more local levels of government in which the more limited jurisdictions are nested within larger jurisdictions. Along the horizontal axis the authority can be dispersed to actors outside of government.

One conceptualization of authority migration has been captured in the term "multilevel governance". The term multilevel governance emerged out of Gary Marks's attempt to better characterize the governance structure of the European Union. Marks argued that what was being witnessed in the European Union was the "emergence of multilevel governance, a system of continuous negotiation among nested levels of governments at several territorial tiers - supranational, national, regional and local - as the result of a broad process of institutional creation and decision reallocation that has pulled some previously centralized functions of the state up to the supranational level and some down to local/regional level" (1993: 392). The basis for Marks's argument was that EU Structural policy did not fit within either a national or supranational conception of governance. Instead, what Marks witnessed was a two-sided process that involved the decentralization of decision making to subnational governments while at the same time powers were centralized at the supranational level. The result of this process was decision-making power being spun away from the national state in both subnational and supranational directions (Marks, 1993: 401-402). In addressing authority migration, multilevel governance does not reject the importance of the state, but instead asserts that the state no longer monopolizes policy-making authority. According to multilevel

governance, decision-making authority is shared among actors at different levels, rather than monopolized by state executives (Marks, Hooghe and Blank, 1996: 346). As stated by Bache and Flinders, the analytical focus of multilevel governance can be seen as the increasingly contested jurisdictional and territorial boundaries both within and beyond the state, the fundamental concern being how to explain the dispersal of central government authority both vertically to actors at other territorial levels and horizontally to non-state actors (2005: 4).

Building upon Marks' work, Liesbet Hooghe and Gary Marks developed two contrasting visions of how to conceptualize multi-jurisdictional governance labeled Type I and Type II multilevel governance. Marks and Hooghe's Type I and Type II multilevel governance typology provides an effective tool for identifying and conceptualizing different forms of multi-jurisdictional governance. Type I multilevel governance has its intellectual foundation in federalism, which is concerned with power sharing among governments operating at different levels (Marks and Hooghe, 2005: 17). Type I multilevel governance is described as the dispersion of authority to a minimal number of jurisdictional levels into which a wide array of policy areas are bundled, with smaller jurisdictions nested within larger ones and only one relevant jurisdiction existing at each territorial scale. Like federalism, Type I multilevel governance is characterized by general-purpose jurisdictions, rather than task specific jurisdictions (Marks and Hooghe, 2003: 236-237; 2005: 17-19). Unlike federalism; however, Type I multilevel governance is not confined by the geographic boundaries of nation states (Marks and Hooghe 2005: 19). As such, Type I jurisdictions include both federal states such as Canada as well as supranational entities such as the European Union.

In contrast with Type I multilevel governance, Type II multilevel governance denotes independent jurisdictions that fulfill specific functions as the unit of analysis. Type II multilevel governance is defined as having intersecting memberships in the sense that borders will be crossed and jurisdictions may overlap; as being organized across a large number of levels in which authority is not neatly layered but diverse in scale; and being flexible in design, allowing it to respond to changing citizen preferences and functional requirements (Marks and Hooghe, 2005: 20-21). According to Marks and Hooghe, Type

II multilevel governance can be conceptualized as a system where citizens are not served by 'the' government, but by several public service industries (2003: 237). The flexibility and territorial diversity means that Type II jurisdictions are located across multiple levels of government ranging from the transnational to the local level. At the international level, Type II jurisdictions can be seen to include organizations such as the Basel Committee for Banking Supervision, the International Monetary Fund and the World Bank. The Basel Committee for Banking Supervision oversees the regulation of international banking, while the International Monetary Fund and the World Bank are charged with the formation of codes of good practice for regulatory and macroeconomic matters (Baker, Hudson and Woodward, 2005: 10). At the local level, Type II jurisdictions may be created to deal with concerns regarding natural resources, fire protection, water supply, housing, sewage, parks and recreation, or any other single function issue area (Marks and Hooghe, 2005: 26).

The construction of both territorial and functional dispersions of power characterized by Type I and Type II multilevel governance are not unlike the Althusian compound state. Michael Burgess describes the Althusian compound state as an "amalgam of political associations based upon consent and built up from below, in which power is distributed both territorially and functionally" (2000: 8). Althusius conceptualized institutional structure made up of a plurality of smaller and larger *consociations,* or self-governing authorities (Hueglin and Fenna, 2006: 92) where the small *consociations* determine what authority was delegated to larger *consociations*, meaning that decisions were apt to remain at the lowest practical level (Hueglin and Fenna, 2006: 96).

In keeping decisions at the lowest practical level, Althusius foreshadowed the modern principal of subsidiarity (Hueglin and Fenna, 2006: 96). The principal of subsidiarity is the normative position that decision-making authority should be placed at the level of government that is closest to the citizen and best positioned to carry out a particular task (Leuprecht and Lazar, 2007: 5). From the perspective of fiscal federalism, which primarily distributes authority along the vertical axis, the most appropriate level of government is the lowest level of government that encompasses the relevant benefits and costs (Oates 2004: 15). In cases where externalities are inter-jurisdictional, regional

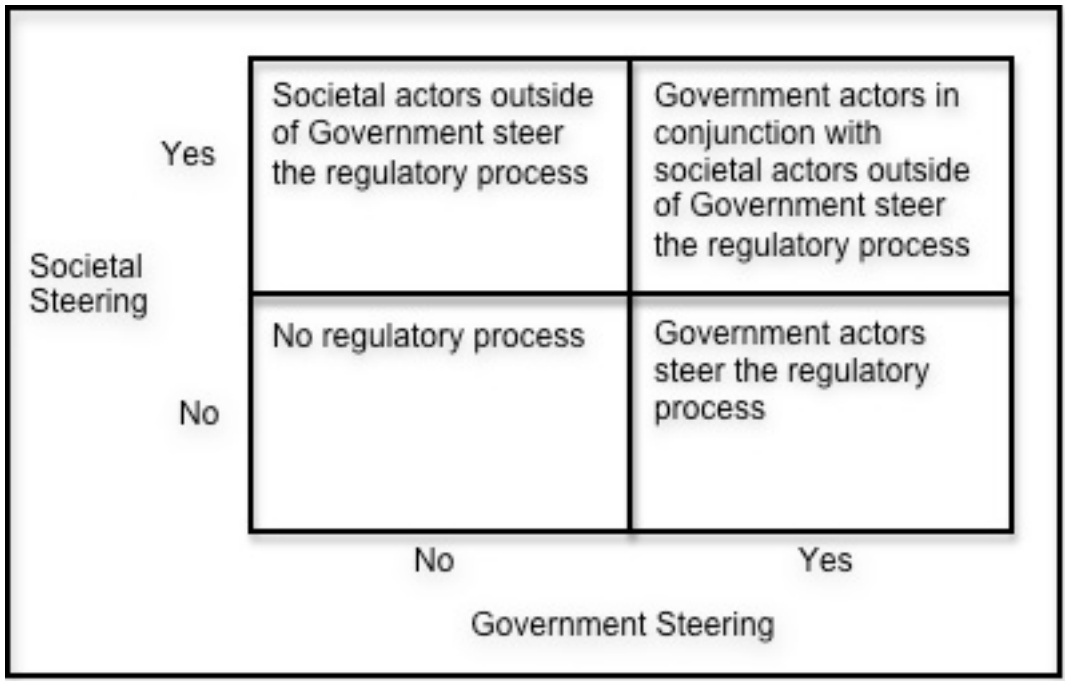
organizations may emerge which are capable of addressing the problem through negotiations and coordinated decision making (Oates 2004: 23), thus pushing authority upwards. While such approaches may result in optimal governance structures, determining the appropriate level at which responsibility rests encompasses political as well as economic factors. Political participation by both citizens and governments interacts with economic efficiency in determining the governance system (Oates 2004: 30-31).

While fiscal federalism typically looks at the division of powers vertically at the territorial level, multilevel governance, like the Althusian compound state, divides powers along both territorial and functional lines. As the principal of subsidiarity is premised upon regulatory tasks being undertaken as close as possible to those being regulated (Bartle and Vass, 2007: 888), the principal is equally suited to both Type I and Type II multilevel governance. The challenge is to build effective processes for collective action that recognize the principle of subsidiarity, without weakening democracy (Skelcher, 2005: 106-107).

While Althusius envisioned the smaller political groupings deciding which decisions should be migrated upward to larger *consociations* (Hueglin and Fenna, 2006: 96), Marks and Hooghe argue that in contemporary multilevel governance arrangements it is common for Type II multilevel governance structures to be embedded in the legal frameworks determined by Type I jurisdictions (2003: 238; 2005: 24). Accordingly, Type I and Type II multilevel governance should not be viewed as competing approaches, but as complementary approaches where the selected model is a function of the problem which needs to be addressed (Marks and Hooghe 2005: 29). Type II multilevel governance bodies can be employed as a tool of government through the delegation of authority in response to a specific policy circumstance. Alternatively, Type II multilevel governance may occur when private actors play a dominant role in the policy making process, causing public actors to adopt the privately negotiated regimes (Marks and Hooghe 2005: 25).

While Type I jurisdictions may involve private actors, Type II jurisdictions have higher rates of private involvement that may result in the opening up of public decision making to private actors to various degrees (Marks and Hooghe, 2005: 24). The potential for either government or non-government actors to be dominant in the policy process suggests that multiple paths with varied degrees of government control can be taken when formulating Type II governance jurisdictions. In essence, the steering of regulatory decision-making for Type II jurisdictions can be conceptualized along two axes, society-centric in which society steers or state-centric in which government steers, as presented in Figure 2.1.

Figure 2.1: Society and Government Steering in Regulatory Decision Making



As shown in Figure 2.1, multilevel governance, unlike traditional models of intergovernmental relationships, includes both public and private actors in the governance process of exchange and collaboration. At the same time, however, the institutional dimension of multilevel governance remains important. Institutions define the linkages between different levels of government as well as shape and constrain the larger web of political actions (Pierre and Peters, 2005: 83). As the linkages, both

vertically and horizontally, have become more complex the role of the traditional political centre has become redefined (Torfing et al., 2012: 97-98).

While Marks and Hooghe's typology is useful for distinguishing between a traditional government approach to governance (Type I) and a special purpose governance jurisdiction that can exist outside of government (Type II), there is no agreement on how governance that spans multiple jurisdictions should be organized. Multiple concepts, including multi-tiered governance and polycentric governance, deal with the same questions of authority dispersal that multilevel governance attempts to answer (Bache and Flinders, 2005: 4). As discussed below, alternative definitions can be found in the works of Blatter, Rosenau, and Frey and Eichenberger.

Joachim Blatter states that common to debates over the institutional transformations that are occurring within the traditional Westphalian state are de-territorialization and unbundling of politics. While the Westphalian system bundles political responsibility on a territorial basis and subordinates all other identities to national identity, it is possible through the unbundling of politics for territorial communities to be supplemented by non-territorial communities (Blatter 2003: 185-186). While the underlying themes may be consistent, in looking at broader regions within both North America and Europe, Blatter distinguishes between the emerging governance structures. The European case, which features institutions with a clear-cut geographic basis and multi-sectoral goals and tasks, is labeled by Blatter as a 'multi-level system' which is described as 'multilevel governance' complemented by an additional layer of institutions of governance and identity formation. The North American case, which features institutions with fluid geographic bases, is described as a 'multi-polity system' where non-territorial polities complement traditional governance structures along single policy dimensions (Blatter, 2003: 203-204). Blatter's identification of 'multi-level' and 'multi-polity' as contrasting systems of governance is not dissimilar to Marks and Hooghe's multilevel governance typology in which Type I is categorized as being multi-level with a minimal number of clearly defined geographically jurisdictions, while Type II multilevel governance is policy focuses and cuts across traditional geographic boundaries.

Rosenau has used the term 'fragmegration' to describe the link between fragmentation and integration as the location of jurisdictional authority is shaped simultaneously by globalization, centralization and integration on one hand and localization, decentralization, and fragmentation on the other (2000: 177-178; 2005: 35). To conceptualize who has the right to exercise authority, Rosenau uses 'spheres of authority' that define the range and capacity of actors to generate compliance on the part of those to whom the directives are issued (2005: 32; 2007: 89). Constructed by formal and informal rules (Rosenau, 2005: 32), Rosenau argues that 'spheres of authority', in comparison to multilevel governance, allow for the study of the full complexity observed in the political world.

Frey and Eichenberger have developed the concept of Functional, Overlapping, and Competing Jurisdictions (FOCJ), which is similar to Marks and Hooghe's conceptualization of non-territorial communities under their label of Type II multilevel governance. According to Frey and Eichenberger, FOCJ allow the emergence of political bodies whose size corresponds with the tasks to be fulfilled. Instead of being based upon historical territories, the geographic extension of a FOCUS[1] is driven by the physical extension of the problem (Frey and Eichenberger, 1999: 3). FOCJ are characterized by four properties: FOCJ are determined by the function to be fulfilled and the jurisdictional size must match accordingly; FOCJ are overlapping in their geographical extensions; FOCJ are competitive and are forced to cater to the preferences of citizens due to the threat of exit and political competition through democratic institutions; and FOCJ are formal political units with powers to regulate and tax (Frey and Eichenberger, 1999: 4-7). As such, FOCJ align with Type II multilevel governance in regard to the emphasis on functionalism, overlapping non-territorial geographic extensions, and competition between jurisdictions, however, the guarantee of political competition through democratic institutions in Frey and Eichenberger's FOCJ limits the number of potential cases in comparison to Marks and Hooghe's Type II multilevel governance.

1 FOCUS is the term Frey and Eichenberger use for the singular of FOCJ.

While there is a lack of agreement on how governance that spans multiple jurisdictions should be organized, Marks and Hooghe's contrasting, yet complementary, forms of multilevel governance are appropriate for understanding the migration of authority at the federal and provincial level within Canada. Using multilevel governance to study politics in Canada is not new. Multilevel governance has been used to study specific policy areas, such Leo and August's look at immigration (2009); the study of voting behaviour in the case of Anderson's exploration of economic voting (2006; 2008); and the creation of the Canada Research Chair in Multilevel Governance in 2003 to promote research into governance and public policies in Canada aimed at identifying the intergovernmental relations and processes that produce the best public policies (Canada. Canada Research Chairs, 2003).

Conceptually, multilevel governance aligns well with Canadian governance. The traditional federal dynamics of Canadian governance is captured under Type I multilevel governance, while the emergence of special purpose jurisdictions, which is the central focus of this research, is incorporated under Type II. Furthermore, Marks and Hooghe's framing of Type I and Type II bodies as complementary, in which the selected governance model is a function of the problem that needs to be addressed (Marks and Hooghe 2005: 29) and that Type II multilevel governance structures can be embedded in legal frameworks determined by Type I jurisdictions (Marks and Hooghe 2003: 238; Marks and Hooghe 2005: 24) aligns with the migration of authority by government actors to external decision-making bodies that has given rise to concerns over public accountability. Lastly, unlike Frey and Eichenberger's FOJC, the definition of Type II multilevel governance lacks the requirement for political competition through democratic institutions. In omitting the need for political competition, Type II multilevel governance more adequately captures the range of institutional arrangements that occur as a result of authority migration in Canada. While there exists bodies, such as the Vancouver Board of Parks and Recreation, that have elected commissioners (Vancouver. Board of Parks and Recreation, 2012), there are many more that fail to incorporate political competition into the institutional design.

While multilevel governance may be useful in terms of both the act and the understanding of governance arrangements, it is not without critique. Peters and Pierre have described multilevel governance as a Faustian bargain (Peters and Pierre, 2005; Pierre and Peters, 2005). In Christopher Marlowe's play *The Tragic History of Doctor Faustus*, Dr. Faustus gives his soul to Lucifer in exchange for Mephistopheles as his servant. As the play draws to a close, however, Dr. Faustus realizes that for the vain pleasure of twenty-four years he has lost eternal joy (Marlowe, 1604). Peters and Pierre argue that multilevel governance may be a Faustian bargain as the capacity to govern has been sold in an attempt to achieve a more inclusive bargaining process (2005, 94). While multilevel governance has the potential for high problem solving capacity and to generate efficient outcomes it also has features that call its democratic nature in to question (Pierre and Peters, 2005: 99).

2.2 State-Centric Multilevel Governance: Government Steering

Decision-making in the public sphere by non-government actors is not new. Voluntary, or third sector, actors have involved in the provision of public services longer than that of the state (Pestoff and Brandsen, 2010: 223). Today, however, the increasing inclusion of new actors in public governance has changed how the role of government is perceived. Two opposing views on the role of government have emerged in the literature: *state-centric* and *society-centric*. The society-centric position argues that changes in governance structures represent a shift away from government dominance toward the increasing reliance on non-state actors, while state-centric view claims that government has remained the principal actor in governance (Robihau, 2011: 116-117). From the state-centric perspective, while actors external to government have long been involved in governance, modern governance has been transformed by becoming increasingly formally organized, legally bound and state controlled. When approached from the society-centric perspective, governance is seen as a multidirectional process between multiple actors within and between complex systems (Bartle and Vass, 2007: 887).

In attempting to understand the changing role of the state, Jon Pierre (2000) identifies three aspects of state governance that can be seen as particularly relevant to multilevel

governance discourse and the understanding of how to attribute responsibility. First, Pierre points to a linkage between the relaxation of regulatory steering within the state and the emergence of public-private exchange. This suggests the emergence of a model in which the state seeks to increase its points of contact with its external environment as a means of conveying its objectives to society. Secondly, Pierre suggests that state power and institutional capacity are becoming increasingly contingent upon both public and private resources and the ability to direct both toward a common set of objectives. Lastly, Pierre states that the model of governance has, to a greater or lesser extent, emerged as a steering model that can be witnessed in the growing interest in public-private partnerships and the migration of functions that are not critical to the state (2000: 242-243). Overall, what Pierre is suggesting is not the weakening of the state, but a shift in state function. Likewise, Wallington, Lawrence, and Loechel claim that new governance arrangements are not the hollowing out of the state, but the result of the state wanting to govern well rather than govern less (2008: 3). In evaluating the role of government in the economy, Crouch argues that while the role of the state changes in response to changes in the governance environment, the state has not withdrawn from the scene, but has remained an active form of governance. While networks and markets have grown in importance, the need for close and constant adjustment of the regulatory regime leaves the question of whether there is more or less state control open to debate (Crouch, 2004: 113). As stated by Skelcher et al., the inclusion of new governance actors does not mean a relationship of equals (2005: 578), the role of new actors may be more modest than society-centred arguments presumes (Leuprecht and Lazar, 2007: 2).

In assessing the changing role of the state, Bob Jessop argues that we are seeing the emergence of a metagoverning state. The state, in response to the re-articulation of different levels of territorial organization of power within the global political system, has enhanced its role in managing inter-scalar relations, thus seeking to control how and where authority is migrated to minimize effects upon the overall power of the state. In response to the shift from government to governance, the state has increased its role in metagovernance, thus getting involved in redesigning markets, constitutional change, jurisdictional reregulation, setting the conditions of self-organization and organizing the overall process for collaboration. As such, the state can be seen as setting the overall

ground rules for governance and regulatory order (Jessop, 2004: 19 and Jessop, 2005: 64-65, Sørensen, 2006: 101). As argued by Chevallier, the government remains central to the governance process, "mais à la manière d'un «stratège» et non plus d'un «pilote»" (2003: 212). It is important to acknowledge, however, that embedded within the idea of metagovernace is the recognition that a number of organizations or processes have attained sufficient autonomy to warrant some degree of control be imposed overtop of the existing governance process (Peters, 2010a: 37).

Regardless of the level of autonomy, governance can be seen to occur in what Scharpf identified as the "shadow of hierarchy" (Scharpf, 1994: 38-39). In the modern state, both public and private actors operate under the shadow of hierarchy where public actors set the legal rules of the game and intervene to correct distortions or outcomes that violate public interests (Börzel, 2010: 196-197). So while the underlying assumption of multilevel governance is that centralization has given way to new forms of governance, resulting in decision-making authority being dispersed across multiple jurisdictions, it can be argued that the state continues to play a fundamental role within the process. If this is indeed the case, and as Jessop argues we are seeing the emergence of metagovernance, we can expect Type II jurisdictions to be accountable to government through its central role in shaping the structure of governance. Furthermore, we can expect accountability mechanisms to be built into the institutional environment created by government in the conception of Type II jurisdictions, as institutionalizing an accountability relationship between government and Type II decision-makers will serve to maintain government control of public policy. The absence of accountability mechanisms within the institutional design does not necessarily mean the absence of state steering as the state may engage in other informal mechanisms of control, however, it can be expected that governments will utilize the institutional design process to preserve their steering capacity.

From this state-centric perspective, while governance structures may have been altered as governments adopted a wider range of governance strategies to address policy issues, government has remained at the centre. According to Bell and Hindmoor regardless of the governance approach put into place, the state has remained the preeminent actor in

the governance process (Bell and Hindmoor, 2009: 10; 2009a: 153-154). Government occupies a privileged position as it alone has the legislative capacity to set the rules of governance (Bartle and Vass, 2007: 895; Rhodes, 2007: 1244; Bell and Hindmoor, 2009: 13). As argued by Bell and Hindmoor, only governments have the legitimate authority to select, alter, and replace governance mechanisms. This power serves to keep other governance actors in line and preserves government dominance in the policy process (Bell and Hindmoor, 2009: 13). According to Elke Löffler, the key question for government is which governance approach to use to deal with a specific problem. There are policy issues that lend themselves to delegation to community groups, those that lend themselves to market mechanisms and those that are best addressed through hierarchy (2009: 230). Consistent with Bell and Hindmoor, Löffler places government at the centre of governance as the result of government's power to select which governance approach is paired with a policy problem.

While government may be the sole holder of legislative authority, this does not mean that government action will result in the desired consequences. As stated by Rhodes, it is important to distinguish between intervention and control. Governments can and often do intervene in the governance process, but such interventions do not always have the intended effects, raising questions of control (Rhodes, 2007: 1248). Matthews argues that intra-governmental capacity shapes government response and a lack of intra-government capacity can result in actions that while intended to shore up government capacity have unintended consequences such as the emergence of new veto points (2012: 185). Through the act of metagovernance, politicians may grant considerable autonomy to stakeholders to govern themselves, while at the same time reducing government's ability to direct and control outcomes (Sørensen, 2006: 99).

The belief that the state has maintained its position at the centre of governance is not universal. There are those who believe that the power of the state has been weakened by the changes in governance. Michael Mann identifies two meanings of state power; despotic power where actions can be taken without negotiations with civil society groups, and infrastructural power which is the capacity of the state to penetrate civil society groups. According to Mann, in Western democracies there has been loss of despotic

power but growing infrastructural power within the state. The growth in infrastructural power has allowed the state, through its powers of taxation and regulation, to penetrate everyday life (Mann, 2003: 54-55). The shift in state function identified by Pierre is taking place within the realm of infrastructural power. According to Giandomenica Majone, two types of infrastructural power are evident: the power to tax and spend, which are constrained by budgetary means and rule-making power where budget constraints have little impact (1997: 148-149). Majone argues that the absence of budgetary constraint for rule-making power has important consequences as neither parliament nor government systematically determines the overall level of regulatory activity in a given period, and that no office is responsible for establishing regulatory priorities across the government (1997: 150). A stronger rejection of the continued strength of the state is put forward by McBride and Shields who argue that the advancement of a neo-liberal agenda aimed at reducing the state and increasing reliance on market mechanisms provides the ideological venue for shifting decision-making outside of politics and is eroding the power of the state (1997: 18). According to Janet Newman, modernization, globalization and privatization all signal profound shifts in the process of governance. Government power is retreating with state institutions being slimmed down and hollowed out while at the same time decentralization and marketization has expanded to reach more aspects of citizens' lives (Newman, 2005: 1).

Falling in between government as the preeminent actor and the retreating of the state is the idea of "interactive governance". Torfing et al. define interactive governance as "the complex process through which a plurality of social and political actors with diverging interests interact in order to formulate, promote, and achieve common objectives by means of mobilizing, exchanging and deploying a range of ideas, rules and resources" (2012: 14). While interactive governance may still be conducted in the shadow of hierarchy (Torfing et al., 2012: 4) and governments often play a crucial role in facilitating and managing interaction, there is no privileged centre. From an interactive governance standpoint, society does not constitute an external environment for the actions of government, but instead societal actors are actively engaged in the formation and achievement of common objectives (Torfing et al., 2012: 15). As Jan Kooiman states, in the interactive governance model societies are governed by a combination of efforts from

the different actors within society (2010: 73). Torfing, Peters, Pierre, Sørensen clarify, however, that while interactive governance is an important form of governance, it may not be appropriate for all policy areas (2012: 4).

2.3 Society-Centric Multilevel Governance: Societal Self-Steering

In contrast to the state-centric approach, which suggests the state continues to play a dominant role in governance, the society-centric perspective places greater emphasis on the actions of societal actors that exist outside of government. While state-centric arguments, such as the government's role in metagovernance, place government in a position of steering (Jessop, 2005: 65; Bell and Hindmoor, 2009), society-centric governance advances the idea that societal actors outside of government are engaged in more self-steering and that government interacts with society to reach mutually acceptable decisions (Peters, 2000: 36). The modern patterns of governance that are seen to be emerging are not unilateral but bilateral or multilateral, as no single actor, public or private, have sufficient knowledge or action potential to act unilaterally (Kooiman, 1993: 4). Furthermore, actors outside of government may take on the role of metagovernance that state-centric theorists reserve for government. From a society-centric perspective, any actor with sufficient resources, be they public or private, may act in a metagovernace capacity (Sørensen, 2006: 102-104). While both government steering and societal self-steering views of governance contain the assumption that society must be governed, different assertions are made as to who the dominant actor is: government or society (Peters, 2000: 36-37).

The governance change at the heart of society-centric governance is the shifting of responsibility outside of government. In 1993, Kooiman observed that in many countries the tendency has been a shift in the balance between government and society – a shift away from the public sector and toward the private (1993: 1). Kooiman claimed that as the capacities of political/administrative governing systems have reached or become close to the point of diminishing returns, governments have reduced the need for governing by deregulating or have shifted the need for governing through privatization (1993a: 35). In responding to the changes in the governance environment, Matthew Flinders states that

government now operates in highly heterogeneous networks of organizations where the control and scrutiny of diverse organizations and partnerships has become a central challenge of modern governance, especially when many actors operate with a significant level of autonomy from elected politicians and legislatures (2006: 223). While still a powerful and relevant participant in governance, government no longer governs in the conventional command and control manner (Pierre and Peters, 2005: 3).

Within the patterns of modern governance, both a positive and negative version can be witnessed. The negative version stresses the capacity of social forces to resist the regulations and impositions of the state and contains the normative element that citizens know better what they want than does the state and are therefore justified in finding ways to avoid the incursions of authority into their lives (Peters, 2000: 40-41). Peters further states that the negative version of modern governance has been embraced in deliberative democracy (2000: 41). For deliberative democrats, strong emphasis is placed upon the protection of the public sphere where actors can deliberate and formulate views and opinions. The preferences of social actors are not fixed but instead are formulated and reformulated through deliberation. It is through participation in deliberation in the public sphere that the authentic will of the people may be discovered, which can then be translated into a discernible common good (Kohler-Koch and Rittberger, 2007: 14-16).

While representative democracy's legitimacy is tied to minimal but equal participation through voting, the legitimacy of participatory democracy requires institutions that are transparent and open to all, but participation need only be from a minority (Wainwright, 2004: 154). New governance arrangements including both government and non-government actors have blurred traditional roles, the result being that legitimacy can no longer be solely understood in terms of the democratic accountability of elected governments (Wallington, Lawrence and Loechel, 2008: 11). Grafting elements of popular authority, like participatory democracy, onto representative democracy may be necessary to ensure the input legitimacy in governance. It has been cautioned, however, that the representational unevenness of direct citizen participation means that it is not a substitute (Skogstad, 2003: 968; Fung, 2006: 66). Psychology research into accountability has shown that individuals respond in a manner that indicates audience

approval matters (Lerner and Tetlock, 1999: 270). If decisions are influenced by the desire for audience approval the unevenness of direct citizen participation risks outcomes that benefit a narrow slice of the population.

The positive version of modern governance is based upon the existence of sufficiently powerful resources within society that are capable of shaping policy at both the input and output stages. Networks, communities and other interest groups that are involved in a policy area are assumed to be in position to shape policy, meaning the strength, or even dominance, of society becomes an asset for governance within individual policy areas. The normative element identified by Peters in the positive approach to modern governance is that society should be capable of managing its own affairs without the intervention of the state (Peters, 2000: 41-42). This is consistent with Paul Hirst's associated democracy model, in which as many functions as possible are devolved from the state to civil society, followed by the democratization of the new civil society organizations. In doing so, governance is shifted from top-down bureaucratic to democratically self-governed associations (Hirst, 2000: 28) According to Sørensen, government can play a role in the democratization of self-governance through the use of metagovernance to ensure that new governance processes are regulated in accordance with democratic criteria (2006: 105).

The traditional pattern of governance has been one of state dominance through a pattern of hierarchical governing in which governments decide the laws and policies to be adopted (Peters and Pierre, 2006: 209-210). The emergence of new forms of governance, however, has increased the number of private and public actors involved in the governance process (Sørensen, 2006: 98). From the society-centric perspective, societal actors have become more engaged in the governance process, with government working with society to bring about mutually agreed upon solutions (Peters, 2000: 36). If societal actors are taking a more prominent role and asserting greater influence in the governance process, we should expect Type II jurisdictions to be increasingly accountable directly to society.

New forms of participation may, however, privilege certain types of actors (Peters, 2010: 217). Peters suggests that, somewhat paradoxically, in an era in which participation has become an increasingly important value to the public, the level of participation in many aspects of political life is declining (2010, 213). With a decline in political participation there is the possibility that organized societal interests may secure a formal accountability relationship that does not exist for the broader population. Peters claims that as organizations are removed from ministerial lines of responsibility influence is not achieved by average citizens acting autonomously, but instead through organized groups (2010: 215). Moreover, goals will not be uniform across members or groups of members within society (Pierre and Peters, 2005: 13). The potential of uneven participation is akin to violating the democratic norm of proportional inclusion as described by the all-affected principle. According to the all-affected principle, individuals have a normative claim to influence collective decisions to the extent that they are affected by those decisions (Warren, 2011: 687). Conversely, as new governance channels tend to grant more influence to stakeholders than to citizens, there also exists the possibility that in accordance with the all-affected principle, each citizen will obtain greater influence over the decisions that affect them most (Sørensen, 2006: 104). It is possible that democratic accountability can be enhanced through a governance process in which those who are most affected have considerable influence in shaping policy solutions (Skelcher, Mathur and Smith, 2005: 580).

While increased participation should be good for democratic accountability, there is still the question of whether increased participation by societal actors affects the decision-making of Type II jurisdictions. As amusingly stated by Sherry Arnstein in 1969, "the idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you" (1969: 216). However, as Arnstein further states, there is a critical difference between going through an empty ritual of citizen participation and citizens having the real power needed to affect outcome and process (1969: 216). Today, the question remains as to whether societal actors are capable of securing accountability mechanisms that promote accountability relationships directly between Type II jurisdictions and society within the institutional environment of Type II jurisdictions.

2.4 Multilevel Governance and Accountability Relationships

Good governance can be thought of as a function of the extent to which citizens can hold political officials accountable for their actions (Adserà, Boix and Payne, 2003: 447). In a representative democracy, accountability is the principal mechanism through which mass publics exert control over their elected officials and is a central tenet of democratic theory (Rudolph, 2006: 99). While constituents are not required to act to be represented, they must be conceived of as being able to (Disch, 2012: 602). Accordingly, the institutional structure must be such that citizen preferences are made known and citizens are able to act to hold decision-makers accountable.

Fritz Scharpf describes the democratic process as an exercise in collective self-determination that operates on two dimensions – inputs and outputs. On the input dimension political choices should be derived directly or indirectly from the preferences of the citizen with government held accountable by those they govern, while the output dimension denotes the effectiveness of policy to achieve goals (Scharpf, 1997: 19). The empowerment of actors outside government to make decisions, however, means that not only must government be held accountable, but all involved in the governance process must also be held accountable. As Bell and Hindmoor state in elaborating on Scharpf's work, for governance arrangements to be considered legitimate, not only must the policy be effective in producing the desired outcomes, the governance process must be democratic and accountable (2009: 29). It is this combination of both input and output legitimacy that compels us to obey collectively binding decisions, even when they do not align with our own personal preferences (Skogstad, 2003: 956). To this end, the act of governance must aim to improve the state of society and maintain and extend democratic values (Skelcher, Mathur and Smith, 2005: 577).

Within the governance process, accountability serves three purposes: to control for the abuse and misuse of public authority; to provide assurance in respect to the use of public resources and adherence to the law; and to promote the continuous improvement in governance and public management (Aucoin and Heintzman, 2000: 45; Auditor General of Canada, 2002: 4). Furthermore, Aucoin and Heintzman argue that due to the integral role accountability plays in the governance process, it is essential that it not be affected

by the extent to which governance processes are undergoing change (2000: 45). However, as stated in the December 2002 Report of the Auditor General to the House of Commons, what accountability means and how it is supposed to work are often disputed, making its application difficult (Auditor General of Canada, 2002: 3).

Defining the concept of accountability is not in itself problematic. Person A is accountable to person B if two conditions are met; there is an understanding that A is obliged to act in some way on behalf of B; and B is empowered by some mechanism to sanction or reward A. Stated in the form of an agency relationship person A can be understood to be an agent, who makes choices on behalf of person B as the principal (Fearon, 1999: 55). While the concept of accountability may not in itself be problematic, assessing accountability is decidedly more so. Assessing accountability can be elusive as accountability means different things to different people, thus becoming a general term for any mechanism that makes institutions responsive to their particular publics (Bovens, 2007: 448-449).

Jonathan Koppell attempts to provide conceptual clarity through the identification of five dimensions of accountability. According to Koppell, accountability can viewed as transparency - whether the organization revealed the facts of its performance; liability - whether the organization faces consequences for its performance; controllability – whether the organization does what the principal desires; responsibility – whether the organization follows the rules; and responsiveness – whether the organization fulfills its substantive expectation (2005: 96). Bovens argues, however, that broad conceptions of accountability make it empirically difficult to operationalize. Dimensions, such as transparency, are instrumental, but alone do not establish accountability. For other dimensions such as responsiveness, there is no general standard to measure against. Accordingly, Bovens provides a narrower definition stating, “Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences” (2007: 450). Bovens’s definition is consistent with the position of the Office of the Auditor General of Canada that states accountability in practice is how those responsible are held to account. Accountability is not working when

there is no or inadequate reporting, there is no serious informed review of the information reported, and there are no consequences for those responsible (Auditor General of Canada, 2002: 10).

Consistent across the above definitions of accountability is the ability to sanction as a necessary element in the accountability relationship, however, as stated by Richard Mulgan, placing sanctions in the core of accountability is contestable (2000: 556). On one extreme, Richard Fraser has gone so far as to state that you cannot have accountability without liability and that accountability without fear of consequences is not likely to be accountability at all (1996: 36). Harlow and Rawlings argue, however, that it is not clear whether the possibility of sanction is an essential element of an accountability relationship (2007: 545). In determining what can be considered a sanctioning act, Hawlow and Rawlings argue that recommendations for improvement are sufficient to satisfy accountability requirements (2007: 546). This weaker conceptualization of sanctions and accountability aligns with what Bovens labels informal accountability in which consequences of accountability are tied to the public rendering of negative reports by an Ombudsmen or other agencies, which may damage the public image of agencies or individuals (2007: 452).

In the tradition of democratic theory, elections are viewed as an important mechanism of accountability through which the policy preferences of citizens can induce government action (Fearon, 1999: 57). Adserà, Boix, and Payne argue that the existence of political control of public officials depends upon the occurrence of regular elections where the electorate holds the relevant information required to appropriately sanction politicians (2003: 478). According to Jane Mansbridge, electoral control can be conceptualized as either promissory or anticipatory. From the promissory perspective, constituent control is based upon the representative's campaign promises. While from the anticipatory perspective representatives anticipate the preferences of future voters in the next election (Mansbridge, 2011: 627). Mansbridge further states that in representative democracies, members of the public most often hold the promissory understanding of representation, while accountability often works through the anticipatory mechanism (2011: 627).

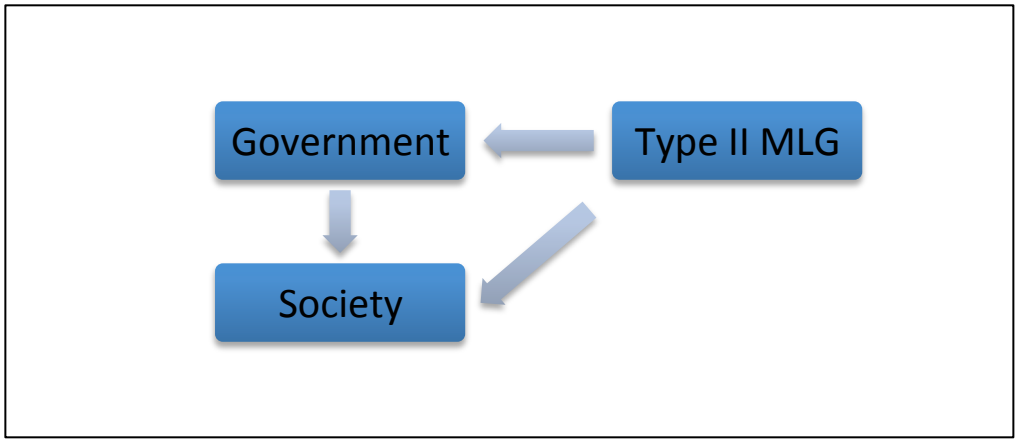
Regular elections form the basis of an accountability relationship between the electorate and their elected representative. The elected representative is accountable to the electorate as the elected representative is expected to act in a way that promotes the preferences of the electorate and if the electorate is not happy with the actions of their elected representative, they can vote them out at the next election. Moreover, in a Westminster-style parliamentary system such as Canada, the use of the power of the state is governed by the principle of responsible government, which means that those who exercise power are held to account. Rooted in the democratic institution of parliament, the exercise of state power is done in accordance with the requirements of ministerial responsibility and parliamentary accountability. In this system ministers are answerable to parliament for the actions of government and parliament has the means to hold to account those who exercise the power of the state, be they elected or non-elected officials (D'Ombrian, 2007: 198-199). The result is a chain of accountability relationships connecting those who exercise state power to the electorate. The Auditor General of Canada states, however, that accountability relationships have become more complex. Public objectives are increasingly achieved through non-hierarchic relationships involving government and the private and voluntary sectors (Auditor General of Canada, 2002: 4-5). The result is the need for an understanding of accountability that includes both traditional accountability relationships and the new relationships that have emerged as new actors become part of the governance process.

When applying the concept of accountability and agency relationships to Type II multilevel governance, with its potential for both government steering and society self-steering, it is evident that multiple principal-agent relationship paths may exist. As illustrated in Figure 2.2, three different accountability arrangements are possible: first, society[2] as principals of Type II bodies where Type II bodies are directly accountable to society; second, citizens as principals of democratic governments who in turn are principals of Type II bodies meaning that Type II jurisdictions would be indirectly

2 Society is referring to both individual citizens and groups outside of government who are affected by the decisions made by Type II bodies operating in the public realm.

accountable to the citizens; third, both the first and second accountability arrangements exist. Not shown in Figure 2.2, but understood, is that an additional possibility is the absence of any accountability relationship.

Figure 2.2: Type II Multilevel Governance: Possible Principal-Agent Relationships



2.5 Multilevel Governance and Problems of Accountability

As authority migrates vertically up or down to different levels of elected government free and fair elections provide the central mechanism for accountability. However, when decision-making authority migrates horizontally to potentially unelected bodies, how decision-makers are held accountable requires consideration. Schattschneider hypothesized that the result of political contests is determined by the scope of public involvement in conflicts (1975: 5). With decision-making authority migrating beyond the reach of the ballot box, questions over the scope of public involvement arise. It must be considered whether the decisions made by government empowered external bodies are as public as those that occur within elected legislatures (Schattschneider, 1975: 65). Schattschneider argues that the origin of politics is strife and that political strategy deals with the exploitation, use of, and suppression of conflict (1975: 65). With the migration of authority, decisions are moved outside the standard arena of political contest – elections. In doing so, conflict is displaced and questions of public participation, accountability and legitimacy of decision-making arise.

While multiple accountability relationships may exist to hold Type II bodies accountable, the introduction of new forms of governance bring with it concern over the ability to hold new forms of public decision-making actors accountable. Responding to such concerns, scholars have explored a wide range of potential challenges to democratic accountability (for example, Anderson, 2006, 2008; Bache and Flinders, 2005a; Benz, 2007; Geber and Kollman, 2004; Kahler and Lake, 2004; Olsson, 2003; Peters and Pierre, 1998, 2005; Sørensen, 2006). The concern for accountability is most strict when considering autonomous actors (Busuioc, Curtin and Groenleer, 2011: 853). The emergence of new forms of governance, including the introduction of third-party decision-makers and arm's-length public corporations, however, all cause the lines of accountability to be less clear (Skelcher, 2007: 63). Clarity is lost as a single organization becomes the agent of several principals, while at the same time the policy-making process is clouded by a mixture of representative, 'delegative', and direct democracy (Skelcher, 2007: 63). As Rhodes argues, "sheer institutional complexity obscures who is accountable to whom and for what" (1997: 101). To understand contemporary accountability and legitimacy one must depart from accountability as characterized by liberal democracy as it is not wholly satisfactory to hold solely elected officials to account (Pierre and Peters, 2005: 118-119).

Concern over the growth and accountability of non-departmental forms of government in Canada is not new. In 1973, in his chapter titled "Structural heretics: the non-departmental forms," J. E. Hodgetts positioned the expansion of non-departmental entities as the result of the workload of conventional departments expanding to the point where tasks are unmanageable, as well as the taking on of new functions by government for which the traditional department structure no longer seemed appropriate (1973: 139). In adopting the new forms of organization, Hodgetts raises concern over the relationship with the Minister and the formal structure of ministerial command and responsibility, citing the obscuring of conventional channels of ministerial responsibility and diminishment of parliamentary supervision (1973: 143). The problem is not isolated to Canada. The challenges facing the hierarchical model of responsibility can be seen in what Dennis Thompson calls the 'problem of many hands.' According to Thompson, many political outcomes are the product of actions from multiple contributors who may

not be individually identifiable or whose individual contributions may not be distinguishable (Thompson, 1980: 907).

In parliamentary systems a contributing factor to the diminishment of parliamentary supervision is the increasing variety of accountability chains brought about by the formal dispersion of authority associated outside the traditional department structure. Chains of delegation are not new; parliamentary democracies exhibit multiple steps in the accountability chain between citizens and those who govern (Laver and Shepsle, 1999: 279; Strøm, 2007: 267). For parliamentary democracies, Strøm identifies four distinct steps in the accountability chain: from voters to their elected representatives; from legislators to the executive branch; from the head of government (prime minister) to ministerial or departmental heads; from the heads of executive departments to the civil servants (2000: 267). Yannis Papadopoulos argues, however, that accountability problems increase with the length of the chain of delegation. As the chain of delegation increases, the policy process becomes visible only to those who are closely involved in the decision-making process, the risk being a loss of direct accountability with delegated decision-makers subject to administrative rather than democratic accountability (Papadopoulos, 2007: 479). Papadopoulos concludes that delegation of authority weakens the direct accountability of policy makers as lines of responsibility become dispersed and do not form a coherent accountability system. While many mechanisms of accountability are believed to exist, they fail to operate in an effective manner (Papadopoulos, 2007: 483). Similarly, Andrew and Goldsmith point to increased complexity brought about by a multi actor system in comparison to that of a single agency. A plurality of actors makes it more difficult for citizens to navigate the political system and more difficult to coordinate between the large number of special purpose bodies (Andrews and Goldsmith, 1998: 107). As the number of bodies outside the hierarchy of traditional government departments increase so do the variations in accountability chains that link citizens to decision-makers.

While the organizational structures that troubled Hodgetts were not beyond the pale of ministerial responsibility and therefore may not have warranted the name ‘structural heretics’ (Aucoin, 2003: 7), experimentation in governance structures in Canada have

continued to raise concerns. In Canada, the 1979 Royal Commission on Financial Management and Accountability (Lambert Commission) stated that a group of corporations, labeled as quasi-public, sat at the edge of the public sector. The commonalities among the corporations included a government role in creation by way of legislation, government funding of the corporation, government appointment of some board members, and the absence of formal accountability linkages (Aucoin, 2003: 8). The Office of the Auditor General of Canada raised similar concerns in 1999, stating that new governance arrangements involving external partners in planning, design and achievement of government objectives created situations where the partners were not accountable to ministers and Parliament (Auditor General of Canada, 1999: 23-5). The Auditor General's report stated that of the new governance arrangements examined, "accountability to Parliament was often weak and good governance not always assured" (Auditor General of Canada, 1999: 23-31). Peter Aucoin also raised specific concerns over the use of independent foundations to distribute public funds in 2003. According to Aucoin, the independent foundations retained the characteristics identified as "quasi-public corporations" by the Royal Commission on Financial Management and Accounting (2003: 8). Moreover, one-time endowments transferred to the independent foundations effectively turned public funds into private funds, making decisions in relation to the funds beyond the reach of government and the legislature (Aucoin, 2003: 10). In such cases, it is not a case of an overly complex accountability chain, but the lack of an accountability linkage altogether between government and decision making bodies. As stated by Timothy Heinmiller, one of the greater virtues of ministerial responsibility is the establishment of clear lines of accountability, however, if ministers no longer have meaningful oversight and control, then ministerial responsibility is little more than a constitutional fiction (2011: 125-128).

A second, but related concern is the information costs of multilevel governance. John Dunn has argued that in the modern state most citizens are unable to form a broad understanding of most of what is going on politically (1999: 335). According to Dunn, without sufficient knowledge and understanding, interaction between citizens and decision-makers in which the behavior of the decision maker is rationally sanctioned is

unlikely[3] (1999: 335). While Dunn's analysis focuses upon the relationship between citizens and their elected representatives, the same argument can be applied to the relationship between citizens and Type II jurisdictions.

The existence of a multilevel system of governance creates further difficulties for citizens in attributing policy decisions to policy actors. As argued by Soroka and Wlezien, effective public responsiveness depends upon an accurate signal of what government is doing, while a vertical division of powers increases the number of different governments making policy in a given policy area thus making it less clear which government is doing what (2004: 552; 2011: 33). Identified by Alexander Hamilton in *The Federalist No. 70,* the information challenges faced by citizens are further exacerbated by the actions of governments who engage in blame shifting and credit taking for policy outcomes (Anderson, 2006: 450; Cutler, 2004: 19; Hamilton, 1788). Cameron Anderson argues that a multilevel environment can create incentives for governments within the multilevel system to camouflage their responsibility for decisions and outcomes (2006: 450). This practice of credit taking can be witnessed in Kathryn Harrison's work on government involvement in Canadian environmental policy. Harrison observed that when environmental policy issues were salient in public opinion, both federal and provincial levels of government sought credit for environmental regulation, however, when public interest subsided the federal government was inclined to leave environmental policy to the provinces (2003: 340-341). Such actions demonstrate the willingness of government actors to attempt to take credit when it appears to be politically advantageous, and to shirk responsibility when it is not.

Anderson argues that as political decentralization increases, the ability of citizens to hold a government accountable for political outcomes decreases (2006: 459). Furthermore, as governance becomes more decentralized and multilayered, the ability of citizens to cope with increased challenges to democratic accountability becomes more pressing

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3 There is a large literature in political behavior on the role of information. For greater insight see Delli Carpini and Keeter, *What Americans Know about Politics and Why it Matters* (1996) or Althaus, *Collective Preferences in Democratic Politics* (2003).

(Anderson, 2006: 459). While both Anderson and Soroka and Wlezien focus upon Type I jurisdictions, many of the same challenges can be applied to Type II jurisdictions. Concerns already exist over the ability of citizens to accurately recognize which powers belong to which level of government (Anderson, 2006; Brzinski, Lancaster, and Tuschloff, 1999; Schneider, Jacoby and Lewis, 2011), as authority migrates horizontally to a myriad of Type II bodies the likely result is the further clouding of citizens' perceptions of who is responsible for which policy decisions. It is possible that the increasing complexity of governance arrangements, including the use of autonomous and quasi-autonomous organizations, may bring the governance process closer to the citizen, while at the same time leading to citizen confusion when confronting problems (Peters, 2010: 211). In exploring the use of the private sector in delivering public services, Lorna Stefanick draws attention to the 1995 and 1998 reports from Alberta's Ombudsman, which found that a major impediment to accountability in Alberta is the increasingly complex governance environment in which it is difficult to determine who is responsible. The report highlighted that members of the Office of the Ombudsman often have difficulty determining responsibility, and raised the question of how the average citizen is to know how to address problems (Stefanick, 2011: 248-249).

In addition to concerns that authority migration has weakened democratic accountability, concerns that authority migration results in the absence of accountability relationships, either directly to society, or indirectly through government, have been put forward. According to Hirst, in many cases the use of the term governance signals a threat to conventional forms of democracy or potentially an attempt to sidestep democracy altogether. Instead of being accountable either directly to the citizens or indirectly to the citizens through government, governance mechanisms are seen to be tools of commercial interests or unaccountable bureaucracies (Hirst, 2000: 13). Adam Harmes provides an example of accountability loss in his look at neoliberalism and multilevel governance. Harmes suggests that multilevel governance is characterized by the dispersal of power away from central government and can be viewed as part of a deliberate neoliberal political project with the goal of separating economic and political power. The effects of this separation of powers can be witnessed in the growing use of legal-juridical mechanisms to lock in neoliberal policies and insulate them from democratic influence

(Harmes, 2006: 726-727). Hirst furthers the argument that accountability is being lost, stating that governance through partnerships and networks is intensely local and difficult for outsiders to penetrate, thus conferring benefits only on existing members (2000: 19). As such, it is conceivable that no formal relationship exist, either indirectly through government or directly with the citizens, by which Type II jurisdictions are held accountable.

While numerous concerns have been raised over the weakening of democratic input and accountability, the possibility has also been put forward that accountability fears have been overblown. Bartle and Vass argue that problems of accountability are overcome when self-regulatory schemes are embedded within the systems of transparency and accountability of the modern regulatory society (2007: 897). The act of metagovernance by the state amounts to the supervision of nonelected bodies. The legitimacy and accountability of nonelected actors then become tied to the ability and willingness of government to exercise a credible response if the delegation of authority fails to engender compliance with the metagoverance arrangements (Bartle and Vass, 2007: 897). The rise of the modern state has brought about institutions, processes, and mechanisms of regulatory governance that reinforce accountability, these processes and mechanisms can be extended beyond traditional government to preserve accountability (Bartle and Vass, 2007: 898).

As Mark Bovens suggested in 1990, however, we are dealing with complex organizations, not rational person-like servants waiting quietly on the edges of society to be called upon (1990: 91). When attempting to ‘steer’ such organizations a minister is often confronted with the need to establish a second complex organization (agency) that has the technical expertise to hold the first in check. The second can then be subsequently steered by the department (Bovens, 1990: 93). So while the possibility for state steering exists, it may not be as easily implemented as it first appears.

2.6 Hypotheses: Migration of Authority and Creation of Type II Bodies

As previously stated, there is the perception that changes have occurred in how we are governed. In some instances this includes decision-making responsibility shifting beyond the boundaries of elected government. In response to the idea that there has been a dispersal of decision-making authority, the extent to which authority has migrated beyond the boundaries of elected government at the provincial level in Canada is explored. The creation of Type II bodies forms the focus of Chapters 4 and 6. Chapter 4 explores both the rate at which Type II bodies are being created and the possible factors that may promote the migration of authority to Type II bodies in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario. Chapter 6 looks specifically at creation of Type II bodies in the area of healthcare provision. In the rest of the chapter, the hypotheses and a brief overview of the rationales put forward in Chapter 4 are provided.

In assessing the extent to which concern over potential negative consequences associated with authority migration is warranted, the extent to which governments have utilized the migration of authority in response to policy issues is first explored. In response to concerns over the increasing use of authority migration the first two hypotheses are put forward as follows:

$H_{4.1}$ – The absolute number of Type II bodies is increasing over time.

$H_{4.2}$ – The annual creation rate of Type II bodies is increasing over time.

Beyond the rate of creation is the question of what factors promote the creation of Type II bodies by government. Two potential explanations are put forward: 1) the capacity of government to meet governance demands plays a role in shaping the location of governance responsibility; and, 2) the ideological persuasion of the governing parties is a factor in the creation of Type II bodies.

The level of government capacity as an explanatory factor is based upon the notion that the demand placed on the modern state outstrips the capacity of government to act. When demand increases and capacity fails to keep pace, the capacity gap can only be filled by

delegation, which allows the state to address a wide range of policy issues while not needing to be involved with the day-to-day socio-political interactions (Flinders, 2006: 223-224). In Canada, the existence of government debts and deficits had a pervasive influence on government operations and reform (Kernagan, Marson and Borins, 2005: 6). While the state is unlikely to be able to fulfill all requests, the capacity argument suggests that the lower the fiscal capacity of the state to fulfill its responsibilities (both new and existing) the greater the rate of creation of Type II bodies is likely to be. Accordingly, the third hypothesis tested in Chapter 4 is as follows:

$H_{4.3}$ - The lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies.

The argument for ideology influencing the extent to which authority has migrated outside of government is anchored in the idea that parties on the left tend to resort to more government intervention and parties on the right are more likely to rely upon the market. It has been suggested that multilevel governance is characterized by the dispersal of power away from the national level of government and can be viewed as part of a deliberate neoliberal political project with the goal of separating economic and political power (Harmes, 2006: 726). While neoliberalism is a recent phenomenon, there are long-standing debates over size of government. Neoclassical liberals argued that government should be as small as possible, while welfare liberals promote a larger role for government (Ball and Dagger, 1995: 77-79). In comparison to both forms of liberalism, social democracy calls for a larger state and promote the expansion of public ownership (Ball and Dagger, 1995: 44). Taking both the recent and historic trends into account, it can be argued that political ideology may influence the rate at which Type II bodies are created due to the differing views of the role of the state. Specifically, governments aligned further to the left are expected to create fewer Type II bodies than governments aligned further to the right. This leads to the fourth and final hypothesis evaluated in Chapter 4:

$H_{4.4}$ – The further to the left-of-centre on the political spectrum a government sits the lower the rate of creation of Type II bodies.

2.7 Hypotheses: Migration of Authority and Accountability of Type II Bodies

While Chapters 4 and 6 explore the creation of Type II bodies, Chapters 5 and 7 delve into the accountability relationships between the new decision-makers and both government and society that emerge once authority has been migrated. Chapter 5 looks at the strength of both accountability relationships over time and which possible factors may promote the strengthening of accountability relationships. Type II bodies are again selected from the provinces of Alberta, British Columbia, Nova Scotia and Ontario. Chapter 7 deals directly with the accountability relationships that have emerged from the creation of special purpose bodies charged with the provision of healthcare. Below the hypotheses and a synopsis of the rationales put forward for each in Chapter 5 are provided.

While an underlying assumption of multilevel governance is that centralization has given way to new forms of governance that result in decision-making authority being dispersed across multiple jurisdictions, it can be argued that the state continues to play a fundamental role in the governance process. Through setting rules and maintaining the ability to intervene when policy outcomes do not appear to be in the public interest government can be seen to dominate the policy process. If government has continued to dominate the public policy process, then we can expect formal accountability relationships between government and Type II bodies to be present and to have either remained stable or increased in strength. The question of government's continued governance capacity leads to the first hypothesis of Chapter 5, which is as follows:

$H_{5.1}$ – The accountability relationships between government and Type II bodies has either remained stable or increased in strength over time.

An alternative view is that the new governance arrangements have weakened the state. McBride and Shields argue that the advancement of a neo-liberal agenda aimed at reducing the state and increasing reliance on market mechanisms provides the ideological venue for shifting decision-making outside of politics and is eroding the power of the state (1997: 18). While neoliberalism is a modern construct, there are long-standing

debates over the role and size of government. Liberalism in both its neoclassical and welfare forms promote a smaller version of the state than social democracy. Taking into account both recent ideological trends and the historical debate over the appropriate size and role of the state, it can be argued that the ideology of the governing party influences the structure of the accountability relationship between Type II bodies and government. Specifically, governing parties aligned further to the right are expected to produce weaker accountability relationships when migrating authority as there is stronger belief in minimal state interference. Accordingly the second hypothesis of Chapter 5 is presented as follows:

$H_{5.2}$ – Governing parties further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governing parties further to the right.

In addition to the accountability relationship between government and Type II bodies there is the accountability relationship between Type II bodies and societal actors. Peters provides two opposing views of governance, a traditional approach where the state steers, and a modern approach where societal actors are involved in more self-steering rather than depending upon the guidance of government (Peters, 2000: 36-37). If social forces are taking a stronger role in the governance process, it follows that Type II bodies should be increasingly accountable directly to society as societal actors assert greater influence over policy inputs and outputs. The idea of increasing societal governance capacity leads to the third hypothesis of Chapter 5:

$H_{5.3}$ – The accountability relationship between society and Type II bodies has increased in strength over time.

An additional area of interest is the influence of geographic scale on the accountability relationships between Type II bodies and both government and society. When considering elected government, a trade-off is seen to exist between the efficiency and coordination gains brought about by centralization and the accountability gains brought about by decentralization of accountability. The idea that accountability is strengthened by decentralization is based on the idea that as government becomes more centralized, the

ability of any one region to select a government based upon the government's perceived performance in that region is diminished (Seabright, 1996: 65).

Given the relative lack of elections for Type II bodies and the dearth of information on the effect of geographic scale on the accountability of Type II bodies, two exploratory questions are asked: First, do Type II bodies succumb to the same trade off as traditional elected government? And second, is there a corresponding weakening of accountability to government that occurs with decentralization?

While Type II bodies for the most part lack elections as an accountability mechanism, it is still possible that centralization results in a similar tradeoff between economies of scale and accountability. When a Type II body moves along the continuum from decentralized to centralized, the number of citizens whose preferences must be taken into account increases. As the number of citizens increases, the ability of any one citizen to hold the Type II body accountable based upon their perceived performance of the Type II body decreases. If this is in fact the case, it is expected that the greater the level of decentralization, the greater the capacity of members of society to hold Type II bodies directly accountable.

While it is expected that decentralization of Type II bodies have accountability benefits for citizens, the second question considers whether decentralization has an effect on the accountability relationship between Type II bodies and government. The premise put forward for testing is that as decision-making is decentralized there may be a willingness on the part of government to shift responsibility for holding decision-makers accountable closer to the citizen. If this is the case, it is expected that the greater the degree of decentralization, the weaker the capacity of government to hold Type II bodies directly accountable. Accordingly, the last two hypotheses of Chapter 5 are presented as follows:

$H_{5.4}$ – The accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases.

$H_{5.5}$ – The accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases.

2.8 Healthcare Governance and Canadian Healthcare

As discussed in greater detail in Chapter 3, the evaluation of the above hypotheses can be divided into groups. In Chapters 4 and 5 the hypotheses are evaluated against an original dataset of cases of Type II bodies operating between the years of 1946 and 2005 in the provinces of Alberta, British Columbia, Nova Scotia and Ontario. In Chapters 6 and 7 case studies and qualitative interviews are leveraged to gain greater contextual understanding of the causes and implications that surround the migration of decision-making authority to regional healthcare bodies. Here, a background on Canadian healthcare systems, regional health authorities, and healthcare reform is provided.

Canada's healthcare systems are publically financed with approximately 70% of expenditures financed by the general tax revenues of the federal, provincial and territorial governments. Within this funding structure the governance, organization, and organization of delivery of services has remained highly decentralized (Marchildon, 2013:19). Marchildon attributes this continued path of decentralization to at least three reasons: 1) provincial responsibility for the funding and delivery of the majority of healthcare services; 2) the continued status of physicians as independent contractors; and 3) the existence of organizations, from regional health organizations to privately run hospitals, that operate at arm's length from government (2013:19).

In a federal state, such as Canada, the division of powers is defined in the constitution. The challenge with the healthcare field, however, is that through time the field steadily changes while the Canadian Constitution has not. Neither the British North American Act nor the Constitution Act, 1982 gave explicit jurisdiction over health care, only the jurisdiction over hospitals to the provinces (Fierlbeck, 2013: 5). In addition to holding jurisdiction over hospitals, Subsection 92(16) of the Constitution has been used historically to grant provinces jurisdiction over healthcare as it has been argued that health is a personal and local matter (Braën, 2004: 32; Fierlbeck, 2013: 5). Personal health at the time of British North American Act was considered a purely private mater by society and by extension politicians (Braën, 2004: 28). From a constitutional perspective, André Braën states that the federal governments powers regarding health are limited to three areas: 1) criminal law (by way of its ability to control the manufacturing

and labeling of potentially hazardous products; 2) spending power; and 3) the authority to ensure peace order and good government (Braën, 2004: 34). While constitutionally limited to three areas, Fierlbeck argues that when considered in light of the extent of the spending power and the regulation over pharmaceuticals and other noteworthy goods their impact is quite extensive (Fierlbeck, 2013: 5).

With responsibility for healthcare being divided along provincial and territorial boundaries, health system planning is done at the provincial/territorial level. In some provinces regional health authorities are responsible for more detailed planning at the regional level. Some provinces have also created health councils and health technology assessment agencies to aid both provincial governments and regional health authorities in their planning process (Marchildon, 2013: 20). Provincial governments, however, maintain primary jurisdiction over both the administration and delivery of pubic health services. This means that healthcare entities ranging from regional health authorities to private hospitals are regulated by the provincial government (Marchildon, 2013: 46). It should also be emphasized that with responsibility for healthcare being at the provincial/territorial level and not the federal there is no one healthcare system. Services are covered in one province that may be subject to fees in another. Some provinces require residents to pay healthcare premiums, while others do not. Private hospitals are legal in some provinces but not in others (Boessenkool, 2013: 160).

As stated above, provincial/territorial healthcare systems differ. One way in which health systems may vary is the degree to which decision-making responsibility is decentralized. In the late 1980s the provincial and territorial public finances were poor shape and being made worse by a recession. Beginning in 1991/92 a series of decisions signaled a retrenchment in healthcare. Over the next five years, provinces either tightened health care expenditures or succumbed to the growth in health service demand and by the end of the 1990s there was a growing sense of stress on the healthcare system including increased wait times (Lazar, 2013: 2). Consistent with hypothesis $H_{4.3}$, Boessenkool attributes the provincial struggle with financial deficits to producing healthcare reforms, as most provinces opting to restructure their healthcare system regionally (2013: 161). Regionalization resulted in the simultaneous centralization and decentralization of

decision-making. Decisions that were previously made by the province were decentralized and pushed to the regional level, while decisions that were once made at the local level were centralized to the newly created regional authorities (Tomblin, 2004: 300). The current trend, however, has been the elimination of regional health authorities (Marchildon, 2013: 20) According to Stephen Duckett, the shift to a single health authority in Alberta is in line with the growing recognition of the failures associated with regionalization (Duckett, 2011: 23). In Alberta, the shift to a single health authority was brought about by the need to correct the negative effects of inequality and unhealthy competition that resulted from the regional system (Duckett, 2009: 156).

Beyond the shift from regionalization and back, the majority of the primary health services in Canada are private and therefore decentralized (Marchildon, 2013: 39). The vast majority of physicians remain profit-making independent contractors who are neither employed by regional health authorities or provincial/territorial governments. Hospitals are owned by a number of sources, some are owned by regional health authorities while others are private, mostly not-for-profit, corporations. Services supporting primary and acute care, including ambulance, laboratory services and many ancillary hospital services are private. Moreover, dental, vision, psychology and rehabilitation services are privately funded and delivered by profit-making independent professionals (Marchildon, 2013: 39).

In regards to reforming one of Canada's 13 healthcare systems, it has been found that for the most part governments focus on improvements within the existing health system model instead of moving toward a new model (Lazar, et al., 2013: 175). As mentioned above, Boessenkool attributes the fiscal challenges of the 1990s with producing a rush of healthcare reforms in which most provinces opting to restructure their healthcare system regionally (2013: 161). According to John Lavis, Canada's lack of veto points suggests that political elites (including government officials) representatives from dominant healthcare providers, representatives from the bio-medical industry and other health-based groups are the reason for the lack of reform (2004: 257-258) Similarly, Lazar et al. observe that the most engaged political actors in the healthcare field were much more effective at preventing reform than creating it (Lazar et al., 2013: 216). The citizens' or

publics' role in health care reform is exogenous. The public exercises influence by electing government, but they remain outsiders to the policy process (Lazar, 2013, 10). Researching trust, Abelson et al. found that individuals tend to portray themselves as outsiders of the health system, either entirely alone or in collaboration with their provider against government and private interests (2009: 68).

2.9 Conclusion

As evident from the discussion above there is the sense that the traditional form of state-centred governance has given way, at least to some degree, to new governance structures. While new governance structures bring with them the potential for positive outcomes, this shift has also brought about questions of democratic accountability as decision-making is spun away from the centre, both vertically to different levels of government, and horizontally to actors outside of traditional government. When authority is migrated outside of government and away from elected officials, concerns are raised over public input into the decision-making process, and how the decision-makers are held accountable for their actions.

Wrapped in the language of multilevel governance, the ensuing chapters explore the rate and causes of authority migration, as well as the structure of the accountability relationships that emerge once authority migration has occurred. While this chapter has developed the theoretical background, the subsequent chapter describes the methodological approach and the data that is drawn on throughout the remainder of this undertaking.

Chapter 3

3 Methodology and Data

The central objectives of the research are two-fold: 1) to assess the extent to which Canadian provinces have opted to migrate decision-making authority horizontally in response to policy issues and what factors explain the use of migration of authority as a policy tool; and 2) to establish the existence, nature, and relative strength of the emergent accountability relationships. To achieve these objectives both quantitative and qualitative research methods are employed. Quantitative techniques are used with a custom dataset containing cases of authority migration in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946 and 2005 to assess the extent of authority migration over time as well as the existence and strength of accountability relations. A combination of qualitative and quantitative methods are then utilized to provide a richer account of how specific non-government bodies are held accountable. This chapter provides a description and rationale of the research methods and types of data used to assess the accountability of non-governmental actors in multilevel governance in subsequent chapters. To begin, a rationale will be provided for the selection of provinces and timeframe used in the study. Next a description of how cases of authority migration are identified is provided. Lastly, both the quantitative and qualitative research designs are presented.

3.1 Province Selection and Case Identification

This research project explores the migration of authority to Type II bodies and the resulting accountability relationships at the provincial level in Canada. A provincial approach was adopted for three reasons: provincial politics is relatively under-studied in comparison to the federal politics; it allows for comparisons across provinces; and it provides a larger sample sizes than using national level data alone. As time constraints prohibited the inclusion of all provinces, the provinces of Alberta, British Columbia, Nova Scotia, and Ontario were selected based on region and political ideology. While region was selected based on the potential for variation across Canada, political ideology was selected based on the data requirements of $H_{4.4}$ and $H_{5.2}$.

Regionalism is viewed as an accepted fact of political life in Canada (Simeon and Elkins, 1974: 397; Ornstein, Stevenson and Williams, 1980: 227; Henderson, 2004: 595). The effects of regionalism are reflected in federal cabinet building (Simeon and Elkins, 1974: 397), the shape of national election campaigns – both under the brokerage party model and regionally based party politics (Cross, 2002: 117), and the birth of Canada through regional self-interest (Savoie, 2006: 14). Given its current and historical significance, regionalism was used to select a subset of provinces from across the whole of Canada. In drawing regional boundaries, however, it must be acknowledged that the lines between provincial boundaries, or groups thereof, are somewhat arbitrary and fail to take into account the cultural and political variations that may occur within the boundaries (Jackson and Jackson, 2001: 99). For the purpose of this research, the standard geographical regions of Canada were adopted, based on Statistics Canada's definition: the Atlantic provinces; Quebec; Ontario; Prairie Provinces; British Columbia; and the Territories (Canada. Statistics Canada, 2011). Just as Simeon and Elkins eliminated Prince Edward Island due to its relatively small population size in their exploration of the regional political cultures in Canada (1974: 401), Prince Edward Island and the Territories were eliminated from this study. In 2013 the populations of the Yukon, Northwest Territories and Nunavut were 36.7, 43.5 and 35.6 thousand respectively, while Prince Edward Island's population was 145.2 thousand (Canada. Statistics Canada: 2013). The province of Quebec was also excluded from the study. The decision not to include Quebec is based on the province's unique nationalism and cultural differences. Quebec has a unique cultural history within Canada stemming from its historical connection to New France in contrast to other province's historical connection to British North America (McRoberts, 1997: 2 Wiseman, 2008: 43).

In addition to region, political ideology was used in the province selection process. To satisfy the political ideology requirement, both left- and right-of-centre parties must have formed the government to test the effect of political ideology on the rate of authority migration and the resulting accountability relationships. As a proxy for political ideology, party systems were used. Politically, the provinces were divided into three groups based upon party system: single-party systems; two-party Liberal-PC systems; and two- or three-party systems with competitive left-right politics. The only province to fall into the

single-party category for the duration of the study is Alberta (Dunn, 2001: 457; Stewart and Carty, 206: 105). The Atlantic provinces historically fall under with in the category of two-party liberal-conservative systems (Dunn, 2001: 457), however, more recently Nova Scotia has witnessed competitive three-party politics (Stewart and Carty, 206: 106) The remainder of the provinces fall within the category of having either a competitive three-party system, or a two-party system with a right-left political polarization (Dunn, 2001: 457; Stewart and Carty, 206: 106).

While also a prairie province, Alberta's inclusion in the study is foremost based on Alberta being the only province in Canada with a single-party system. Alberta's Social Credit Party was at the far right of the Canadian political spectrum, believing in a limited role for the state in the economy, and resisting calls for government regulation of the oil and gas industry, marketing boards, and subsidies for new industries (Finkel, 1989: 138-139). When the Social Credit Party was eventually defeated in 1971 it was by the Progressive Conservatives, another right-of-centre party. This party governed consistently from the right of the Canadian political spectrum, the inclusion of Alberta serves an ideological control throughout the study.

The remaining three provinces were selected from the remaining geographic regions, with competitive left-right party politics being the criteria for selection between provinces within a region. Historically the Liberal and Conservative governments that emerged throughout Canada's Atlantic region did not differ ideologically. As a whole, the region was elite-oriented, conservative and traditional (Wiseman, 2008: 24). For its early history, this holds true for the province of Nova Scotia, however, the March 24th 1998 election saw the New Democrats and Liberals finish with 19 seats each and 35% of the vote. The Progressive Conservatives finished third with 14 seats and 30% of the vote. The results marked the emergence of the NDP as a major political player in Nova Scotia (Bickerton, 2001: 63). In the 2009 election the NDP took another step, winning the general election and Darrell Dexter becoming the first New Democratic Premier in the Atlantic region (Nova Scotia. Nova Scotia Legislature, 2014). The recent growth in competitive left-right party politics in Nova Scotia formed the basis for its selection

among the Atlantic Provinces. Ontario and British Columbia were included as both were classified as regions unto themselves and have competitive left-right party politics.

Within each of the four provinces, the identification of cases of authority migration to Type II bodies is based upon the definition of Type II multilevel governance and authority migration. Type II bodies are defined as independent jurisdictions that fulfill specific functions. As discussed in detail in Chapter 2, Type II bodies are characterized by: intersecting memberships in the sense that borders will be crossed and jurisdictions may overlap; being organized across a large number of levels in which authority is not neatly layered but diverse in scale; and being flexible in design (Marks and Hooghe, 2005: 20-21). In terms of authority migration to Type II bodies three conditions must be satisfied: authority over some part of the public realm must be granted to a new or existing body through an act of provincial legislation; the majority of decision-makers within the body must be comprised of individuals who are from outside of the government, legislature, and the public service; and the legislated decision-makers must have decision-making autonomy. Based on these criteria, bodies that act in an advisory rather than a decision-making capacity would be excluded, as would those where fifty-per cent or more of the board is made up of elected representatives or public employees. For Example, the District Health Councils in Ontario, while charged with identifying areas of need, assessing health care alternatives, and establishing priorities at the local level, had no decision-making authority (Ontario. Ontario Health Review Panel, 1987: 14-15). As such, the District Health Councils where excluded from the study. In contrast, Alberta's Regional Airport Authorities were included as the provincial government granted decision-making authority and the boards were not comprised of elected representatives or member of the public service. The range of policy areas where authority has migrated to Type II bodies includes: financial regulation, food and agriculture, education, healthcare, natural resources, public safety, social services, sports and entertainment, transportation, and other public goods.

To summarize, instances of authority migration to Type II bodies in the province of Alberta, British Columbia, Nova Scotia and Ontario between the years of 1946 and 2005 form the universe of cases. In addition, Type II bodies must: be granted authority over

some part of the public realm through an act of provincial legislation; have a majority of decision makers comprised of individuals who are from outside of the government, legislature or public service; and have decision-making autonomy.

3.2 Quantitative Methods – Chapters 4 and 5

In assessing the extent to which provinces have utilized the horizontal migration of authority in public governance and the nature and strength of the ensuing accountability relationships a quantitative approach was first employed. The universe of cases for the quantitative analysis is comprised of all instances of authority migration to Type II bodies in the provinces of Alberta, British Columbia, Nova Scotia and Ontario where the Type II body was in existence at some point between the years of 1946 to 2005. The 1946 to 2005 timeframe was selected as it provides a sixty-year observation window beginning with the emergence of Keynesianism and followed by the shift to neoliberalism as the dominant policy paradigm during the post-WWII time period. In Canada Keynesianism lasted as the dominant paradigm through the 1970s to some point in the early 1980s (Bradford, 2000: 63-64). Keynesianism was characterized as a period of state involvement in both society and economy and the building of a comprehensive welfare state, while the neoliberal period that followed has been characterized by pressures to create a lean state through shrinking social welfare expenditures and the reduction of state regulation (Burke, Mooers and Shields, 2000: 11- 13). The Keynesian paradigm was influenced by the work of John Maynard Keynes. Keynes principal assumption was the existence of a national economy that could intervene to influence levels of investment and domestic income. In doing so, the state could regulate the effects of unemployment through national policies (Teeple, 2000: 17). In contrast to Keynesianism is the neoliberal philosophy of reducing the state and increasing reliance on market mechanisms. Neoliberalism is seen to provide an ideological venue for shifting decision-making outside the public realm and erode the power of the state (McBride and Shields, 1997: 18). As will be discussed in greater depth in Chapter 4, the shift in the perceived role of state suggests that a higher rate of authority migration may be occurring under the neoliberal paradigm than did under Keynesianism.

To test the hypotheses put forward in Chapters 4 and 5 a master dataset was created containing the universe of cases as defined above. The master dataset was then used in combination with provincial fiscal statistics retrieved from Statistics Canada and provincial election results to build topic specific datasets for each chapter. The creation of the master dataset, the creation of the annual authority migration rate dataset, the analysis of the authority migration rate dataset, the creation of the accountability relationship dataset, and the analysis of the accountability relationship dataset will be discussed in turn.

3.2.1 Building the Master Dataset

To build the master dataset instances of authority migration to Type II bodies were identified using the revised statutes for each province (Alberta: 1955, 1970, 1980, 2000; British Columbia: 1948, 1960, 1970, 1996; Nova Scotia: 1954, 1976, 1989; and Ontario: 1950, 1960, 1970, 1980, 1990) and the online publication of statutes from provincial government websites. Annual statute volumes were used to provide details on incremental changes to the legislation that altered the accountability relationship when multiple amendments made it impossible to obtain the information from the revised statutes. Working in chronological order, each piece of legislation in the revised statutes and on government websites was evaluated based upon the criteria for authority migration outlined above. Dataset records were created for: each Type II body in existence in 1946 but created prior to 1946; each new Type II body created between 1946 to 2005; each termination of a Type II body between 1946 to 2005; and each modified accountability relationship for a Type II body that occurred between 1946 to 2005. A record type based upon the four scenarios described was coded for each new record to allow for differentiation when working with the data. For example, the record type would enable the distinction between records of authority migration that occurred between the years 1946 to 2005 and records of authority migration that occurred prior to 1946. In cases where a single piece of legislation creates multiple Type II bodies with the identical governance structure only one record is created. For example, the Alberta Public Libraries Act allows for the creation of both municipal and regional library boards. While multiple municipal and regional boards exist as a result of this legislation only two

records have been created in the dataset, one record for municipal libraries and one record for regional libraries. In taking this approach, instances of decision-making authority being migrated are captured and not the resulting number of Type II bodies.

When collecting the data a unique id was assigned for each instance of authority migration to a Type II body. Subsequent records for termination or modification of the accountability relationships for that Type II body were coded with the same id – linking all records associated with a specific Type II body together. Not captured in the dataset are instances where the legislation has been amended, but the accountability relationships remained unchanged. Moreover, in cases when the Type II body remains in place, but the legislation that created it is repealed and replaced, the Type II body is not coded as terminated and recreated. Instead, only changes to the accountability relationships (if occurring) are captured. In cases when an amendment resulted in one or more of the criteria for authority migration to be no longer satisfied, the Type II body was treated the same as if the Type II body had been terminated and a termination record was entered.

In addition to the type of record, the data collected from the provincial statutes include: the year, chapter, and title of the statute; the year, and chapter of the revised statute; the name or description (i.e. municipal libraries) of the Type II body; the policy area in which authority was migrated; the geographic scale of Type II body; whether the Type II body is a Professional Self-Regulatory body; and the existence of specified accountability mechanisms. The geographic scale of each Type II body was coded based on whether the Type II body's geographic jurisdiction matched: that of a single municipality as in the case of municipal library boards; spanned municipalities as in the case of regional library boards; covered an entire province as does Alberta Health Services; or spanned multiple provinces as does the Atlantic Provinces Special Education Authority. A Type II body was coded as a Professional Self-Regulatory body when government granted responsibility for regulation over a specified profession to a body whose membership and majority of its board is composed of practitioners of that profession.

In coding accountability relationships, a total of fifty-four specific accountability mechanisms, as detailed in Appendix A, were identified. The list of accountability

mechanisms was developed in accordance with Bovens's definition of accountability as discussed in Chapter 2. To be included, the mechanism must either oblige the Type II body to explain and to justify its conduct, enable the public or government to ask questions and pass judgement, or enable the public or government to sanction the Type II body. A preliminary list of accountability mechanisms was initially created and tested against the cases of authority migration for the province of Alberta. New accountability mechanisms were appended to the list as they were identified in the Alberta statutes. Any previously coded statutes were then reexamined to ensure that the newly added accountability mechanisms had not been missed. Following the completion of Alberta, the provinces of British Columbia, Nova Scotia, and Ontario were processed. Each accountability mechanism was coded as a 1 when the mechanism was present within the legislation and a 0 when it was not. In cases where a new authority mechanism was identified in the remaining three provinces, it was added to the list, however, previously coded statutes were not revisited. The decision not to review previous coded statutes was based upon the experience gained reexamining statues in Alberta. When the Alberta statutes were reexamined no additional occurrences of the new accountability mechanism were found.

Once all statutes had been coded, the accountability mechanism variables were used to create six additional variables for each record: three for the accountability relationship between the Type II body and government; and three for the accountability relationship between the Type II body and society. For each relationship, the three variables correspond with the three components of Bovens's definition of accountability: the obligation to justify and explain; the capacity to question and pass judgment; and the ability to sanction. When determining the nature of an accountability relationship, all members of the public must be able to utilize the accountability mechanism for the accountability relationship to be with society. Accountability mechanisms that can only be utilized by narrowly defined subgroups of the population were deemed as supporting accountability to special interest groups. For example, only members of the College of Physicians and Surgeons of Ontario are able to hold members of their board accountable through their capacity to elect board members. All six variables are coded as either

present (1) or absent (0), based on the existence of an accountability mechanism that meets the particular criteria for the variable.

In addition to the six variables used to denote the existence or absence of each element of Bovens's accountability definition, four overall accountability scores were created. For each of the three relationships listed above the scores for the three individual variables were added together to capture the overall strength of the relationship.[4] For example, the existence of all three elements of Bovens's definition of accountability would result in an accountability score of three, while the existence of any two would result in an accountability score of two, and so on, for each of the four accountability scores.

3.2.2 Chapter 4: Dataset Creation

Using the data compiled in the master dataset in conjunction with provincial election results and provincial fiscal data obtained from Statistics Canada a secondary dataset was created. The second dataset was used to evaluate the rate of authority migration to Type II bodies and the extent to which provincial finances and governing party ideology influence the authority migration rate. The secondary dataset contains a record for each province and year between 1946 and 2005. For each record two annual Type II body creation rates are created: one for all Type II bodies; and a second excluding Professional Self-Regulatory bodies. As discussed later in the chapter, the decision to evaluate the rate of authority migration with and without Professional Self-Regulatory bodies in the dataset is based upon the possibility that the inclusion of Professional Self-Regulatory bodies skew results. The decision to evaluate the rate of authority migration with and without Professional Self-Regulatory bodies was taken as a robustness check of the central findings for this chapter's analyses. The rate of authority migration is calculated as the number of instances of authority migration in a calendar year minus the number of terminated instances of authority migration. A cumulative variable is also calculated for

4 Assigning equal value to each of the three components of accountability gives the obligation of a Type II body to justify its actions the same weighting as the ability to sanction, when it could be argued that the ability to sanction is of greater value. When changes were made to the model, for example scoring sanctioning as a 2 or a 0 instead of a 1 or a 0, the results remained consistent with those reported in Chapter 5.

each record and is equal to the cumulative value for the previous year plus the annual rate of authority migration for the current year.

For each row in the secondary dataset the political composition of the legislature is also compiled. Dummy variables were created to denote if a left-of-centre party formed a majority government, a minority government, or the loyal opposition. In distinguishing between political ideologies, the New Democratic Party (NDP) and the Cooperative Commonwealth Federation (CCF) were labeled left-of-centre as content analysis of federal political party manifestos between 1945 and 2000 demonstrated consistent ideological disagreement between parties at the federal level with the NDP to the left of both the Liberal and Progressive Conservative parties (Cochrane, 2010: 590-591). When populating the dummy variables, if a left-of-centre party had both formed the government and been the loyal opposition during the same calendar year the variables were coded based upon which of the two options occurred for the longest duration in that calendar year. For example, if a left-of-centre party was in power for seven months and formed the loyal opposition for the remaining five months, the dummy variables would be coded as 1 (yes) for having a left-of-centre government in power and 0 (no) for having a left-of-centre party as the loyal opposition.

In addition to capturing the political environment in a binary manner, the seat and vote percentage for the left-of-centre parties and the party in power were compiled for each calendar year. In cases where there was an election in the middle of the calendar year the seat and voter percentages were calculated base on the proportional value for that year. For example, if a left-of-centre party held 25% of the seats for 75% of the year and 40% of the seats for 25% of the year, the percentage of seats held would be calculated as (25 * .75) + (40 * .25) for a result of 28.75% of seats.

To populate the political data for Alberta, election results were obtained from the Elections Alberta website (http://www.elections.ab.ca/Public%20Website/746.htm) which provides the votes and seats received by party for each election from 1905 to 2012. British Columbia election results were obtained from two Elections British Columbia publications, *Electoral History of British Columbia 1871-1986* and *Electoral History of*

British Columbia Supplement, 1987-2001, as well as recent election results from the Elections British Columbia website. Nova Scotia election results were obtained from Election Nova Scotia's Election Statistics website (http://electionsnovascotia.ca/election-data/statistics). Ontario elections results, as Elections Ontario does not provide vote level data, were obtained from the results complied by Alan Siaroff in Christopher Dunn's *Provinces: Canadian Provincial Politics* 2nd edition.

In addition to political data, variables were included in each record for disposable income, provincial debt, and provincial deficit. Disposable income is used as an indicator of provincial economic performance as it is the longest running macroeconomic time-series available for Canada (Bélanger and Nadeau, 2010: 171), and the only macroeconomic indicator that provides consistent time-series data from 1946-2005. Disposable income data was obtained from Statistics Canada's *Historical Statistics of Canada* for the years prior to 1980 and from table 384-0012 of Statistics Canada's CANSIM socioeconomic database for the years after 1986. For the five years of overlapping data from 1981 through to 1985 the average of the historical statistics and CANSIM data was used to smooth out the small differences between the two sets of statistics. Disposable income data was recorded on a per capita basis and in 2005 dollars to allow for consistency across provinces and across time. In addition, the percentage change in disposable income per capital over the previous four, five, and six years were calculated. Change over periods of four, five and six years were calculated based on the rationale that a government is more likely to respond to a fiscal trend than smaller shifts in the fiscal environment, while longer periods of time run the risk of smoothing out trends in the fiscal data that the government may have responded to.

Provincial debt was captured as it is considered to be a key measure of the overall financial strength of government (Baker and Rennie, 2011: 359). Unfortunately, no continuous data source was available for government debt, and changes in how debt was calculated over time presented challenges in building a continuous time-series. To produce a single provincial debt variable multiple sets of provincial debt data were obtained from Statistics Canada. Table H404-415 from the *Historical Statistics of Canada* dataset was used to obtain the data for direct and indirect provincial debt for the

years 1933 through to 1975. Net fiscal debt collected from CANSIM table 385-0014 plus the debt guaranteed by the provincial government from CANSIM table 386-0026 were used to calculate public debt for the years 1971 through to 2005. Changes in the method of debt calculation resulted in different debt values being reported for the same year. As a result, for each of the five years in which the two datasets overlapped the average of the two scores was used to calculate the provincial debt value in order to smooth the transition from one dataset to another. Provincial debts were recorded on a per capita basis in 2005 dollars and as a percentage change per capita over four, five, and six year periods.

The third fiscal component, budgetary surplus or deficit, also presented challenges when collecting the data, as an eight-year gap exists in the data available through Statistics Canada. Historical tables H197-208 (Total Net General Expenditures) and H124-135 (Total Net Revenue) were used to calculate the annual deficit for all years up until 1969. Data for 1970 through to 1980 was obtained from CANSIM table 384-0023, while data for 1989 through to 2005 was obtained from CANSIM table 385-0001. Provincial deficits were recorded on a per capita basis in 2005 dollars. As a result of the eight-year gap only a short-term variable, annual per cent change per capita, could be created to present changes in deficit across time.

When appending each piece of fiscal data to the yearly provincial record annual fiscal data is applied to the subsequent calendar year. For example, the fiscal results for 1995 in British Columbia are appended to the record of authority migration in British Columbia for 1996. The rationale for this approach is that government can only respond to what has already occurred or the existing trends in the province's finances.

Also included within the dataset were dummy variables for each of the four provinces, election year, and neoliberalism. All six dummy variables are used as control variables in the regression models discussed below. The province variables are populated with a 1 when the record contains data for that province and 0 if not. The election year variable contains a 1 if there was an election held in that calendar year and 0 if not. Lastly the neoliberalism variable is coded as either a 1 or a 0 to denote the shift from Keynesianism

to neoliberalism, with 1980 onward being coded with a 1. While Keynesianism entered into crisis during the 1970s, 1980 was selected as the breaking point between the two paradigms as it was not until the 1980s that neoliberalism became embedded (Bradford, 2000: 63-64).

3.2.3 Chapter 4: Data Analysis

A full list of Type II bodies can be found in Appendix B. In assessing the migration of authority, both descriptive statistics and regression techniques are employed. First, descriptive statistics are used to evaluate the hypotheses that the rate of authority migration is increasing over time and the absolute number of instances of authority migration is increasing over time. Line charts are used to plot both the annual rate of authority Migration of Type II bodies and the cumulative number of Type II bodies across time for each of the four provinces.

Next, ordinary least square (OLS) regression is used to test the effect of fiscal capacity and political ideology on the annual rate of authority migration. A sequential modeling approach is used to test the independent variables, with a regression model run for each independent variable and a final regression model containing all independent variables. In all models the control variables are included. A sequential approach was adopted so that the R-square, which provides an estimate of the effect of an independent variable on the dependent variable (Pollock, 2009: 180), could be observed for each independent variable and to ensure that results remained robust when all other independent variables were controlled for. Statistical significance is report for 90, 95, and 99 per cent confidence levels. Furthermore, independent variables are evaluated for each province separately and against combined provincial data to allow for comparisons across provinces and to assess overall trends in authority migration.

In addition to looking at both provincial and aggregate data, both the descriptive and regression techniques are used to evaluate the rate of authority migration and the effect of provincial fiscal capacity and political ideology with and without the inclusion of Professional Self-Regulatory bodies. The decision to evaluate the annual rate of authority migration with and without Professional Self-Regulatory bodies in the dataset was based

upon the possibility that the inclusion of Professional Self-Regulatory bodies would skew results.

In three of the four provinces the increase in the rate of creation of Professional Self-Regulatory bodies was most prevalent in the area of healthcare. In Alberta, the Dental Discipline Act resulted in the addition of two Type II bodies in 1990, while the Alberta Healthcare Professionals Act saw an additional seven Type II bodies added between 1999 and 2005. Together the two acts accounted for nine of the eleven Professional Self-Regulatory bodies created in Alberta between the years of 1990 and 2005. In British Columbia the enactment of the Healthcare Professions Act resulted in the creation of nine new Type II bodies since 1994, accounting for eighty-two per cent of new Professional Self-regulatory Bodies created since 1990 in British Columbia. The Regulated Health Professions Act in Ontario resulted in an additional nine Type II bodies since 1991, account for seventy per cent of the new professional self-regulatory bodies created since 1990 in Ontario. The only province that did not experience a sharp increase in the number of healthcare related Type II bodies in the 1990s and early 2000s was Nova Scotia, which only had an increase of three. However, the total number of new Professional Self-Regulatory bodies in Nova Scotia during this fifteen-year period was ten.

When collecting the data it was observed that the frequency at which authority had migrated to Professional Self-Regulatory bodies was higher during the last fifteen years included in the study. Overall, the increase in the number of Professional Self-Regulatory bodies created in the four provinces during the last fifteen years being studied appear to be the result of one of two trends: 1) the increasing degree of specialization within an existing area of healthcare expertise, and 2) the legal recognition and assignment of regulatory responsibilities to existing fields of professional practice. An example of the increasing degree of specialization is the change from one regulatory body governing both physiotherapists and massage therapists in British Columbia to two regulatory bodies, one to govern physiotherapists and a second to govern message therapists, in 1994. Similarly, in Alberta a regulatory body for practical nurses was created through legislation in 2003; this act brought the number of professional nursing bodies in Alberta from two to three. Increased specialization within the healthcare field in general can be

seen in the emergence of Type II bodies charged with regulating professions such as medical laboratory technologists in Alberta, occupational therapists in British Columbia, respiratory therapists in Nova Scotia, and speech and language pathologists in Ontario. Special cases have also occurred, such as the legalization of midwifery that necessitated the need to regulate the new legalized professional body.

To guard against changes in the rate of creation of Professional Self-Regulatory bodies unknowingly biasing the results, the decision was made to assess the data with and without Professional Self-Regulatory bodies in the dataset.

3.2.4 Chapter 5: Accountability Relationships

As with assessing the migration of authority, a secondary dataset was created to assess the accountability relationships that emerge once authority had been migrated. The new dataset uses data collected in the master dataset in conjunction with provincial election results. All records of authority migration between the years of 1946 and 2005 as well as all records for changes in the accountability mechanisms of existing Type II bodies are included in the dataset, while instances of termination of authority migration and records for the creation of Type II bodies prior to 1946 are excluded. Data elements included from the master dataset are: the unique id assigned to each instance of authority migration to a Type II body; the year, chapter, and title of the statute; the name of the Type II body; the record type code (new or modified), policy area, whether the Type II body is a Professional Self-Regulatory body; and the accountability scores for the relationship between the Type II body both government and society.

Using the same data sources used to create the dataset for Chapter 4, the political composition of the legislature was again included. For each record, dummy variables were created to denote if a left-of-centre party formed a majority government, a minority government, or the loyal opposition. Seat and vote percentage variables for the left-of-centre parties and the party in power were also created. The date of the legislation was used to determine which party was currently in power and which election results to use to calculate voter and seat percentages.

Also included within the dataset were dummy variables for each of the four provinces, geographic scale of the Type II body, whether the Type II body is Professional Self-Regulatory, and time period. The province variables are populated with a 1 when the record contains data for that province and 0 if not. Four geographic scale variables were created: single municipality; spans municipalities; single province; and spans provinces. The geographic scale dummy variables were populated with a 1 if the geographic scale of the Type II variable fell into that category, and 0 when it did not. To create time period variables the overall timeframe being studied is divided into six ten-year periods and a dummy variable is created for each. All instances of creation or modification of Type II bodies were coded according to which time period it occurred in, with 1 indicating that it occurred in that time period and 0 indicating it did not.

3.2.5 Chapter 5: Data Analysis

To test the effect of time period, political ideology and geographic scale on the strength of the accountability relationships ordinary least square (OLS) regression is used. As with the analysis of the annual rate of authority migration a sequential modeling approach is used. Each independent variable was separately modeled. To ensure that results remain robust, an additional model with all independent variables is run. Statistical Significance is again reported at 90, 95, and 99 per cent confidence levels. Also consistent with the approach taken for Chapter 4, the independent variables are evaluated against the records for each individual province separately, as well as for all provincial records. This is again done to allow for cross province comparison in addition to the assessing the overall trend in accountability relationships.

Differing from the approach used in Chapter 4 is the treatment of Professional Self-Regulatory Type II bodies. While, Chapter 4 required a separate analysis of the annual rate of authority migration for all Type II bodies and non Professional Self-Regulatory Type II bodies, Chapter 5 uses a Professional Self-Regulatory dummy variable in the regression model. Furthermore, the decision to control for Professional Self-Regulatory bodies is not the result of an increase in number of Professional Self-Regulatory bodies, but instead the fact that Professional Self-Regulatory bodies represent a unique category

of Type II body. As these bodies are self-regulatory, there is the potential for a weaker accountability framework in comparison to other forms of Type II body.

3.3 Quantitative and Qualitative Methods – Chapters 6 and 7

In chapters 6 and 7, a combination of qualitative and quantitative approaches is used to gain additional understanding. While all incidents of legislated authority migration to Type II bodies between the years of 1946 and 2005 in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario formed the universe of cases for Chapters 4 and 5, Chapters 6 and 7 focus on specific case studies from each of the four provinces. The cases include: Alberta Health Services, British Columbia's Health Authorities, Nova Scotia's District Health Authorities, and Ontario's Local Health Integration Networks.

Discussed in great depth in Chapter 6, the decision to select the creation of Health Authorities for case study is multifaceted. The criteria for case selection included the migration of authority in the policy area being consistent across all four provinces, while still providing sufficient provincial difference to allow for cross case comparisons. Provincial differences could include but is not limited to the timing of authority migration, or the institutional design of the Type II body to which authority was migrated. With the creation of Local Health Integration Networks in Ontario in 2006 the Type II health authorities met the "all province" criteria, while the institutional differences between the four provinces met the "provincial difference" criteria. The specific institutional difference of interest is the difference in geographic scale, with Alberta having one province wide health authority, while each the other three provinces have regional health authorities, and the unique decision in Ontario to maintain local hospital boards where in the other three provinces local hospital boards were completely replaced by regional or, in the case of Alberta, provincial boards.

The decision to explore the migration of decision-making authority in healthcare was also influenced by the level of importance Canadian citizens place on healthcare. When asked, "Which of these five issues is the most important issue to you PERSONALLY in this election," the results found that 48.8 per cent of respondents selected healthcare as the

most important issue in 2004 and 40.8 per cent selected healthcare in 2006 (Blais et al., 2007). In addition, the decision took into account the relative lack of academic literature on migration of authority to health authorities since the initial wave of authority migration in the 1990s (Black and Fierlbeck, 2006: 507). Since the initial wave of authority migration the provinces of Alberta and Ontario have moved in directions that have substantially different institutional designs than those that were introduced in the 1990s. Lastly, while the focus of analysis is on the creation of Type II bodies and the resulting accountability mechanism in the Canadian provinces, the migration of decision-making authority in healthcare is widespread, meaning the study of authority migration in Canada has the potential to provide value beyond the Canadian border.

In investigate the migration of authority to Health Authorities and how they are subsequently held accountable, both primary document sources and interviews were used. The remainder of this section describes the collection of documents, the interview process and how the data was analysed for Chapters 6 and 7.

3.3.1 Government Healthcare Document Collection Process

To provide context to the results of the quantitative analysis of the enabling legislation both government publications and contracts or accountability agreements between governments and regional health authorities were utilized. Government publications came from two categories: documents produced by or at the request of the ministry responsible for healthcare; and documents produced by external agencies or offices. Examples of documents produced by or on behalf of the ministry include task force or royal commission reports, government responses to task force and royal commission reports, and government white papers and policy papers. Examples of publications produced by external government agencies or offices include ombudsman reports, provincial auditor reports, or reports by other autonomous or semi-autonomous entities such as the Health Quality Council of Alberta.

To obtain recent government publications a search of government websites was initiated. To find older publications the library catalogues of the University of Western Ontario and the University of Guelph were searched. Each document collected was then searched for

references to other government documents. Referenced documents were checked against those that had already been identified, with new documents then being retrieved. The search criteria for websites and library catalogues included: accountability, citizen engagement, citizen participation, and governance. Contracts or accountability agreements between governments and regional health authorities were searched for on both ministry and health authority websites. A full list of documents is provided in Appendix C.

3.3.2 Interview Questions

Interviews were semi-structured in design, with a set of predefined questions forming the general structure of the interview. The interviewer was free, however, to ask probing questions in response to the participant's answers. The predefined interview questions are provided in Appendix D. The interview questions are divided into three sections: Section 1 approaches accountability as defined by the participant; Section 2 approaches accountability as defined by Bovens; and Section 3 is specific to Alberta and asks about the shift from regional health authorities to one province-wide health authority.

In Section 1, the first question asks the participant to define accountability. This is done to provide perspective to subsequent answers. Questions 1.2 and 1.3 are intended to determine whom the participant believes the Type II body is most accountable to and whose interests the Type II body most represents. Both questions are based on questions asked by Lomas Woods and Veenstra in their study of the motivations, attitudes and approaches of regional health authority board members published in 1997 (1997a: 673). Questions 1.4 ask the participant to describe the accountability relationship between the Type II body and government if not previously discussed, while question 1.5 does the same for relationship between the Type II body and society. Following each question, additional probes regarding the specific accountability mechanisms, the perceived effectiveness of the accountability mechanism or the need for change or strengthening of the accountability mechanism could be employed to further flesh out the participant's position.

The questions in Section 2 are based upon Mark Bovens's definition of accountability and mirrors the data collected for quantitative analysis. In modelling the questions after the variables used for the quantitative analysis the results can be directly compared and contrasted to the quantitative findings. As a result the case study objective of providing additional context to the quantitative results can be achieved. As previously stated, Bovens identifies three parts to an accountability relationship including the obligation of the actor to explain and to justify his or her conduct, the ability for the forum to pose questions and pass judgement, and that actor may face consequences (Bovens, 2007: 450). For both the relationship between government and the Type II body and society and the Type II body the participant is asked to what extent there is an obligation on the part of the Type II body to explain and justify their actions; to what extent the ability exists to pose questions to the Type II body regarding their actions; and to what extent there is the ability to sanction the Type II body if their actions do not meet expectations. After each question follow-up questions are used to determine not only the formal existence of each of the three aspects of the accountability relationships, but perceived success or failure in enacting each component.

The third section was only asked to participants from the province of Alberta. In Alberta nine regional health authorities were migrated into a single province wide health authority in 2008. Participants are asked what impact the shift from regional authorities the single province health board have had on the ability of both government and society to hold decision-makers accountable. The question is included to gain greater insight on influence of geographic scale on accountability relationship. Participants from Alberta are asked this question, as Alberta is the only province to move to a single provincial entity from regional boards.

3.3.3 Interview Participants

All names, e-mail address and phone numbers used to contact perspective participants were obtained from organizational websites or publically available reports, such as year-end reports. Interview participants were selected across four categories: elected representatives, ministry employees, interest groups members, and members of the

organization being studied. The purpose of including participants from a diverse set of stakeholders is to obtain a wide range of viewpoints for inclusion in the analysis.

The elected representatives category includes members of both governing and opposition parties. Within a parliamentary system, the exercise of state power is done in accordance with parliamentary accountability where the government answerable to Parliament and Parliament has the means to hold to account those who exercise the power of the state, be they elected or non-elected officials (D'Ombrian, 2007: 198-199). For this reason, the views of the party forming the government and those who are charged with holding government to account were sought. Interviews were sought from the Minister as well as the health critics from the opposition parties. Introductory e-mails were sent directly to each potential participant and followed up with additional e-mail requests, and finally a phone call if no response was received. A copy of the standard text used in the introductory e-mail is included in Appendix E.

Interviews were also sought from public service employees. The size, complexity, and number of functions undertaken by the state make it impossible for elected officials to be involved in all aspects of how we are governed. Consequently, members of the public service perform large portions of government activities (Flynn, 2011: 43). As public employees perform much of the activities of government, they are attuned with the operational reality of accountability mechanisms. To recruit participants an introductory e-mail was sent to the appropriate branch of the public service requesting an interview with a representative of the department. In Ontario the introductory e-mail was sent to the Health System Accountability and Performance branch of the Ministry of Health and Long-Term Care. In Alberta, British Columbia, and Nova Scotia the appropriate area within the ministry was not clearly identified on publically available organizational charts. As a result, introductory e-mails were sent to the deputy minister's office. If no response was received a follow-up e-mail was sent. In all cases, responses to the follow-up e-mail were received.

The views of interest group representatives where sought to gain insight into how the accountability of the Type II bodies were perceived from outside of government and the

Type II body. In each province the provincial associate of the Canadian Health Coalition and the province's medical association were contacted for interviews. The health coalitions were selected due to their position as coalitions of organizations and individuals who are active or interested in healthcare policy at the provincial level. Medical associations were selected as they represent an important constituency group in the delivery of health services. For both the health coalitions and the medical associations introductory e-mails were sent in accordance with the contact information provided on the website to request an interview with a representative of the organization. In cases of non-response follow-up e-mails were sent and finally if needed a phone call was placed to the organization.

Similar to the need to interview both elected politicians and public service employees, both board members and upper management were recruited from the health authorities. In each province, members of both the board and management were recruited from the health authority responsible for the capital region. Participants from a second health authority – with the exception of Alberta, which has only one health authority – were recruited to allow for additional perspectives to be put forward. In selecting a second regional authority, regions that include rural areas were selected to offset the largely urban characteristics of the capital region. In recruiting participants from the capital region prior members of the board and management were recruited when existing members declined to be interviewed. In selecting a second regional health authority, when members declined to participate an alternative region was identified and approached. When contact information was available, board chairs and CEOs were contacted directly. When such contact information was not available, the introductory e-mail was sent either to organizational e-mail accounts, or to specified individuals identified on the organizations website, with the request that it be passed along to the desired recipient.

While ideally participants from each category and groups within each category would have been interviewed, this was not the case as not all possible interviewees consented to being interviewed. The number of participants per category by province is shown in Table 3.1.

Table 3.1: Interview Participants by Category

	Alberta	British Columbia	Nova Scotia	Ontario	Total
Elected Representatives	1	1	1	2	5
Ministry Employees	1	1	1	1	4
Interest Groups	2	1	1	1	5
Type II Board	0	2	1	2	4
Type II Management	1	2	2	2	7
Total	5	7	6	8	26

Lastly, all participants were also required to read and sign a research consent form. The research consent form outlines the purpose of the research, the interview procedure and questions, possible risks and benefits, details pertaining to withdrawing from the study, and protection of participant confidentiality. In signing the consent form the participants state that they have read the research consent form, have had the nature of the study explained to them, and agree to participate. A copy of the research consent form is included in as Appendix F.

3.3.4 Interview Procedure

All interviews were conducted over the phone or over the Internet through Skype. While it is acknowledged that there are inherit disadvantages in using phone interviews, it was felt that the advantages far outweighed them. The disadvantages of conducting phone interviews include: evidence that suggests that open ended questions, such as those asked in this study, yield shorter answers in comparison to face to face interviews (Singleton and Straits, 2005: 241); there is increased difficulty in establishing trust and rapport with the respondents (Singleton and Straits, 2005: 241); and there is an inability on the part of both respondents and the interviewer to make use of visual in addition to verbal communication channels (Berg, 2007: 110). The largest advantage to conducting the interview by phone is the substantial savings in both time and money. There are additional advantages in terms of flexibility as interviews could be scheduled on very short notice with participants on both the East and West coast of the country.

When contacting the participant the option was given for the respondent to provide a contact number, or initiate the phone call. This option was provided as not all phone numbers were publically available. At the start of each phone interview participants are asked to consent to having a digital recording made of the interview. A set of predefined questions then formed the overall framework for interview. The order, however, in which the questions were asked, was not standardized across all participants. Instead, leeway was given to the interviewer to adjust the order based upon the responses to initial questions. For all participants the questions in Section 1 were asked in the predetermined order, with the participant defining accountability and then specifying whom they believe the health authorities are most accountable to. This is done to ensure that participant's answers are not biased by the definition of accountability as set out in the quantitative analysis. Depending upon how the participant defines accountability and their response to the question, whom do you believe the health authority is most accountable to? Questions from Section 2 may be asked as part of the discussion. For example, if the participant defines accountability along the lines of Bovens's definition and states that health authorities are most accountable to government, then questions from Section 2 regarding government can be asked as part of this discussion. In instances where the participant's and Bovens's definition of accountability do not align, the questions from Section 2 are asked upon the completion of Section 1. The same approach is taken with Section 3; if the topic emerges as part of a different discussion the questions regarding the shift from regional to one single provincial body in Alberta may be asked out of order.

This semi-structured approach was taken as it provided sufficient structure to ensure that key questions were asked, while providing enough flexibility to the interviewer to discuss topics as the emerged within the conversation and to pursue topics that may or may not have been included within the predefined interview questions. For example, while the predetermined questions do not touch on the ideal number of health authorities in Ontario, such a line of inquiry can be pursued if a participant engages in this topic in relation to accountability to either citizens or government.

The interviews were on average 46 minutes in length. For all interviews notes are taken throughout the duration of the interview. In addition, each participant was asked if they

would consent to having an audio recording of the interview made. In total eighty-five per cent of the participants agreed to the audio recording. Upon completion of the interview the interviewers notes, as well as the digital recording were transcribed. In instances where the participant's answer is unclear a follow-up email is sent to the participant to ensure that the participants intent is captured correctly. All participants are asked at the end of the interview process if they desire a copy of the complete work.

3.3.5 Data Analysis: Chapter 6

Chapter 6 examines the factors leading to the migration of authority to Type II bodies in provincial health care. In each of the four provinces the initial migration of authority to Type II bodies as well as subsequent changes to the governance model is explored. Consistent with Chapter 4, Chapter 6 assesses the effect of fiscal capacity and political ideology, but also seeks to identify additional factors that have contributed to the migration of authority in each province. In investigating which factors played a role in the decision to migrate authority to Type II bodies, the provincial governments' framing of the challenges facing the health care system were explored. To determine how the challenges facing health were defined, government policy documents, commission or task force reports, provincial legislation, and provincial regulations are used. Both the description of the existing structure and the recommendations or proposals for change were examined to build an understanding of how policy challenges in health care were framed leading up to the migration of authority.

In addition to exploring how the policy problem was framed, the eventual policy outcomes are also considered. Specifically, the initial policy framing and the resulting policy implementation are assessed for inconsistencies.

3.3.6 Data Analysis: Chapter 7

Chapter 7 uses both quantitative and qualitative approaches to explore the accountability relationships between the regional health bodies and both government and society. The chapter evaluates the effect of time, political ideology, and geographic scale on the accountability relationships. This is done through the evaluation of government documentation, contracts or accountability agreements between governments and

regional health authorities, and the use of descriptive statistics as well as individual interviewee responses from participant data. In evaluating accountability relationships both the existence and effectiveness of accountability mechanisms are considered.

The existence and strength of the accountability relationships between health authorities and both government and society is first assessed based upon the existence of documented accountability mechanisms. In doing so, government-mandated mechanisms as set forth in the legislation, regulations, and accountability or operating are taken into account. Accountability mechanisms are identified based upon Bovens's definition of accountability. The strength of the accountability relationship is assessed based upon the extent to which all three aspects of each accountability relationship exist.

Moving beyond the formal prescribed accountability mechanisms, the ability of both society and government to hold health authorities accountable is evaluated. To do so the interview transcripts are used. To code the data, the widely accepted three-step procedure consisting of: 1) open coding or theming; 2) axial coding or tagging; and 3) selective coding (Archer and Berdahl, 2011: 350-351) is employed. In employing this approach, the data will be first explored for general patterns or themes, then searched for specific instances of each theme, and finally reviewed for both additional supporting and discrepant evidence (Archer and Berdahl, 2011: 350-352).

3.4 Ethical Considerations

The risks posed by this research are minimal. Interviewees may feel some psychological or emotional discomfort answering questions about the organization's level of accountability if they have concerns over how the organization or those working for or with the organization will be perceived. Participants may feel some stress over being identified if they believe their comments to be unfavourable to the organization they are associated with. There is also the risk that the participant may be identifiable due to the small number of overall participants and the public nature of the organizations being studied.

In response to the potential risks, no information that discloses the identity of the participant will be released or published without the participant's consent. Furthermore, at the recommendation of the Research Ethics Board, findings will be presented in a summarized manner to minimize the risk that participants will be identified as a result of the small number of potential participants linked with each organization.

To further protect the privacy of participants all audio recordings and transcripts will be stored electronically and encrypted. Four copies of each file will be maintained: One on a personal laptop, one on an external backup drive, one on DVD and one on the H: (home) drive on the social science network to provide offsite backup. Audio recordings will be kept for 5 years after the thesis defence. Transcripts will be maintained indefinitely.

3.5 Conclusion

The purpose of this research is to assess the extent to which provinces have utilized Type II multilevel governance bodies in public governance and to gain a greater understanding of the nature and strength of the accountability relationships that emerge when authority is migrated. To achieve these objectives both quantitative and qualitative research methods are employed. A quantitative approach was first employed to make use of the large number of cases available across the four provinces. Qualitative analysis was then employed to investigate specific cases in considerably more depth. The strength of existing theories regarding the migration of authority and the resulting accountability relationships were tested using OLS regression, while qualitative coding of documents and interview responses allowed new areas of inquiry to emerge and provide context to the quantitative findings.

Chapter 4

4 Creation Myths: The Migration of Authority

My little girl Miller can take the fridge magnets with the letters on them, put any three letters on the fridge in any order she wants to and she'll get some government agency that you've never heard of but you're paying millions and millions a year to sustain."

-Tim Hudak, 2011 Ontario Leader's Debate

For the majority of the past three centuries governance in the public realm has been associated with the state and a dominant pattern of hierarchical governing in which government decides the laws and policies to be adopted (Peters and Pierre, 2006: 209). This traditional approach to governance, however, has been challenged as societal actors seek greater autonomy (Peters and Pierre, 2006: 209-210) and the governance demands on the state expand to the point where capacity requirements cannot be fulfilled without widespread delegation (Finders, 2006: 223). Caught between increased demands on one hand and limited fiscal budgets on the other, governments have engaged a range of private and public actors in the governance process (Torfing and Triantafillou, 2011: 5).

The demands placed upon government as the provider of public goods and services have pushed government toward the use of external actors to meet public demand, while at the same time growing societal complexity has made governance more difficult in terms of both managing demand and managing the growing number of interconnections (Pierre and Peters, 2005: 121-122). The attitude and actions of citizen have also played a role in challenging the traditional patterns of governance. There has been a decline in citizen confidence in the public sector, a reduction in citizen participation in politics, and a pattern of voting for governments who pledge to reduce the role of the state (Peters, 2004: 130). The resulting change in governance model has been described as the 'marketization' of the public sector, where an increasing number of special purpose bodies and private actors are enlisted to deal with specific policy problems (Andrew and Goldsmith, 1998: 104).

In response to the idea that the traditional model of public governance is undergoing a change that is resulting in the dispersal of decision-making authority, this chapter

explores the extent to which authority has migrated beyond the boundaries of elected government at the provincial level in Canada. To do so, legislated instances of authority migration in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946 and 2005 form the universe of cases. Two areas of inquiry are explored: the extent to which the aforementioned provinces have migrated decision-making authority; and the degree to which period in time, political ideology and government fiscal capacity are able to explain variation in the likelihood of government migrating authority.

4.1 Migration of Authority and Governance

One dimension along which governance can vary is centralization of authority. Authority can be highly concentrated in a single hierarchical entity that claims exclusive jurisdiction or dispersed among various nodes, each exercising only limited jurisdiction (Kahler and Lake, 2004: 409). The dispersion of authority can then be thought of as occurring along both a vertical and horizontal axis. Along the vertical axis authority can be distributed to successively more local levels of government in which the more limited jurisdictions are nested within larger jurisdictions. Along the horizontal axis the authority can be dispersed to actors outside of government.

As discussed in Chapter 2, the dispersion of authority, both vertically and horizontally, is captured by Marks and Hooghe's Type I and Type II models of multilevel governance. The analytical focus of multilevel governance is the increasingly contested jurisdictional and territorial boundaries both within and beyond the state, with the fundamental question being how to explain the dispersal of central government authority both vertically to actors at other territorial levels and horizontally to non-state actors (Bache and Flinders, 2005: 4). Marks and Hooghe provide two contrasting models for the dispersion of authority outward from the centre: Type I multilevel governance, which is concerned with power sharing among governments operating at different levels; and Type II multilevel governance, which denotes independent jurisdictions that fulfill specific functions. Focused on the vertical dispersion of authority, Type II bodies are defined as having intersecting memberships in the sense that borders will be crossed and jurisdictions may overlap; as being organized across a large number of levels in which

authority is not neatly layered but diverse in scale; and being flexible in design, allowing it to respond to changing citizen preferences and functional requirements (Hooghe and Marks, 2005: 20-21).

While contrasting in structure, the applications of Type I and Type II multilevel governance are complementary with the selected model of multilevel governance being a function of the problem to be addressed (Marks and Hooghe 2005: 29). Furthermore, Type II multilevel governance structures can be embedded in legal frameworks determined by Type I jurisdictions (Marks and Hooghe, 2003: 238, 2005: 24). The use of Type II multilevel governance as a tool of government where government delegates authority in response to a specific policy circumstance can be witnessed at the provincial level. While Type II multilevel governance may occur when private actors play a dominant role in the policy making process, causing public actors to adopt privately negotiated regimes (Marks and Hooghe, 2005: 25), it is a government's use of Type II bodies to delegate authority outside the confines of elected government that is the focus of this chapter.

The first objective is to place recent trends in the creation and termination of Type II bodies within a historical context. It has been argued that policy areas are becoming increasingly crowded, with government becoming just one of many actors involved in the governance process (Kennett, 2010: 20). If, as suggested, there has been an increased interest in governance partnerships between government and societal actors and an increase in the dispersal of political authority across multiple governance actors (Kooiman, 1993: 1, 35; Andrew and Goldsmith, 1998: 104; Peters, 2004: 130; Flinders, 2006: 224) an increase in both the rate and absolute number of Type II bodies should be witnessed across time. This leads to the chapter's first two hypotheses, which are as follows:

$H_{4.1}$ – The absolute number of Type II bodies is increasing over time.

$H_{4.2}$ – The annual creation rate of Type II bodies is increasing over time.

Beyond the rate of creation, there is also the question of what factors promote the creation of Type II bodies by government. Two potential explanations are put forward in this chapter: first, the capacity of government to meet governance demands shapes the location of governance responsibilities; and, secondly, the ideological persuasion of the governing parties is a causal factor in the creation of Type II bodies. Both of these potential explanations are considered in greater detail.

The argument that increased demands placed on government leads to increased migration of authority to Type II bodies is based upon the premise that the demands on the modern state outstrip the capacity of government. The growth in responsibilities demand a structural capacity that can only be filled with the widespread delegation that allows the state to address a wide range of policy issues, while not needing to be involved with the day-to-day socio-political interactions and in doing so simultaneously blurring the public/private distinction (Flinders, 2006: 223-224). The influence of capacity as a rationale for including new governance actors in the public realm can be seen in the argument put forward for the use of public-private partnerships that emerged in Canada in the mid-1990s. Changes to the governance structure were made with the intent of minimizing on-budget government expenditures and not increasing current levels of government debt (Vining and Boardman, 2008: 12). Kernagan, Marson, and Borins identified the pervasive influence of debt and deficit on public-service reform and government reform, which included privatization and the contracting out of public services (2005: 6). When the state is unable to fulfill the governance demands placed upon it, the capacity argument suggests that the lower the fiscal capacity of the state to fulfill its responsibilities (both new and existing) the greater the rate of creation of Type II bodies is likely to be. Accordingly the chapter's third hypothesis accesses the effect of fiscal capacity on the rate of Type II body creation and is presented as follows:

$H_{4.3}$ - The lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies.

The argument for ideology influencing the extent to which authority is migrated outside of government is anchored in the idea that parties on the left tend to resort to more

government intervention and parties on the right are more likely to rely upon the market. Adam Harmes suggests that multilevel governance is characterized by the dispersal of power away from central government and can be viewed as part of a deliberate neoliberal political project with the goal of separating economic and political power. The effect of this separation of powers can be witnessed in the growing use of legal-juridical mechanisms to lock in neoliberal policies and insulate them from democratic influence (Harmes, 2006: 726-727). Similarly, the emergence of new public management in the 1980s, with its promotion of the private sector and the delegation of authority as a remedy for the high taxes and deficits associated with the welfare state, has been characterized as a neoliberal approach (Hoehn, 2011: 77). As argued by McBride and Shields, the advancement of a neoliberal agenda, aimed at reducing the state and increasing reliance on market mechanisms, provides the ideological venue for shifting decision-making outside of politics and is eroding the power of the state (1997: 18). This suggests that the more closely aligned the government in power is with a neoliberal ideology the greater the rate of creation of Type II bodies, while governments on the left would be expected to resort less frequently to the use of Type II bodies in the governance process.

While neoliberalism is a recent phenomenon, there are long-standing debates over size of government. Neoclassical liberals have long argued that government should be as small as possible and act as a night watchman whose only role is to protect the person and property of individuals, while welfare liberals have promoted a larger role for government, including the existence of state run institutions (Ball and Dagger, 1995: 77-79). In comparison to both forms of liberalism, social democracy calls for a larger state and promotes the expansion of public ownership (Ball and Dagger, 1995: 44). Drawing upon both the recent and historic trends, it can be argued that differences in political ideology, specifically how the role of the state is viewed, may influence the rate at which Type II bodies are created. Specifically, governments aligned further to the left are expected to create fewer Type II bodies than governments aligned further to the right due to their belief in an expanded role for the state. Accordingly this leads to the chapter's final hypothesis:

$H_{4.4}$ – The further to the left-of-centre on the political spectrum a government sits the lower the rate of creation of Type II bodies.

4.2 Data and Methodology

To test each hypothesis the custom dataset described in full in Chapter 3 is used. The dataset includes the incidents of creation, termination, and modification of Type II bodies in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946 and 2005. The reasons to use provincial data are threefold: provincial politics is relatively under-studied in comparison to the federal level, it allows for comparisons across provinces, and it allows for the creation of a larger sample size than the use of national level data alone would provide.

The dataset includes records for Type II bodies created prior to 1946 and still in effect in 1946, new Type II bodies created after 1946, and cases of Type II body termination since 1946. For a Type II body to be included in the dataset three conditions must be satisfied: authority over some part of the public realm must be granted to the body through an act of legislation; the majority of decision-makers within the body must be comprised of individuals who are from outside of the government, legislature, or public service; and Type II body must have decision-making autonomy. For example, the Alberta's Child and Family Services Authorities created under the Child and Family Services Authorities Act of 1996 are included within the dataset as they are created by legislation, the boards are comprised of non-government members, and they have the autonomy to make decisions for their region including: the planning and managing the provision of child and family services; the determining of priorities in the provision of child and family services and allocating resources accordingly; and working with other Authorities, the Government and other public and private bodies to co-ordinate the provision of child and family services.

To test the effect of political ideology and government fiscal capacity on the creation of Type II bodies the annual creation rate of Type II bodies is used as the dependent variable. The annual creation rate is calculated by subtracting the number of terminated Type II bodies from the number of newly created Type II bodies in each calendar year.

The independent variables used as a proxy for government fiscal capacity are disposable income as an indicator of overall provincial economic health, and provincial debt as an indicator of government fiscal capacity. Both the provincial economic health and the government finances are included as they measure different financial aspects within the province. It is possible that provincial finances are structured in a way that limits capacity even during a booming economy. In assessing government finances, provincial debt is utilized as it is considered to be a key measure of the overall financial strength of government (Baker and Rennie, 2011: 359). Disposable income is used as an indicator of provincial economic performance. As the longest running macroeconomic time-series available for Canadian data (Bélanger and Nadeau, 2010: 171), disposable income is the only macroeconomic indicator that provides consistent time-series data from 1946 to 2005.

Both disposable income and provincial debt are measured using the percentage change per capita over the previous five years. A five-year period is used based on the rationale that a government is more likely to respond to a fiscal trend than smaller blips in the fiscal environment and that too long a time period runs the risk of smoothing out trends in the fiscal data that the government may have responded to. As discussed in Chapter 3, no continuous data source was available for government debt, and changes in how debt was calculated over time presented challenges in building a continuous time-series. To produce a single provincial debt variable two datasets from Statistics Canada were used, one containing records of public debt from 1933 to 1975 and a second containing records of public debt from 1971 to 2005. The changes in the method of debt calculation resulted in different debt values being reported for the same year. For each of the five years in which the two datasets overlapped the average of the two scores was used for the provincial debt value in order to smooth the transition from one dataset to the other. For both disposable income and provincial debt, the previous year's fiscal data is used as governments can only react to what has previously happened.

To test the effect of political ideology the percentage of seats held by a left-of-centre party is used as an independent variable. While a brokerage model has been traditionally applied to Canadian party politics, Cross and Young's examination of party attitudes

suggest clear patterns of ideological differentiation between parties (2002: 859). Cross and Young conclude the Canadian party system manifests some characteristics of an ideological model (2002: 878). Content analysis of federal political party manifestos between 1945 and 2000 has demonstrated an ideological disagreement between parties at the federal level. The analysis places the NDP consistently to the left of both the Liberal and Progressive Conservative parties that alternate holding the position on the far right (Cochrane, 2010: 590-591). While organizational independence exists between the federal Liberal and Conservative parties and their provincial counterparts, the NDP remains a fully integrated organization with membership at the provincial level resulting in automatic membership in the federal party (Esselment, 2010: 871-872). Given the connection between the provincial and federal NDP parties, and the NDP's consistent position to the left at the federal level, the percentage of seats held by the NDP or CCF party forms the percentage of seats held by left-of-centre parties.

An alternative independent variable, a left-of-centre party forming the government, was considered, however, the absence of left-of-centre governments in Alberta and Nova Scotia facilitated the decision to use the number of seats held by left-of-centre parties as it allows for a consistent regression model across all datasets. Furthermore, it is expected that the greater the percentage of seats held by left-of-centre parties, the stronger the voice of the left will have in parliament and the greater the influence the left-of-centre will have on how the province is governed.

Ordinary least square (OLS) regression is used to test the effect of each independent variable on the rate of creation of Type II bodies. A Sequential modeling approach is used in which each independent variable is tested separately and then as part of a larger model. Sequential modeling was adopted so that the effect of each independent variable on the dependent variable, as expressed by the adjusted R^2, could be observed independently. For each hypothesis the models are run for the entire dataset to identify overall trends and then for each province individually to identify differences between the provinces. Due to the skewing effect caused by Professional Self-Regulatory bodies

discussed in Chapter 3[5], when working with the aggregated provincial dataset the models will be run first for all Type II bodies, then for all Type II bodies excluding Professional Self-Regulatory bodies. When working at the individual province level, Professional Self-Regulatory bodies are omitted from the dataset.

The regression models also contain a number of control variables. An election year dummy variable is included within all models to control for any effect an election may have on the rate of creation of Type II bodies. The election year dummy variable is coded with a 1 for years in which an election is held and 0 for all other years. Dummy variables are also created for each province to control for provincial differences. The provincial dummy variables are included in the model when the aggregate provincial dataset is evaluated. The Ontario dummy variable is omitted from the regression models, making Ontario the provincial variable against which all other provincial variables are compared.

An additional control variable for neoliberalism is also included in the regression models. The neoliberalism dummy variable is used to denote the shift in policy paradigm from the Keynesian welfare state to a neoliberal political agenda. While as discussed above, there has been and remains an ideological difference between the left and right in regard to the role of the state, the shift from Keynesianism to neoliberalism is reflected in the policy platforms of parties on both sides of the political spectrum (Larner, 2000: 8-9). The neoliberalism dummy variable allows for the across party shift toward neoliberalism to be controlled for by denoting the years in which neoliberalism has been the more dominant policy paradigm. Neoliberalism existed prior to 1980; however, it was not until the 1980s that it became embedded (Bradford, 2000: 63-64). While the exact timing of the shift between paradigms, especially for each political party can be contested, the neoliberalism dummy variable is coded as a 1 for the years of 1980 through 2005 and 0 for the years 1946 through 1979.

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5 Between 1990 and 2005 the number of Professional Self-Regulatory bodies increased rapidly as existing professional bodies, largely in healthcare, splintered into multiple new Type II bodies. The occurrences of such events cause spikes in the creation rate of Type II bodies, skewing the data. Testing the hypotheses with and without Professional Self-Regulatory bodies is done to control for such spikes.

While OLS regression is utilized in testing the effect of political ideology and government fiscal capacity, descriptive statistics are used to test the hypotheses that the rate and absolute number of Type II bodies is increasing over time. As with the regression analysis, the data is presented first for all forms of Type II bodies and then excluding Professional Self-Regulatory bodies. The cumulative number of Type II bodies is calculated by adding the annual creation rate to the previous years cumulative value. The baseline for the cumulative number of Type II bodies is the number of Type II bodies operating in and not terminated during the 1946 calendar year.

4.3 Results: Annual Rate of Creation and Absolute Number of Type II Bodies

The first of the four hypotheses to be evaluated is $H_{4.1}$ – the absolute number of Type II bodies is increasing over time. Results are presented in Figure 4.1a through 4.1d, which containing all forms of Type II bodies, and Figure 4.2a through 4.2d in which Professional Self-Regulatory bodies are excluded.

As depicted in Figure 4.1a through 4.1d the trend across provinces has been the gradual increase in the cumulative number of Type II bodies over the past sixty years. In Alberta, this trend began to reverse in the late 1980s, with the cumulative number of Type II bodies decreasing between 1990 and 2005. However, a corresponding shift, from an increasing to decreasing cumulative number of Type II bodies, is not evident in any of the other provinces. While the other provinces have sudden decreases in the cumulative number of Type II bodies during specific years – 2003 in British Columbia, 1999 in Ontario, and 2001 in Nova Scotia – all three provinces have since continued to add to the number of Type II bodies.

Also evident in Figure 4.1a through 4.4d is a decline in the rate of accumulation of Type II bodies during the time period immediately prior to 2005. In Alberta, Nova Scotia and Ontario the leveling of the cumulative number of Type II bodies begins in approximately 1988, while in British Columbia the trend begins a decade earlier in 1978. While the cumulative results show a decrease in the creation rate across all four provinces, the annual results indicate that in each of the four provinces new Type II bodies have

continued to be created throughout the entire duration of the period being studied. Overall, the results suggest a continuing increase in the number of Type II bodies supporting the hypothesis that the absolute number of Type II bodies is increasing over time.

Figure 4.1: Type II Body Annual and Cumulative Creation Rate by Province

Figure 4.1a

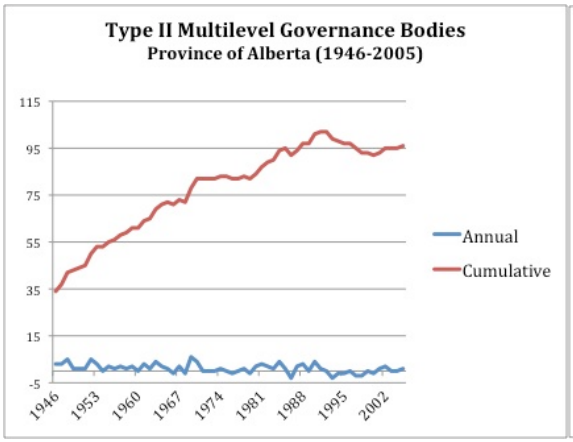


Figure 4.1b

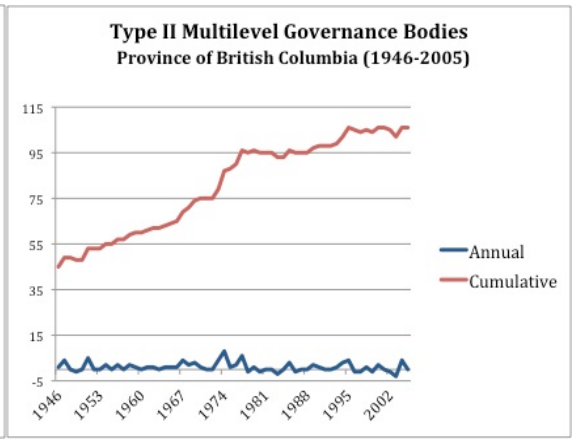


Figure 4.1c

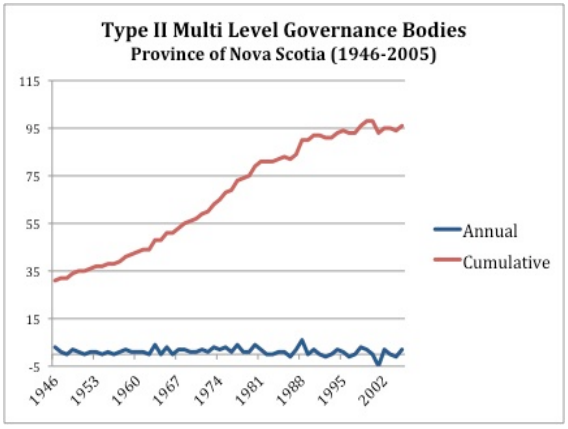
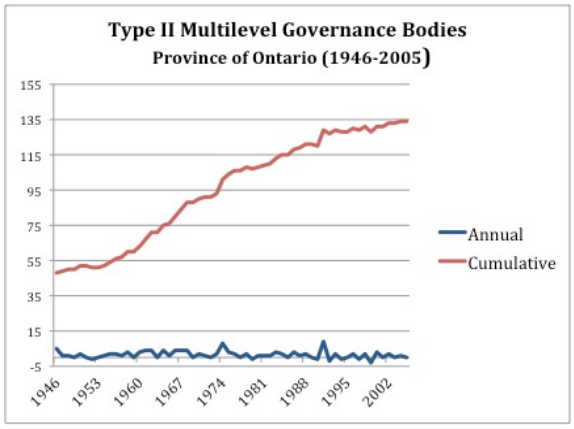


Figure 4.1d



When Professional Self-Regulatory bodies are omitted from the dataset the decline in the rate of accumulation of new Type II bodies becomes more prevalent. As shown in Figure 4.2a through 4.2d, a more pronounced decrease in the slope of the line representing the cumulative number of Type II bodies is apparent when Professional Self-Regulatory bodies are removed from the dataset. In three of the four provinces the cumulative

number of Type II bodies ceases to increase after 1988 and then either decreases or remains at approximately the same level for the remainder of the period being studied. The exception is British Columbia, where the cumulative number of Type II bodies ceases to increase in 1978 and then remains relatively stable for the remaining 27 years included in the study.

Figure 4.2: Type II Body (Excluding Professional Self-Regulatory) Annual and Cumulative Creation Rate by Province

Figure 4.2a

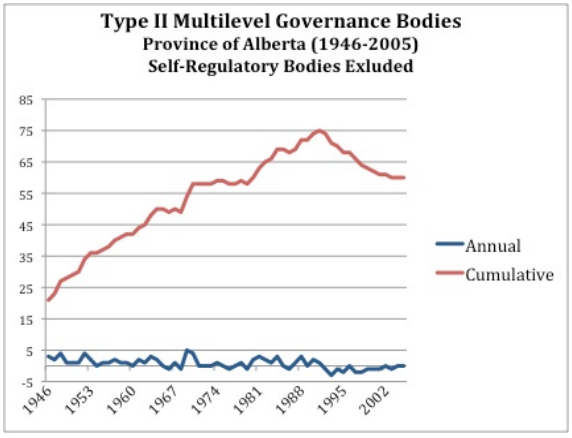


Figure 4.2b

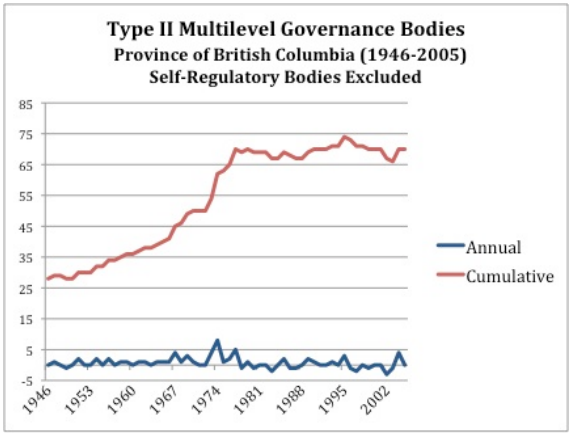


Figure 4.2c

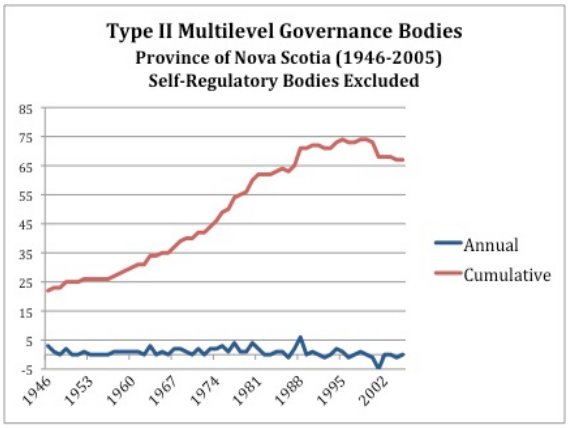
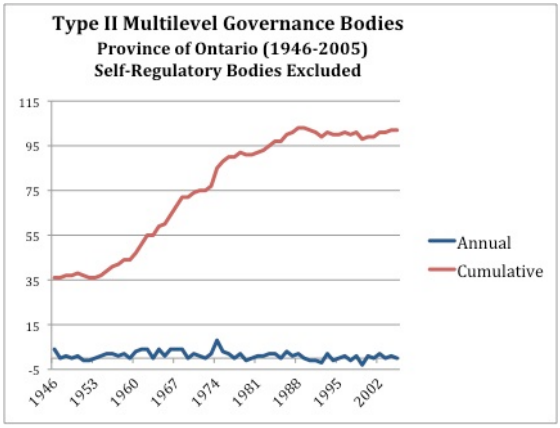


Figure 4.2d



Consistent with the results for all forms of Type II bodies, Figure 4.2a through 4.2d show the continuous use of Type II body creation as a solution to policy requirements. Unlike when all forms of Type II bodies are analyzed, however, Figure 4.2a through 4.2d show

that when Professional Self-Regulatory bodies are removed from the dataset a decrease in the rate of creation, as shown by the stabilization of the cumulative number of Type II bodies, exists. While some fluctuation is observed between years, in all four provinces, after an initial period of growth, the cumulative number of Type II bodies either decreases or stabilizes. When Professional Self-Regulatory Type II bodies are removed from the data set the results do not support the hypothesis that the absolute number of Type II bodies is increasing over time.

The second hypothesis to be evaluated is $H_{4.2}$ – the annual creation rate of Type II bodies is increasing over time. As depicted in Figure 4.1a through 4.1d, the annual rate of creation remains fairly consistent across the 60-year period. While both dips and spikes appear in the charts for each of the four provinces, there is no evidence of a trend toward an increasing rate of Type II body creation over time. This is consistent with the results for the absolute number of Type II bodies, which shows a gradual flattening of the slope, suggesting if anything a decrease in the annual rate of Type II body creation. As presented in Figure 4.2a through 4.2d, the results remain consistent when Professional Self-Regulatory bodies are removed from the data set. This suggests that no support exists for the hypothesis that the annual rate of creation of Type II bodies in increasing over time.

What the above charts do show is that the use of Type II bodies is not new, in contrast there has been a history of Type II body use in public governance. Looking at the 60-year period between 1946 and 2005 the overall trend is toward a continuous increase in the cumulative number of all Type II bodies. The exception to this trend is the province of Alberta in which the cumulative number of Type II bodies decreases starting in the late 1980s. When Professional Type II bodies are removed a decline is witnessed in both Alberta and Nova Scotia while the cumulative number of Type II bodies in British Columbia and Ontario become stable. Overall, when all forms of Type II bodies are included, the results support the hypotheses that the absolute number of Type II bodies is increasing with time, however, the results also show that the number of Professional Self-Regulatory bodies has been increasing at a rate that compensates for the stabilization or

decrease in the number of other forms of Type II body. Moreover, the uniqueness of Alberta's results means that caution must be taken when forming generalizations.

4.4 Results: Aggregated Datasets - Creation Rate of Type II Bodies

Two hypotheses are put forward regarding changes to the creation rate of Type II bodies: $H_{4.3}$ - the lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies; and $H_{4.4}$ – the further to the left-of-centre on the political spectrum a government sits the *lower the rate of creation* of Type II bodies. Each hypothesis will be examined in turn starting with the aggregate dataset containing all provinces and all forms of Type II bodies, then with the aggregated provincial dataset without Professional Self-Regulatory bodies, and lastly with each of the four provincial datasets.

The results of the regression analysis for each hypothesis against the dataset containing all provinces and all forms of Type II bodies are presented in Table 4.1. When looking at the effect of fiscal capacity on the annual rate of Type II body creation, two independent variables are tested. Provincial debt is used as it is considered to be a key measure of the overall financial strength of government (Baker and Rennie, 2011: 359). Disposable income, which captures funds available for individual and household consumption (OECD, 2003), is used as a macroeconomic indicator of provincial economic performance (Bélanger and Nadeau, 2010: 171). Based on the results in Table 4.1, Model 1, an increase of one per cent in disposable income per capita over the previous five years produces an increase of 2.707 in the rate of Type II body creation, and is significant at the 95% confidence level. The results, however, are not in the predicted direction, with the strengthening of the provincial economic health suggesting a higher level in the rate of creation of Type II bodies. When both disposable income and provincial debt are included in the regression model, as shown in Table 4.1, Model 3, the results for disposable income remain positive and are significant at the 99% confidence level. When all independent variables are included within the regression model (Model 5) the results

for disposable income again remain significant at the 99% level and in the positive direction.

As shown in Table 4.1, Model 2, the provincial debt coefficient is positive as predicted, but does not produce significant results. When disposable income is included in the regression model as presented in Model 3, provincial debt remains positive but not significant. When all independent variables are included in the model the provincial debt coefficient again remains positive but not significant at the 90% confidence level.

Taking into consideration the results for provincial debt and disposable income there is no support for the hypothesis that the lower the fiscal capacity of government the higher the rate of creation of Type II bodies. Instead, the results across all three models for disposable income are statistically significant in the opposite direction, suggesting that increased fiscal capacity is associated with a higher level of Type II body creation as opposed to the lower level that is predicted.

When looking at the effect of political ideology on the annual rate of Type II body creation, the results for percentage of seats won by left-of-centre parties are not in the expected direction. As shown in Table 4.1, Model 4, when all provinces and forms of Type II bodies are included in the dataset the changes in the number of left-of-centre seats produces significant results. As displayed in Model 4, a one per cent increase in the number of seats held by a left-of-centre party produces an increase of 0.024 in the rate of type II body creation, with the results significant at the 95% confidence level. When all independent variables are included in the regression model (Model 5) the results indicate that an increase of one per cent in the number of seats held by a left-of-centre party produces a 0.025 increase in the annual rate of creation, with the results remaining significant at the 95% confidence level. While a lower level in the annual rate of creation of Type II bodies was expected the results indicate a higher level, suggesting that the hypothesis be rejected.

Table 4.1: Creation Rate of Type II Bodies (Dataset includes AB, BC, NS and ON)

	Model 1[6]	Model 2	Model 3[7]	Model 4	Model 5
Disposable Income	2.707(1.057)**		2.925(1.066)***		2.966(1.056)***
Provincial Debt		0.222(0.211)	0.303(0.209)		0.298(0.208)
Left Seats				0.024(0.0102)**	0.025(0.011)**
Neoliberalism	-0.626(0.260)**	-0.853(0.244)***	-0.552(0.264)**	-1.087(0.254)***	-0.746(0.275)***
Election Year	-0.466(0.267)*	-0.521(0.269)*	-0.472(0.266)*	-0.528(0.267)**	-0.485(0.264)*
Alberta	-0.532(0.336)	-0.481(0.341)	-0.605(0.339)*	-0.120(0.363)	-0.288(0.363)
British Columbia	-0.465(0.334)	-0.493(0.339)	-0.489(0.334)	-0.885(0.381)**	-0.904(0.376)**
Nova Scotia	-0.522(0.338)	-0.397(0.338)	-0.552(0.338)	-0.154(0.350)	-0.321(0.350)
Adjusted R^2	0.102	0.0815	0.110	0.0968	0.101
Number of Cases	240	240	240	240	240

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
Ontario is the category for comparison for province variables.

As shown in Table 4.1, Model 5, neoliberalism, election year, and British Columbia also produce significant results. The results indicate that the time period in which neoliberalism is the dominant paradigm (1980-2005) is associated with a decrease of 0.746 in the annual rate of creation. The results for neoliberalism are consistent across all models at the 95% confidence level or higher. The results indicate that election years are associated with a decrease of 0.488 in the annual creation rate and are consistent across all models at the 90% confidence level or higher. The results for British Columbia suggests a decrease of 0.929 in the annual rate of Type II body creation in comparison to Ontario, however, the results are only significant when the percentage of seats held by left-of-centre governments is included in the model.

6 Change in provincial disposable income was also tested at 4 [3.864(1.285) ***] and 6 [2.882(0.883) ***] years to ensure that the 5-year results were not anomalous.

7 Provincial Annual Surplus and Debt was included in previous models. The variable was removed as it was found to not be a significant predictor of the rate of creation of Type II bodies and due to a gap in the available data resulted in the dropping of 15% of the available cases.

Overall, the results suggest that both hypotheses be rejected. The results presented in Table 4.1 provide no support for the hypothesis suggesting that governing parties on the ideological left creates fewer Type II bodies. There is also no support for the hypothesis that government would turn to the creation of Type II bodies to meet new of governance demands when confronted with diminished fiscal capacity. Moreover, the results for disposable income, which was significant at the 99% confidence level when all independent variables were included in the regression model, suggests a strengthening of overall provincial economic performance is associated with a higher level in the creation rate of Type II bodies.

The results of the regression analysis for each hypothesis against the dataset containing all provinces when Professional Self-Regulatory bodies are excluded are presented in Table 4.2. When testing the effect of fiscal capacity on the creation rate of Type II bodies both disposable income and provincial debt are again evaluated. When evaluating the effect of disposable income, as shown in Table 4.2, Model 1, a one per cent increase in disposable income per capita over the previous five years produces an increase of 2.906 in the annual rate of Type II body creation and is significant at the 95% confidence level. As shown in Model 3, when provincial debt is added to the regression model the results for disposable income remain in the positive direction and are significant at the 99% level. When all independent variables are included in the regression model the results again remain unchanged. As presented in Model 5, a one per cent increase in disposable income per capita over the previous five years produces a higher level in the annual rate of Type II body creation, with a positive coefficient of 3.18. The results are significant at the 99% confidence level.

When testing the effect of provincial debt, as shown in Table 4.2, Model 2, the results failed to produce significant results, however, when disposable income was added to the regression model a one per cent increase in provincial debt was associated with an increase of 0.365 in the annual rate of Type II body creation. The results are significant at the 95% confidence level and are in the expected direction. As shown in Model 5, when all independent variables are included in the regression model, the coefficient for provincial debt remains positive and significant at the 95% confidence level. Taking the

results for both disposable income and provincial debt into account there is mixed support for the hypothesis that the lower the fiscal capacity of government the higher the rate of creation of Type II bodies. An increase in provincial debt indicates weakened fiscal capacity, and is associated with a higher level of annual creation rate of Type II bodies, however an increase in disposable income indicates a strengthening of the provincial fiscal environment, but is also associated with a higher level in the annual Type II body creation rate.

Table 4.2: Annual Creation Rate of Type II Bodies (Data Includes AB, BC, NS and ON – Excluding Professional Self-Regulatory Bodies)

	Model 1[8]	Model 2	Model 3	Model 4	Model 5
Disposable Income	2.906(0.926)***		3.168(0.929)***		3.180(0.930)***
Provincial Debt		0.276(0.185)	0.365(0.183)**		0.363(0.183)**
Left Seats				0.007(0.010)	0.007(0.009)
Neoliberalism	-0.799(0.228)***	-1.037(0.215)***	-0.710(0.231)***	-1.140(0.226)***	-0.767(0.242)***
Election Year	-0.283(0.233)	-0.343(0.237)	-0.290(0.232)	-0.338(0.237)	-0.294(0.232)
Alberta	-0.573(0.294)*	-0.526(0.300)*	-0.660(0.296)**	-0.379(0.323)	-0.568(0.320)*
British Columbia	-0.450(0.293)	-0.484(0.298)	-0.480(0.291)	-0.577(0.312)*	-0.600(0.331)*
Nova Scotia	-0.516(0.296)*	-0.383(0.287)	-0.551(0.295)*	-0.302(0.312)	-0.484(0.308)
Adjusted R^2	0.131	0.103	0.142	0.096	0.141
Number of Cases	240	240	240	240	240

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance.
Ontario is the category for comparison for province variables.

In evaluating the effect of political ideology on the annual rate of Type II body creation, no significant results are produced when Professional Self-Regulatory bodies are removed from the dataset. As shown in Models 4 and 5, the results remain consistent when all independent variables are included in the regression model.

8 As with Model 4.1 the results for change in provincial disposable income was tested at 4 [4.138(1.122) ***] and 6 [2.955(0.772) ***] years to ensure that the 5-year results were not anomalous.

While not related to specific hypotheses, the results for neoliberalism and British Columbia again produce significant results. As shown in Table 4.2, Model 5, the results for neoliberalism suggest a decrease of 0.767 in the annual creation for years in which neoliberalism was the dominant paradigm. When all variables are included in the regression model, the results for British Columbia suggests a decrease of 0.6 in the annual rate of Type II body creation in comparison to Ontario. For British Columbia, the results are again only significant when the percentage of seats held by a left-of-centre party is included in the regression model. Unlike the results presented in Table 4.1, election year produced no significant results.

In addition, two new variables produced significant results when Professional Self-Regulatory bodies were excluded from the dataset. When evaluating provincial fiscal capacity, Nova Scotia produced significant results when disposable income was included in the dataset, suggesting a lower level in the number of Type II bodies created annually in comparison to Ontario. However, the results failed to remain significant when all independent variables were included in the model. As shown in Model 5, the results for Alberta suggest a decrease 0.568 in the annual rate of creation in comparison to Ontario and the results are significant at the 90% confidence level. The results for Alberta are significant across models 1 through 3, however, are not significant in Model 4, which evaluates the effect of political ideology.

Overall, when Professional Self-Regulatory Bodies are removed from the dataset the results remain largely consistent with those of the entire dataset. No support is found for the hypothesis that governments further to the left-of-centre on the political spectrum create fewer Type II bodies. There is mixed support, however, for the hypothesis that the more limited the fiscal capacity of government to meet governance demands the higher the annual rate of Type II body creation. As expected the results suggest that an increase in provincial debt, which indicates a decrease in government fiscal capacity, is associated with a higher level in the annual rate of Type II bodies created. Unexpectedly, however, an increase in disposable income, which indicates an overall strengthening of the provincial economic health, is also associated with a higher level in the annual rate of creation of Type II bodies.

4.5 Results: Provincial Datasets - Creation Rate of Type II Bodies

Having tested the hypotheses against the aggregate dataset the next step is to test at the individual province level. For all provincial datasets, Professional Self-Regulatory bodies have been removed so that results are not skewed by the sudden increase in the number of Professional Self-Regulatory bodies as discussed in Chapter 3. The results for each hypothesis by province are presented in Tables 4.3 through 4.7.

When looking at the effect of government fiscal capacity on the annual creation rate of Type II bodies at the individual province level, the results are varied. For Alberta, as shown in Table 4.3, Model 1 disposable income fails to produce significant results, however, as shown in Model 2, provincial debt produce statistically significant results in the positive direction as predicted. When both disposable income and provincial debt are included in the regression equation as, shown in Model 3, the results for disposable income and provincial debt remained consistent. When all independent variables are included in the regression model the results again remained unchanged. The results in Model 5 suggest a 0.438 increase in the annual creation rate for each one per cent increase in provincial debt per capita over the past five years and are significant at the 95% confidence interval.

In the case of British Columbia (Table 4.4), neither disposable income nor provincial debt produced statistically significant results. In the case of Nova Scotia (Table 4.5) and Ontario (Table 4.6) disposable income produces significant results in the positive direction, while the results for provincial debt were not significant. When all independent variables are included in the regression model, a one per cent increase in disposable income over the past five years was associated with a 3.624 increase in the annual creation rate in Nova Scotia and an increase of 6.754 in Ontario. The results for both Nova Scotia and Ontario are significant at the 95% confidence level, but not in the expected direction. Neither the results for Nova Scotia nor Ontario provide support for the hypothesis that weaker government fiscal capacity increases the annual rate of Type II body creation.

Table 4.3: Alberta – Creation Rate of Type II Bodies (Excluding Professional Self-Regulatory)

	Model 1	Model 2[9]	Model 3	Model 4	Model 5
Disposable Income	1.224(1.463)		1.648(1.441)		2.073(1.443)
Provincial Debt		0.375(0.204)*	0.409(0.205)*		0.438(0.203)**
Left Seats				0.052(0.041)	0.067(0.040)
Neoliberalism	-0.955(0.454)**	-0.910(0.424)**	-0.700(0.461)	-1.358(0.466)***	-0.971(0.483)**
Election Year	-0.252(0.471)	-0.313(0.461)	-0.299(0.460)	-0.284(0.468)	-0.320(0.454)
Adjusted R^2	0.076	0.118	0.123	0.090	0.149
Number of Cases	60[10]	60	60	60	60

Standard errors are reported in parentheses.

*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).

Table 4.4: BC – Creation Rate of Type II Bodies (Excluding Professional Self-Regulatory)

	Model 1	Model 2	Model 3	Model 4	Model 5
Disposable Income	3.683(2.438)		3.764(2.914)		3.229(2.785)
Provincial Debt		-0.435(0.577)	0.035(0.679)		-0.110(0.650)
Left Seats				0.033(0.127)**	0.033(0.013)**
Neoliberalism	-0.857(0.526)	-1.331(0.436)***	-0.846(0.573)	-0.902(0.455)***	-1.254(0.570)**
Election Year	-0.755(0.479)	-0.872(0.480)*	-0.753(0.485)	-0.902(0.455)*	-0.793(0.463)*
Adjusted R^2	0.158	0.133	0.1143	0.218	0.222
Number of Cases	60	60	60	60	60

Standard errors are reported in parentheses.

*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).

9 Consistent with evaluating the robustness of disposable income in the aggregated dataset, the per cent change in provincial debt per capita over the past 4 [0.429(0.249) *] and 6 [0.163(0.178)] years were tested. Unlike the disposable income results, which were robust over both longer and shorter timeframes, results for Alberta's provincial debt were consistent only for the 4-year timeframe, suggesting less robust results.

10 The number of cases (60) is consistent across all provinces, as the dataset contains one record per year per province. See Chapter 3 for details.

Table 4.5: Nova Scotia – Creation Rate of Type II Bodies (Excluding Professional Self-Regulatory)

	Model 1[11]	Model 2	Model 3	Model 4	Model 5
Disposable Income	3.624(1.472)**		3.513(1.484)**		3.398(0.420)**
Provincial Debt		0.744(0.740)	0.591(0.714)		0.361(0.716)
Left Seats				-0.054(0.029)*	-0.047(0.028)*
Neoliberalism	-0.504(0.379)	-0.599(0.395)	-0.453(0.385)	-0.229(0.445)	-0.097(0.434)
Election Year	0.847(0.422)**	0.701(0.436)	0.841(0.423)*	0.808(0.430)*	0.929(0.420)**
Adjusted R^2	0.133	0.056	0.128	0.098	0.156
Number of Cases	60	60	60	60	60

Standard errors are reported in parentheses.

*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).

Table 4.6: Ontario – Creation Rate of Type II Bodies (Excluding Professional Self-Regulatory)

	Model 1[12]	Model 2	Model 3	Model 4	Model 5
Disposable Income	6.754(3.016)**		6.829(3.075)**		7.230(3.021)**
Provincial Debt		-0.164(1.094)	0.179(1.068)		0.430(1.056)
Left Seats				-0.028(0.017)	-0.031(0.017)*
Neoliberalism	-0.584(0.539)	-1.320(0.457)***	-0.563(0.558)	-1.062(0.467)**	-0.229(0.577)
Election Year	-0.974(0.485)**	-0.900(0.505)*	-0.977(0.489)*	-0.913(0.494)*	-0.995(0.479)**
Adjusted R^2	0.200	0.123	0.186	0.166	0.218
Number of Cases	60	60	60	60	60

Standard errors are reported in parentheses.

*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).

11 Change in disposable income in Nova Scotia was tested at 4 [4.849(1.777) ***] and 6 [3.444(1.205) ***] years to ensure that the 5-year results were not anomalous.

12 Change in disposable income in Ontario was tested at 4 [7.609(3.599) **] and 6 [6.754(3.016) **] years to ensure that the 5-year results were not anomalous.

Overall, the results for the individual provinces provide mixed support for $H_{4.3}$. Supporting the hypothesis, the results for Alberta indicate that an increase in provincial debt is associated with a higher level in the annual creation rate of Type II bodies. When looking at the results for the other three provinces, none provide support for the hypothesis. In all three cases, provincial debt does not produce significant results, and the results for disposable income are in the opposite direction than predicted. In the cases of Nova Scotia and Ontario, the results for disposable income are significant at the 95% confidence level, and suggest that an increase in government fiscal capacity is associated with a higher level in the annual rate of Type II body creation.

When the effect of political ideology is explored at the individual province level, the percentage of seats held by left-of-centre government produces significant but conflicting results. For British Columbia (Table 4, Model 4) a one per cent increase in the number of seats held by left-of-centre parties indicates a 0.033 increase in the annual rate of Type II body creation and is significant at the 95% confidence level. When all independent variables are included in the regression model, the results remain consistent..

In contrast, the results for Nova Scotia and Ontario indicate a negative relationship between the percentage of seats held by left-of-centre parties and the annual creation rate of Type II bodies. When all independent variables are included in the regression model the results for Nova Scotia (Table 4.5, Model 5) suggest that a one per cent increase in the amount of seats held by a left-of-centre party suggested a decrease of 0.097 in the annual Type II body creation rate. The results for Ontario (Table 4.6, Model 5) suggested a decrease of 0.031 in the annual creation rate of Type II bodies for each one per cent increase in the seats held by left-of-centre parties. For both relationships the results were statistically significant at the 90% confidence level.

In Alberta (Table 4.3) the number of seats held by a left-of-centre party does not produce significant results. When considering the results for all four provinces, support for the hypothesis that the greater the number of seats held by left-of-centre parties the lower the annual creation rate of Type II bodies is inconsistent. The results for British Columbia are in the opposite direction than expected, suggesting a higher level in the annual rate of

Type II body creation when there are greater numbers of elected representatives from left-of-centre parties. In contrast, the results for Nova Scotia and Ontario are in the expected direction and support hypothesis $H_{4.4}$.

The neoliberalism and election year variables also produce statistically significant results, but not consistently across all four provinces. When all independent variables are included in the regression model (Model 5) neoliberalism produces statistically significant results at the 95% confidence level for the provinces of Alberta and British Columbia. For both Alberta and British Columbia the results are in the negative direction suggesting a lower level in the annual rate of Type II body creation for years in which neoliberalism is the dominant paradigm. The result for election year is significant in all provinces with the exception of Alberta. In British Columbia and Ontario the results suggest a negative relationship with fewer Type II bodies being created during an election year. However, the results for Nova Scotia are in the opposite direction, suggesting a higher level in the annual number of Type II bodies created during an election year.

4.6 Results Summary

A summary of whether support was found for either hypothesis is presented by dataset in Table 4.7. When the results for each of the provincial datasets and the aggregate dataset are taken into account, as shown in Table 4.7, partial support exists for $H_{4.3}$ - the lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies. Support for $H_{4.3}$ is found in the results for provincial debt in Alberta and the aggregate dataset when Professional Self-Regulatory bodies are excluded. However, the results for disposable income suggest that the hypothesis be rejected. The results for disposable income are consistently in the opposite direction than expected, with an increase in disposable income suggesting a higher level in the annual rate of Type II bodies created. The results for $H_{4.4}$ – the further to the left-of-centre on the political spectrum a government sits the *lower the rate of creation* of Type II bodies, are again contradictory. Support for $H_{4.4}$ is again centered in the provinces of Ontario

and Nova Scotia, however, results for the province of British Columbia are significant and in the opposite direction.

Table 4.7: Annual Creation Rate - Support for Hypotheses by Dataset

	$H_{4.3}$ – Fiscal Capacity		$H_{4.4}$ – Ideology
	Disposable Income	Provincial Debt	% Left Seats
All Provinces	No Support	No Support	No Support
All Provinces – Excluding Self-Regulatory	No Support	Support	No Support
Alberta	No Support	Support	No Support
British Columbia	No Support	No Support	No Support
Nova Scotia	No Support	No Support	Support
Ontario	No Support	No Support	Support

4.7 The Creation of Type II bodies: Time and Governing Paradigm

While the results reject the hypotheses that the annual creation rate of Type II bodies is increasing over time, the pattern of Type II body creation over the 60 year period warrants discussion. In looking at the annual rate of creation of Type II bodies, as shown in Figure 4.1a to 4.1d, the trend that emerges is three decades of increase followed by a shift toward stabilization or decline. Furthermore, as shown in Figure 4.2a to 4.2d, the trend becomes more pronounced when Professional Self-Regulatory bodies are removed. As supported by the regression results for neoliberalism, this pattern is not dissimilar to the time periods associated with the rise of the Keynesian welfare state and the following period of neoliberalism. The time period directly following World War II, 1946 to the early 1970s, has been characterized as a period of steady economic growth and Keynesianism. During this time the state was involved in both society and economy with the aim of building a comprehensive welfare state (Burke, Mooers and Shields, 2000: 11-13). In contrast, the neoliberal period that followed was characterized by the aim to create a lean state and policy goals became those of shrinking social welfare expenditures and

reducing state regulation (Burke, Mooers and Shields, 2000: 11- 13). Neil Bradford identifies three distinct time periods and two governing paradigms in Canada after World War II: first a period of technocratic Keynesianism as the governing paradigm which lasted from the 1940s through to the end of the 1960s; second, a period of interlude between governing paradigms which lasted through the 1970s; and third the arrival of neoliberalism as the governing paradigm in the 1980s and 1990s (2000). Bradford describes technocratic Keynesianism as bureaucratic with its influence dependent upon administrative leadership in renovating the bureaucracy's analytic capacity. The result was the recruitment of new technical and statistical expertise that produced a statist advisory setting that provided 'neutral' experts with the opportunities to perform a range of public policy functions. Neoliberalism, in contrast to being bureaucratic, was formed on the idea of substituting the market for the state. Under the neoliberal paradigm, not only bureaucrats, but politicians and other organized interests must all be disciplined by the market and market rules replaced policy discretion (Bradford, 2000: 57-65).

The parallels between the timing of Bradford's shifts in governing paradigm and the time of the changes in annual rate of creation are intriguing. It may be that the changes in the rate of creation of Type II bodies witnessed over time is a shift in the balance between state as regulator and market as regulator or as labelled by Bradford, the shift in paradigm from technocratic Keynesianism to neoliberalism. While the state will continue to be active in a regulatory function, changes to the dominant governing paradigm can alter the balance between the desired levels of state and market as regulators. The economic turmoil of the 1970s facilitated the emergence of a new governing paradigm in Canada in the 1980s, a paradigm that placed market rules at the forefront (Bradford, 2000: 63-65). The neoliberal paradigm sought to downsize the state and liberate market forces from the state's regulatory constraints (McBride and Shields, 1997: 101). With the new governing paradigm focused on the minimization of state involvement during the 1980s and 1990s, it could be argued that the results above demonstrate a weakening of the willingness of the state to take on new responsibility, whether as part of the machinery of government or through delegation. The result may be a decrease in the legal delegation of authority to existing or newly created Type II bodies as market mechanisms are looked towards to produce regulatory constraints.

4.8 Creation of Type II Bodies: The Role of Ideology

Beyond the possible effect of governing paradigm, the question remains as to what the impact of political ideology is on the annual creation rate of Type II bodies. When using the percentage of left-of-centre elected representatives to evaluate the effect of ideology, the results for Nova Scotia and Ontario support hypothesis $H_{4.4}$, however, results of the aggregated and the Alberta and British Columbia datasets do not. Given the conflicting results, one possibility is that a change in the percentage of seats held by parties to the left-of-centre may not make a significant difference to the policies of government unless the percentage change makes the difference between whether a left-of-centre party forms the government or not.

Instead of testing the percentage of seats held by left-of-centre parties, it may be more appropriate to test the effect of electing a left-of-centre government on annual Type II body creation rates. The cases evaluated will be limited to British Columbia and Ontario as they were the only provinces to elect left-of-centre governments during the period being studied. Using regression analysis, the results for the effect of a left-of-centre government being in power on the annual rate of Type II body creation for both Ontario and British Columbia are presented in Table 4.8. As Table 4.8 shows, the results for a left-of-centre government is different than the results for the percentage of elected members from left-of-centre parties. As shown in Table 4.8 a left-of-centre government in British Columbia suggests an increase of 1.026 in the annual rate of Type II body creation. The results are significant at the 90% confidence level and are in the positive direction. While the results for British Columbia are in the opposite direction than expected, the results for Ontario are not significant.[13]

13 In addition to evaluating the effect of a left-of-centre party forming the government both percentage of votes for a party and the effect of a left-of-centre party forming the loyal opposition in both a majority and minority government were tested. None provided support for the hypothesis.

Table 4.8: Effect of Political Ideology on Annual Creation Rate – Percentage of Left-of-centre Seats vs. Left-of-centre Government

	British Columbia		Ontario	
	Left Government	Left Seats	Left Government	Left Seats
Disposable Income	3.760(2.852)	3.229(2.785)	6.356(3.078)**	7.230(3.021)**
Provincial Debt	-0.055(0.666)	-0.110(0.650)	0.217(1.062)	0.430(1.056)
Ideology	**1.026(0.557)***	**0.033(0.013)****	**-1.188(0.924)**	**-0.031(0.017)***
Neoliberalism	-1.106(0.579)*	-1.254(0.570)**	-0.428(0.564)	-0.229(0.577)
Election Year	-0.663(0.478)	-0.793(0.463)*	-1.081(0.493)**	-0.995(0.479)**
Adjusted R^2	0.188	0.222	0.195	0.218
Number of Cases	60	60	60	60

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).

Overall, the results for the effect of ideology on the rate of Type II body creation provide little support $H_{4.4}$. The results for the number of seats held by a party to the left-of-centre are inconsistent, while the results for the presence of a left-of-centre government suggest the hypothesis by rejected. Moreover, in both British Columbia (Figure 4.1b) and Ontario (Figure 4.1d), NDP governments were responsible for the highest annual rates of increase.

Adding to the debate over the role of ideology in Type II body creation is Neil Bradford's account of governance paradigm shift in Ontario during the 1990s. Bradford argues that both the NDP and Progressive Conservatives embraced public-private partnerships in the face of policy challenges; however, they did so in different ways (Bradford, 2003: 1006). According to Bradford, the NDP introduced a social partnership approach which saw substantial policy discretion devolved to new multipartite bodies which operated at arm's length of government (Bradford, 2003: 1010). Given the observed readiness of the NDP government in Ontario to shift governance outside of the traditional realm of government, having the regression results for the percentage of seats held by a left-of-centre party show a lower level in the annual rate of Type II body creation is surprising. Together the results indicate that in the face of fiscal challenges, the Ontario NDP acknowledged the benefits of public-private partnerships. However, the NPD's usage of Type II bodies as a policy tool remained lower in comparison to other governments. This shows that

regardless of the ideology of the governing party, they are still subject to the climate in which they govern. However, within that climate, ideological differences between parties can still result in differences in policy outcomes..

4.9 The Creation of Type II Bodies: Government Fiscal Capacity

As with political ideology, the effect of fiscal capacity on the annual creation rate of Type II bodies is inconsistent. The regression results for Alberta and the aggregated dataset excluding Professional Self-Regulatory Type II bodies suggests an increase in provincial debt is associated with a higher level in the annual rate of Type II body creation. The results for Nova Scotia, Ontario and the aggregate provincial datasets, however, show that an increase in disposable income is associated with a higher level in the annual creation rate of Type II bodies, which is in the opposite direction to the hypothesized relationship. The conflicting results bring the exact nature of the relationship into question.

The results for Alberta indicate that changes in the amount of provincial debt per capita have a significant effect on the number of Type II bodies created annually, with an increase in debt predicting a higher level in the annual creation rate of Type II bodies. This relationship is in the expected direction, as increasing provincial debt represents a weakening of government fiscal capacity. No support is evident, however, when evaluating the other three provincial datasets. The difference in the results may be attributed to Alberta being the only province in the dataset to have undergone a sustained period of debt reduction. Figure 4.3a through 4.3d presents provincial debt and disposable income per capita in 2005 dollars for the years of 1946 through 2005 for each of the four provinces. As depicted in Figure 4.3a through 4.3d, while each province experienced periods of debt reduction, Alberta is the only province of the four to have undergone sustained reduction in provincial debt. Beginning in 1990 Alberta experienced a sustained decreased in provincial debt per capita, which continued throughout the duration of the study. With Alberta being the only province to undergo a sustained period of debt reduction the results indicate that a reduction in provincial debt leads to a lower

level in the annual creation rate of Type II bodies in Alberta, however, they are not generalizable.

Figure 4.3: Per Capita Disposable Income and Provincial Debt by Province

Figure 4.3a

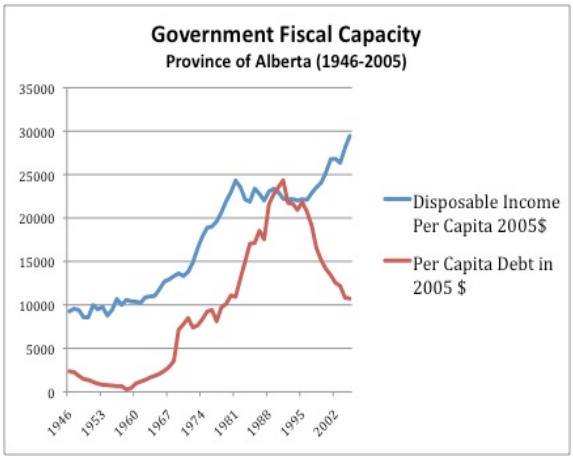


Figure 4.3b

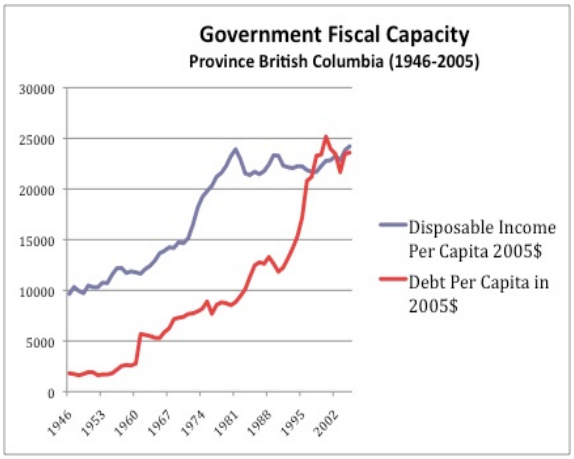


Figure 4.3c

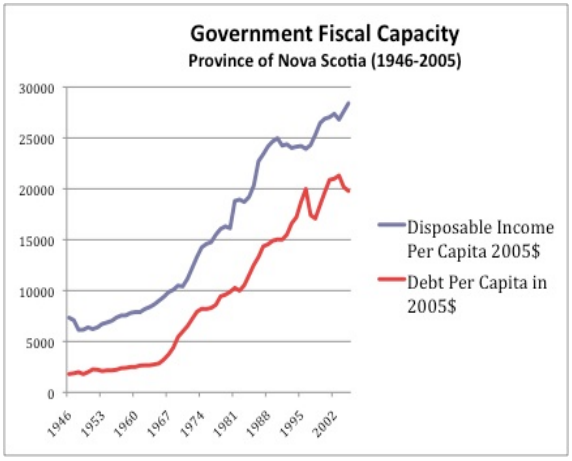
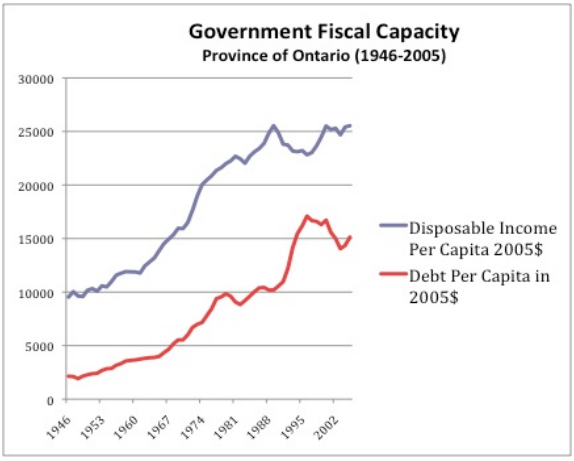


Figure 4.3d



While the decrease in provincial debt was unique to Alberta, the evaluation of disposable income produced more consistent results. The results from both aggregate datasets suggest that an increase in the level of disposable income produce a higher level in the annual creation rate of Type II bodies. Further support, while not as strong, for the existence of a positive relationship between disposable income and annual creation rate is evident at the province level, with the results for Nova Scotia and Ontario producing

statistically significant results. The relationship between disposable income and annual creation rate, however, is not in the expected direction. While the regression analysis suggests an increase in disposable income results in a higher level in the annual creation of Type II bodies, it was expected that an increased level of disposable income would result in a lower level of Type II bodies. One possible explanation for the unexpected result is that changes in personal disposable income, as the amount left over after payment of personal direct taxes, is capturing both changes in provincial economic conditions and changes in taxation strategies of government. What we may be observing is reductions in taxation levels that contribute to an increase in disposable income and a decrease in government capacity.

If change in personal disposable income is capturing both changes in provincial economic conditions and changes in taxation strategies of government in which government is reducing taxation, a negative relationship can be predicted between disposable income and government revenue. What would be expected is an increase in disposable income resulting in a decrease in government revenue. The effect of disposable income on government revenue can be tested using ordinary least squares regression, with disposable income per capita and government revenue as the independent and dependent variables. With the exception of an eight-year gap in government revenue across all provinces, data for disposable income and provincial government revenue are available from Statistics Canada for the years 1946 to 2005. The results for the effect of personal disposable income on government revenue per capita are presented in Table 4.9. According to the results in Table 4.9, when looking at the relationship between disposable income and government revenue across all four provinces, disposable income is significant at the 99% level and indicates that a one-dollar increase in disposable income per capita results in a 40-cent increase in government revenue per capital. When province is controlled for, as shown in Model 2, the results remain consistent.

Table 4.9: Disposable Income as a Predictor of Change in Government Revenue (1946-2005)

	Model 1	Model 2
Disposable Income	0.395(0.013)***	0.406(0.0128)***
AB		1079.517(233.935)***
BC		623.462(233.750)**
NC		1330.575(236.147)***
Adjusted R^2	0.8006	0.8286
Number of Cases	208	208

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
Ontario is omitted from the regression model.

With an increase in disposable income resulting in a higher level in government revenue, the scenario where an increase in disposable income is weakening the government's fiscal capacity is unfounded. Based on the findings above, an increase in disposable income results in a higher level of annual creation rate of Type II bodies as well as a higher level of government revenue. This would confirm that the relationship between disposable income and the annual creation rate of Type II bodies is in the opposite direction to that expected in $H_{4.3}$. An increase in the fiscal capacity of government, as indicated by the correlation between disposable income and government revenue, results in an increase in the annual rate of Type II body creation.

A plausible explanation for government capacity being positively associated with the annual rate of Type II body creation is the role of government in funding both public and private actors engaged in welfare provision and regulatory responsibility. Gregg Olseen points out that while public and private forms of welfare provision can be distinguished, states continue to play an important role in private provision. Private actors may be funded through tax revenues by the state or be the beneficiaries of tax incentives and disincentives aimed either at encouraging the contributions of others to the organization or lessening the financial costs to the organization (Olseen, 2002: 25-26). Furthermore, Olseen identifies a quasi-market form of welfare provision where governments provide the funding and private actors deliver the service, which is evident in the Canadian health insurance system where medical practitioners are private providers, but their services are

paid for by the state (Olseen, 2002: 26). As governments contribute either partially or fully to the financial operation of Type II bodies operating in the public realm it is reasonable that decreases in fiscal capacity reduce the rate at which government creates or enlists new actors in the act of public governance. During periods of economic downturn it may be more efficient for government to add new responsibilities to the portfolio of existing actors already operating in the governance field.

The regression results for neoliberalism support the idea that government, when faced with fiscal challenges, is unlikely to create or enlist new actors in the act of public governance. While the neoliberal approach to public management has been characterized as the promotion of the private sector and the delegation of authority as a remedy for the high taxes and deficits associated with the welfare state (Hoehn, 2011: 77), the results suggest that neoliberalism is associated with a decrease in the legislative delegation of decision-making authority to Type II bodies. When the overall number of new Type II bodies is considered, the results in Figure 4.1a through 4.1d show a flattening of the slope and in the case of Alberta a decrease in the number of Type II bodies beginning during what Bradford describes as the period of interlude between Keynesianism and neoliberalism that lasted through the 1970s (Bradford, 2000: 63). As shown in Table 4.1, the results for the neoliberal time period are negative and significant when compared with the Keynesian time period.

Taking into account the descriptive statistics and the regression analysis, the results suggest that a reduction in the number of Type II bodies created began in the 1970s, with reductions in the provinces of Ontario and British Columbia beginning earlier than in Alberta or Nova Scotia. With the emergence of neoliberalism as the dominant policy paradigm in the 1980s, a statistically significant decrease in the rate of authority migration to Type II bodies is observed in comparison to 1946 to 1979 period of Keynesianism. While the enlisting of the private sector may have been promoted as a remedy of public debt, the results indicate that the neoliberal period was not one of increased migration of decision-making authority by the state. Instead, what we may be witnessing in the face of increasing governance demands is the entrenchment of state

authority where the state feels it is most necessary, and the willingness of government to leave to market mechanisms that which the state feels the market can best regulate.

4.10 Election Year and Type II Body Creation

In addition to the variables used to test the specified hypotheses, the election year dummy variable produced statistically significant results when all independent variables were included in the regression model for four of the six datasets. The results at the aggregate level produced statistically significant results in the negative direction when all Type II bodies were included in the dataset. At the provincial level, the British Columbia and Ontario cases also produced statistically significant results in the negative direction, while Nova Scotia produced statistically significant results in the positive direction.

The results for election year in the case of Nova Scotia are not unexpected, as Francesco Lagona and Fabio Padovano have argued that legislators attempt to maximize their probability of being re-elected by concentrating the passing of laws directly before the elections and engaging in other activities the remainder of the time (Lagona and Padovano, 2008:202). It was unexpected, however, to find statistically significant results in the negative direction. An explanation for these finding may be the existence of a period of time both before and after an election when no legislation is passed. In this scenario, even if there is a spike in the volume of passed legislation in the last months before the closing of a legislature (Lagona and Padovano, 2008: 214), the ensuing campaign period and time required to get the new legislature up and working results in an extended period of time during which no legislation is passed. For example, during British Columbia's 37th general election in 2001 the legislature was dissolved in on the 18th of April 2001 and the new legislature opened on the 19th of June 2001 – meaning that no legislative work was done for the two-month period beginning April 18th (Government of British Columbia, 2002: 37). Furthermore, with the change in party in power from NDP to the Liberal Party (British Columbia. Legislative Assembly, 2002: 21, 37) the volume of legislation passed in the following six months would likely be low.

4.11 Decreasing Creation Rates: Why the Disconnect between Expectations and Results?

While an increase in the annual creation rate of Type II bodies was expected over the period included in the study, the results have not born this out. It was expected that the growth in government responsibilities had placed a level of demand upon government that exceeded the structural capacity and could therefore not be fulfilled without widespread delegation across a wide range of policy issues (Flinders, 2006: 223-224). Instead, the results indicate a pattern of increasing and decreasing annual rates of Type II body creation that move in lock step with the post World War II rise of the Keynesian welfare state and the subsequent supplanting of Keynesianism by the neoliberal paradigm. This raises the question of how we account for the difference in expectations and results.

Two possible reasons are offered. First, the use of Type II bodies may in fact be increasing, however, the function of the majority of such bodies may not be decision-making or regulatory responsibility per se, but instead augmenting the delivery of government services. In this scenario, the government remains the dominant actor in the governance structure, maintaining decision-making authority, but delegating delivery. As argued by Bell and Hindmoor, the existence of governance relationships between the state and society does not mean the relationships are equal (2009: 11). While still a concern in terms of efficiency and accountability, the use of external actors as solely service delivery mechanisms without decision-making authority sits outside the scope of this project. Second, the disconnect between expectations and results may not be due to numbers of Type II bodies but the policy areas in which Type II bodies are being used. New Type II bodies are being created in policy areas that have high public profiles and have a long history of being perceived as the responsibility of government. In this scenario it is not an increase in the number of Type II bodies, but their emergence in key policy areas that has led to an expectation of increased delegation of government authority.

While the role of external actors in service delivery is of importance, it falls outside the scope of this research project. However, the possibility that the disconnect between

expectations and results is a function of the use of Type II bodies in higher profile policy areas warrants consideration. Support for this hypothesis is found in the public opinion literature which indicates an overall low level of political knowledge among citizens but also that while citizens cannot focus on every issue, they do have a higher level of knowledge about the issues that they care deeply about (Hayes and Bishin, 2012: 133; Hutchings, 2001: 848). This suggests that citizens would be more informed of instances of authority migration in areas of higher interest than instances of authority migration in general.

In considering the possibility that the migration of authority in key policy areas has led to the *perception* of increased involvement of new governance actors in the public realm the creation of Type II bodies in the policy area of healthcare is be explored. Healthcare has been chosen due to its level of importance to Canadians. As reported by Stuart Soroka in a report to the Health Council of Canada in 2005, 85% of Canadians believed that eliminating public healthcare represented a fundamental change to the nature of Canada. Additionally, more respondents viewed eliminating healthcare as a fundamental change than any of the other policies listed in the survey, including abandoning English and French as Canada's official languages, and ending peacekeeping missions (Soroka, 2007: 5). A 1994 Ekos Research Association Inc. poll found that Canadians rank health 3rd in a list of 22 values, behind freedom and a clean environment (Fortier, 1996: 21). Furthermore, when asked what policy issues they are most concerned about, respondents have overwhelmingly expressed concerned for healthcare since 1997 and have not shifted from this position (Soroka, 2007: 5).

When we look at the number of Type II bodies created in the area of healthcare[14], including the regulation of healthcare professionals, as depicted in Table 4.7, we see that in the case of each province the largest percentage of Type II bodies created in the healthcare field over the 60 year period being studied is during the 1991 to 2005 time period. Furthermore, in the case of British Columbia and Ontario, 50% of the Type II

14 A list of all Type II bodies is provided in Appendix B.

bodies created since 1946 in the healthcare policy area were created between 1991 and 2005.

Table 4.10: Number of Type II Bodies in the Healthcare Policy Area

	Alberta	British Columbia	Nova Scotia	Ontario	All Provinces
1946-1960	5 (17%)	3 (17%)	2 (15%)	6 (21%)	16(18%)
1961-1975	7 (24%)	4 (22%)	3 (23%)	7 (25%)	21(24%)
1976-1990	8 (27%)	2 (11%)	3 (23%)	1 (4%)	14(16%)
1991-2005	9 (31%)	9 (50%)	5 (38%)	14(50%)	37(42%)
Total	29 (100%)	18 (100%)	13 (100%)	28 (100%)	88 (100%)

When looking at the results for the creation of Type II bodies for healthcare, what appears is a reversal of the overall trend. While the annual rate of Type II body creation overall has been decreasing since the late 1980s, what we can see when looking at Table 4.10 is that in the healthcare policy area the rate of creation has increased since the late 1980s, with two cases having 50% of the bodies created since 1946 being created during the last 15 years being studied. This suggests that it is possible, at least to an extent, that the perceived increase in the rate of Type II bodies is derived from the increase of Type II bodies in policy areas that are of high importance to citizens and not the overall rate of authority migration.

4.12 Conclusion

The creation of Type II bodies is a tale of consistency and difference. There is a consistent pattern across the four provinces in which the annual creation rate is initially sufficiently high to push the cumulative number of Type II bodies higher on a year over year basis. However, over time the creation rate decreases to the point of stability or decline in the cumulative number of Type II bodies. Beyond the consistency in the pattern of Type II body creation, there are also differences across the provinces in what factors are shown to contribute to changes in the annual creation rate. Such differences showcase the economic and political uniqueness of each province, but also serve to produce conflicting results and limit the ability to make generalizations.

Overall, the results produce two principal findings and one curious question. The first principal finding is that over the sixty-year period being reviewed the annual rate of creation and the cumulative number of Type II bodies have fluctuated over time. The existing data for Alberta, British Columbia, Nova Scotia, and Ontario demonstrate that the use of Type II bodies in public governance is not a recent phenomenon, as Type II bodies have been used as a tool of government for over sixty years and the prevalence of the use of this tool is subject to periods of both increase and decline.

The second principal finding is that the pattern of increase, stability, then decrease in the annual creation rate of Type II bodies mirrors that of the shift from the technocratic Keynesian approach that was the governing paradigm from the post-war period until the early 1970s through to the emergence of neoliberalism as the dominant governing paradigm in the 1980s. The emergence of this pattern is unexpected, as neoliberal thinking tends to be associated with the shrinking of the state and the increased involvement of external actors in the business of the state. Two factors, however, provide insight into the unexpected results: 1) the neoliberalism paradigm places the market in the position of preferred regulator, and 2) government is a funding source for both public and private actors engaged in the provision of state delegated regulatory responsibility. As the goal of neoliberalism is the shrinking of fiscal commitments and the regulatory reach of the state, a weakening of the willingness of government to take on new regulatory responsibility, whether as part of the machinery of government or through existing or newly created Type II bodies, can be observed.

As for the disconnect between expectations and reality, as the number of Type II bodies have not been increasing in recent years as expected, the question emerges as to why. The answer put forward to this question is that the perceived increase in the rate of Type II bodies is not derived from the overall rate of authority migration, but from the increase of Type II bodies in policy areas that are of high importance to citizens and traditionally viewed as the sole jurisdiction of the state.

Chapter 5

"Another cause for the increase in alienation and cynicism is a feeling that too many policy decisions that affect individuals have been taken out of any system that has accountability or that they can influence."

-Robert Teeter

5 Accountable to Whom: Migration of Authority and Accountability

Elections, in the tradition of democratic theory, have been seen as an important mechanism of accountability through which the policy preferences of citizens can induce government action (Fearon, 1999: 57). However, new forms of governance introduce new challenges for the theory and practice of public accountability (Skelcher, 2007: 63). The migration of regulatory responsibility outside the boundaries of elected governments necessitates a different conceptualization of accountability relationships between citizens and public policy decision makers. As demonstrated in Chapter 4, while the annual rate of Type II body creation has not increased over the past sixty years, the absolute number of Type II bodies engaged in public decision making has. As stated by Peters and Pierre, the growing number of new governance actors and the dispersal of political authority led to questions of democratic input and accountability within the governance process (2006: 209). The shift from a single agency system to a plurality of bodies increases complexity and opens the system to increased problems of accountability which in turn lead to problems of coordination and strategic direction as different agencies compete for limited resources (Andrew and Goldsmith, 1998: 107).

In responding to concerns of accountability brought about by the dispersal of governance authority, this chapter explores the accountability environment that has emerged when government has delegated decision-making authority. To do so, legislated instances of authority migration in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario between the years of 1946 and 2005 form the universe of cases. Two areas of inquiry are explored: the existence and relative strength of accountability relationships between new governance actors and both government and society as stipulated in the

legislation; and the extent to which political ideology, geographic scale, and the timing of the legislation are able to explain the strength of accountability relationships.

5.1 Accountability and Public Governance

Without accountability, there is no popular control. In a democracy, accountability is the principal mechanism through which mass publics exert control over their elected officials and is a central tenet of democratic theory (Rudolph, 2006: 99). As discussed in Chapter 2, the concept of accountability is not in itself problematic: person A is accountable to person B if two conditions are met; there is an understanding that A is obliged to act in some way on behalf of B; and B is empowered by some mechanism to sanction or reward A. Stated in the form of an agency relationship person A can be understood to be an agent, who makes choices on behalf of person B as the principal (Fearon, 1999: 55). The assignment of a principal-agent relationship to elected representatives is straightforward; the elected representative is accountable to the electorate and is expected to act in such a way that promotes the preferences of the electorate. If the electorate is not happy with the actions of their elected representative, they can vote them out at the next election.

Defining accountability relationships associated with Type II multilevel governance, however, is more complex as there is the potential for multiple principal-agent relationship variations. Society may be the principals and Type II bodies the agents, meaning that Type II bodies are understood to be directly accountable to society. Society as principals of democratic governments may hold Type II bodies indirectly accountable through the principal-agent relationship between government and Type II bodes. A third possibility is that each of the before mentioned accountability arrangements exist. Alternatively, there is the potential for the absence of any accountability relationship.

While governments have migrated authority to address specific policy needs, it has been argued that Type II bodies remain accountable to the government and as such indirectly to the citizen. Jessop has argued that the governments, in responding to the institutionalization of political decision making upwards, downwards and sideways from the state, have enhanced the state's role in managing inter-scalar relations, thus seeking to control how and where authority is migrated to minimize effects upon the overall power

of the state (2005: 64). Through what Jessop labeled 'metagovernance', the state provides the rules for governance and in doing so sets the conditions for self-organization and the overall process of collaboration. In doing so the state sets the overall ground rules for governance and regulatory order (2005: 64-65). Similarly, Tanja Börzel argues that in the modern state both public and private actors operate under the shadow of hierarchy where public actors set the legal rules of the game and intervene to correct distortions or outcomes that violate public interests (2010: 196-197).

The underlying assumption of multilevel governance is that centralization has given way to new forms of governance that result in decision-making authority being dispersed across multiple jurisdictions. According to Bell and Hindmoor, however, regardless of the governance approach put into place, the state remains the preeminent actor in the governance process (Bell and Hindmoor, 2009: 10; 2009a: 153-154). In setting the rules and being positioned to intervene on outcomes that violate public interests, government can be seen to dominate the policy process. If government has continued to dominate the public policy process, then we should expect formal accountability relationships between government and Type II bodies to be present and to have either remained stable or increased in strength. This leads to the chapter's first hypothesis, which assesses the ongoing strength of the accountability relationship with government, and is presented below as follows:

$H_{5.1}$ - The accountability relationships between government and Type II bodies has either remained stable or increased in strength over time.

As stated in Chapter 2, the belief that shifts in state function and new forms of governance have not weakened the state is not universal. McBride and Shields argue that the advancement of a neo-liberal agenda aimed at reducing the state and increasing reliance on market mechanisms provides the ideological venue for shifting decision-making outside of politics and is eroding the power of the state (1997: 18). Furthermore, the term governance can signal a threat to conventional forms of democracy or potentially an attempt to sidestep democracy altogether. Instead of being accountable either directly to the citizens or indirectly to the citizens through government, governance

mechanisms are seen to have become the tools of commercial interests or unaccountable bureaucracies (Hirst, 2000: 13). According to Harmes, the dispersion of power away from the centre can be viewed as a deliberate neoliberal political project with the goal of separating economic and political power (2006: 726-727).

While neoliberalism is a modern construct, there are long-standing debates over the role and size of government. Since the second half of the 19th century neoclassical liberals have consistently argued that government should be as small as possible and act as a night watchman whose only role is to protect the person and property of individuals. In contrast, welfare liberals have promoted a larger role for government arguing that the powers of the state can be a positive force for promoting liberty and equal opportunity through the creation of regulations and state run institutions (Ball and Dagger, 1995: 77-79). The desired role of the state is further expanded within the framework of social democracy. Being linked to socialism, social democracy calls for government to play a larger role in the lives of the people, promotes public ownership, and promotes the redistribution of wealth (Ball and Dagger, 1995: 44).

Taking into account both recent ideological trends and the historical debate over the appropriate size and role of the state, it can be argued that the ideology of the governing party may influence the structure of the accountability relationship between Type II bodies and government. Specifically, governing parties aligned further to the right are expected to produce weaker accountability relationships when migrating authority as there is stronger belief in minimal state interference in the lives of individuals, while governing parties on the left are expected to develop stronger accountability relationships due to their stronger belief in government intervention. Accordingly, this leads to the second hypothesis:

$H_{5.2}$ – Governing parties further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governing parties further to the right.

The second relationship under consideration is the accountability relationship between Type II jurisdictions and society. Peters outlines two opposing views of governance, a traditional approach where the state steers, and a modern approach where societal actors are involved in more self-steering rather than depending upon the guidance of government. While both government steering and self-steering views of governance contain the assumption that society must be governed, different assertions are made as to who the dominant actor is – government or society (2000: 36-37). Hirst's 'associated democratic' model goes as far as stating that as many functions as possible should be devolved from the state to civil society, followed by the democratization of civil society organizations, thus shifting governance from top-down bureaucratic to democratically self-governed associations (2000: 28).

As argued by Neil Nevitte, there has been a trend toward a decline in deference to authority by Canadians (1996: 38). Canadians have become increasingly dissatisfied, not necessarily at specific office holders, but with the office itself as they demand more meaningful participation in the political process (Nevitte, 1996: 55). Nevitte further states that while voting provides one avenue for participation, there is no consensus that voting is the most effective way for citizens to state the preference and make demands of government and that citizens are increasingly interested in utilizing other forms of participation (1996: 76). What has been witnessed is a culture shift where citizen access and participation in the policy making process have become more closely tied to legitimacy (Skogstad, 2003: 963). If social forces are seeking more meaningful participation and taking a stronger role in the governance process, it follows that Type II bodies should be increasingly accountable directly to society as societal actors assert greater influence over policy inputs and outputs. As such, the third hypothesis accesses the strength of the relationship with society and is presented as follows:

$H_{5.3}$ - The accountability relationship between society and Type II bodies has increased in strength over time.

An additional factor to be explored is the effect the geographic scale of a Type II body has on the existence and relative strength of accountability relationships. With elected

government, a trade-off exists where centralization produces efficiency and coordination gains, however, diminishes accountability. This loss of accountability is based on the idea that as government becomes more centralized, the ability of any one region to select a government based upon the government's perceived performance in that region is diminished (Seabright, 1996: 65). Similarly it has been found that while larger municipalities benefit from economies of scale, the gains come at a democratic cost as the increase in size is associated with a decrease in citizens' perceived political efficacy (Dreyer and Serritzlew, 2011: 255).

Like traditional elected governments, Type II bodies exist at different geographic scales. However, unlike elected government few Type II bodies have citizen-elected boards, consequently minimizing the electoral accountability benefit associated with traditional government. Taking into consideration the lack, or limited, accountability benefits of elections, and a dearth of information on the effect of geographic scale on the accountability of Type II bodies, this chapter puts forward two exploratory questions. First, do Type II bodies succumb to the same trade off as traditional elected government? While lacking the accountability function of elections, it is still possible that centralization results in a similar tradeoff between economies of scale and accountability of Type II bodies. When a Type II body moves along the continuum from decentralized to centralized, the number of citizens whose preferences must be taken into account increases. As the number of citizens increases, the ability of any one citizen to hold the Type II body accountable based upon their perceived performance of the Type II body decreases. If this is in fact the case, it is expected that the greater the level of decentralization, the greater the capacity of members of society to hold Type II bodies directly accountable.

While it is expected that decentralization of Type II bodies provide accountability benefits for citizens, the second question posed is whether there is a corresponding weakening of accountability to government that occurs with decentralization. When decision-making bodies are decentralized there may be a willingness on the part of government to shift both decision-making and responsibility for holding decision-makers accountable closer to the citizen. If this is the case, it is expected that the greater the

degree of decentralization, the weaker the capacity of government to hold Type II bodies directly accountable. Accordingly the final two hypotheses address the effect of geographic scale and are presented as follows:

$H_{5.4}$ – The accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases.

$H_{5.5}$ – The accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases.

5.2 Data and Methodology

To test each hypothesis the custom dataset described in full in Chapter 3 is utilized. To be included in the dataset the Type II body must satisfy each of the following conditions: decision-making authority over some part of the public realm must be granted to the body through an act of provincial legislation; the majority of decision makers within the body must be comprised of individuals who are from outside of the government, legislature or public service; decision-making autonomy must exist; and the Type II body must have been operating in either the province of Alberta, British Columbia, Nova Scotia or Ontario at some point between 1946 and 2005. Type II bodies included in the dataset come from a wide range of policy areas including: financial regulation, food and agriculture, education, healthcare, natural resources, public safety, social services, sports and entertainment, transportation, and other public goods. The dataset contains incidents of Type II body creation, termination, and modification. Captured at the point of creation for each Type II body and for each subsequent amendment are the accountability mechanisms included within the legislation. The dataset does not capture cases where the legislation was amended but the accountability relationship was unchanged. In cases when the Type II body remains in place, but the legislation that created it is repealed and replaced, the Type II body is not coded as being terminated and recreated, but instead only changes to the accountability relationships (if occurring) are captured.

Accountability is coded based upon the accountability mechanisms that are established directly in the legislation. The coding of the accountability relationships uses Mark

Bovens's definition of accountability that states: "Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences" (2007: 450). Through the elimination of constructs which are instrumental but not essential, Bovens's definition identifies three elements of an accountability relationship that are identifiable and can be easily coded: processes which force agents to explain and justify actions to their principals, processes which allow principals to question agents and pass judgment upon their actions, and processes which enable principals to sanction their agents. The decision to use Bovens's definition is based upon its ability to capture the concept of accountability as discussed in the accountability section above and to allow for the standard coding of data along three easily identifiable elements. For each record six pieces of data are captured, three for the accountability relationship between the Type II body and government and three between the Type II body and society. Each element is coded as either present (1) or absent (0), allowing for an accountability score to be calculated for each of the relationships as the dependent variable.[15]

Again using Alberta's Child and Family Services Authorities as an example, in this case, the accountability relationship with government would score a 2 in 1996 as the Child and Family Services Authorities must justify their actions to government through the submission of reports to government and the provincial government is able to sanction members of the board through mechanisms of appointment and the ability to transfer the Authority's powers to an alternate entity. Missing is a mechanism that legislates the ability of the Provincial Government to pose questions to the Authorities. The accountability score between the Authorities and society would be a 1 as the only

15 The complex nature of accountability poses challenges for operationalization. This chapter captures the formal accountability rules that can be used by government or society; however, it fails to capture whether the formal rules are utilized, or whether an alternate form of accountability, be it informal or market mechanisms, exists. Furthermore, assigning equal value to each of the three components of accountability gives the obligation of a Type II body to justify its actions the same weighting as the ability to sanction, when it could be argued that the ability to sanction is of greater value. When changes were made to the model, however, scoring sanctioning as a 2 or a 0 instead of a 1 or a 0 produced results consistent with the reported findings.

accountability mechanism built into the legislation is the requirement for board records to be open to the public. A subsequent amendment that mandated board meetings being open to the public changed the accountability score to 2, as now society members would also be able to question members of the Authority's board. Missing is a mechanism that legislates the ability of society members to sanction board members in response to the actions (or inactions) of the Authority.

Consistent with Chapter 4, one of the hypotheses explores the effect of political ideology on accountability. As discussed in Chapter 4, content analysis of Canadian party manifestos between 1946 and 2000 demonstrates an ideological disagreement between parties at the federal level. This analysis demonstrates that at the federal level the NDP is consistently to the left and the Liberal and Progressive Conservative parties taking turns holding the position on the far right (Cochrane, 2010: 590-591). While it is acknowledged that organizational independence exists between federal parties and their provincial counterparts, the NDP remains a fully integrated organization with membership at the provincial level resulting in automatic membership in the federal party (Esselment, 2010: 871-872). Given the connection between the provincial and federal NDP parties, and NDP's consistent position to the left at the federal level, the percentage of seats held at the provincial level by the NDP or CCF party is used to test the effect of political ideology. The formation of government by a left-of-centre party was considered as an independent variable; however, no left-of-centre party formed the government in either Alberta or Nova Scotia during the 1945 to 2005 time period.

To assess the influence of time period on the strength of accountability relationships, the overall timeframe being studied is divided into six ten-year periods and a dummy variable is created for each.[16] All instances of creation or modification of Type II bodies were coded according to which time period it occurred in, with 1 indicating that it occurred in that time period and 0 indicating it did not. In the regression model, the 1946-1950 dummy variable was omitted, making it the reference category for all other time

16 The division of time by Keynesianism and neoliberalism as dominant policy paradigms as was done in Chapter 4 was also considered. The results remained consistent with that of results based upon decade.

periods. The 1946 to 1955 time period was selected as the reference category because it represents the starting point and therefore forms a baseline against which accountability scores from each subsequent time period can be assessed.

To assess the influence of geographic scale the Type II bodies are coded according to four categories: Type II bodies that are geographically confined to one municipality; Type II bodies that span municipalities but are smaller in geographic scale than an entire province; Type II bodies that encompass the entire province; and Type II bodies that span provincial boundaries. For each category a dummy variable is created with a score of 1 indicating that the Type II body operates at that geographic scale and a score of 0 indicating that it does not. In the regression model the dummy variable for Type II bodies that operate within the boundaries of a single municipality is omitted, making it the reference category against which all other categories of geographic scale are compared. The geographic scale of single municipality was selected as the reference category as it is easier for comparison purposes to have the reference category at one end of the continuum and not all provinces have created Type II bodies that span provinces, which occupies the other end of the continuum.

Ordinary least square (OLS) regression is used to test the effect of the independent variables on the dependent. As in Chapter 4, sequential modeling is used in which each independent variable is tested separately and then as part of a larger model. A sequential approach was again adopted so that the effect of the independent variables on the dependent variable, as expressed by the adjusted R^2, could be observed separately for each independent variable. For each hypothesis the models will be run for the entire dataset to identify overall trends and then for each province individually to identify differences between the provinces. Due to the unique characteristics of Professional Self-Regulatory Type II bodies outlined in Chapter 3 a self–regulatory control variable is included in all regression models with Professional Self-Regulatory Bodies coded as a 1 and all other forms of Type II body coded as zero. Provincial control variables are also included in the regression models when evaluating the aggregate provincial dataset. Dummy variables are created for each province with a score of 1 indicating the Type II body's province of origin. The Ontario dummy variable is omitted from the regression

models, making Ontario the provincial variable against which all other provincial variables are compared.

The total number of cases evaluated, broken down by province and decade are presented in Table 5.1.

Table 5.1: New and Modified Type II bodies by Province by Decade

	Alberta	British Columbia	Nova Scotia	Ontario	Total
1946-1955	31	10	10	23	82
1956-1965	31	14	21	41	107
1966-1975	43	43	32	65	183
1976-1985	43	27	26	24	120
1986-1995	39	32	43	42	147
1996-2005	43	31	34	64	172
Total	230	165	157	259	811

5.3 Results: Accountability Relationship with Government

Three hypotheses are tested in relation to the strength of the accountability relationship between government and Type II bodies. The first ($H_{5.1}$) considers the extent to which the accountability relationship between government and Type II bodies has either remained stable or increased in strength over time. The second ($H_{5.2}$) proposes that governing parties on the left of the political spectrum will produce stronger accountability relationships between Type II bodies and government than governments further to the center and right. The third ($H_{5.4}$) hypothesizes that the accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases. The results for each hypothesis when using the aggregated dataset are presented in Table 5.2. In testing each hypothesis, two regression models are used, one containing only the pertinent independent variables for the specific hypothesis and an overarching model including the combined set of independent variables from all three hypotheses.

Table 5.2: Government Accountability Index (Dataset includes AB, BC, NS and ON)

	Model 1	Model 2	Model 3	Model 4
1956-1965	0.229(0.129)*			0.225(0.129)*
1966-1975	0.331(0.117)***			0.324(0.118)***
1976-1985	0.487(0.125)***			0.478(0.126)***
1986-1995	0.434(0.121)***			0.416(0.130)***
1996-2005	0.647(0.118)***			0.642(0.118)***
Left Government		0.002(0.002)		0.001(0.003)
Spans Municipalities			-0.040(0.168)	-0.038(0.166)
Single Province			-0.136(0.144)	-0.127(0.142)
Spans Provinces			-0.012(0.427)	0.007(0.420)
Alberta	-0.009(0.080)	0.003(0.086)	-0.024(0.081)	0.003(0.087)
British Columbia	0.093(0.087)	0.042(0.101)	0.098(0.089)	0.085(0.102)
Nova Scotia	-0.291(0.089)***	-0.257(0.091)***	-0.270(0.091)***	-0.279(0.093)***
Self-Regulatory	-0.814(0.069)***	-0.762(0.069)***	-0.727(0.071)***	-0.794(0.073)***
Adjusted R^2	0.176	0.1439	0.142	0.174
Number of Cases	811	811	811	811

Standard errors are reported in parentheses. *, **, ***
indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
Ontario, 1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

Evaluating the effect of time period on the strength of the accountability relationship between government and Type II bodies produces significant results in the expected direction. As presented in Table 5.2, Model 1, each subsequent time period after 1946-1955 is associated with a higher level in the government accountability index score and is significant at the 90% confidence level or higher. The results trend in the direction of higher levels in the government accountability index scores in comparison to 1946-1955 as the time period becomes closer to present day. Type II bodies that were enacted or updated between 1996 and 2005 suggest an increase of 0.647 in the government accountability index score which ranges from 0 to 3. The exception to the upwards trend is the 1986-1995 time period, which produced a smaller coefficient than the immediately preceding time period (1976-1985), but still larger than the next most recent time period (1966-1975). As shown in Model 4, when all independent variables are included in the regression model, the results remain consistent. The results presented in both Model 1 and Model 4 provide support for the hypothesis that the accountability relationships

between government and Type II bodies have either remained stable or increased in strength over time.

When assessing the effect of a left-of-centre governing party on the strength of the accountability relationship between government and all Type II bodies, the results shown in Table 5.2, Model 2 are not significant. As displayed in Model 4, the results remain consistent when all independent variables are included in the regression model. The results from both models suggest that $H_{5.2}$, governing parties further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governing parties further to the right, be rejected.

As shown in Table 5.2, Model 3, the results for differences in geographic scale produced no statistically significant results. As presented in Model 4, the results again remain consistent when all independent variables are included in the regression model, suggesting that hypothesis $H_{5.4}$ be rejected.

Although not related to the hypotheses, the dummy variable for Nova Scotia produces significant results across all models in Table 5.2. The results for Nova Scotia consistently suggest a negative relationship and are significant at the 99% confidence level. As shown in Model 4, when all independent variables are included in the regression model the result is a 0.279 decrease in the government accountability index in comparison to Ontario. Neither Alberta nor British Columbia produces statistically significant results. As Nova Scotia is the sole province to produce significant results, it suggests that the formal accountability relationship between special purpose Type II bodies and government, as measured by this study, are weaker in Nova Scotia than the other provinces.

The dummy variable for Professional Self-Regulatory bodies also produced statistically significant results at the 99% confidence level across all models in Table 5.2. The results in Model 4 suggest that within a possible range of 0 to 3 there is an average decrease of 0.794 in the government accountability index score when comparing Professional Self-Regulatory bodies to other forms of Type II bodies. This result indicates that Professional

Self-Regulatory bodies tend to be held less accountable by government than other forms of Type II bodies.

Discussion now turns to the province specific outcomes. The results for each hypothesis by province are presented in Tables 5.3 through Table 5.6. In testing the hypothesis that the accountability relationship between government and Type II bodies has either remained stable or increased in strength over time, all provinces but Nova Scotia produce statistically significant results in the expected direction. All three provinces produce statistically significant results for the 1996-2005 period when compared to 1946-1955. Of the four provinces, the results for Alberta (Table 5.3) produced the largest coefficient for government accountability index score. As shown in Table 5.3, Model 4, when all variables are included in the regression model a Type II body enacted or updated between 1996 and 2005 indicates an increase of 1.051 in the government accountability index. The results are significant at the 99% confidence level.

To evaluate $H_{5.1}$, the results for the province of Alberta are presented in Table 5.3, Model 1. The results indicate a higher level in the accountability index score for each time period variable in comparison to the 1946-1955 time period. With the exception of the 1956-1965 period, all are significant at the 99% confidence level. The overall trend is an increase in the government accountability index score over time, however, the results show that change is not linear but varies from one time period to another. As shown in Table 5.3, Model 4, when all independent variables are included in the regression model the results remain consistent.

To evaluate the effect of time the results for British Columbia are presented in Table 5.4, Model 1. While the three decades preceding 1946-1955 produced no significant results, both 1986-1995 and 1996-2005 produced significant results in the predicted direction. When all independent variables are included in the regression model, as shown in Model 4, only the 1996-2005 time period remains significant.

Table 5.3: Government Accountability Index - Alberta

	Model 1	Model 2	Model 3	Model 4
1956-1965	0.293(0.213)			0.268(0.215)
1966-1975	0.630(0.198)***			0.605(0.204)***
1976-1985	0.898(0.198)***			0.811(0.202)***
1986-1995	0.540(0.198)***			0.628(0.255)**
1996-2005	1.042(0.200)***			1.051(0.200)***
Left Seats		-.009(0.010)		0.008(0.015)
Spans Municipalities			-0.700(0.325)**	-0.628(0.320)**
Single Province			-0.531(0.293)*	-0.434(0.287)
Spans Provinces			Omitted[17]	Omitted
Self-Regulatory	-0.921(0.123)***	-0.819(0.127)***	-0.822(0.133)***	-0.933(0.130)***
Adjusted R^2	0.226	0.151	0.161	0.260
Number of Cases	230	230	230	230

Standard errors are reported in parentheses. *, **, ***
indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

Table 5.4: Government Accountability Index – British Columbia

	Model 1	Model 2	Model 3	Model 4
1956-1965	-0.041(0.315)			-0.089(0.307)
1966-1975	0.134(0.252)			-0.241(0.264)
1976-1985	0.124(0.269)			-0.049(0.265)
1986-1995	0.600(0.259)**			0.123(0.282)
1996-2005	0.766(0.258)***			0.803(0.249)***
Left Government		0.009(0.003)***		0.014(0.004)***
Spans Municipalities			0.262(0.433)	0.171(0.401)
Single Province			0.012(0.278)	0.040(0.262)
Spans Provinces			Omitted	Omitted
Self-Regulatory	-0.605(0.162)***	-0.453(0.155)***	-0.467(0.163)***	-0.653(0.160)***
Adjusted R^2	0.123	0.087	0.039	0.181
Number of Cases	165	165	165	165

Standard errors are reported in parentheses. *, **, ***
indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

17 Spans Provinces is omitted when no Type II bodies that span provinces exist within the dataset.

Table 5.5: Government Accountability Index – Nova Scotia

	Model 1	Model 2	Model 3	Model 4
1956-1965	0.183(0.303)			0.175(0.315)
1966-1975	0.002(0.286)			-0.004(0.294)
1976-1985	0.467(0.293)			0.469(0.297)
1986-1995	0.128(0.283)			0.142(0.289)
1996-2005	0.278(0.286)			0.374(0.413)
Left Seats		0.004(0.007)		-0.004(0.116)
Spans Municipalities			0.305(0.453)	0.203(0.467)
Single Province			0.263(0.404)	0.248(0.410)
Spans Provinces			0.162(0.535)	0.205(0.538)
Self-Regulatory	-1.373(0.142)***	-1.375(0.142)***	-1.350(0.141)***	-0.382(0.151)***
Adjusted R^2	0.394	0.387	0.379	0.380
Number of Cases	157	157	157	157

Standard errors are reported in parentheses. *, **, ***
indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

Table 5.6: Government Accountability Index Ontario

	Model 1	Model 2	Model 3	Model 4
1956-1965	0.301(0.232)			0.261(0.231)
1966-1975	0.324(0.216)			0.369(0.217)*
1976-1985	0.113(0.259)			0.230(0.270)
1986-1995	0.187(0.234)			0.568(0.310)**
1996-2005	0.426(0.217)**			0.446.(0.215)**
Left Seats		-0.008(0.004)*		-0.012(0.006)*
Spans Municipalities			0.093(0.267)	0.096(0.268)
Single Province			-0.242(0.234)	-0.219(0.236)
Spans Provinces			Omitted	Omitted
Self-Regulatory	-0.467(0.131)***	-0.370(0.131)***	-0.381(0.128)***	-0.319(0.140)**
Adjusted R^2	0.051	0.060	0.060	0.071
Number of Cases	259	259	259	259

Standard errors are reported in parentheses. *, **, ***
indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

The results for Ontario are presented in Table 5.6, Model 1. When evaluating the effect of time, the only time period to produce statistically significant results in comparison to 1946-1955 was 1996-2005. When all variables are added into the regression model, as

presented in Model 4, the 1966-1975, 1986-1995 and 1996-2005 time periods produce significant results at the 90% confidence level or higher. The results for the 1996-2005 time period suggests an increase of 0.446 in the government accountability index score (which ranges from 0 to 3) in comparison to the 1946-1955 period.

Overall, the results for all four provinces support $H_{5.1}$ – that the accountability relationships between government and Type II bodies have either remained stable or increased in strength over time. While occasional reductions in the government accountability score from one period to another are evident in all provinces, these results were not statistically significant. As predicted, the trend has been toward either higher levels of accountability as time progresses as seen in Alberta, British Columbia, and Ontario, or stability as witnessed in Nova Scotia.

When testing the hypothesis that governing parties further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governing parties on the right, the results for the individual provincial datasets produce conflicting results. Of the four provinces only British Columbia and Ontario produce significant results, however, the results are in opposite directions.

When evaluating $H_{5.2}$ the results for the province of British Columbia are presented in Table 5.4, Model 2. The results suggest that a 1% increase in the number of seats held by a left-of-centre party are associated with an increase of 0.009 in the government accountability index score which ranges from 0 to 3. The results are significant at the 99% confidence level. When all variables are included in the regression model, as shown in Model 4, the results remain consistent. The results for Ontario are presented in Table 5.6, Model 2. The results for Ontario indicate that a 1% increase in the number of seats held by a left-of-centre party is associated with a decrease of 0.008 in the government accountability index score and is significant at the 95% confidence level. When all independent variables are included, as shown in Model 4, the results remain consistent.

Based on the individual provincial results, there is conflicting support for hypothesis $H_{5.2}$ – governments further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governments

further to the right. The existing support is contingent upon the province in question, with each province producing statistically significant results, but in the opposite direction. Depending upon the province, it could be argued that the presence of a left-of-centre government suggests either a decrease (Ontario) or increase (British Columbia) in the strength of the accountability relationship between Type II bodies and government.

When evaluating the hypothesis that the accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases only the province of Alberta returns significant results, and the results are not in the expected direction. When evaluating $H_{5.4}$ the results for the province of Alberta are presented in Table 5.3, Model 3. The results suggest a decrease of 0.700 in the government accountability index for Type II bodies that span municipalities and a decrease of 0.531 for Type II bodes that are the same geographic scale as the province when compared to Type II bodies whose jurisdiction is at the geographic scale of a single municipality. When all variables are included within the regression model the results remain in the opposite direction than what was predicted, however, only the dummy variable for Spans Municipalities remains statistically significant. In assessing the results of each of the four provincial datasets there is no indication of support for $H_{5.4}$ – the accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases.

Also of interest are the results for the Professional Self-Regulatory dummy variable. For all models in Tables 5.3 through 5.6 the results indicate statistically significant results at the 95% confidence level or higher, and all in the negative direction. Consistent with the aggregate dataset, the results suggest that Professional Self-Regulatory bodies are held less accountable by government than other forms of Type II bodies.

A summary of whether support was found for each of the three hypotheses by dataset is provided in Table 5.7. As highlighted in Table 5.7 there is support across each of the provincial datasets and the aggregate dataset for $H_{5.1}$ – the accountability relationships between government and Type II bodies have either remained stable or increased in strength over time. The Nova Scotia case is an outlier, however, as the accountability

relationship between government and Type II bodies remained stable in Nova Scotia, but strengthened in the other four datasets.

In contrast to $H_{5.1}$, Table 5.7 shows that no support was found for $H_{5.4}$ – the accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases.

Table 5.7: Government Accountability Index - Support for Hypotheses by Dataset

	$H_{5.1}$ – Time	$H_{5.2}$ – Ideology	$H_{5.4}$ – Geographic
All Provinces	Support	No Support	No Support
Alberta	Support	No Support	No Support
British Columbia	Support	Support	No Support
Nova Scotia	Support	No Support	No Support
Ontario	Support	No Support	No Support

Moreover, Table 5.7 shows mixed support for hypothesis $H_{5.2}$ – governing parties further to the left on the political spectrum produce stronger accountability relationships between Type II bodies and government than governing parties further to the right. In testing the effect of a left-of-centre government, Ontario and British Columbia produced significant results, however, the results were in opposite directions, with British Columbia indicating a strengthening of the relationship as predicted, while Ontario predicted a weakening of the accountability relationship.

To test the robustness, the effect of a left-of-centre government on the accountability relationship with government and Type II bodes was evaluated using regression analysis. The results for $H_{5.2}$ substituting left-of-centre government for percentage of seats held by a left-of-centre party is presented in Table 5.8. The results in Table 5.8 shows that the effect of a left-of-centre government is consistent with the findings for seat percentage. A left-of-centre government in British Columbia indicates an increase of 0.549 in the government accountability index, while a left-of-centre government in Ontario suggests a decrease of 0.673.

Table 5.8: Effect of Left-of-centre Governments on Accountability to Government

	British Columbia	Ontario
1956-1965	-0.059(0.310)	0.317(0.229)
1966-1975	-0.191(0.267)	0.308(0.213)
1976-1985	0.110(0.264)	0.091(0.256)
1986-1995	0.210(0.283)	0.597(0.291)**
1996-2005	0.568(0.259)**	0.414(0.214)*
Left Government	0.549(0.173)***	-0.673(293)**
Spans Municipalities	0.104(0.406)	0.090(0.266)
Single Province	0.036(0.265)	-0.233(2.34)
Self-Regulatory	0.655(0.162)***	-0.309(0.139) **
Adjusted R^2	165	259
Number of Cases	0.161	0.078

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively(two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

5.4 Results: Accountability Relationship with Society

In looking at the accountability relationship between society and Type II bodies two hypotheses are tested: $H_{5.3}$ – the accountability relationship between society and Type II bodies has increased in strength over time; and $H_{5.5}$ – the accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases. When testing each hypothesis, two regression models are again used, the first model containing only the pertinent independent variables for the specific hypothesis and the second model including the combined set of independent variables for both hypotheses. Each hypothesis is examined in turn using the aggregated provincial dataset and then again using the individual provincial level datasets. The results for each hypothesis when using the aggregated data set are presented in Table 5.9.

Table 5.9: Society Accountability Index (Dataset includes AB, BC, NS and ON)

	Model 1	Model 2	Model 3
1956-1965	0.232(0.115)**		0.217(0.113)*
1966-1975	0.270(0.105)***		0.276(0.102)***
1976-1985	0.190(0.112)*		0.177(0.110)
1986-1995	0.500(0.108)***		0.489(0.106)***
1996-2005	0.506(0.106)***		0.499(0.103)***
Spans Municipalities		0.121(0.147)	0.099(0.145)
Single Province		-0.402(0.126)***	-0.412(0.124)***
Spans Provinces		-0.676(0.373)*	-0.732(0.367)**
Alberta	-0.117(0.071)	-0.142(0.071)**	-0.108(0.070)
British Columbia	-0.161(0.078)**	-0.129(0.078)*	-0.117(0.077)
Nova Scotia	-0.249(0.079)***	-0.200(0.080)**	-0.203(0.079)***
Self-Regulatory	0.401(0.062)***	0.568(0.062)***	0.506(0.063)***
Adjusted R^2	0.116	0.113	0.146
Number of Cases	811	811	811

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
Ontario, 1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

When looking at the effect of time period on the strength of the accountability relationship between society and Type II bodies, the results displayed in Table 5.9, Model 1, indicate that all time periods yield statistically significant results at the 90% confidence level or higher. For all time periods the relationship is positive; suggesting a higher level in the society accountability index score, which ranges from 0 to 3, for each subsequent time period when compared to 1946-1955. When all independent variables are included in the regression model, as shown in Model 3, the results remain consistent with the exception of the 1976 to 1985 time period, which is no longer statistically significant. The results for both Model 1 and Model 3 indicate that the most recent time period (1996-2005) produces the largest coefficient. The results in Model 3 suggest an increase of 0.499 in the society accountability index score for Type II bodies created or modified between the years of 1996 to 2005 in comparison to Type II bodies created or modified between the years of 1946 to 1955. Overall the observed trend is toward the strengthening of the accountability relationship between society and Type II bodies over

time, lending support to the hypothesis that the accountability relationship between society and Type II bodies has increased in strength over time.

When considering the effect of geographic scale on the strength of the accountability relationship between society and Type II bodies. The results in Table 5.9, Model 2 indicate that Type II bodies that operate at the provincial geographic scale or higher produce statistically significant results in the negative direction at the 90% confidence level or higher. Based on the results in Model 2, a Type II body operating at the provincial geographic level suggests a decrease of 0.40, while a Type II body that spans provinces indicates a decrease of 0.676 in society accountability index score in comparison to a Type II body operating at the municipal geographic scale. When all variables are included within the regression model, as shown in Model 3, the results remain consistent, providing support for the hypothesis that the accountability relationship between society and Type II bodies increases as the geographic scale of the Type II body decreases.

It should also be noted, as presented in Table 5.9, that the each of the provincial dummy variables produced statistically significant results in at least one of the three models. However, when all independent variables were included in the regression model, as shown in Model 4, only Nova Scotia remained significant. In Model 3, the results for Nova Scotia indicate a decrease of 0.203 in the society accountability index score in comparison to the province of Ontario. Overall the results suggest a weaker accountability relationship between society and Type II bodies in Nova Scotia than that which exist in the other provinces being studied. To a lesser extent, however, the results in Models 1 and 2 suggest a stronger accountability relationship between society and Type II bodies in Ontario than in either Alberta or British Columbia.

As with the evaluation of the accountability relationship between government and Type II bodies, the dummy variable for Professional Self-Regulatory bodies produced statistically significant results at the 99% confidence level across all models in Table 5.9. In evaluating the accountability relationship between society and Type II bodies, however, the relationship is in the opposite direction with a Professional Self-Regulatory body

producing an increase in the society accountability index score in comparison to other forms of Type II bodies. This result suggests that Professional Self-Regulatory bodies have more accountable mechanisms to society than other forms of Type II bodies.

Proceeding to the evaluation of each hypothesis at the individual province level, the results for Alberta, British Columbia, Ontario, and Nova Scotia will now be explored. The results for each hypothesis by province are presented in Tables 5.10 through Table 5.13.

Table 5.10: Society Accountability Index - Alberta

	Model 1	Model 2	Model 3
1956-1965	-0.047(0.179)		-0.020(0.170)
1966-1975	0.394(0.167)**		0.452(0.159)***
1976-1985	0.155(0.166)		0.249(0.160)
1986-1995	0.494(0.170)***		0.477(0.161)***
1996-2005	0.982(0.168)***		0.940(0.234)***
Spans Municipalities		1.133(0.268)***	0.940(0.253)***
Single Province		0.358(0.242)	0.235(0.229)
Spans Provinces		Omitted[18]	Omitted
Self-Regulatory	0.546(0.104)***	0.806(1.109)***	0.682(0.104)***
Adjusted R^2	0.294	0.237	0.369
Number of Cases	230	230	230

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively(two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

18 Spans Provinces is omitted when no Type II bodies that span provinces exist within the dataset.

Table 5.11: Society Accountability Index – British Columbia

	Model 1	Model 2	Model 3
1956-1965	0.609(0.285)**		0.497(0.277)*
1966-1975	0.433(0.228)*		0.351(0.221)
1976-1985	0.260(0.244)		0.252(0.235)
1986-1995	0.656(0.234)***		0.546(0.229)**
1996-2005	0.735(0.233)***		0.731(0.225)***
Spans Municipalities		-0.643(0.370)*	-0.720(0.362)**
Single Province		-0.926(0.237)***	-0.893(0.236)***
Spans Provinces		Omitted	Omitted
Self-Regulatory	0.239(0.146)	0.359(0.139)**	0.317(0.143)**
Adjusted R^2	0.065	0.089	0.133
Number of Cases	165	165	165

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

Table 5.12: Society Accountability Index – Nova Scotia

	Model 1	Model 2	Model 3
1956-1965	0.141(0.275)		0.006(0.256)
1966-1975	0.022(0.260)		0.138(0.241)
1976-1985	0.043(0.267)		0.005(0.246)
1986-1995	0.144(0.258)		0.181(0.238)
1996-2005	0.180(0.260)		-0.151(0.241)
Spans Municipalities		0.280(0.371)	0.383(0.385)
Single Province		-0.666.(0.331)**	-0.614(0.339)*
Spans Provinces		-0.948(0.439)**	-0.917(0.446)**
Self-Regulatory	0.253(0.129)*	-0.406(0.115)***	0.401(0.124)***
Adjusted R^2	0.005	0.175	0.157
Number of Cases	157	157	157

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

Table 5.13: Society Accountability Index – Ontario

	Model 1	Model 2`	Model 3
1956-1965	0.208(0.219)		0.201(0.218)
1966-1975	0.082(0.203)		0.059(0.203)
1976-1985	0.200(0.244)		0.163(0.244)
1986-1995	0.509(0.221)**		0.504(0.219)**
1996-2005	0.114(0.204)		0.118(0.203)
Spans Municipalities		-0.211(0.253)	-0.164(0.252)
Single Province		-0.411(0.222)*	-0.393(0.222)*
Spans Provinces		Omitted	Omitted
Self-Regulatory	0.427(0.124)***	0.579(0.121)***	0.499(0.128)***
Adjusted R^2	0.078	0.075	0.087
Number of Cases	259	259	259

Standard errors are reported in parentheses.
*, **, *** indicates significance at the 90%, 95%, and 99% level, respectively (two-tailed test of significance).
1946-1955, and Single Municipality are used as the categories of comparison for dummy variables.

When evaluating the effect of time period on the accountability relationship between society and Type II bodies at the individual provincial level the results vary across provinces. The results for Alberta are presented in Table 5.10, Model 1. For Alberta 1966-1975, 1986-1995, and 1996-2005 produce statistically significant results – each in the positive direction. For Alberta the most recent time period, 1996-2005, produces the largest coefficient of 0.982, while the 1986-1995 period generated the second largest. Both the 1986-1995 and 1996-2005 results are significant at the 99% confidence level and the results are consistent when all independent variables are included in the regression model as shown in Table 5.10, Model 3.

When evaluating $H_{5.3}$ for British Columbia the results are presented in Table 5.11, Model 1. All time periods produce results in the positive direction and are statistically significant at the 90% confidence level or higher with the exception of the 1976-1985. Like Alberta the most recent period, 1996 to 2005, produces the largest suggested increase in the society accountability index score, indicating an increase of 0.735 in comparison to 1946-1955, while the 1986-1995 time period produced the second largest coefficient. The results for both the 1986-1995 and 1996-2005 time periods are significant at the 99% confidence level. When all independent variables are included in the regression model, as

shown in Table 5.11, Model 3, the results for 1966 to 1975 are no longer statistically significant.

The results for the effect of time on the strength of the accountability relationship between society and Type II bodies for Nova Scotia are presented in Table 5.12, Model 1. No statistically significant results are produced and the results remain consistent when all independent variables are included in the regression model as show in Model 3.

When evaluating $H_{5.3}$ for Ontario the results are shown in Table 5.13, Model 1. For Ontario the only time period to produce statistically significant results is 1986-1995, which indicates an increase of 0.509 in the society accountability index score in comparison to 1946-1955 and is significant at the 95 % confidence level. When all independent variables are included in the regression model the results remain consistent.

Of the four provinces, the results for both Alberta and British Columbia provide support for the hypothesis that the accountability relationship between society and Type II bodies has increased in strength over time. Conversely neither the Nova Scotia nor Ontario case provides support for the hypothesis.

Testing the effect of geographic scale on the accountability relationship between society and Type II bodies produce conflicting results. When evaluating $H_{5.5}$ for Alberta the results are presented in Table 5.10 Model 2. In the case of Alberta, spans municipality is the only variable to produces statistically significant results. While spans municipality is expected to produce a negative coefficient, the results are in the positive direction. The results suggest an increase of 1.333 in the society accountability index in comparison to Type II bodies that operate within the jurisdictional boundaries of a single municipality and are significant at the 99% confidence level. As shown in Model 3, the results remain consistent when all independent variables are included in the regression model.

When evaluating hypothesis $H_{5.5}$ for British Columbia the results are presented in Table 5.11, Model 2. The results are in the expected direction, with increases in the geographic scale of Type II bodies suggesting a decrease in the society accountability index score. As shown in Table 5.11, Model 2, spanning municipalities indicates a decrease of 0.643

and operating at the same geographic scale as the province indicates a decrease of 0.926 in comparison to Type II bodies that operate within the boundaries of a single municipality. The results are significant at the 90% and 99% confidence level and remain consistent when all variables are added to the regression model as shown in Table 5.11, Model 3.

When evaluating the effect of the geographic scale on Type II bodies in Nova Scotia the results are presented in Table 5.12, Model 2. In the case of Nova Scotia the results for Single Province and Spans Provinces produce statistically significant results in the expected direction at the 90% confidence level. As shown in Model 2, Type II bodies that operate on the same geographic scale as the province suggest a decrease of 0.666 and Type II bodies that span provinces suggest a decrease of 0.948 when compared to Type II bodies that operate within the boundaries of a single municipality. When all independent variables are included in the regression model the results remain significant at the 90% confidence level or higher as shown in Table 5.11, Model 3.

When evaluating $H_{5.5}$ for the province of Ontario the results are presented in Table 5.13, Model 2. For Ontario, single province is the only variable to produce statistically significant results. As shown in Model 2, the results of Single Province are statistically significant at the 90% confidence level and suggest a decrease of 0.411 in the society accountability index in comparison to Type II bodies that operate within the boundaries of a single municipality. As presented in Table 13, Model 3, the results remain consistent when all independent variables are included within the regression model.

Overall, at the individual provincial level, the results for Albert refute the hypothesis that the accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases, while the results for British Columbia, Nova Scotia, and Ontario provide support for the hypothesis.

In addition to the results for the independent variables being tested, the results for the Professional Self-Regulatory dummy variable are again noteworthy. As shown in Model 3 in Tables 5.10 through 5.13 the results for the Self-Regulatory variable indicates a higher level in the society accountability index across all provinces. This suggests that

Professional Self-Regulatory bodies have a stronger accountability relationship with society than other forms of Type II bodies.

When the regression models are run for each of the provincial datasets the results are inconsistent. A summary of whether support was found for each of the hypotheses by dataset is provided in Table 5.14. As shown in Table 5.14 there is mixed support for $H_{5.3}$ – the accountability relationship between society and Type II bodies has increased in strength over time. When evaluating the effect of time, the Alberta and British Columbia datasets produce significant results in the positive direction for both the 1986-1995 and 1996-2005 time periods. The results suggest an increase in strength of the accountability relationship between society and Type II bodies in comparison to 1946-1955. The provincial dataset for Ontario produced significant results for 1986-1995; however, the results for 1995-2005 are not significant in comparison to 1946-1955. The results for Ontario suggest that any gains in accountability have since been lost. The Nova Scotia dataset produced no significant results, suggesting that the strength of the accountability relationship has remained consistent across the sixty years being studied.

Table 5.14: Society Accountability Index - Support for Hypotheses by Dataset

	$H_{5.3}$ – Time	$H_{5.5}$ – Geographic
All Provinces	Support	Support
Alberta	Support	No Support
British Columbia	Support	Support
Nova Scotia	No Support	Support
Ontario	No Support	Support

As shown in Table 5.14 mixed support also exists for $H_{5.5}$ – the accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases. When testing geography, the results for all datasets with the exception of Alberta are significant in the expected direction. In British Columbia, Nova Scotia, and Ontario the results suggest a decrease in the society accountability index score when the Type II body is operating at the same geographic scale as the province in comparison to a Type II body that is operating on the same geographic scale as a municipality. The results for British Columbia further indicate a lower level in the society

accountability index score for Type II bodies that span municipalities, while the results for Nova Scotia further suggest a lower level for Type II bodies that span provinces. The results for Alberta, however, are significant in the opposite direction, suggesting an increase in the society accountability index for the Type II bodies that span municipalities in comparison to Type II bodies that operate within the jurisdictional boundaries of a single municipality.

5.5 Comparing the Strength of Accountability Relationships

In responding to concerns of accountability brought about by the dispersal of authority outside of government, this chapter has sought to gain an understanding of the accountability environment that has emerged when government has delegated decision-making authority. In doing so, the effect of political ideology, time, and geographic scale on the accountability relationships between Type II bodies and both government and society have been explored.

In looking at the accountability environment that emerges when authority migrates, two of the principal findings are that the accountability relationships between both Type II bodies and government and Type II bodies and society have been strengthened over time. This indicates that the ability for both government and society to hold Type II bodies accountable for decisions made and actions taken is greater today than it has been in the past, lessening concerns over democratic accountability. However, while the accountability relationships between both Type II bodies and government and Type II bodies in society have become stronger, it is important to note that the accountability relationship between Type II bodies and society remains weak when compared to the relationship between Type II bodies and government.

As shown in Tables 5.15, the mean government accountability index scores, which are used to assess the relationship between government and Type II bodies, are consistently higher than society accountability index scores, which are used to assess the relationship between Type II bodies and society. Across all four provinces the mean government accountability index score for the entire time frame is above 1, while the society accountability score is below 1 and for no time period is the society accountability index

score higher than that of the government accountability index score. This is consistent with Tanja Börzel's argument that in the modern state both public and private actors operate under the shadow of hierarchy where public actors set the legal rules of the game and intervene to correct distortions or outcomes that violate public interests (Börzel, 2010: 196-197). So while an underlying assumption of multilevel governance is that centralization has given way to new forms of governance, resulting in decision-making authority being dispersed across multiple jurisdictions (Marks and Hooghe, 2005 15-6), the state continues to play a dominant role within the governance process.

Table 5.15: Mean Accountability Index Scores Across Time by Province

	Alberta		British Columbia		Nova Scotia		Ontario	
	Gov Acc Index	Soc Acc Index	Gov Acc Index	Soc Acc Index	Gov Acc Index	Soc Acc Index	Gov Acc Index	Soc Acc Index
1946-1955	1.32	0.42	1.61	0.33	1.50	0.60	1.70	0.74
1956-1965	1.64	0.35	1.79	0.86	1.57	0.76	2.07	0.88
1966-1975	2.06	0.74	1.98	0.67	1.66	0.59	2.08	0.78
1976-1985	2.20	0.58	1.93	0.52	2.12	0.62	1.83	0.92
1986-1995	1.85	0.92	2.34	0.94	1.68	0.74	1.74	1.38
1996-2005	2.14	1.53	2.39	1.06	1.38	0.85	2.05	0.92
All Years	1.91	0.79	2.06	0.75	1.66	0.71	1.96	0.93

The results in Table 5.15 also bring to the forefront questions over the continued strengthening of the accountability relationship between Type II bodies and government and Type II bodies and society. While the results for Alberta and British Columbia indicated a reasonably continuous strengthening of accountability relationships, the sudden decrease in the mean government accountability index score for Nova Scotia during the most recent two 10-year periods raises concerns over democratic input and accountability within the governance process. Presented above in Table 5.2, the Nova Scotia case was unique among the provinces studied. Nova Scotia is the only province in which the government accountability index is consistently decreasing across regression models in comparison to Ontario. In Table 5.15, the Nova Scotia case shows that accountability gains can be lost. Small increases in the strength of the accountability relationship between Type II bodies and society are more than offset by decreases in the accountability relationship between government and Type II bodies.

Furthermore, the highest mean accountability for the 1996 to 2005 time period presented in Table 5.15 is 2.39, which is far from the maximum accountability score of 3. This suggests that while the strength of both accountability relationships may be improving, a full accountability relationship with either government or the public does not exist for a large number Type II bodies. The limited nature of accountability relationships for a portion of Type II bodies bolsters concerns over a loss of public input and democratic accountability when decision-making processes are delegated to Type II multilevel governance bodies.

While time period had a positive effect on the accountability relationships between Type II bodies and government and Type II bodies and society, the geographic scale of a Type II body had an effect only on the relationship between Type II bodies and society. Specifically, Type II bodies that exist on a smaller geographic scale have stronger accountability relationships with society than Type II bodies that have boundaries that align with the province. In contrast, the accountability relationship between Type II bodies and government remains constant across geographic levels. As government is in control of the legislation used to create Type II bodies, the results indicate that governments are willing to, and in fact do, incorporate mechanisms that provide for a stronger accountability relationship between Type II bodies and society when the Type II body is operating and making decisions at a geographic scale that is less than the area of the province. Perhaps not surprisingly, the results also indicate that there is no willingness on the part of government to give up any control they may gain over the actions of the Type II body through their accountability relationship, as the strength of the accountability relationships between Type II bodies and government remain constant across geographic scales.

Just as the strength of the accountability relationship between government and Type II bodies remains constant regardless of geographic scale, so too does the relative strength of the two accountability relationships. The mean government and society accountability index scores for Type II bodies smaller in scale than the provincial boundaries are presented by decade in Table 5.16. Consistent with the overall results, the results in Table 5.16 shows than the mean government accountability index score remains consistently

higher than the mean society accountability index scores when looking at Type II bodies that are smaller in geographic scale than provincial boundaries. This indicates that the stronger of the two accountability relationships remains the relationship between government and Type II bodies. While the ability for societal actors to hold Type II multilevel governance bodies accountable increases as the geographic scale of the Type II body deceases, the state continues to hold the dominant position.

Table 5.16: Mean Accountability Index Scores for Type II bodies at the Single Municipality or Spans Municipalities Geographic scale

	Government Accountability Index	Society Accountability Index
1946-1955	1.82	1.18
1956-1965	2.00	1.05
1966-1975	2.29	1.03
1976-1985	2.27	0.63
1986-1995	2.27	1.14
1996-2005	2.46	1.50
All Years	2.22	1.07

One area in which the strength of the accountability relationships between Type II bodies and government and Type II bodies and society approaches parity is for Professional Self-Regulatory bodies. The results for Professional Self-Regulatory bodies show the strength of the accountability relationships to be moving in opposite directions, producing a statistically significant increase in the accountability relationship between Type II bodies and society and a statistically significant decrease in the accountability relationship between Type II bodies and government when compared to other forms of Type II bodies. The mean government and society accountability index scores for Professional Self-Regulatory Bodies as compared to other forms of Type II bodies are presented in Table 5.17. As the results in Table 5.17 show, the decrease in government accountability index scores and the increase in society accountability index scores for Professional Self-Regulatory bodies in comparison to all other forms of regulatory body are consistent across time periods.

Table 5.17: Mean Accountability Index Scores for Professional Self-Regulatory Bodies

	Government Accountability Index		Society Accountability Index	
	Non Self-Regulatory Bodies	Professional Self-Regulatory Bodies	Non Self-Regulatory Bodies	Professional Self-Regulatory Bodies
1946-1955	1.83	0.85	0.40	0.53
1956-1965	2.16	0.45	0.66	0.86
1966-1975	2.13	1.07	0.68	0.89
1976-1985	2.22	1.50	0.53	1.00
1986-1995	2.17	1.39	0.78	1.40
1996-2005	2.17	1.82	0.90	1.28
All Years	2.13	1.37	0.68	1.14

While being a Professional Self-Regulatory body has opposite effects on the two accountability relationships, the relationships only approach but do not reach parity. The results in Table 5.16 show that although the government accountability index scores decrease and the society accountability index scores increase, the accountability relationship between society and Type II bodies remains the weaker of the two relationships. Furthermore, when the difference between the means of the two accountability index scores is tested using a t-test the results indicate the difference between means to be significant at the 99% confidence level.[19] This indicates that while the two accountability scores may be converging, a significant difference in strength of the two accountability relationships remains, meaning the state retains its position as the dominant actor.

5.6 Discussion: What makes Nova Scotia Different?

The results for Nova Scotia also indicate significantly weaker accountability to both government and society. One possible explanation for the difference is Nova Scotia's smaller population size. To test the effect of population the provincial dummy variables were replaced with the provincial population size in the regression models. When testing

19 Satterthwaite's approximation formula for the degrees of freedom is used to when conducting the t-test (StataCorp, 2013: 2242), as variances between samples were not assumed to be equal.

the effect of population on the accountability relationship with government the results are not significant, however, when testing the effect of population on the relationship with society the results are significant and suggest an increase of 0.000186 in the society accountability index score for every additional 10000 people. These findings suggest that while population size does not help to explain the weak accountability relationship with government, it has some explanatory power for the weaker relationship between Type II bodies and society.

A second possible explanation for the different results is the effect of political culture. The effects of cultural differences on the political processes, government institutions, and policy choices have long been recognized. Cultural differences influence both the policy problems that confront government, and the types of policies elected officials are likely to pursue (Lieske, 2012: 108). While in the recent past all provinces have been subject to the pressures to balance budgets and shrink the role of the provincial state (Dyck, 2006: 57), historical differences exist that have shaped unique political cultures. Historically, the political culture of Nova Scotia has been firmly based on a clientist model (Black and Fierlbeck, 2006: 522). Nova Scotia's political culture has been characterized as hierarchical, elite oriented, conservative and traditional (Wiseman, 2006: 24, 31). Furthermore, the Conservative and Liberal parties, which governed the province during the duration of timeframe being studied, lacked substantive ideological difference and both maintained the dominance of traditional conservative politics (Wiseman, 2006: 24; Bickerton, 2001: 53). What developed between the late eighteenth and mid-twentieth centuries was a pervasive system of patronage and deference to authority that became cemented in the Maritimes Provinces (Wiseman, 2006: 38). While the 1990s brought change to the political landscape in Nova Scotia, with the Buchanan government, who practiced traditional elitist politics, replaced by a government with a more reformist agenda (Bickerton, 2001: 60), the traditional hierarchical elitist nature of Nova Scotia politics may still play a role in the development of accountability relationships between Type II bodies and government. With the provincial elites dominating politics and political rewards doled out through a patronage system, they may have been little need for politicians to build formal mechanisms into the legislation that enforce the accountability relationship between Type II bodies and government. The elites have a

vested interest in maintaining the status quo, while those rewarded patronage positions have a vested interested in acting according to preferences of those handing out the rewards. The threat of being replaced, coupled with the deference to authority associated with hierarchy may be sufficient to keep Type II bodies in check.

5.7 Conclusion

In looking at the accountability environment that emerges when authority migrates, two overarching trends emerge: 1) the strength of accountability relationships between Type II bodies and government and Type II bodies and society have increased over time, and 2) that regardless of increases in the strength of the accountability relationship between Type II bodies and society, the relationship between Type II bodies and government remains the stronger of the two relationships.

As the cumulative number of Type II bodies involved in the governance process continue to expand, as the results from Chapter 4 show, the increase in both the strength of the accountability relationship between Type II bodies and government and Type II bodies and society can be seen as positive for public input and democratic accountability. As laid out at the start of the chapter, three different accountability arrangements may exist to hold Type II bodies accountable to citizens. First, society may act as principals with Type II bodies as agents where Type II bodies are directly accountable to society. Second, citizens may act as principals with democratically elected government as agents, who are in turn acting as principals with Type II bodies again as agents where Type II bodies are indirectly accountable to the citizens. Finally both accountability arrangements may exist. The results indicate the existence of both accountability arrangements, with citizens increasingly able to hold Type II bodies directly accountable and able to hold Type II bodies accountable indirectly through the chain of accountability from citizens through government to Type II bodies.

While the overall increase in the strength of accountability relationships is an encouraging sign of democratic accountability, there is still some reason for concern. As shown in Table 5.15, decreases in the mean government accountability index score for Nova Scotia during the two most recent ten-year periods presents a situation where past

gains in accountability are lost. While the results for Nova Scotia are unique among the provinces studied, it does raise concerns over democratic accountability when Type II bodies are brought into the governance process. Moreover, in the Nova Scotia case, small increases in the strength of the accountability relationship between Type II bodies and society were more than offset by decreases in the accountability relationship between government and Type II bodies during the most recent time period. In the case of Ontario, the increase in society accountability index for the 1986 to 1995 time period is statistically significant compared to 1946-1955, while the 1996 to 2005 time period is not. Both the Nova Scotia and the Ontario case raise concern over the ability to maintain accountability gains and secure public input and democratic accountability once decision-making authority has migrated.

Chapter 6

"There will come a time when the Ministry of Health is the only Ministry we can afford to have and we still won't be able to afford the Ministry of Health"

- Dalton McGuinty, Premier of Ontario

6 Migration of Authority and Healthcare Reform

Chapters 4 and 5 explored the rate at which the provincial governments of Alberta, British Columbia, Nova Scotia, and Ontario migrated decision-making authority to actors outside of elected government and the accountability relationships that emerged once authority migrated. Having evaluated the migration of authority using the universe of cases from 1946 to 2005, Chapters 6 and 7 now focus on a specific policy area – healthcare. In doing so, a more nuanced account of the factors and reasoning that led to the migration of decision-making authority away from elected officials is provided.

In Canada, the trend toward migrating healthcare authority away from the centre of government emerged in the 1970s with the creation of District Health Councils in Ontario. While having no decision-making authority, the councils identified areas of need, assessed healthcare alternatives, and established priorities at the local level (Ontario. Ontario Health Review Panel, 1987: 14-15). New instances of authority migration emerged in the 1990s, as Alberta, British Columbia, New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, Quebec, and Saskatchewan all devolved authority to regional bodies between the years of 1991 and 1994, with Manitoba following suit in 1996 (Lomas, Woods and Veenstra, 1997: 371). While implementing District Health Councils as advisory boards in the 70s, Ontario was the last province to devolve decision-making authority with the creation of Local Health Integration Networks in 2006.

Building on the results of previous chapters, this chapter explores the process by which Alberta, British Columbia, Nova Scotia and Ontario legislated the migration of authority and the creation of new Type II bodies in each provincial healthcare system. In doing so specific attention will be paid to determining what factors may have precipitated the

migration of decision-making authority in each case. To continue to develop an understanding of why authority migrates, both the fiscal capacity and political ideology hypotheses put forward in Chapter 4 will be evaluated against the migration of authority in the four healthcare systems. To reiterate, the hypotheses put forward in Chapter 4 are:

$H_{4.3}$ - The lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies.

$H_{4.4}$ – The further to the left-of-centre on the political spectrum a government sits the lower the rate of creation of Type II bodies.

A summary of the support found for each hypothesis in Chapter 4 is provided in Table 6.1. As shown in Table 6.1, the analysis in Chapter 4 produced inconsistent results, with support evident in some datasets, but not in others.

Table 6.1: Type II Body Annual Creation Rate – Support for Hypothesis by Dataset

	$H_{4.3}$ Fiscal Capacity		$H_{4.4}$ – Ideology
	Disposable Income	Provincial Debt	% Left Seats
All Provinces	No Support	No Support	No Support
All Provinces – Excluding Self-Regulatory Bodies	No Support	Support	No Support
Alberta	No Support	Support	No Support
British Columbia	No Support	No Support	No Support
Nova Scotia	No Support	No Support	Support
Ontario	No Support	No Support	Support

While Chapter 4 evaluated the effect of fiscal capacity and political ideology on the migration of authority to Type II bodies, this chapter further seeks to explore the existence of other factors that may have contributed to the migration of authority in provincial healthcare. The unique context surrounding the creation of Type II healthcare bodies in each province offers the potential to further identify additional factors that promote the migration of authority. One factor that may either promote or suppress the creation of Type II bodies is how problems are defined or framed. Due to the inconsistent

results in Chapter 4, the impact of how policy problems in the healthcare system are framed by government for public consumption is also considered. To do so, government policy documents, commission reports, provincial legislation, and provincial regulations will be used to gain an understanding of how policy challenges in healthcare were framed during the authority migration process. Consistency in policy framing in relation to policy solutions and eventual policy outcomes are considered in the evaluation of factors that contributed to authority migration. For each of the four provinces the initial migration of authority as well as subsequent changes to the governance model will be explored.

6.1 Problem Definition, Issue Framing and Policy Images

To gain insight into what factors played a role in the migration of authority from central provincial governments to multilevel governance Type II bodies, how each province defined the challenges facing the healthcare system will be explored. There is universal agreement that a key factor in policy response is how the problem, or the situation that is considered to be problematic, is defined (Pal, 2006: 97). How a problem is structured acts as a steering mechanism that shapes of all subsequent phases of policy development (Dunn, 2004: 72; Pal, 2006: 97). Simply stated, as policies are responses to problems, how the problem is defined shapes the nature of the policy response (Pal, 2006: 97).

Linked to the idea of problem definition is the concept of issue framing. On a basic level, issue framing can be characterized as something akin to an optimal rhetorical strategy through which policy actors emphasize the aspects of an issue that gives their preferred solution a rhetorical edge (Jerit, 2008: 1-2). When expanded upon, framing can be defined as "a way of selecting, organizing, interpreting, and making sense of a complex reality so as to provide guideposts for knowing, analyzing, persuading and acting" (Rein and Schon, 1991: 263). As argued by Rein and Schon, it is through framing that vague issues can be made sense of and eventually acted upon (1991: 263). However, frames do not simply reduce the issue to an argument on one side or another. Frames are broader; they suggest how an issue should be thought of and recommend what, if anything should be done (Nelson and Kinder, 1996: 1057). In essence, frames shape how citizens think about political issues (Sniderman and Theriault, 2004: 136).

Rein and Schon suggest that frames are never self-interpreted. Instead the interpretation of policy issues, in its various frames, is usually undertaken by a group of individuals or by informal or formal organizations. Sponsors of the frame, such as government officials, seek to develop the frame, make explicit its implications for action and establish grounds for arguments surrounding it (Rein and Schon, 1991: 274-275). As all people cannot be equally interested in or knowledgeable on all policy issues facing society, specialists in any particular area have an advantage over others. When communicating with the broader public and political elites specialists explain issues and justify policy approaches in a simplified manner. The result is a set of policy images that are a combination of empirical information and emotional appeals, leaving the problem understood in simplified and symbolic terms (Baumgartner and Jones, 2009: 25-26).

At the centre of the process of transforming issues into policy problems are causal ideas. As stated by Deborah Stone, "Problem definition is a process of image making, where images have to do fundamentally with attributing cause, blame, and responsibility" (1989: 282). As such, difficulties or issues do not have inherent properties that make them more or less likely to be seen as problems, but instead, political actors deliberately portray them in ways calculated to give support for their position (Stone, 1989: 282). Stone further contends that, in the world of public policy, there is always choice about which factors to address. Focusing on different storylines will locate the responsibility and burden of reform differently (Stone, 1989: 296). When considering the migration of authority to Type II bodies in provincial healthcare, what are the causal factors that promote the adoption of Type II healthcare bodies as a corrective action? Reflecting back on the original hypotheses, will the policy problem be defined in terms of fiscal capacity, political ideology, or something yet to be defined?

A challenge posed by issue framing is that it is possible for multiple, potentially conflicting, frames to be built using the same underlying facts or evidence. At play is the reality that divergent worldviews produce differences in how the underlying facts are interpreted. As a result there is the potential for variation in how issues are framed and what if any action should be taken in response to the issue (Rein and Schon, 1991: 264-265; Baumgartner and Jones, 2009: 26). No one individual has the power to define the

policy image or to guarantee that a specific solution will be adopted; both are the result of political conflict (Baumgartner and Jones, 2009: 29). In basing the analysis of the migration of authority in the healthcare system on government documents, the frame that is being assessed is the policy image that emerged as successful from the political battlefield. On the political battlefield, the differing conceptions of both the policy problem and policy solutions would have been contested.

6.2 Why Healthcare?

The decision to explore the migration of decision-making authority in healthcare provision is rooted in high level of importance placed on healthcare by Canadian citizens and the declining presence of academic literature on healthcare decentralization since the early days of authority migration as a vehicle for healthcare reform. The importance of healthcare to Canadians is evident in Canadian Election Study results. Results for both the 2004 and 2006 Canadian Election Study identify healthcare as the most frequently selected issue, chosen over taxes, social welfare programs, the environment and corruption in government when asked, "Which of these five issues is the most important issue to you PERSONALLY in this election." The results found that 48.8 of respondents selected healthcare as the most important issue in 2004 and 40.8 per cent selected healthcare in 2006 (Blais et al., 2007). Also, as discussed in Chapter 4, in 2005 85% of Canadians stated that they believed that eliminating public healthcare represented a fundamental change to the nature of Canada, with more respondents viewing eliminating healthcare as a fundamental change than any other policy in the survey, including abandoning English and French as Canada's official languages, and ending peacekeeping missions (Soroka, 2007:5). However, while healthcare is identified as an important issue to Canadians, the literature on the decentralization of the healthcare system has diminished. Paradoxically, as authority migration has become common-place across provincial healthcare systems, Black and Fierlbeck lament that there is less literature now than when the policies were first being implemented (Black and Fierlbeck, 2006: 507).

In addition to political salience and the decline in academic focus stated above, the selection of healthcare is also guided by practical considerations. With the creation of LHINs in Ontario a degree of decision-making authority was migrated outside of the

central provincial governments in all 10 Canadian provinces, which allows for the continued use of cross provincial comparisons between Alberta, British Columbia, Nova Scotia and Ontario. Furthermore, how decentralization works within each province is affected by contextual differences such as: variation in size, economies, political cultures and other local features (Black and Fierlbeck, 2006: 523). This perception of decentralization is consistent with outcomes in provincial healthcare, as they are not uniform, but differ in governance models, degree of authority migration, and, in the case of Ontario, timing of events. Taken together, the common use of horizontal migration of authority as a healthcare reform policy solution coupled with differences in its implementation provide a venue for investigating how contextual differences influence the hypothesis put forward in Chapter 4 as well as factors specific to each provincial context.

Lastly, while the focus of analysis is on the creation of Type II bodies and the resulting accountability mechanism in the Canadian provinces, the migration of decision-making authority in healthcare is not unique to Canada. For example, in New Zealand the district offices of the Department of Health were merged with local hospital boards to create Area Health Boards during the 1980s (Anderson, 1996: 78). Subsequent reforms saw New Zealand's Area Health Boards broken up and their functions divided among a number of public and private actors (Anderson, 1996: 82). In the United Kingdom the management of the National Health Service was decentralized to regional and district levels through the creation of Health Authorities (Dekker, 1994: 283), while the Netherlands has traditionally been a mix of public and private, with regulation of services falling to government and quasi-autonomous non-government organizations (Dekker, 1994: 284). Given the widespread adoption of devolved decision-making authority in healthcare, the analysis of authority migration in healthcare reform has the potential to provide value beyond Canada.

6.3 Healthcare Reform and Authority Migration

While an important issue, the migration of decision-making authority in healthcare reform has proven to be complex (Vaughan, 1990: 139). Mills argues that patterns of institutionalized local behaviour, even those that are peripheral to healthcare, can

influence which healthcare governance structure is ultimately adopted (1990:38). The unique historical experiences of each jurisdiction have made generalizations over the reason for authority migration in healthcare difficult. Countries with their own unique historical context and with governments differing in political beliefs and policies have felt the need to reform healthcare by way of shifting authority to some degree away from central government (Vaughan, 1990: 139).

In assessing what decentralization in healthcare looks like, Mills states that while decentralization can be defined in terms of transferring authority from higher levels to lower levels of government, decentralization in the health system takes on many forms, making decentralization not only an important theme in healthcare, but a confused one (1990, 11). Four paths through which aspects of the healthcare system can be shifted outside of central government are identified: deconcentration, devolution, delegation and privatization (Mills, 1990: 16). Deconcentration is the movement of administrative authority to locally based offices of central government (Mills, 1990, 16). Devolution is the creation or strengthening of subnational levels of government that are substantively independent from central government (Mills, 1990, 19). Delegation is the transfer of managerial responsibility for defined functions to organizations that are outside the government and are only indirectly controlled by central government (Mills, 1990, 21). Lastly, Privatization involves the transfer of government functions to voluntary organizations, private profit-making organizations, or non-profit enterprises (Mills, 1990, 22).

Lomas views the four paths put forward by Mills as a continuum along which the central branch of government has decreasing a level of direct control over the decisions being made (1996: 28). An alternative conceptualization is a continuum between state-centric and society-centric steering along which decision-making control shifts between the central state and societal actors. To determine where authority migration to Type II healthcare bodies would be placed on that continuum, the three conditions laid out in Chapter 3 must be considered. Authority migration to Type II bodies must satisfy three conditions: authority over some part of the public realm must be granted to a new or existing body through an act of provincial legislation; the majority of decision-makers

within the body must be comprised of individuals who are from outside of government, the legislature, and the public service; and the legislated decision-makers must have decision-making autonomy. As such, the operationalization of migration of authority to Type II bodies is consistent with delegation and privatization but not deconcentration and devolution.

Where on the continuum each instance of healthcare decentralization occurs, however, is a negotiation process as pressures on the state combined with local attitudes shape the decentralization process (Lomas, 1996: 28). In combination, three sources grant power during the authority migration process. The government grants the newly formed healthcare body formal powers. Health professionals and institutions recognize and conform to the decisions made by the new healthcare body. Citizens provide credibility to the new healthcare body and a mandate to represent their needs, wants, and preferences. As each source of power has its own agenda, the new healthcare authorities are situated at the intersection of government's expectations, providers' interests and citizens' preferences (Lomas, Woods and Veenstra, 1997: 734). The successful policy image that ultimately triumphs within the negotiation process will be a product of the unique historical experiences of the specific jurisdiction. While the state must work within the confines of the internal and external pressures placed upon the healthcare system, it maintains the capacity to set the overall ground rules and regulatory order. Despite the participation of government, health professionals, and citizens in the negotiation process, government continues to occupy a privileged position as the lone entity with the legislative capacity to set the rules of governance (Bartle and Vass, 2007: 895; Rhodes, 2007: 1244; Bell and Hindmoor, 2009: 13).

Informing the negotiation process and ultimately the devolved structure that emerges are the perceived advantages and disadvantages of devolved authority that have been developed by issue framers in promoting their preferred solution. Consistent with the assertion that multiple frames be built using the same underlying facts or evidence, Mills argues that attributing advantages and disadvantages to devolution is complex, as alongside each advantage exists a corresponding disadvantage. For example, increased citizen participation is promoted as an advantage, while increased difficulty in developing

national policies, priorities and standards can be seen as a disadvantage (Mills, 1990: 38). This is not unique to healthcare; authority migration is cast in both positive and negative light more broadly. As discussed in Chapter 2, from the positive perspective, authority migration holds the potential for more responsive governance than a single political monopoly (Bollens, 1986: 119; Lowndes and Wilson, 2001: 633). From the critical perspective, however, authority migration has the potential to weaken legitimacy and create disillusionment with the political process (Andrew and Goldsmith, 1998: 104). In healthcare, experts have continued to debate over the success of decentralization. Some experts claim that the promise of greater accountability and increased citizen participation in decision-making has been realized, while others argue that such claims have remained unfulfilled (Collier, 2010: 331).

In the Canadian context, there is no one national system of healthcare, but instead a set of provincial systems (Deber, 2003: 20). While each province has its own unique story, there is a degree of commonality across the provincial healthcare systems due to their shared history. When Canada was formed, healthcare was the concern of religious groups, charitable organizations or individuals (Braën, 2004: 25). Though coming under provincial jurisdiction, the healthcare systems remained largely a matter of local public initiative, with the delivery of health services remaining in the hands of municipal hospitals, or religious and charitable institutions (Dorland and Davis, 1996: 4). Personal health was seen as purely a private matter (Braën, 2004: 28) and a direct financial relationship, with the recipients of local healthcare services paying the healthcare providers directly (Lomas, 1996:29).

The expansion of the social welfare system following the end of World War II altered the provincial healthcare systems as both provincial and federal governments became more involved in healthcare policy (Braën, 2004: 25). This movement toward centralization was spurred on by the increasing complexity of medical care and corresponding rising costs (Dorland and Davis, 1996: 4; Johnson, 2004: 208) as well as a shift in perception from individual to social importance of healthcare (Braën, 2004: 28; Dorland and Davis, 1996: 4) As mindsets changed, the financial relationship between patients and service providers became increasingly indirect with the provinces reimbursing healthcare

professionals for services (Lomas, 1996: 29). By 1971, all provinces and territories were participating in the medical and hospital services programs in which funding was shared by the provincial and federal governments (Deber, 2003: 21; Naylor, 1999: 11). The resulting healthcare environment was one in which funding decisions and setting of healthcare standards was centralized while hospital boards continued to operate at the local level.

Just as increased costs facilitated the shift from a largely local healthcare system to one that was increasingly centralized, growing financial pressures in healthcare helped again to bring healthcare reform onto the public agenda. Inflationary pressures in the 1970s led to increasingly harder lines being taken by governments in collective bargaining with organized medicine, leading some practitioners to levy extra charges, which prompted concerns over the erosion of Medicare's principle of accessibility. The federal government responded with the Canada Health Act in 1984. The Canada Health Act consolidated previous insurance legislation and reduced federal funding to provinces that allowed hospitals and doctors to impose extra fees. Over the next two years all provinces passed legislation that abolished such fees (Naylor, 1999: 11-12). While the Canada Health Act reaffirmed a commitment to the principles of Medicare (Johnson, 2004: 205), the federal proportion of health expenditures fell (Hurley, Lomas and Bhatia, 1994: 491; Naylor, 1999: 12). The combination of ever-growing expenditures and reduced revenue streams pushed provincial governments to reevaluate their healthcare systems and initiate major healthcare reforms (Hurley, Lomas and Bhatia, 1994: 491).

One of the possible factors contributing to the migration of authority discussed at the beginning of the chapter is the weakening of a government's ability to meet the fiscal obligations of a growing governance demand. Hurley, Lomas, and Bhatia described such a scenario in Canadian provincial healthcare where ever-growing demands and reductions in revenue sources pushed provincial governments to consider healthcare reforms (1994: 491). However, internal fiscal pressures alone did not drive the widespread enactment of provincial healthcare reforms. In conjunction with the changing fiscal circumstances came changes in public confidence in the functioning of their healthcare system. While citizens remained generally satisfied and supportive of provincial healthcare in the early

1990s, a shift from support to concern emerged throughout the 90s (Tomblin, 2004: 291; Lavis 2004: 257). The public continued to support the principles of a publicly funded universal system, however, there were growing concerns over the system's sustainability (Tomblin, 2004: 291). As concerns rose, the Canadian public began to call for large-scale change in the healthcare system (Lavis, 2004: 257). The growing public worry added to the existing government concerns over the fiscal sustainability of the existing healthcare systems. During a health policy conference focused on regionalization and decentralization, then Ontario Premier David Peterson remarked, "you can introduce change at two times – when all is quiet and successful or when there is a sense of crisis. I believe that, right now, we are close enough to a sense of crisis that the time is ripe for a change in the health-care system" (Peterson, 1996: 14).

One hypothesis evaluated in Chapter 4 is that when the fiscal capacity of government fails to keep pace with the demand placed on government to deliver a good, government is more likely to migrate authority. Flinders argues that through the delegation of authority the state retains the ability to address a wide range of policy issues, while removing itself from the day-to-day socio-political interactions (2006: 223-224). With fiscal and public pressure mounting in the late 80s and early 90s the majority of Canada's provincial and territorial governments created royal commissions or task forces charged with producing a strategy for change in the healthcare system. The issues and solutions brought forward through this exercise were consistent, with solutions all involving devolving some degree of authority away from central government (Lomas, Woods and Veenstra, 1997: 371-172). While fiscal pressures led the provinces and territories to examine health system alternatives, cost containment was one of many reasons given to devolve authority. The reasons cited for devolving authority away from provincial governments included cost containment, improving health outcomes, increasing flexibility and responsiveness of delivery, and the better coordination of services (Lomas, Woods, and Veenstra, 1997: 372; Lomas, 1996: 25). Following the blueprints developed by the commissions and task forces, all provinces but Ontario proceeded to devolve authority away from central government during the 1990s. Through the provincial creation of new healthcare bodies, there was the devolution of some degree of provincial administrative and budgetary authority as well as a shift of administrative control

previously held by local institutions and agencies (Naylor, 1999 13-14; Lomas, Veerstra, and Woods, 1997: 514).

Having explored the broader issue of authority migration in health, attention is now turned to the migration of authority in the provinces of Alberta, British Columbia, Nova Scotia, and Ontario. Given their shared history and the common fiscal constraints faced by the provinces, it is not surprising that the proposed solutions, and reasons given for the solutions, share commonalities. Not all provinces, however, initially adopted the migration of authority as the preferred policy alternative. Ontario waited a decade after the other nine provinces had already moved forward. Moreover, not all ten provinces adopted the same governance arrangements, nor have all ten provinces kept their initial devolved structure. Instead, provincial differences have emerged from the unique contexts of each jurisdiction. For Alberta, British Columbia, Nova Scotia, and Ontario the initial migration of authority as well as subsequent changes to the governance model in healthcare will be explored. In doing so, a greater understanding of how the healthcare system policy challenges were framed during the authority migration process will be gained. Beyond evaluating solely fiscal capacity and political ideology, as was done in Chapter 4, exploring the unique contextual realities of each province offers the potential to further identify additional factors that promote the migration of authority.

6.3.1 Healthcare Authority Migration in Alberta

In Alberta, an order-in-council established the Premier's Commission on future healthcare for Albertans in 1987. The purpose of the Commission was to examine changes in future health requirements for Albertans. The Commission was instructed to take into account such issues as population and illness trends, technological advances, organizational funding, and public needs and wants. In addition, the Commission was instructed to examine the roles, responsibilities, and expectations of individual Albertans, volunteers, community agencies, medical professionals, private sector interests and governments in planning, delivering, and funding healthcare (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 11-12).

After two years of consultations, the Commission released the *Rainbow Report: Our Vision for Health.* While the Commission's report identified Alberta's healthcare system as one of the best in the world, concerns were raised over the fragmentation and availability of resources (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 13). The Commission identified five principles: people, choice, change, decisions, and opportunity, stressing that people are the core of the healthcare system and that "people must have meaningful control" (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 17-18). Continuing on the theme of people, the Commission recommended greater personal responsibility and accountability for managing health and health resources and the need to return the power to make choices closer to Albertans (Alberta. Premiers's Commission on Future Health Care for Albertans, 1989b: 116). As such, the Commission report framed the challenges facing the healthcare system in terms of both fiscal capacity and citizens' attitude toward healthcare.

In response to the fiscal and attitudinal challenges, and consistent with the stated belief that people need meaningful control of their healthcare system, the Commission recommended that the province be divided into nine autonomous administrative areas with an appropriately named health authority being responsible for the provision of healthcare services (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 40-41). It was recommended that healthcare funding would be made available directly to health authorities, which would then be responsible for the provision of services and appropriate compensation methods within their administrative areas (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 41). Moreover, it was recommended that each health authority board be comprised of locally elected trustees plus a representative from the department of health (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 40). The Commission report stated that the creation of regional health authorities would allow for responses to changes at the local level, resulting in a better mix of services and treatments that matched local needs (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989b: 117).

While the Alberta government initially rejected the idea of autonomous regional bodies (Church and Smith, 2008: 221), the Alberta government eventually followed the direction of the Commission's report with the enactment of the Regional Health Authorities Act, 1994. The Act established regional health authorities with the power to determine priorities in the provision of health services and allocate resources accordingly within their region (Alberta. Legislative Assembly, 2000: 3-4). The Act replaced nearly 200 existing local health and public health boards with initially seventeen, then eventually nine regional authorities (Church and Smith, 2008: 234). As recommended in the Commission's report, the health authorities were created with provisions for elected board members (Alberta. Legislative Assembly, 2000: 4). A subsequent taskforce, however, recommended that the elections option not be implemented and instead board positions be filed by appointment (Church and Smith, 2008, 232).

The shift from rejecting to implementing the autonomous health authorities can be viewed as political in nature. Initially, political resistance to change made the introduction of regional governance models too risky. However, with a shift in focus toward a government wide issue of deficit and debt reduction, the creation of autonomous regional authorities was able to be embedded within a broader fiscal agenda (Church and Smith, 2008, 218). In 1992, the Alberta government began work on a plan to reduce spending, balance the budget, and pay down provincial debt. As part of this goal, each department, including health, was required to produce a three-year business plan including spending targets (Philippon and Wasylyshyn, 1996: 74). The timing of the change in governance model coinciding with the government wide focus on debt reduction supports the fiscal capacity hypothesis. The government's focus on debt reduction would limit the fiscal capacity of the department to fulfill its governance obligations in healthcare and promote the migration of authority to Type II bodies. Beyond the direct focus on the broader fiscal pressures facing government, Church and Smith identify the influence of two policy paradigms in the government's decision to implement autonomous health authorities. First, is the idea of personal responsibility and self-reliance, or that individuals are responsible for their own wellbeing (Church and Smith, 2008, 224), which is consistent with the message that Albertans need to take greater responsibility for their own health. The second is the new public management

message emphasizing smaller government (Church and Smith, 2008, 224), which is consistent with the migration of authority away from central government. The new public management component lends a political ideology component to the creation of Type II healthcare bodies in Alberta. New public management is associated with the promotion of the private sector and delegation of authority as a remedy for high taxes and deficits, which are characteristic of a neoliberal approach (Hoehn, 2011: 77).

In addition to altering the governance structure, the reform process also involved a shift in emphasis on who should be making decisions regarding public healthcare. The *Rainbow Report* called for residents of Alberta to have more meaningful control of their healthcare system (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989a: 18) and the movement of healthcare decisions closer to the people, stating the need to delegate certain responsibilities to a more appropriate level of authority (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989b: 117). The shift towards citizen participation in the healthcare process is also evident in the recommendation for and the initial legislating of elected regional boards. The subsequent shift away from an elected model in favour of appointed board members, however, may have been an indication of changes to come.

During the decade that followed the creation of regional health bodies, reports on the direction of healthcare in Alberta recommended increases in the scope and authority of the regional Health Authorities (Alberta. Premier's Advisory Council on Health, 2001; Alberta. Alberta Health and Wellness, 2004). In May of 2008, however, it was announced that Alberta would move from the existing governance model to a single fully integrated province wide health system. The creation of Alberta Health Services brought together the regional health authorities as well as the Alberta Alcohol and Drug Abuse Commission, Alberta Mental Health Board, Alberta Cancer Board and ground ambulance service (Alberta Health Services, 2012). The reasons given for the amalgamation to a single health authority were financial. According to government reports, there was concern over the ability to provide accessible high quality care in a sustainable manner to Albertans (Alberta. Alberta Health and Wellness, 2008: 3).

While regionalization had been identified as healthcare's solution in the *Rainbow Report*, the *Provincial Service Optimization Review: Final Report* emphasized the need for better healthcare coordination. The report cited challenges in coordinating health services in Alberta, including a lack of coordination across regions, sites of care, and providers. As well, the report critiqued the lack of standardization of care within facilities and organizations. The report stated that the "regional health authority-based organizational and funding structure did not optimally facilitate coordination of care delivery among the regions. Incentives and structure drove a regional focus rather than a focus on care across the province" (Alberta. Alberta Health and Wellness, 2008: 38). The report further stated that Alberta could "use its new found scale as a single 'system' to ensure greater performance transparency and continuous improvement (Alberta. Alberta Health and Wellness, 2008: 2).

Today, with the creation of Alberta Health Services, decision-making remains outside of central government, but the governance structure moved from nine regional Type II bodies to one provincial wide Type II body. With the formation of Alberta Health Services, the preferred policy solution remained an autonomous body outside of government, but went from regional to provincial in geographic scale. The initial change in governance model was consistent with the fiscal capacity hypothesis, as the fiscal challenges facing the healthcare system in Alberta played a pivotal role in kicking off the exploration process. Moreover the shift toward new public management appears to have given the final push required to move the changes from recommendations to reforms. Beyond fiscal capacity, the migration of authority was also framed in terms of increased public participation and the moving of decision-making closer to the citizen. By moving decision-making closer to the citizen, the specific needs of each region could be better met. With the move from regionalization back to centralization, the framing shifted from the need for each region to better meet local needs to the need for increased coordination and standardization across the province.

6.3.2 Healthcare Authority Migration in British Columbia

In 1991, the British Columbia Royal Commission on Healthcare and Costs released its final report entitled *Closer to Home*. The Commission was tasked with examining the

structure, organization, management and mandate of the current healthcare system in BC (British Columbia. Royal Commission on Health Care and Costs, 1991: iii). In its report, the Commission stated that in regard to healthcare, "there has never been an overall plan, and, quite naturally, the structure that has evolved lacks coherence and, sometimes, logic. It also lacks the ability to assess itself, to objectively judge how just, efficient and effective it is in providing healthcare," and called for the creation of an independent advisory body that, reporting directly to parliament, would be independent of the government, the Ministry of Health and the healthcare profession (British Columbia. Royal Commission on Health Care and Costs, 1991: A-15).

In addition to an independent province-wide body to provide guidance and advise the government on healthcare issues, the Commission recommended the distribution of healthcare decision-making to the regional and local levels. The Commission's final report recommended the Ministry of Health retain responsibility for province wide goals including priorities, strategic plans, standards and guidelines. The Commission did not recommend the migration of decision-making authority outside the Ministry of Health, but instead the adoption of regionally placed general managers who would report to an assistant deputy minister responsible for all regions within the Ministry of Health (British Columbia. Royal Commission on Health Care and Costs, 1991: B-38). Included within the Commission's recommendations was the need for decisions to be made with community involvement and that improvements to the healthcare system must be made with current levels of spending. In regard to community involvement, the Commission argued that government should be prepared to fund coordinators, to encourage the creation of advisory boards and to not force citizens to participate in schemes designed by the Ministry of Health (British Columbia. Royal Commission on Health Care and Costs, 1991: A-6).

The recommendations in Alberta called for the delegation of authority, where managerial responsibility for specified functions are outside of government and only indirectly controlled by central government (Mills, 1990, 21). In contrast, the recommendations in British Columbia called for the deconcentration of authority, with the movement of administrative authority to locally based offices of central government (Mills, 1990, 16).

Responding to the recommendations of the British Columbia Royal Commission on Healthcare and Costs', the Ministry of Health published *New Directions for a Healthy British Columbia* in February of 1993. Acknowledging the Commission's recommendations for increased local management of the healthcare system, the government announced two pertinent reforms. In contrast to the recommendation of advisory boards, however, the NDP government announced the establishment of community health councils at the local level with individual board members being both elected and appointed. The community health councils would be primarily responsible for the planning and coordinating of health services and identifying local health priorities. The councils would absorb existing hospital boards and have a goal of providing greater accountability and reducing duplication within the system. The second reform was the creation of Regional Health Boards. Members of the Regional Health Boards would include representatives from the community health councils and individuals appointed by the Minister. While the initial role would be regional health planning and service coordination, the long-term goal was to have the regional boards allocate budget resources amongst the local councils (British Columbia. Ministry of Health, 1993: 14-15). The proposed reforms fundamentally altered the decision-making structure for healthcare in British Columbia; shifting a broad set of planning, management, and funding decisions to regional and local bodies (Hurley, Lomas and Bhatia, 1994: 496).

The framing of the challenges facing the healthcare system in British Columbia centred on fiscal concerns (consistent with the hypothesis that the weaker a government's fiscal capacity to meet governance demands the higher the rate of Type II body creation). The Commission's report highlighted the belief that "in these times of rapidly expanding population, changing technologies and rising costs, innovative solutions are a necessity, and creative alternatives a must" (British Columbia. Royal Commission on Health Care and Costs, 1991: A-10). Likewise, the government's policy position called for fiscal responsibility, stating that funds are limited and there are many demands for funding within the healthcare system (British Columbia. Ministry of Health, 1993: 11). One proposed solution to the fiscal woes facing British Columbia's healthcare system was decentralization. The Commission's report stated that the decentralization of control would encourage public accountability for the management of healthcare resources and

cost control through greater efficiency, coordination and integration of services that serve local needs (British Columbia. Royal Commission on Health Care and Costs, 1991: B-36). The government claimed that a decentralized partnership approach was imperative to building and maintaining the healthcare system (British Columbia. Ministry of Health, 1993: 17).

Beyond fiscal framing, the government's policy statement argued that increased public participation and responsibility was an important part of a responsive and flexible health system (British Columbia. Ministry of Health, 1993: 13). In addition to the creation of community health councils the government announced an increase in public participation on professional boards, with lay representation constituting at least one-third of members (British Columbia. Ministry of Health, 1993: 13). The intent of the government's policy to shift power over health services to the community level can be viewed as an attempt to both counter the power of health professional elites, and foster a community orientation toward wellness. It was hoped that a combination of democratic community development, an active citizenry, and collaboration among institutional actors would bring about the emergence of a health community. The health community in turn would create the social and economic conditions required for healthy individuals and encourage the mindset of parsimony with regard to healthcare utilization (Davidson, 1999: S35).

In December of 2001, the Liberal government announced the streamlining of the 11 Regional Health Boards, 34 Community Health councils and 7 Community Health Services Societies then existing in the province. Replacing the existing structure were 15 health service delivery areas organized under five new geographic Health Authorities. A sixth governing body responsible for the governing and administering provincial programs and highly specialized services was also included within the new governance design (British Columbia. Ministry of Health Planning, 2001: 1-2). The restructuring again centred on issues of cost, with the existing structure described as "one of the most complicated and expensive governance and management systems in the country" (British Columbia. Ministry of Health Planning, 2001: 1). In simplifying the governance structure, the British Columbia government promised the highest possible levels of

efficiency, service, coordination and accountability (British Columbia. Ministry of Health Planning, 2001: 1).

Moving from a highly localized model to one that encompassed fewer but larger regions, the government documents assured citizens that there would be an elimination of duplication, and with an increase in jurisdictional size, the ability to realize economies of scale (British Columbia. Ministry of Health Planning, 2001: 5). Like Alberta, British Columbia's initial governance changes were set into motion by fiscal concerns. Similarly, further restructuring continued to place decision-making authority outside the boundaries of central government, but in the hands of a small number of individuals. Unlike in Alberta, where the initial governance changes came about while the right-of-centre Progressive Conservatives were in power, the creation of Regional Health Boards in British Columbia were undertaken by a left-of-centre NDP government.

6.3.3 Healthcare Authority Migration in Nova Scotia

In November of 1990, the Nova Scotia Royal Commission on Healthcare released *Health Strategies for the Nineties: Managing Better Health*. In contrast to the British Columbia Royal Commission, which claimed their healthcare system was one of the best in the world (British Columbia. Ministry of Health, 1993: 1), the Nova Scotia Royal Commission expressed great concern over Nova Scotia's healthcare system. The Nova Scotia Royal Commission stated that the level of expenditures on healthcare was not reflected in health outcomes for the people of Nova Scotia. When compared to other Canadian provinces the health of Nova Scotia's residents was poor with its overall mortality and disability rate being the highest in the country (Nova Scotia. Royal Commission on Healthcare, 1990: ix).

While the perception of the quality within British Columbia and Nova Scotia healthcare systems were divergent, both provinces still identified fiscal capacity as their central challenge. The framing of their fiscal challenges, however, differed across provinces. The challenge in British Columbia was positioned as the need to maintain the existing high level of quality while also maintaining the current level of funding. In contrast, the challenge in Nova Scotia was framed in terms of the existing level of expenditure not

resulting in positive health outcomes (Nova Scotia. Royal Commission on Healthcare, 1990: ix). The Nova Scotia Royal Commission on Healthcare report suggested that the health system in Nova Scotia was a legacy of insurance programs for hospital and physician services that had resulted in 80% of the Department of Health and Fitness budget being allocated to hospitals and physicians, while the occupancy rate of hospital beds sat below the national average (1990: vii). Accordingly a combination of healthcare expenditures and health outcomes were the focus of the Commission in Nova Scotia, with a goal of optimal health outcomes and more efficient management (Nova Scotia. Royal Commission on Healthcare, 1990: xi). In the Commission's report, the reduction of the rate of growth for healthcare expenditures is stated as one of the guiding precepts (Nova Scotia. Royal Commission on Healthcare, 1990: xii). In suggesting how to control healthcare costs the Commission recommended more attention be paid to disease prevention and health promotion, moving from institutional to community based care, and greater user participation in the planning of health services (Nova Scotia. Royal Commission on Healthcare, 1990: 29).

As was the case in Alberta and British Columbia, the decentralization of healthcare authority in Nova Scotia was framed as a way to increase citizen participation and alleviate fiscal challenges. Consistent with Alberta, Nova Scotia's Royal Commission on Healthcare recommended the delegation of authority over health services through the creation of autonomous Regional Health Authorities that would be responsible for the planning and management of health services and program delivery (1990: 5). The Commission argued that creating autonomous regional bodies would increase responsiveness and flexibility to meet regional needs, increase the coordination and integration of health services, increase efficiency, and allow for greater participation of citizens in health planning (Nova Scotia. Royal Commission on Healthcare, 1990: 6).

Taking the Commission's recommendations into account, the Nova Scotia government announced its reform program in 1993. The original plan for healthcare reform in Nova Scotia was to unfold opposite to healthcare reform in British Columbia. While the Commission called for planning and managerial responsibility to be devolved away from the provincial government, the health authorities announced by the Progressive

Conservative government were to be merely advisory bodies with all members appointed by the Ministry of Health (Hurley, Lomas and Bhatia, 1994: 500). Contrary to the political ideology hypothesis, the left-of-centre government in British Columbia delegated authority to Type II healthcare bodies, while the right-of-centre government in Nova-Scotia planned hold onto the existing healthcare governance model and maintain central decision-making authority. Upon the Liberals assuming office, however, the government announced a far more decentralized governance structure (Hurley, Lomas and Bhatia, 1994: 500). In 1996, the Liberal government in Nova Scotia implemented its decentralization strategy through the creation of four Regional Health Boards. In doing so, the existing 36 local hospital boards were amalgamated into the new Regional Health Boards (Black and Fierlbeck, 2006: 507).

In 1999, the Minister's Task Force on Regionalized Healthcare released its Final Report and Recommendations. The mandate of the task force was not to study the validity of regionalization, but the strengths and weaknesses of the existing governance structure and present recommendations for improvement (Nova Scotia. Minister's Task Force on Regionalized Healthcare in Nova Scotia, 1999: 4). The Task Force reported that both providers and consumers were critical of the existing system of healthcare, believing that the main goal was to cut costs and that they has less input into the healthcare system since the inception of the Regional Health Boards. Moreover, the Task Force believed that the existing levels of dissatisfaction were the result of an incomplete transition to the new governance structure as key components of the healthcare systems remained outside of the control of the Regional Health Boards. The Task Force argued that for the existing governance structure to work it must be strengthened and completed and that reversing the regionalization process would disrupt the system, increase costs and lead to a fragmented healthcare system. To strengthen and complete the system, the Task Force recommended defining in law the status of the already established Community Health Boards, ensuring that two-thirds of the members of Regional Health Boards are selected by Community Health Boards, and funding for health services be administered by the Regional Health Boards (Nova Scotia. Minister's Task Force on Regionalized Healthcare in Nova Scotia, 1999: 4-6). The Task Force, however, did not recommend the altering of the boundaries for the four existing healthcare regions, stating that any changes would be

premature and disruptive (Nova Scotia. Minister's Task Force on Regionalized Healthcare in Nova Scotia, 1999: 7).

Despite recommendations against changes altering the existing boundaries, in June of 2000 Bill 34 received royal assent, replacing the Regional Health Boards with District Health Authorities (Nova Scotia. Legislative Assembly, 2000). By 2001 the four health regions had become nine District Health Authorities (Black and Fierlbeck 2006: 508). The initial creation of the four regional health units and the expansion to nine District Health Authorities shared a common set of justifications – cost containment, accountability, and citizen engagement (Black and Fierlbeck, 2006: 508). As Black and Fierlbeck identify, contradictions and tensions characterize many theories of regionalization: cost efficiencies through the removal of duplication requires greater centralization, while enhanced public participation typically means greater decentralization (Black and Fierlbeck, 2006: 508). While a degree of cost effectiveness has been attributed to regionalization in general, Black and Fierlbeck attribute regionalization in Nova Scotia to neither cost containment nor public participation (2006: 523). Rather, Black and Fierlbeck argue that the shift from authority from Regional Health Boards to District Health Authorities took place for political purposes as it restored the system of elite representation (2006: 522-523).

As with the other provinces, fiscal capacity and concerns over the ability to fulfill obligations in healthcare played roles in raising questions over the shape of the governance model in healthcare. The creation of the Regional Health Boards and District Health Authorities, however, were political in nature. While the creation of the Regional Health Boards shifted decision-making authority downward away from central government and upward out of the hands of the local elite, political power was lost at the local level. The decision to move to District Health Authorities restored some degree of power to local elite.

6.3.4 Healthcare Authority Migration in Ontario

While the provinces of Alberta, British Columbia, and Nova Scotia initiated similar health system policy choices in the 1990s, the province of Ontario was both an early

adopter of decentralization, and a late adopter of migrating decision-making authority. In 1973, twenty years ahead of the decentralization curve in healthcare, the Ontario Council of Health via the Mustard Report devised the idea of District Health Councils (Warren, 1996: 128). In 1974, Ontario's Health Planning Taskforce recommended that District Health Councils, operating within the framework of guidelines and standards set out by the Ministry, be responsible for the development of policies and plans for healthcare within each district (1974: 25). The Health Planning Task Force was charged with the responsibility of developing proposals for a comprehensive plan to meet the health needs of Ontario residents (Ontario. Ontario Health Review Panel, 1974: 1). The Task Force stated that for effective planning and operation of the health services to take place a suitable organizational arrangement needed to be established. To this end, the task force stated that there should be local responsibility for planning within the healthcare system. However, the existing mix of agencies and organizational arrangements operating in the healthcare system did not allow for the development of a comprehensive health services plan. To resolve this problem, the District Health Councils were recommended as an additional level of planning. (Ontario. Ontario Health Review Panel, 1974: 23-24).

In 1975 The Ontario Ministry of Health responded to The Health Planning Task Force regarding the proposed changes to the Ontario healthcare system. The Ministry of Health claimed that the proposed changes were too wide in scale to be completed without further understanding, support and cooperation from public health, health professionals, and health agencies. As such, further consultation was sought on the part of the Ministry (Ontario. Ministry of Health, 1975: 2). In regard to the establishment of District Health Councils, the Ministry's consultation efforts found widespread support for this recommendation from both the health community and public groups. A second recommendation, the creation of area health service management boards responsible for logical grouping of facilities and resources was found to be more contentious. In the end, while the Ministry concurred that this recommendation would improve coordination and efficiency, the Ministry conceded imposing such a change in the face of opposition from health professionals and the public would be unproductive (Ontario. Ministry of Health, 1975: 12-13). The implementation of the District Health Councils was voluntary. Lead citizens in the various districts had to take the initiative and convince local politicians,

citizens, and health providers of the value of the District Health Councils. The result of this strategy was a prolonged implementation, taking over 20 years to develop a full network of District Health Councils across the province. Moreover, the responsibilities of the District Health Councils were limited and defined as advisory in nature (Warren, 1996: 128).

In 1986, the minority Liberal government appointed the Ontario Health Review Panel to look at Ontario's health policy. The Panel reported its findings to the Premier in June of 1987 (Spasoff, 1992: 130). The report outlined five pressures on the existing healthcare system: the changing demographic makeup of the province; changing patterns of illness; changing public expectation of healthcare; new technology; and rising expenditures on healthcare. In terms of expenditures, the report highlighted the 50% increase per capita in expenditures on healthcare between 1981 and 1985, bringing healthcare to one-third of the province's total expenditures (Ontario. Ontario Health Review Panel, 1987: 17-18). Consistent with the fiscal capacity hypothesis the report argued that participation from government, individuals and organizations outside of government was necessary to meet the challenges facing the healthcare system. The report further suggested there was a need for a concept of health that embraced the totality of an individual's wellbeing, integrated government policy across all ministries that share responsibility for health, and provided a balance between provincial and local perspectives (Ontario. Ontario Health Review Panel, 1987: 63).

Calling for a local health strategy, the Ontario Health Review Panel report stated that it is at the local level where interaction with the health system takes place. The report identified inequity across the different regions in terms of health status, population, and access to basic care. To address these inequities the report stressed the need to be able to meet the unique priorities and experiences of all regions of the province, be they northern, southern, rural or urban (Ontario. Ontario Health Review Panel, 1987: 71-72). The report concluded, however, that no new mechanisms were required as the District Health Councils already reflected these basic principles. The Panel believed that, with the assistance of local boards of health, the District Health Councils could assume responsibility for local health strategies. To achieve this end, the Panel stated the need for

government to strengthen the capacity of the District Health Councils (Ontario. Ontario Health Review Panel, 1987: 72. In its concluding remarks the Panel stated, "Ontario has an unprecedented opportunity to open lines of communication and broaden the base of participation in enhancing the health of its residents" (Ontario. Ontario Health Review Panel, 1987: 75).

Further calls for delegation of authority came in 1991 when the Premier's Council on Health Strategy released its report on local decision-making in healthcare. The report recommended that government work towards devolving responsibility for the provision of health services to local agencies. Two models were proposed, one based on local government, and one based on special purpose bodies. The Council called for the implementation and evaluation of both models on a pilot basis (Spasoff, 1992: 130-131). However, the Premier's Council on Health Strategy, which was established in 1987 under a Liberal government, only met once after the NDP came to power in 1990. The NDP replaced the Premier's Council on Health Strategy with the Premier's Council on Health, Well-Being and Social Justice, but the momentum for change was lost (Spasoff, 1992: 132). While the NDP government in British Columbia had moved further than recommended and delegated authority to Type II healthcare bodies, in Ontario the NDP government allowed the reform process in healthcare to stall.

In 2003, the newly elected Liberal government faced both a healthcare reform agenda as well as the need for major fiscal and bureaucratic reforms (Fenn, 2006: 528). With nearly half of the Ontario budget used to fund health expenditures, there was concern that continued unconstrained growth in costs would undermine other policy priorities including economic performance (Fenn, 2006: 529). In response to the need for changes in the healthcare system, the Liberal government instituted the Health Results Team (Fenn, 2006: 528). Among the set goals for the Health Results Team was the creation of an integrated healthcare system through the establishment of Local Health Integration Networks (Ontario. Health Results Team, 2005: 4).

Speaking at the St Lawrence Market, then Minister of Health and Long-Term Care George Smitherman introduced the creation of Local Health Integration Networks to the

public. In the speech, Smitherman built the image of a healthcare system under strain from an aging population, increasing demands for access and innovation. Smitherman stated that to respond to pressures in health almost every other sector in government had been asked to make sacrifices to free up funding, but that this approach was not sustainable (Ontario. Minister of Health Health and Long-Term Care, 2004, 2). To make the changes necessary to protect Ontario's healthcare system, Smitherman claimed that it was time to create "a comprehensive and integrated system of care that is shaped with the active leadership of communities" (Ontario. Minister of Health Health and Long-Term Care, 2004, 7). Local Health Integration Networks were stated to be a crucial step on the path to better systems integration. According to Smitherman:

> *Although most healthcare is local, we are not all that effective at planning and responding to local health needs. We call Ontario diverse yet often fail to recognize the health implications of that diversity. Things like average age, how far you live from the nearest hospital and whether your area has a higher incidence of an ailment.*
>
> *That's why we will be taking some of the authority, which currently resides at Queen's Park, away from Queen's Park, and shifting it to local networks, closer to real people, closer to patients (Ontario. Minister of Health Health and Long-Term Care, 2004: 19).*

Faced with substantial fiscal obligations and the fear that continued growth in demand would undermine future policy objectives Ontario had finally followed the other nine provinces and delegated authority in healthcare. With the introduction of Bill 36, the Local Health System Integration Act, 2005 Ontario had moved to a regional healthcare governance structure. Unlike the legislation in other provinces that abolished local hospital boards and other local health organizations, the Ontario legislation left the existing local boards in place (Ronson, 2006: 46). The District Health Councils, which had served in an important advisory capacity in the planning and provision of healthcare for the past thirty years, ceased operations and the Local Health Integration Networks became the primary vehicle for planning, coordinating, integrating, and funding the

delivery of healthcare services at the regional level (Ontario. Health Results Team, 2005a). As laid out in the Preamble to the Local Health System Integration Act, the transformation in regional health integration was positioned by the Liberal government as a confirmation of the commitment to the *Canada Health Act* (Canada), a commitment to enabling local communities to make decisions about their local healthcare systems, and recognition that communities, health service providers, Local Health Integration Networks and the government need to work together to reduce duplication and better coordinate health service delivery (Ontario, Legislative Assembly, 2006).

6.4 Discussion

Chapter 6 reevaluated two hypotheses: $H_{4.3}$ – the lower the fiscal capacity of government to meet governance demand the higher the rate of creation of Type II bodies; and $H_{4.4}$ – the further to the left-of-centre on the political spectrum a government sits lower the rate of creation of Type II bodies. When assessing the effect of fiscal capacity in provincial healthcare there is support for $H_{4.3}$ as the findings suggest that a decline in fiscal capacity promotes the creation of Type II bodies. The gap in time between the migration authority in British Columbia and Ontario, however, suggests that there is more to the story than just fiscal capacity. Mixed support was also found for the hypothesis $H_{4.4}$.

A summary of the healthcare governance reforms discussed above is presented in Table 6.2. Instances that resulted in the migration of decision-making authority outside of traditional government structure are highlighted in grey. As shown in Table 6.2, in each instance of authority migration the challenges facing the healthcare system were framed in terms of fiscal capacity and concern over the continued ability to fund the healthcare system at a level that afforded the accustomed quality of care. In contrast, the results for political parties indicate mixed support as was found in Chapter 4. As was evident above, governments from both sides of the political spectrum play direct roles initiating and halting the process of authority migration. While the results for hypothesis $H_{4.3}$ provided inconsistent support in Chapter 4, the results for healthcare policy were not unexpected based on previous research. In regard to fiscal capacity, Hurley, Lomas and Bhatia argued in 1994 that the combination of ever-growing expenditures and reduction of revenue

streams had pushed provincial governments to reevaluate their healthcare systems and initiate major healthcare reforms (1994: 491). Moreover, J. P. Vaughan had previously observed that governments across political belief systems had felt the need to reform healthcare by shifting authority to some degree away from central government (Vaughan, 1990: 139).

Table 6.2: Migration of Authority Timeline for Regional Healthcare

Year	
1975	Ontario – PC government established District Health Councils as advisory boards. Creation of advisory boards framed in terms of **increasing coordination** and responsibility for planning at the local level.
1993	British Columbia – NDP government migrates authority to Community Health Councils and Regional Health Authorities. Migration of authority framed in terms of **controlling healthcare costs**, **increasing citizen participation** at the local level and increased citizen responsibility for healthcare.
1994	Alberta - PC government migrates authority to Regional Health Authorities. Migration of authority framed in terms of **controlling healthcare costs**, **increasing citizen participation** at the local level, increased citizen responsibility for health decisions, and the reduction of the size of central government.
1996	Nova Scotia – Liberal government migrates authority to four Regional Health Boards. Migration of authority was framed in terms of terms of **controlling healthcare costs**, **increasing citizen participation** at the local level, and **increasing coordination** and integration of healthcare services.
2000	Nova Scotia – PC government replaces existing Regional Health Boards with nine District Health Authorities. Restructuring framed in terms of **controlling healthcare costs** and **increasing citizen participation** at the local level.
2001	British Columbia – Liberal Government replaces existing Community Health Council and Regional Health Authority structure with five Health Authorities. Restructuring framed in terms of **controlling healthcare costs** and **increasing coordination** in the healthcare system.
2005	Ontario – Liberal Government replaces District Health Councils with Local Health Integration Networks. Restructuring framed in terms of **controlling healthcare costs**, **increasing coordination** in the healthcare system and keeping local decisions at the local level.
2008	Alberta - PC government eliminates the remaining nine Regional Healthcare Authorities and created a single provincial entity, Alberta Health Services. Restructuring framed in terms of **controlling healthcare costs** and **increasing coordination** in the healthcare system.

Consistent with the underlying fiscal challenges the migration of authority in healthcare was consistently framed in terms of fiscal capacity, however, it was not framed in terms of fiscal capacity alone. When looking at Table 6.2, it is evident that, in addition to fiscal capacity, challenges facing healthcare were framed in the following manner: 1) between 1993 to 2000 decentralization and the migration of authority is consistently framed in terms of the need for increased citizen participation in healthcare governance; 2) beginning in 1996, the framing begins to migrate toward the need to improved coordination within the healthcare system when recommending healthcare reform. It is the inclusion of the second frame that makes healthcare reform palatable to citizens. It makes healthcare reform not just about the reduction of healthcare spending but about increased citizen participation or increased coordination (better service) within the healthcare system.

In addition to the larger trends, province-specific frames were also evident, such as the reduction of the size of government in Alberta. As discussed above, the reduction of government size in Alberta was associated with both new public management and a neoliberal ideology.

The availability of issue frames may also account for the delay in authority migration in Ontario. The creation of the District Health Councils in 1975 produced healthcare bodies that, while not having decision-making authority, limited the increased citizen participation frame, as provincial, regional and local healthcare bodies already existed. Moreover, subsequent government task forces supported the already institutionalized District Health Councils. When support for devolved authority did emerge, a change in government allowed the initiative to stall. When authority did migrate in Ontario, healthcare reform was not framed in terms of citizen participation but in terms of keeping local decisions local and the need for increased coordination in the healthcare system. The government emphasized the need to work together to reduce duplication and better coordinate health service delivery (Ontario, Legislative Assembly, 2006). Just as the framing of the problem and solution within the healthcare system was different so was the solution. Unlike the other provinces, which eliminated the existing hospital boards, Ontario maintained local boards when the LHINs were created.

The framing of authority migration in healthcare is also relevant in the question of state – centric or society-centric governance. Framing the decentralization of healthcare in terms of increased citizen participation in healthcare governance may appear consistent with a society-centric approach to multilevel governance. Society-centric governance advances the idea that actors outside of government are engaged in more self-steering and that government interacts with society to reach mutually acceptable decisions (Peters, 2000: 36). When only the initial cases of decision-making authority migration are considered, as highlighted in Table 6.2, three of the four cases framed authority migration in terms of increased citizen participation. In the case of Ontario, the evidence shows the issue being framed in terms of keeping local decisions local, but not on specifically 'increasing' citizen participation. Ontario was also unique, however, in that it did not eliminate existing local hospital boards and health organizations, but instead left the existing structure in place (Ronson, 2006: 46). In Ontario, the creation of LHINs resulted in decision-making authority being divided across three levels.

Skelcher et al. argue the creation of new governance actors does not mean a relationship of equals (2005: 578). The role of external actors may be more modest than society-centred arguments presumes (Leuprecht and Lazar, 2007: 2). Still, by not removing the existing local boards, the creation of Local Health Integration Networks in Ontario presented the potential for increased citizen involvement as it left the existing pathway of participation intact while at the same time creating another governance body for citizens to engage with. Furthermore, the LHINs' enabling legislation specified that Local Health Integration Networks "shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities" (Ontario. Legislative Assembly, 2006). In contrast, the removal of existing local boards within the other provinces removed venues for citizen participation at the local level while adding one at the regional level.

Healthcare system reforms up until the year 2000 were largely framed in terms of the need to meet growing fiscal requirements and the desire to increase citizen participation – giving the appearance that central government was guided by those two factors when

migrating decision-making authority. As discussed above, however, Black and Fierlbeck argue that despite the casting of healthcare reforms in terms of cost savings and citizen engagement the shift of authority from Regional Health Boards to District Health Authorities in Nova Scotia took place for political reasons. According to Black and Fierlbeck, the change in governance structure was aimed at restoring the system of elite representation that existed at the local level prior to the creation of Regional Health Boards (2006: 522-523).

The movement toward increasing the number of regional units in Nova Scotia can be viewed as driven by physicians who were discontent with having their direct influence over local hospital boards curtailed (Black and Feirlbeck, 2006: 519-520). According to Lomas, Woods, and Veenstra there are three groups that grant power during the authority migration process: government, health professionals, and citizens. Moreover, each source of power has its own agenda, with government's health system expectations, providers' interests and citizens' preferences pitted against each other (Lomas, Woods, and Veenstra 1997: 734). Drawing on Black and Feirlbeck's explanation of the shift from four to nine healthcare bodies in Nova Scotia it can be argued that the initial migration of authority to Regional Health Boards constituted a curtailing of the ability of health professionals to exercise their power to achieve their interests. In altering the health systems design, the government moved to ensure the health system met the government's expectations. As subsequent changes were undertaken, however, the previously held power of the healthcare elite was somewhat restored. If this is indeed the case, the shift from Regional Health Boards to District Health Authorities, while framed in terms of cost containment and citizen, participation was in fact undertaken to restore the balance of power between government and healthcare professionals.

Turning to Alberta and British Columbia, the similarities regarding the replacement of local boards with regional governance structure suggests the same desire to curtail the medical community's ability to promote and protect their interests as initially occurred in Nova Scotia. By migrating authority to the regional level while at the same time eliminating the local level, decision-making was moved away from local decision makers through the same process that moved decision-making authority away from central

government. In doing so, the influence of medical professionals over the administration of the healthcare system was curtailed. While inflationary pressure in the 1970s led to increasingly harder lines being taken by governments in collective bargaining with organized medicine (Naylor, 1999: 11), the migration of authority to newly created regional bodies served to weaken the ability of organized medicine to negotiate. Davidson argues that the government's policy to shift power over health services in British Columbia was an attempt to counter the power of health professional elites (Davidson, 1999: S35). However, the changes in governance structure provided more than a counteracting of the power of medical professionals - it truncated the power of the medical profession.

In British Columbia the decision to restructure health services can be seen as an attempt to an orientation toward community wellness (Davidson, 1999: S35). A similar framing of healthcare restructuring was also present in Alberta and Nova Scotia. In Alberta the Commission report recommended greater personal responsibility and accountability for managing health and health resources and the need to return the power to make choices closer to Albertans (Alberta. Premier's Commission on Future of Health Care for Albertans, 1989b: 116). In the case of Nova Scotia, there was the call for greater user participation in the planning of health services (Nova Scotia Royal Commission on Healthcare, 1990: 29).

The removal of local boards, however, is contradictory to the stated goal of increased citizen participation. While aspects of decision-making may have migrated from the province to the region, local decisions that once occurred at local hospitals boards were also shifted upward. In shifting decision-making to a regional level, it is unclear how citizens are able to participate in the healthcare decision-making process to a greater extent than when decisions were made at the local level. While healthcare advocates in Nova Scotia may have initially embraced the regionalization of healthcare governance, believing that it would provide a substantial level of grassroots decision-making, they were in the end disappointed as community bodies were simply not strong enough to challenge political decisions from higher up (Black and Fierlbeck, 2006: 519-520). As stated above, the migration of authority to special purpose bodies has the potential for

more responsive governance than area-wide jurisdictions (Bollens, 1986: 119; Lowndes and Wilson, 2001: 633), however, at the same time the risk exists that the governance structure can become closed to public influence (Andrew and Goldsmith, 1998: 104; Peters, 2004: 133).

While citizen participation played a large role in framing authority migration as a solution to the challenges facing healthcare, the resulting outcomes do not align with the stated objective. Instead, it can be argued that the underlying objective of government when migrating authority was to strengthen their ability to control costs in the healthcare system through the weakening of medical professionals. With the underlying factor leading to healthcare reform being the concern over the ability to meet the increasing fiscal demands placed upon the systems, migrating authority to Type II bodies served to strengthen the provincial governments' ability to respond to this challenge by removing control at the local level from organized medicine. In this scenario, the creation of Type II healthcare bodies became a tool for altering the existing balance of power to the benefit of central government, consequently strengthening their ability to take action in the specific policy area.

As discussed in depth in Chapter 2, the underlying assumption of multilevel governance is that state centralization has given way to new forms of governance. The result has been the dispersion of decision-making authority among new actors across multiple levels, rather than monopolized by state executives (Marks, Hooghe, and Blank 1996: 346). Regardless of the level of autonomy of new governance actors, however, governance continues to occur within the shadow of hierarchy (Scharpf, 1994: 38-39). In the modern state, both public and private actors can be seen to operate under the shadow of hierarchy where government sets the legal rules of the game and intervenes to correct distortions or outcomes that violate public interests (Börzel, 2010: 196-197). In the case of public healthcare in Alberta, British Columbia, Nova Scotia, and Ontario, regional health authorities serve to strengthen the ability of government to set the rules of the game and intervene to correct distortions or outcomes that are perceived to violate public interests. Specifically, government has become better able to step in and address fiscal distortions or outcomes without the unwanted interference of healthcare professionals.

6.5 Conclusion

By legislating the creation of the Local Health Integration Networks in 2005, Ontario joined the other nine Canadian provinces that had already delegated authority in healthcare services to the regional level. Consistent with the hypothesis that a decline in fiscal capacity promotes the creation of Type II bodies, all four provinces studied in this chapter framed the need for healthcare reform in terms of concerns over meeting the ever-growing funding requirements to deliver healthcare in the face of increasing demand for services. The gap between the migration of authority in British Columbia and Ontario suggests that more than just weakened fiscal capacity is required to devolve authority. In Alberta, British Columbia, and Nova Scotia healthcare reform is framed in terms of both controlling healthcare costs and increasing citizen participation. In the Ontario case, healthcare reform is framed in terms of controlling healthcare costs and increasing coordination within the healthcare system.

Mixed support was found for the hypothesis that parties further to the left are less likely to delegate authority to Type II bodies. As seen throughout the chapter, parties from both sides of the political spectrum migrated and ceased the migration of authority to Type II bodies.

While the underlying pressures to initiate healthcare reforms can be seen to be fiscal, how the changes were framed for public participation appear at odds with reality. To the public, the framing of the healthcare restructuring included a strong element of increased citizen participation and local decision-making. The migration of decision-making authority to regional bodies, however, was used to curtail the power of local and medical elites within the decision-making process. The outcomes were not consistent with the stated goals of increased public participation or grassroots decision-making, but instead shifted the power balance between government and organized medicine towards government. Although Marks originally characterized multilevel governance as the dispersal of power away from the centre (Marks 1993: 401-402), the results demonstrated the potential for the opposite to also occur. In the case of healthcare reform, the creation of Type II bodies was used as a tool of central government to shift the existing balance of power in a policy area to its advantage. While authority did migrate from central

government to newly created Type II bodies, the elimination of local boards in three of the four provinces moved some aspects of decision-making upwards to regional bodies and away from local elite. In doing so the provincial governments increased their ability to control costs within the healthcare system by the curtailing of organized medicine's control over healthcare decisions.

Chapter 7

"Within the traditional political dynamics of our federal system, the issue has become: who gets to blame who – when funds earmarked for diagnostic equipment are used to buy a lawn-mower?"

-Bruce Harber and Ted Ball, Redefining Accountability in the Healthcare Sector

7 Accountability and Healthcare Reform

With the creation of Local Health Integration Networks in Ontario in 2006 all provincial healthcare systems had migrated some degree of decision-making authority away from central government toward non-elected Type II multilevel governance bodies. Having explored how government framed the shift in decision-making authority in Chapter 6, attention is now turned to the accountability relationships that emerged when decision-making authority in healthcare shifted to Type II jurisdictions. As in previous chapters, the accountability relationships between Type II bodies and both government and society will be assessed in the provinces of Alberta, British Columbia, Nova Scotia and Ontario.

To gain a better understanding of how Type II bodies are held accountable once decision-making authority has migrated, Chapter 7 investigates both formal accountability and perceived accountability. Formal accountability is evaluated based upon the mechanisms put in place by government through legislation and regulations. Perceived accountability is assessed using the interview responses of members of provincial health authorities, public service employees, elected representatives, and members of interest groups active in the healthcare field. In doing so, this chapter begins where Chapter 5 stops – the evaluation of the strength of accountability relationships through the existence of formal accountability rules – and continues on to evaluate whether the formal rules are perceived as adequate to exercise meaningful democratic accountability and control. Moreover, Chapter 7 attempts to capture which factors either advance or impede the emergence of effective accountability relationships.

Returning to Chapter 5, the strength of both the accountability relationship between Type II bodies and government and the accountability relationship between Type II bodies and society were evaluated. To test the strength of accountability relationship between Type II bodies and government three hypotheses were put forward:

$H_{5.1}$ - The accountability relationships between government and Type II bodies has either remained stable or increased in strength over time.

$H_{5.2}$ – Governing parties further to the left on the political spectrum will produce stronger accountability relationships between Type II bodies and government than governing parties further to the right.

$H_{5.4}$ – The accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases.

A summary of whether support was found for each of the three hypotheses by dataset is presented in Table 7.1. As shown in Table 7.1, when assessing the strength of the accountability relationships between government and Type II bodies, the positive effect of time was consistent across all datasets. Based on formal accountability rules the strength of the accountability relationships with government strengthened in Alberta, British Columbia, and Ontario and remained stable in Nova Scotia. The results for $H_{5.2}$ were mixed, with only British Columbia producing results in the expected direction. The results produced no support for the hypothesis that the accountability relationship between government and Type II bodies decreases as the geographic scale of the Type II body decreases.

Table 7.1: Government Accountability Index - Support for Hypotheses by Dataset

	$H_{5.1}$ – Time	$H_{5.2}$ – Ideology	$H_{5.4}$ – Geographic
All Provinces	Support	No Support	No Support
Alberta	Support	No Support	No Support
British Columbia	Support	Support	No Support
Nova Scotia	Support	No Support	No Support
Ontario	Support	No Support	No Support

Two additional hypotheses were tested when looking at the strength of the accountability relationship between Type II bodies and society:

$H_{5.3}$ - *The accountability relationship between society and Type II bodies has increased in strength over time.*

$H_{5.5}$ – *The accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases.*

A summary of whether support was found for each of hypotheses is provided in Table 7.2. As shown in Table 7.2, mixed support was found for both hypotheses.

Table 7.2: Government Accountability Index - Support for Hypotheses by Dataset

	$H_{5.3}$ – Time	$H_{5.5}$ – Geographic
All Provinces	Support	Support
Alberta	Support	No Support
British Columbia	Support	Support
Nova Scotia	No Support	Partial Support
Ontario	Partial Support	Support

When assessing the effect of time on the strength of the accountability relationships the results suggest an increase in the strength of formal rules across all datasets with the exception of Nova Scotia. When assessing the effect of geographic scale, the results suggest an increase in the strength of formal accountability rules as the size of the geographic scale decreased for all datasets but Alberta.

7.1 Data and Methodology

As stated above, this chapter explores the relationship between accountability and the migration of decision-making authority to Type II multilevel governance bodies in healthcare in the provinces of Alberta, British Columbia, Nova Scotia and Ontario. The specific cases are Alberta Health Services (AHS), British Columbia Health Authorities

(BCHA), Nova Scotia's District Health Authorities (DHA), and Ontario's Local Health Integration Networks (LHIN). As discussed in greater depth in Chapter 3, the four provinces were selected based on a combination of political regions and political ideology. As discussed in Chapter 6, healthcare was selected due to the high level of importance placed upon it by Canadian citizens and the consistency at which some degree of authority has migrated outside of the central provincial government across all Canadian provinces. The migration of authority has not been uniform across the provinces: not all provinces transferred the same degree of authority; provincial outcomes have varied; different governance models were employed; and the timing of authority migration has not been consistent across all provinces. Consider the four provinces under study: Alberta has moved from regionally distributed health authorities to one single province-wide health body; British Columbia has also reduced the number of health bodies, moving from fifty-four to nine; Nova Scotia in contrast has moved in the opposite direction, expanding the number of health care bodies from four to nine; and Ontario, unlike the other provinces, left existing hospital boards in place when migrating provincial authority.

To assess accountability of Type II health care bodies both the formal accountability rules as stipulated in the provincial legislation and the perceptions of individuals active in the healthcare policy area were examined. When assessing the formal accountability rules, Mark Bovens's definition of accountability, which states "Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences" (2007: 450), is used. For each piece of legislation, both the accountability relationship with government and the accountability relationship with society will be evaluated against the elements present in Bovens's definition of accountability: processes which force agents to explain and justify actions to their principals, processes which allow principals to question agents and pass judgment upon their actions, and processes which enable principals to sanction their agents.

Moving beyond the existence of formal accountability rules, semi-structured interviews were conducted to assess how accountable the Type II healthcare jurisdictions were

perceived to be by key individuals. Interview participants were selected from four categories: elected representatives, members of Type II body boards and management teams, public employees from the Ministry of Health, and representatives of special interest groups active in the healthcare policy field. For the elected representatives category interviews were sought with both ministers and health critics, however, attempts to interview health ministers were unsuccessful across all four provinces.

Interviews were sought with senior public employees, as the size, complexity, and number of functions undertaken by the government makes it impossible for elected officials to be involved in all aspects of how we are governed. As a result members of the public service perform large portions of government activities (Flynn, 2011: 43). As public employees perform much of the activities of government, they are attuned with the operational reality of accountability mechanisms. A member of the department responsible for health services was interviewed for each of the four provinces.

The views of interest group representatives were sought to gain insight into how accountability of the Type II bodies was perceived outside of government and the organization. In each province, the provincial associate of the Canadian Health Coalition and the province's medical association were contacted for interviews. The health coalitions were selected due to their position as coalitions of organizations and individuals who are active or interested in health care policy at the provincial level. Medical associations were selected as they represent an important constituency group in the delivery of health services.

Similar to the need to interview both elected politicians and public service employees, both board members and upper management were recruited from the health authorities. In each province, members of both the board and management were recruited from the health authority responsible for the capital region. Participants from a second health authority – with the exception of Alberta, which has only one health authority – were recruited to allow for additional perspectives to be put forward. In selecting a second regional authority regions that include rural areas were selected to offset the largely urban characteristics of the capital region.

As discussed in Chapter 3, it would have been ideal to interview participants from each category and from each sub-category; unfortunately this was not the case as not all possible interviewees consented to being interviewed. The number of participants per category by province is shown in Table 7.3.

Table 7.3: Interview Participants by Category

	Alberta	British Columbia	Nova Scotia	Ontario	Total
Elected Representatives	1	1	1	2	**5**
Ministry Employees	1	1	1	1	**4**
Interest Groups	2	1	1	1	**5**
Type II Board	0	2	1	2	**5**
Type II Management	1	2	2	2	**7**
Total	**5**	**7**	**6**	**8**	**26**

As discussed in depth in Chapter 3, the interviews were semi-structured in design, with a set of predefined questions forming the general structure of the interview. A list of interview questions is available in Appendix D. The interview process was comprised of two sections. The first approached accountability from the perspective of the participant. Participants were asked to first define or describe what being accountable meant to him or her. Participants were then asked whom they believed the Type II healthcare bodies were most accountable to and then whom they most represented in their decision-making. Both questions were based on questions asked by Lomas et al. in their study of the motivations, attitudes and approaches of regional health authority board members published in 1997 (Lomas, Woods and Veenstra, 1997a: 673). For each accountability relationship identified by a participant, probing questions were asked to obtain a fuller understanding of the participant's view of the relationship – such as the effectiveness of the accountability relationship. When a participant did not identify an accountability relationship between either Type II healthcare bodies and government or Type II healthcare bodies and the public, participants were asked to provide their perspective on each omitted accountability relationship.

To facilitate comparison between the formal mechanisms of accountability examined in the healthcare system and in Chapter 5, the second part of the interview utilizes Mark Bovens's definition of accountability. As touched on above, Bovens's definition identifies three parts to an accountability relationship: the obligation of the actor to explain and to justify his or her conduct, the ability for the forum to pose questions and pass judgement, and that the actor may face consequences (Bovens, 2007: 450). For both the potential accountability relationship between the Type II body and government and the Type II body and society each participant was asked to what extent there is an obligation on the part of the Type II body to explain and justify their actions; to what extent the ability exists to pose questions to the Type II body regarding their actions; and to what extent the ability exists to sanction the Type II body if their actions do not meet expectations. After each question unstructured follow-up questions were used to gain a better understanding of how successful the participant believed the Type II body was at fulfilling that aspect of the accountability relationship and what may have contributed to or hindered accountability.

While a general framework for asking questions was employed, there were cases when the participant's definition of accountability was consistent with Bovens's. This resulted in questions from the second section being answered in the first. In such cases, the unanswered questions from the second section were asked as part of the first section of the interview.

In the case of Alberta a third section dealt with the migration of Alberta's nine regional health authorities into a single provincial wide health authority in 2008. Participants from Alberta were asked to describe the impact the shift from regional authorities to the single province health board had on the ability of both government and society to hold decision-makers accountable. The question was asked to gain insight into the influence of geographic scale on accountability relationships between Type II healthcare bodies and both government and society. Only participants from Alberta were asked, as Alberta was the only province to move from regional health authorities to a single provincial entity – making it unique among the cases being studied.

7.2 Formal Accountability Rules

As stated above, the formal accountability rules were first evaluated using Bovens's definition of accountability. For each of the four cases, the legislation is assessed in terms of the requirement of Type II bodies to explain and justify their actions, the opportunity for government and members of society to question the Type II body and the opportunity for government and members of society to impose sanctions on the Type II body.

7.2.1 Alberta Health Services

In the Alberta case, the formal accountability rules specified in the *Regional Health Authorities Act* and the accompanying regulations suggest a strong accountability relationship between government and Alberta Health Services (AHS). AHS is required by law to submit an annual report, including both financial and performance information, to the Minister who must then table the report in the Legislative Assembly. In addition to the annual report, the Minister receives quarterly financial reports, AHS audit reports (including observations and recommendations), board meeting minutes and may request in writing any records, reports or returns deemed necessary to assess the performance of AHS. Beyond written reports and records, the Minster has inspection powers that authorize the Minister or a person delegated by the Minister to enter and inspect any place under the jurisdiction of the AHS and access for the purpose of examination any documents or records in the possession of the AHS. In combination, the above measures produce a legal requirement for the AHS to explain and justify actions and the right of government to ask questions and pass judgment.

Beyond the capacity to ask questions, the government has substantial tools to sanction the AHS. The most powerful mechanism at the province's disposal may be the dismissal of members of the AHS board. As stated in the *Regional Health Authorities Act*, if the Minister believes that AHS is not properly exercising its powers, carrying out its duties, or acting in the best interest of the public the Minister may dismiss the board and appoint an official administrator in the board's place. While less dramatic, the Minister also has the power to not reappoint a board member upon completion of the board member's term,

meaning that poor performance can be sanctioned by not renewing the member's appointment.

The accountability relationship between AHS and the public as specified in the legislation is centered on the obligation to explain and justify and to a lesser extent the ability of members of the public to ask questions. The legislation dictates that all meetings of the AHS board must be open to the public unless holding the meeting in public would result in the release of information relating to the personal interests, reputation or privacy of any one person, or that would impair the ability of AHS to carry out its responsibilities. Furthermore, when a meeting is held completely or partially in private, no resolution relating to the subject matter discussed may be passed without the meeting reverting to being public. The AHS must also make all meeting minutes available for inspection by the public. A limited potential for the asking of questions can be seen in the requirement to establish community health councils. In accordance with the legislation, community health councils must be established to act in an advisory capacity to AHS on the provision of health services. Missing from the accountability relationship between AHS and the public is the formal ability to sanction. While the legislation allows for either elected or appointed board members, the Minister appoints all AHS board members.

When comparing the formal accountability between the AHS and government and the AHS and society the rules mirror the results found in Chapter 5. While AHS is expected to explain its actions to the people of Alberta and there are some rules in place that allow citizens to ask questions, government maintains the more comprehensive of the two accountability relationships.

7.2.2 British Columbia Health Authorities

The accountability relationship between the BC government and BC's Health Authorities as specified in the BC *Health Authorities Act* is again strong. Each Health Authority is required to send to the Minister an annual report detailing the Authority's operations and fiscal statements for the proceeding fiscal year. The Minister also has the authority to require an Authority to report on any matter deemed necessary by the Minister for the

purpose of monitoring the Health Authority's performance. Each Authority is also required to have its books open for inspection by the Minister or a designate at all times and the Minister may direct the Comptroller General to examine and report to the treasury board on any or all financial or accounting operations of a Health Authority board. In terms of sanctioning power, the government appoints board members and the government has the power to dismiss the board and appoint a public administrator to undertake the functions of the board. The Minister may also issue a special directive with respect to the exercising of the board's powers and performance of duties. Boards are legally obligated to comply with all such directives.

Legislated accountability rules governing the relationship between BC's Health Authorities and the public is comparatively sparse. While the BC *Health Authorities Act* dictates that all board meetings be open to the public, creating an obligation on the part of Authority boards to explain and justify decisions, there is no legislated capacity for members of the public to ask questions or sanction decision-makers. When comparing the formal accountability relationship between the government and the BC's Health Authorities and society and the BC Health Authorities the relationship with government is, like Alberta, the more comprehensive of the two. When comparing the British Columbia and Alberta, the gap between the two accountability relationships appears to be wider in British Columbia.

7.2.3 District Health Authorities (Nova Scotia)

Consistent with Alberta and British Columbia, the legislated accountability rules in Nova Scotia provide for a strong accountability relationship between the District Health Authorities and government. Satisfying the obligation to explain and justify, the Nova Scotia *Health Authorities Act* requires each DHA to produce an annual report detailing financial statements and results achieved in respect to performance objectives over the previous year. The annual report is submitted to the Minister who then must table it in the House of Assembly. Moreover, each DHA is required to provide the Minister with monthly and quarterly financial statements and an audited year-end financial statement including any management letters issued by the auditors. The Minister may also appoint an individual to carry out an audit or review a District Health Authority or any program,

facility or service, which satisfies Bovens's second criteria, the ability to ask questions and pass judgment. In terms of sanctioning power, the Minister has the power to appoint DHA board members and Chairs, and has the power to remove or suspend any member of a board of directors.

In looking at the accountability relationship between the District Health Authorities and the public, DHA are required to hold a minimum of two public forums each year for the purpose of providing information on the operations and activities of the DHAs and seek input from the public. In this regard the legislation obligates the DHAs to explain and justify their actions and provides the opportunity for those it serves to pose questions and pass judgment. As in Alberta and British Columbia, the public in Nova Scotia lacks the capacity to sanction, meaning the formal accountability relationship between government and the District Health Authorities is again the more comprehensive of the two accountability relationships.

7.2.4 Local Health Integration Networks (Ontario)

In the Ontario case, the formal accountability rules set out in the *Local Health System Integration Act* suggest a strong accountability relationship between government and the Local Health Integration Networks. Satisfying the obligation to explain and justify, each LHIN is required to submit an annual report to the Minister and the Minister is required to table the report in the Assembly. As the LHINs are subject to the powers of the Auditor General there is the capacity to pose questions and pass judgment. Government is also capable of sanctioning LHINs through its appointment power, which includes the appointment, reappointment and termination of board members and board chairs and vice-chairs.

Adding additional strength to the accountability relationship between the LHINs and government is the legislated requirement for each LHIN to have an accountability agreement with government. The accountability agreements set out detailed reporting obligations, the ability of government to request meetings to discuss performance factors, government inspection authority, and a performance management framework that allows the government to initiate performance management activities including increased

reporting, external reviews and changes to the governance structure. In essence, the accountability agreements strengthen each aspect of the accountability relationship as defined by Bovens.

Turning to the formal rules governing the accountability relationship between LHINs and the public, all full board and committee meetings are open to the public and each LHIN must carry out some form of community engagement. LHINs are required to engage the community of diverse persons and entities involved with the health care system on an on-going basis, and the methods of engagement may include community meetings, focus group meetings, or the establishment of advisory committees. Again missing from the formal accountability rules is the capacity to sanction. Consistent with the other three provinces, the lack of the public's capacity to sanction results in the formal accountability relationship between government and the Local Health Accountability Networks being the more comprehensive of the two relationships.

7.2.5 Overall Results

When looking at the health authority legislation in each of the four provinces, the results consistently show a more comprehensive accountability relationship between government and the Type II healthcare body than society and the Type II healthcare body. Table 7.4 provides a summary of which three aspects of Bovens's definition of accountability are legislated into the accountability relationships between Type II healthcare bodies and both government and society for each of the four provinces. As shown in Table 7.4 in each province the relationship with government satisfies all aspects of Bovens's definition of accountability, while this is not the case for the accountability relationship with society. When evaluating the provincial legislation, Type II healthcare bodies are consistently obligated to justify their actions to government, while governments are able to question, pass judgment and impose sanctions. Type II healthcare bodies are also required to explain and justify their actions to the public in all provinces. In all provinces but British Columbia the public was able to ask questions, however, the ability for the members of the public to ask questions regarding decisions made is limited in comparison to government. As shown in Table 7.4, the ability for the public to sanction Type II healthcare bodies is lacking within the legislation across all four provinces.

Table 7.4: Government and Society Formal Accountability Relationship by Province

	Relationship with Government			Relationship with Society		
	Obligation to Justify	Ability to Question	Ability to Sanction	Obligation to Justify	Ability to Question	Ability to Sanction
Alberta	Yes	Yes	Yes	Yes	Yes	No
British Columbia	Yes	Yes	Yes	Yes	No	No
Nova Scotia	Yes	Yes	Yes	Yes	Yes	No
Ontario	Yes	Yes	Yes	Yes	Yes	No

7.3 Perceptions of Accountability

As discussed above, interview questions were divided into two or three sections depending upon province. The first section approached accountability from the perspective of the interview participant. The second looked at accountability from the perspective of Mark Bovens's definition of accountability. The third section sought to gain insight into the migration of multiple health authorities into a single authority in the province of Alberta. In presenting the interview results, participants' definition of accountability, or what it meant for the Type II healthcare bodies to be accountable, is presented first, followed by the results from the remaining sections.

7.3.1 Defining Accountability

Accountability – as an idea – is consistently viewed in a positive light, however, what it means to be accountable has remained elusive, as it conjures up different images for different individuals (Koppell, 2005: 94; Bovens, 2007: 448). As discussed in Chapter 3, each interview participant was first asked to describe what accountability means to him or her. Of the twenty-six participants, twenty-two provided characteristics that they felt necessary for the existence of accountability. The remaining four participants did not provide a description of accountability, but instead provided examples of accountability relationships that existed within the provincial healthcare system. There were also

participants who provided both characteristics of accountability and described existing accountability relationships.

When all the participant's responses are considered, a number of themes emerge. A frequent theme was the need for clear and well-understood responsibilities. As stated by one participant, "ideally accountabilities are clear in terms of who is responsible for what," and "when there isn't clarity that's when there are problems." At least one participant from each participant category with the exception of public employees identified clarity in knowing who has the authority to make what decision as part of accountability. In fact, the theme of clarity in decision-making authority was so pronounced throughout the interview process, that greater attention is given to it later in the chapter.

A second recurring theme when describing accountability was the obligation to report goals and performance to those you are accountable to. At least one participant from each of the five participant categories included some form of goals and performance reporting against those goals in their definition of accountability. Multiple participants also described accountability in terms of answerability. One interviewee stated that to be accountable you must "help people to understand what you're are doing with the resources they have entrusted to your care. It's answering for your actions." The requirement to be answerable and consult with those that you are accountable to was again present across all five participant categories.

Accountability was also described in terms of transparency. Accountability was described as having a "process in place, which allows us to have transparency in our decision-making," as well as "having a framework and reasoned rationale as to how we make decisions." At least one member from both Type II healthcare body management and the public employee category included the need for transparency within the decision-making process when describing accountability. In addition, at least one participant from the Type II body board member, elected representative, and interest group member categories described accountability in part as the need to take ownership for decisions

made. Moreover, both the Type II body management and the interest group member categories included the ability to sanction within their definition of accountability.

While not capturing each individual definition of accountability, the characteristics of accountability provided by the twenty-two participants have been compiled and presented by category in Table 7.5. The columns in Table 7.5 provide a consolidated accountability definition compiled from the varied descriptions provided by the different members of each group of participants.

Table 7.5: Characteristics of Accountability Reported by Participant Group

Type II Body Board Members	Type II Body Management	Elected Representatives	Public Employees	Interest Group Members
- Need to know who is making what decision	- Need to know who is making what decision	- Need to know who is making what decision	- **Obligated to report goals and performance to those you are accountable to**	- Need to know who is making what decision
- **Obligated to report goals and performance to those you are accountable to**	- **Obligated to report goals and performance to those you are accountable to**	- **Obligated to report goals and performance to those you are accountable to**	- **Required to consult and be answerable to those you are accountable to**	- **Obligated to report goals and performance to those you are accountable to**
- **Required to consult and be answerable to those you are accountable to**	- **Required to consult and be answerable to those you are accountable to**	- **Required to consult and be answerable to those you are accountable to**	- Actions and decision-making process must be transparent	- **Required to consult and be answerable to those you are accountable to**
- Taking ownership of decisions you make	- Able to sanction if expectations are not met	- Taking ownership of decisions you make		- Able to sanction if expectations are not met
	- Actions and decision-making process must be transparent			- Taking ownership of decisions you make

As stated in Chapter 2, Bovens's definition of accountability is a "relationship between an actor and a forum in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face

consequences" (2007: 450). All three aspects of Bovens's definition of accountability are evident in Table 7.5. The obligation to explain and to justify one's conduct (while not identical) is similar to the notion of reporting on goals and performance against those goals. The ability of the forum to pose questions and pass judgement aligns well with the underlying tone of the requirement to consult and be answerable to those you are accountable to. Lastly, Bovens's view that actors may face consequences is consistent with participant responses that accountability requires the ability to enact sanctions if expectations are not met. Of the three aspects both the obligation to report on goals and performance and the obligation to consult and be answerable are consistent across all participant categories, while the need for sanctioning is only evident in the Type II body management and the healthcare interest group categories.

The inconsistent inclusion of sanctioning within even the consolidated definitions of accountability is interesting as it mirrors the contested perception of the need to sanction (Mulgan, 2000: 556) discussed in Chapter 2. On one extreme, there is the opinion that one cannot have accountability without liability and that accountability without fear of consequences is not likely to be accountability at all (Fraser, 1996: 36). Others question whether sanctioning is an essential element of an accountability relationship (Harlow and Rawlings, 2007: 545). For example, Harlow and Rawlings suggest that recommendations for improvement alone may be sufficient to satisfy accountability requirements (2007: 546). In mirroring the debate over the need for sanctioning, the inconsistency of the inclusion of sanctioning in Table 7.5 supports asking the question of whether sanctioning is an essential element of accountability.

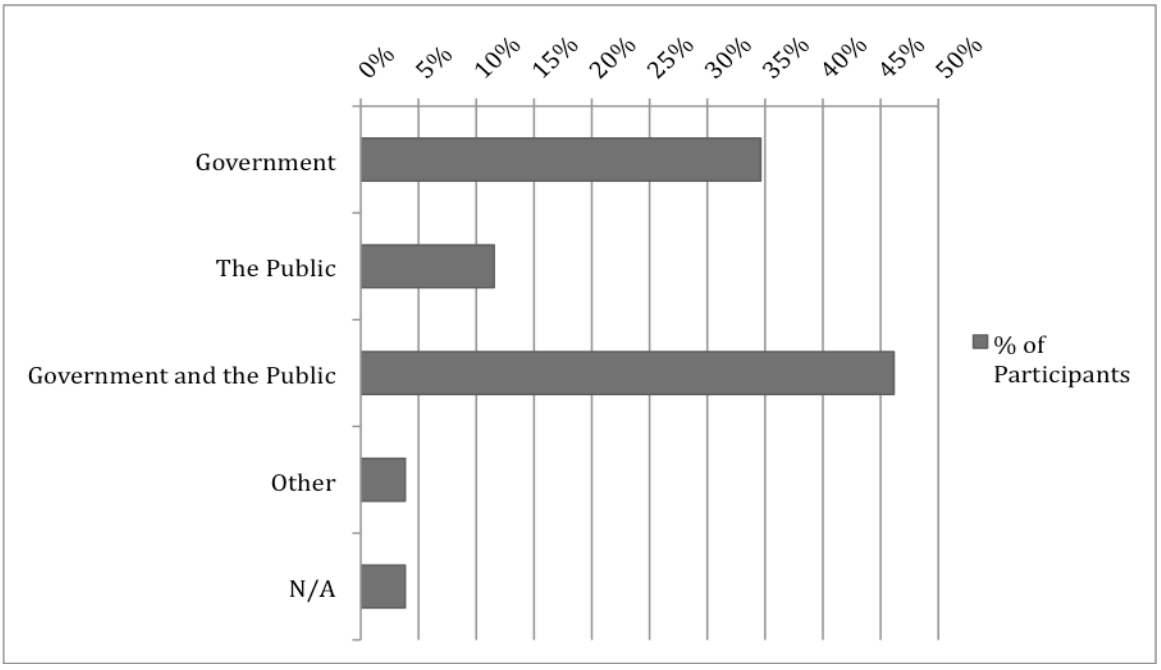
In addition to raising questions over the necessity of sanctioning within an accountability relationship, the participant groups that included the ability to sanction as part of the definition of accountability are noteworthy. The two groups include interest group members and the healthcare bodies' senior management. Interest group members are currently unable to sanction Type II healthcare bodies through formal means, while members of senior management could be sanctioned for administrative decisions.

Aside from the contested nature of sanctioning, what is evident across the five participant categories is that there exists degree of consistency regarding how accountability is described. The most pressing concern is a need for clarity in who is making which decision. Furthermore, the most consistent descriptive statements regarding what it means to be accountable focus on the need to provide information to and consult with those you are accountable to.

7.3.2 To whom do you feel the Type II Healthcare Body is Most Accountable To?

In identifying to whom the Type II healthcare bodies were most accountable to, the majority of respondents stated that they were most accountable to either government or to both government and the public. As shown in Figure 7.1, forty-six per cent of participants identified government as the most prominent accountability relationship, while thirty-five per cent of participants identified both the accountability relationship with government and the accountability relationship with the public. Also shown in Figure 7.1, eleven per cent of participants stated that the Type II healthcare bodies were most accountable to the public; all were from the healthcare bodies' senior management category.

Figure 7.1: Whom do you feel the Type II Healthcare Body is Most Accountable To?



The number of participants who identified multiple relationships when asked to identify the most important accountability relationship suggests complex multifaceted accountability environments. In describing the complex nature of accountability, one participant described the existence of both a legal and a moral accountability, stating that there is a legal accountability to government that ties back to the community through the election process, and a moral accountability that is directly to the community. Other participants noted that the public nature of the healthcare system means that either through direct or indirect means that Type II healthcare bodies are ultimately accountable to the public. One participant described the nature of being accountable to the public in the following manner:

> *"Being accountable to the public has the two faces to it, it is the actual individual person on the street that's in their local area getting services, but there is also the public writ large as the group of individuals who pay taxes and elects a government to represent them [sic]."*

In describing the relationship between Type II healthcare bodies and the public in this manner the relationship expands beyond the local to the public at large. Public issues are no longer limited to local health service delivery but transcend the boundaries of the health authority when issues of fund management or more importantly mismanagement arise.

Participants also commented on the potential for tension between the public nature of the healthcare system and professional accountability. While ultimately accountable to the public, healthcare professionals must also maintain their professional accountability. Participants identified a need to remove the 'either/or' mindset and encouraging individuals to feel accountable to the health system as a whole, while at the same time maintaining their professional accountability.

The sole participant who did not identify government, the public, or a combination of the two as the entity to whom the Type II healthcare body is ultimately most accountable instead suggested that there are four possible entities to which the healthcare body could be most accountable. Specifically, the Type II healthcare body was stated as being most

accountable to one of the four entities depending upon the issue at hand: government as its funding agency, elected officials at all levels of government as the peoples' elected representatives; the public as the recipients of health services; and internal staff and volunteers and providers of those services.

Lastly, as shown in Figure 7.1, one participant did not indicate whom they believed the Type II healthcare body was most accountable to. In this instance, the participant continued to cite the specifics of legislation and regulations and was careful not to convey their opinion on how the legislation and regulation was working in practice.

In addition to responses that highlighted the duality of accountability, there were responses that were aligned with conclusions drawn in Chapter 6. As discussed in the previous chapter, how changes to the healthcare system were framed were not always consistent with the form changes to the system took once implemented. Restructuring was framed in terms of increased citizen participation. Outcomes, however, were not consistent with the stated goals of increased participation or grassroots decision-making, but instead shifted the power towards government. Consistent with this position, both elected representatives from the opposition parties and members of interest groups responded that Type II healthcare bodies should be most accountable to the public but were most accountable to the government. In total, five, out of the ten participants from the elected representatives and members of interest groups categories stated that Type II healthcare bodies are most accountable to government in their current form, but should be most accountable to the public.

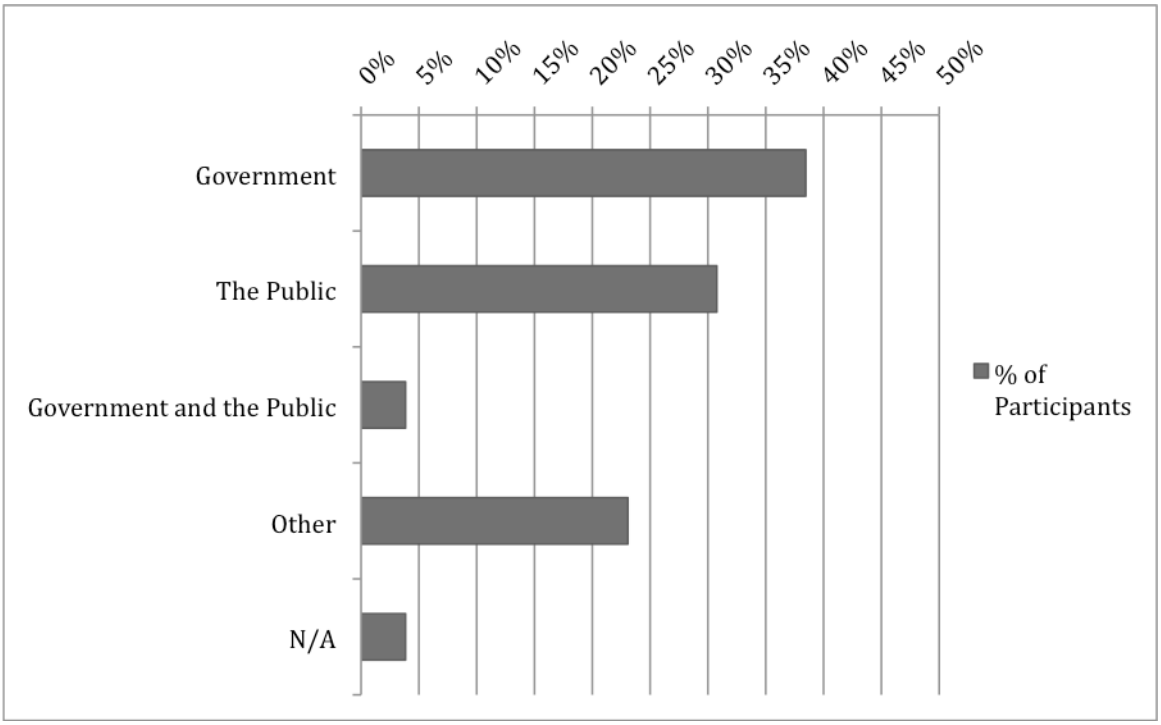
7.3.3 Whose interests do you feel the decisions of the Type II healthcare body most represent?

When assessing whose interests the decisions of the Type II healthcare bodies most represented, the most frequent answer was government. The most common responses to whose interest do the decisions of Type II healthcare bodies most represent are presented in Figure 7.2. As shown in Figure 7.2, thirty-eight per cent of participants believed that the decisions of the Type II healthcare bodies most represented the interests of government, while thirty-one per cent of believed that decisions most represented the

interests of the public. One participant felt that the decisions represented the interests of both government and the public.

In addition to the participants who believed that decisions made by Type II healthcare bodies represented the interests of the public, government or a combination of the two, five participants provided an alterative account. Two participants stated that decisions most represented the interests of both public and staff. One participant stated that decisions surrounding the actions of Type II healthcare bodies were most frequently made based on the interests of the stakeholder group that was most impacted by the decision. Another participant felt that the decisions most represented the interests of the CEO and staff. Finally, two participants were unsure whose interests the decisions made by the Type II healthcare body most represented. One participant did not provide an answer to the question, "Whose interests do you feel the decisions of the Type II healthcare body most represent?"

Figure 7.2: Whose Interests do you feel the Decisions of the Type II Healthcare body Most Represent?



While Figure 7.2 presents a fairly even divide between the number of participants who felt that the Type II healthcare bodies acted in the interest of the public and in the interest of government, a different picture emerges when the results are broken down by participant category. When asked who the decisions of Type II healthcare bodies most represented, all seven members of the senior management category included the public in some form. Five of the Type II healthcare body management participants stated that decisions represented the interests of the public. One participant provided a particularly nuanced perspective stating, who decisions should most represent, "is something that we struggle with, we toil with everyday." The constant struggle stems from a feeling of obligation to all stakeholders. The participant believed that the Type II healthcare body attempted to orient itself depending "on the scale and the magnitude and the impact of the decision in the sense of who is likely to be most negatively impacted by the decision." From the participant's perspective, all stakeholders are important within the healthcare system and all need to be treated as such. The final participant from the Type II body management category believed that decisions represented the interests of both the public and staff.

In contrast to Type II healthcare body senior management, the views put forward by both elected representatives and the members of interest groups placed the interests of government closer to the center of the decision-making process of Type II healthcare bodies. Two main accounts were put forward as the reasoning behind government's interest being dominant over the interests of other parties in the decision-making processes. First, members from both elected representatives and interest groups stated that governments interests must come first as they have the entire health system to consider. Drawing on the words of one of the participants, decisions must first represent the "broader framework strategic priorities and structure," then they are to "carry out that mandate on behalf of the people in their local area." The second account, again put forward by both elected representatives from the opposition parties and members of interest groups, states that the fiscal power held by government places Type II healthcare bodies in a position where they must adhere to the wishes of provincial government.

Participants from both the public employee and board member categories demonstrated more diverse opinions. Of the five board members interviewed, two stated that decisions ultimately represented government, while three stated that decisions represented the will of the public. In the case of public employees, the responses were even more diverse, with each of the four participants providing a different answer. One participant stated that decisions represented the interests of the government, a second stated the public and government, a third stated the public and the staff, while the final participant declined to provide an answer.

A couple of observations can be made in comparing the responses to the following questions: To whom do you feel the Type II healthcare body is most accountable to?; and Whose interests do you feel the decisions of the Type II healthcare body most represent? First, in terms of accountability the vast majority of participants believe that Type II healthcare bodies are most accountable to government, either solely or jointly with the public. Second, there is no agreement as to whom the decisions of Type II healthcare bodies most represent. Moreover, given the general agreement that Type II healthcare bodies are accountable to government it would seem logical that a similar consensus would exist surrounding who Type II healthcare body decisions most represent. However, in contrast to definitions of accountability which suggest A is obligated to act in someway on behalf of B, the results indicate that perceptions of who decisions most represent are highly dependent upon the participant group the interviewee belongs to.

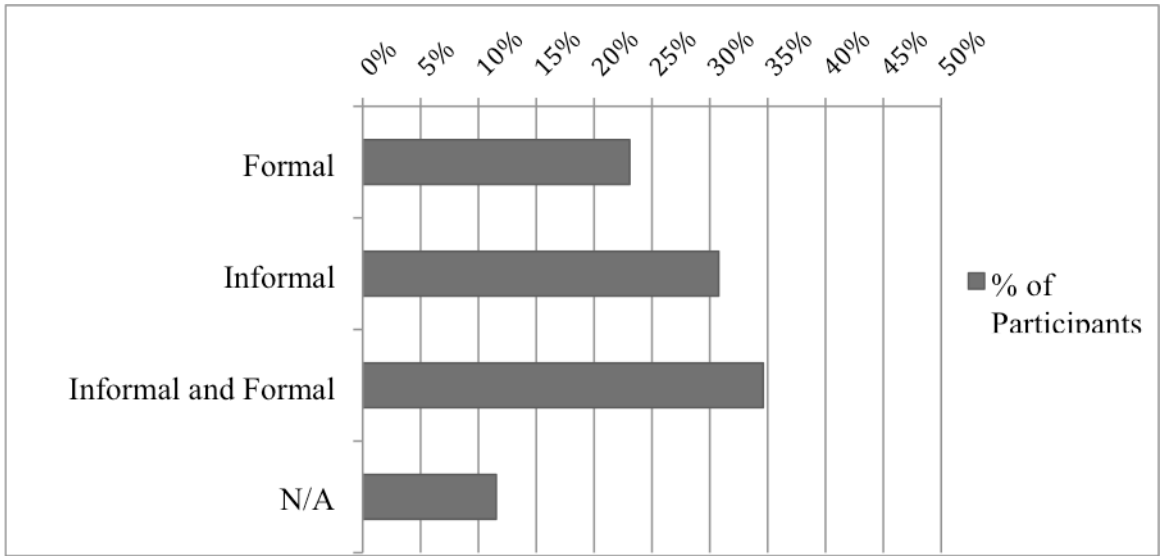
7.3.4 Explain, Question, and Sanction – Accountability to Government

When asked to assess the accountability relationship between the provincial Type II healthcare bodies and government using Bovens's definition of accountability (2007: 450), participant results closely resembled the formal accountability rules dictated in the legislation and regulations. For the most part, participants believed that Type II healthcare bodies are obligated to explain and justify their actions to government. That government is able to ask questions and pass judgment and government has the capacity to sanction healthcare bodies if the healthcare bodies are not fulfilling their obligations as set forth by government.

When asked about the need for Type II healthcare bodies to explain and justify their actions to government, all participants stated that there was an obligation on the part of the healthcare bodies to report back to government and keep government apprised of the activities of the healthcare body regarding either healthcare outcomes, how they were meeting their fiscal obligations, or both. Participants from all provinces but Ontario, however, raised concerns that while an obligation to explain and justify decisions existed, shortcomings existed within the current structure. As reflected in their observations, concerns were raised by public employees, healthcare body management and members of interest groups that a focus on financial reporting overshadowed reporting on health outcomes. Participants argued that the time had come to expand reporting requirements beyond issues of healthcare costs and procedure time requirements to issues of health system sustainability and the delivery of better health outcomes.

In assessing the ability of government to question and pass judgement on the Type II healthcare bodies, respondents from all four provinces and across all five participant groups felt that government was able to question and pass judgement on Type II healthcare bodies. As discussed above, formal mechanisms are made available to government through the enabling legislation, however, an evenly distributed numbers of participants identified formal and informal mechanisms. As presented in Figure 7.3, twenty-four per cent of participants identified formal means, thirty-one identified informal means and thirty-five per cent of participants identified both formal and informal methods. Three of the participants did not provide an indication of whether the accountability relationship with government includes the ability to pose questions and judgement. Two participants from the interest group member category focused on the ability of societal members to pose questions, while an elected representative provided an account of the inability of members of the opposition to effectively pose questions, but did not touch directly upon the ability of the government to pose questions.

Figure 7.3: Participant Description of Methods used by Government to Question Actions of Type II Healthcare Bodies



The formal mechanisms described by participants included: standing meetings at various organizational levels that allow government officials to question the actions of the healthcare body; monthly meetings between Minister and board chair and CEO; the creation of formal joint government and Type II healthcare body committees; quarterly healthcare body performance reviews; and annual budget and planning processes. From an informal perspective a great deal of emphasis was placed upon the ability of the Minister as well as department officials to pick up the phone when it was felt necessary to question the actions of the Type II healthcare body. Of the eighteen participants interviewed from the healthcare board and management as well as public employee groups, fifteen commented on the informal ability of government officials to ask questions of Type II healthcare bodies. Multiple participants described communication as being bi-directional and daily between the healthcare body and government. It was mentioned, however, that there is a hierarchy to communication: the board communicates with the Minister, the CEO communicates with the Deputy Minister, and so on.

When asked about the capacity to sanction, no participant denied government held political authority. Not all participants believed, however, that the sanctioning capabilities provided to government through legislation were effectively used. Concerns

were raised that poor performance was only met with either "a slap on the wrist" or prolonged discussion without repercussions for poor performance. Concerns over the effectiveness of sanctions were raised in all provinces with the exception of Ontario, and concerns came from participants both internal and external to the healthcare bodies. In contrast, however, to concerns over government's unwillingness to utilize the tools available to deal with underperformance, others warned of government's unwarranted use of the same mechanisms. There were claims that government had used the available tools not to sanction underperformance, but to remove board members who had publically criticized the actions of government.

Just as dictated in the legislation, the responses of the participants suggest that all three elements of Bovens's definition of accountability are present in the accountability relationship between government and Type II healthcare bodies. Their existence, however, does not mean that challenges in fulfilling the requirements do not exist. Of the three elements, the ability for government to question and pass judgement is the least fragile. As evident from the survey responses, government has both formal and informal methods of questioning the actions of the Type II healthcare bodies. Both the requirement to explain and justify and the ability to sanction, however, were called into question. Questions were raised about whether the current reporting regime was sufficient as well as whether government was utilizing its sanction power to address issues of performance.

7.3.5 Explain, Question, and Sanction – Accountability to the Public

As discussed above, participant results provide a picture of the accountability relationship between Type II healthcare bodies and government that closely resembled the relationship mandated by the provincial legislation that migrated decision-making authority. When looking at the accountability relationship between the healthcare bodies and the public, however, the results show a greater degree of difference between the formal accountability rules as laid out in the legislation and perceptions brought forward by the participants.

Using the three components of Bovens's definition of accountability (2007: 450), Table 7.6 presents the formal accountability relationship as legislated by the provinces. As discussed above, in each of the four provinces the Type II health care bodies are obligated to explain and justify their actions to the public. In all cases, with the exception of BC's Health Authorities, there is an obligation on the part of the healthcare bodies to provide a venue for members of the community to question their actions within the legislation. In the accountability relationship with society, however, no formal mechanism exists by which to sanction a Type II healthcare body in any of the four provinces.

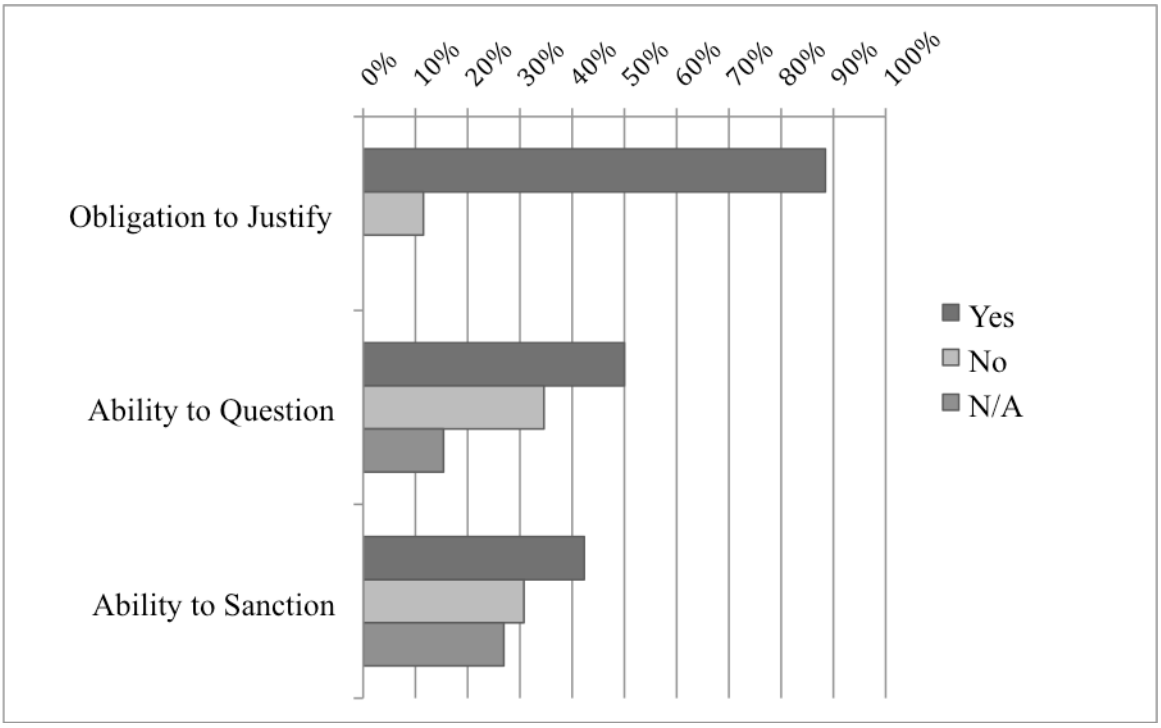
Table 7.6: Relationship with Society – Meeting Formal Accountability Criteria by Province

	Obligation to Justify	Ability to Question	Ability to Sanction
Alberta	Yes	Yes	No
British Columbia	Yes	No	No
Nova Scotia	Yes	Yes	No
Ontario	Yes	Yes	No

Continuing to use Bovens's definition of accountability, Figure 7.4 captures how participants perceive the accountability relationship between Type II healthcare bodies and society. As shown in Figure 7.4, consistent with the formal accountability rules, eighty-eight per cent of participants believed that healthcare bodies are obligated to explain and justify their actions, while twelve per cent believed they have no such obligation. In regard to the ability to ask questions, fifty per cent of participants responded in the positive, thirty-five responded in the negative, while fifteen did not provide an answer. If we consider only the participants from British Columbia, the sole province in the study where the ability to ask questions is not legislated, fifty-seven per cent responded in the positive, twenty-nine in the negative and fourteen did not provide an answer. The BC results suggest that even though not required by legislation, there are efforts being made to engage the public and provide forums through which the public can

question the actions the Type II healthcare bodies. Returning to the full sample, when asked about the ability to sanction Type II healthcare bodies, forty-two per cent of participants stated that society was able to sanction healthcare bodies, thirty-one per cent stated it was not and twenty-seven per cent did not provide an answer.

Figure 7.4: Participant Perception of Accountability Relationship with Society



While the majority of participants believed that Type II healthcare bodies had an obligation to justify their actions to society, concern was raised by a number of interest group members and elected representatives from opposition parties that the obligation to fully explain and justify the actions of the healthcare body was either absent or not adhered to. In responding to the ability of members of the public to question and pass judgment, responses indicated that while there is a lot of work done to engage the community prior to decisions being made, there is limited capacity for members of the public to pose questions afterwards. In two cases, once by an elected representative, and once by a board member, freedom of information requests were listed as a mechanism by which members of the public could question and access information on how decisions were made after the fact. On a positive note, in three instances the participants' responses

suggest that the legal requirements were treated as minimal requirements with members of the public either able to speak and pose questions at board meetings or other formalized proceedings. In responding to the ability to sanction, forty-two per cent of the respondents indicated that while no formal sanctioning capacity existed, the public has the means to informally sanction the healthcare bodies through the use of the media, demonstrations, complaints to elected officials, or any other venues that would bring the issue to the forefront.

When describing the overall effectiveness of the accountability relationships three themes emerged: a lack of role clarity within the healthcare system; a lack of knowledge at the citizen level; and concerns over the type of information provided to the public. Concern over a lack of role clarity was raised by at least one participant from each of the four provinces. While such concerns came mostly from interest group representatives, at least one public servant and an elected representative also brought the issue forward. Perhaps not surprising due to their familiarity with the system, no individual working within a Type II healthcare body raised clarity of roles within the healthcare system as a concern. When describing role clarity as a problem, participants suggested that an inability to clearly delineate the role of the Type II healthcare bodies in relation to other actors in the healthcare field limited the ability of the public to hold the correct actor accountable for decisions made.

Participants from each of the four provinces also expressed the issue of low levels of citizen knowledge. Just less than two-thirds of interviewees, comprised of participants from all categories, expressed the belief that citizens held a limited understanding of the role of the Type II healthcare body in their region, the decision-making process, or the work that their healthcare body is undertaking. In regard to accountability the concern was concisely put by one participant who stated that “you cannot hold someone to account if you do not know who they are or what they are doing.” While a number of participants did state that public knowledge around the role and activities undertaken by healthcare bodies is increasing, the same respondents frequently acknowledged that in terms of public education there is still “a ways to go”. On a positive note, multiple

healthcare body representatives, from both the executives and the boards, spoke of the need for healthcare bodies to continue to educate the public.

Closely tied to citizen knowledge is the type of information provided by the healthcare bodies to the public. At least one participant from each province called into question the type of information provided to the public. The most prevalent concern was that the information provided to the public was the same information produced for government consumption. While meeting the informational demands of government, the information is described as overly technical and bureaucratic and not accessible to a majority of the public. To a lesser extent, concerns were raised over the likelihood of a citizen knowing where to look for the information that is available to him/her.

Overall, participant perceptions of the accountability relationship between Type II healthcare bodies and society, while weaker than the relationship with government, may be stronger than the relationship that appears on paper. While challenges of role clarity, citizen knowledge, and information distribution must be met, participant responses indicate that there are those within the healthcare system that view the legal requirements as minimal requirements. Furthermore, there is a belief that while no legal means to sanction Type II healthcare bodies exists, the public is able use informal channels to sanction Type II healthcare bodies when performance does not meet with expectations.

7.3.6 And then there was One: From Nine Regional Authorities to a Single Provincial Board in Alberta

In Alberta nine regional health authorities, the Cancer Board, the Mental Health Board and the Alcohol and Drug Abuse Commission, were dissolved and rolled into Alberta Health Services (Liepert, 2009). As a result of this dramatic change in the Alberta healthcare system, participants were asked to describe the effect of moving from nine regional authorities to a single province wide health board on the ability to hold decision-makers accountable. Out of the five participants from Alberta, four provided insight into the impact of the change in direction undertaken by the province.

When comparing the responses on the effect of moving from regional to a provincial healthcare body three themes were identified. The most commonly shared belief was that

in moving from regional health authorities to a provincial authority, there was a loss of connection between the decision-makers and the community. All four participants expressed a degree of concern over the loss of local connection within the decision-making process. Moreover, two of the four respondents commented on the loss of connection between the people and decision-makers that previously occurred when the regional healthcare bodies where implemented. At each step, from local hospital boards to Regional Health Authorities to AHS, there has been a "loss of connection between the people of Alberta and healthcare decisions." One participant also noted that with shifting to one large provincial body there is the impression that "Calgary and Edmonton make all the decisions". While four participants expressed a degree of concern over the weakening of the connection between citizens and healthcare decisions, one participant (from outside of AHS) expressed this as a known problem that Alberta Health Services is actively working to overcome.

In contrast to concerns over the loss of connection between Alberta Health Services and the public, two participants suggested that the shift from nine regional health authorities to one provincial body has strengthened government control over decisions made in the healthcare system. One participant speculated that the shift from regional authorities to a single health authority was based on the perceived need of government to obtain greater control than that which existed under the regional system. Lastly, one participant noted that the change has made it increasingly difficult to distinguish where Alberta Health ends and Alberta Health Services begins.

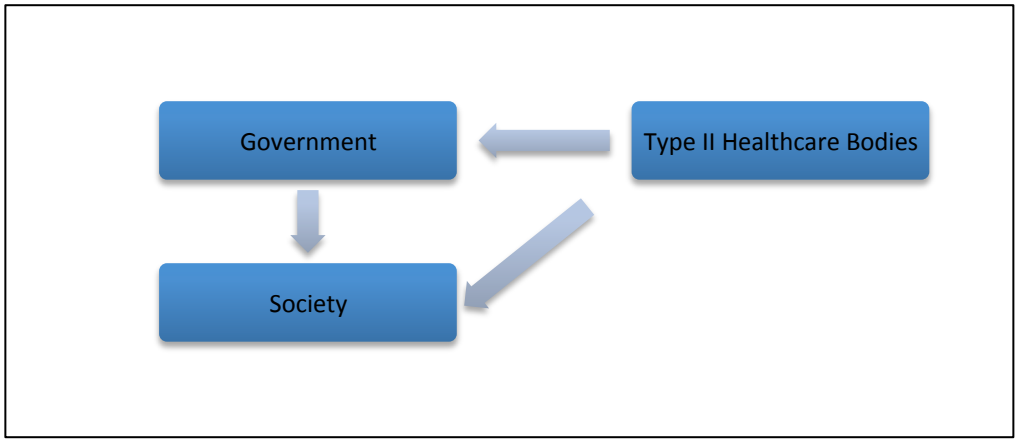
While not asked about the effect of the shift from nine regional bodies to one provincial wide healthcare authority in Alberta, at least one participant in each of the other three provinces specifically commented on the institutional change made in Alberta. Two participants believed that the current number of Type II healthcare bodies in his/her province was too many and resulted in inefficiencies, by moving to a single provincial body, as was done in Alberta, the system would lose sight of local differences. Another participant, however, viewed a move to a single Type II healthcare body as potentially being in her/his province's best interest. One participant did not speculate on whether his/her province would benefit from following the same path as Alberta but simply stated

that it appeared that the shift from nine regional authorities to one provincial bodies had left little room for local decision-making and that the change could be seen as a move by the provincial government to retake control of decision-making in the healthcare system.

7.4 Discussion: Direct and Indirect Accountability in Healthcare

When looking at the migration of authority in healthcare for the provinces of Alberta, British Columbia, Nova Scotia, and Ontario the results suggest a strong accountability relationship between provincial governments and Type II healthcare bodies alongside a weaker accountability relationship between healthcare bodies and the public. The difference in capacity between the two relationships is evident in both the formal accountability rules as described in the legislation and the perception of accountability provided by interview participants. As discussed in Chapter 2 and shown in Figure 7.5, the relationships can be considered direct and indirect accountability relationships between the public and the Type II healthcare bodies.

Figure 7.5: Type II Healthcare Bodies Accountability Pathways in Healthcare



While the direct accountability relationship with government is stronger, society is intended to remain the benefactor of the relationship. Within each of the four provinces, the ability to hold the Type II healthcare bodies to account is rooted in the democratic institution of parliament. Within each provincial parliament or legislative assembly, provincial power is executed in accordance with the requirements of ministerial

responsibility and parliamentary accountability. Ministers are answerable to Parliament for the actions of government and Parliament may hold to account all those who exercise the power of the state, be they elected or non-elected (D'Ombrian, 2007: 198-199).

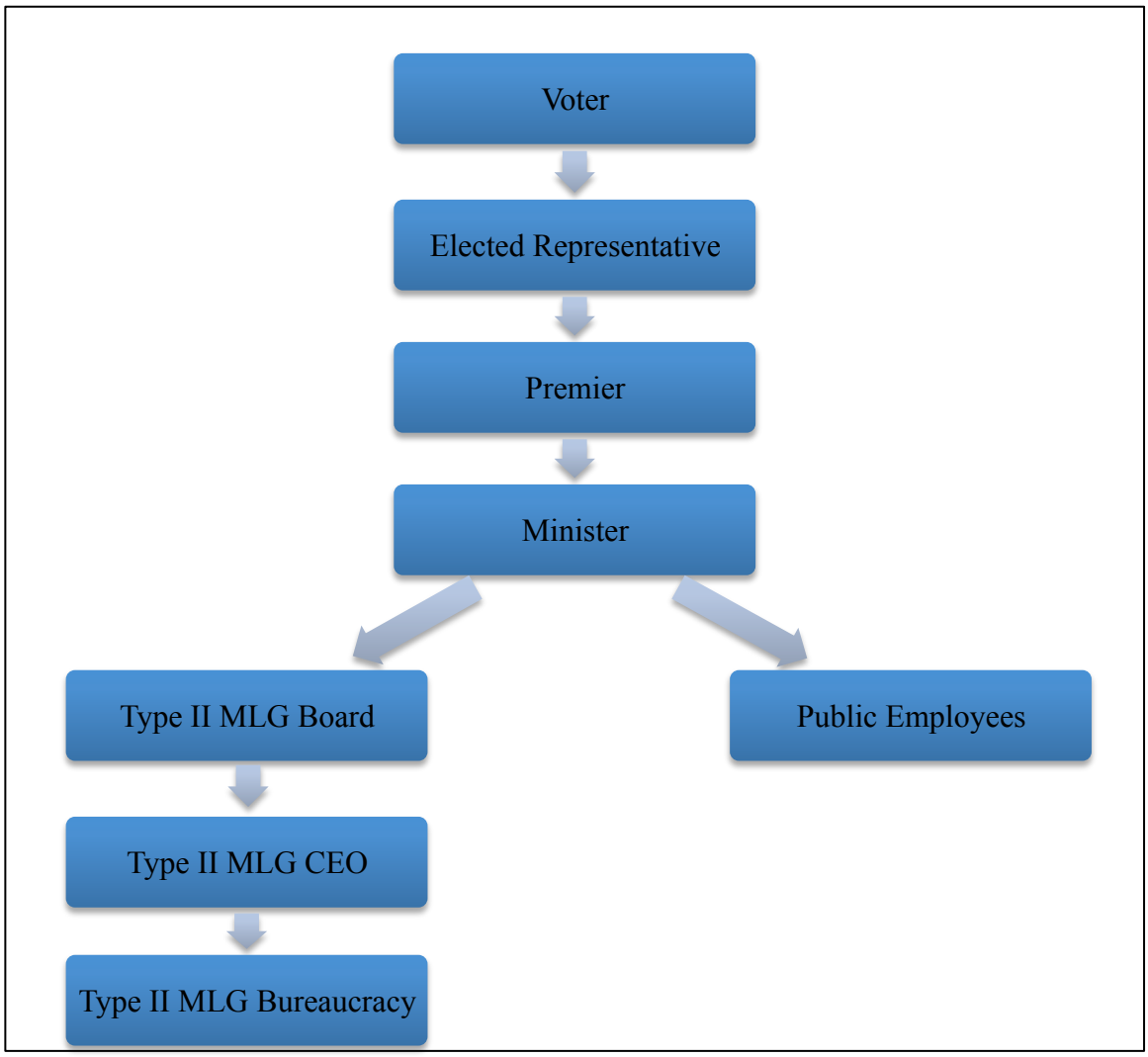
Despite the potential for both a direct and indirect accountability relationship through government, however, both pathways may be undermined by limited clarity and lack of citizen knowledge surrounding the decision-making in the healthcare system. In a representative democracy, accountability is the principal mechanism through which mass publics exert control over their elected officials (Rudolph, 2006: 99), but for public responsiveness to be effective an accurate signal of what government is doing is required (Soroka and Wlezien, 2004: 552; 2011: 33). As stated in Chapter 2, the dispersion of decision-making authority vertically to an increasing number of government levels lessens the ability of citizens to accurately attribute which decision-making authority belongs to which level of government (Anderson, 2006; Brzinski, Lancaster and Tuschloff, 1999; Schneider, Jacoby and Lewis, 2011). In the case of authority migration in healthcare, interview results suggest that the migration of decision-making authority horizontally to Type II multilevel governance bodies has clouded citizens' perceptions of who is responsible for policy decisions.

Within the provincial healthcare systems the shifting of decision-making power horizontally increased both the length and number of accountability chains. This can be seen as the result of the growing number of institutions involved in the decision-making process. In a parliamentary democracy, four steps in an accountability chain can be identified: 1) voters to their elected representatives; 2) elected representatives to the executive branch; 3) from the head of government (prime minister or premier) to executive departmental heads (ministers); and 4) from the heads of executive departments to the civil servants (Strøm 2000: 267). As each of the four provincial governments being studied added a Type II multilevel governance body to the provincial health care system, a second accountability chain was created. Both of the accountability chains are presented in Figure 7.6. In each of the four provinces a portion of the healthcare decisions remained within the purview of the provincial government. As a result, Strøm's accountability chain remained in place, while at the same time the new accountability

chain was brought into existence. The new accountability chain includes the following additional accountability steps: from the head of the ministry responsible for healthcare to the boards of the Type II healthcare bodies; from the board of the Type II healthcare body to the CEO; and from the CEOs of the healthcare bodies the healthcare body bureaucracies.

In migrating decision-making authority horizontally, the provincial governments increased the number of actors in the provincial healthcare systems and in doing so created a second accountability chain. Interview responses suggest that the result has compromised the ability of citizens to accurately attribute decision-making authority. As Papadopoulos would predict (2007: 479), the interworking of the healthcare policy process is most clear to those working within the system. Participants from each of the four provinces raised concerns regarding the ability of citizens to clearly attribute the roles and responsibilities of actors within the provincial healthcare system. The majority of such concerns came from members of the special interest group category who are furthest from the centre of the healthcare system. The issue was also brought forward, however, by at least one public employee and elected representative. Supporting Papadopoulos' argument, not one participant working within the four Type II healthcare bodies raised the ability of citizens to accurately attribute responsibilities as a concern. The results suggest that as healthcare policy processes have become increasingly obscured to all but the most closely involved it is becoming increasingly difficult for citizens to accurately attribute responsibility for policy actions.

Figure 7.6: Parliamentary and Type II Healthcare Body Accountability Chains



The fear that democratic accountability will be lost as the number of players within the policy process increases is not new. As stated by Alexander Hamilton in 1788, "one of the weightiest objections to a plurality in the Executive, and which lies as much against the last as the first plan, is, that it tends to conceal faults and destroy responsibility" (Hamilton, 1788). Much more recently, Cameron Anderson argued that governances could create incentives for governments within the multilevel system to camouflage their responsibility for decisions and outcomes (2006: 450). Looking specifically at health policy, Jonathan Lomas claimed that devolved authorities make an easy way to shift blame and place a buffer between provincial governments and the discontent that comes

with unpopular decisions (1997:821). Harber and Ball observe that an unintended consequence of healthcare systems, structures and processes is blame-avoidance at the cost of true accountability (2004: 41).

At risk within the healthcare system is the loss of public input and democratic accountability. Delegation of authority threatens to weaken democratic accountability, as citizens are unable to accurately attribute responsibilities across the healthcare system. While mechanisms of accountability may exist within the legislation and regulation, democratic accountability may not exist. If a citizen is unable to accurately attribute the responsibilities and actions of the various policy actors within the healthcare system they cannot effectively hold policy actors to account. For example, consider the capacity to sanction. Dunn states that it is unlikely that a decision-maker will be rationally sanctioned without sufficient public knowledge and understanding (1999: 335). Based on participants' remarks, in the public sphere there exists a weak understanding of the roles and responsibilities of actors involved in the governance of the healthcare system. Without the background knowledge, citizens do not have the necessary tools to make rational conclusions about the effectiveness or appropriateness of a Type II healthcare body's actions, let alone sanction them. Moreover, within an accountability chain, the policy process is most visible to those who are most closely involved in the decision-making process, and in multilevel environments actors are more likely to be subject to administrative rather than democratic accountability (Papadopoulos, 2007: 479). As such, accountability mechanisms may exist within each province's legislation and regulations, but a lack of role clarity within the healthcare system may limit the effectiveness of such mechanisms to the detriment of democratic accountability.

7.5 Discussion: Accountability and the Quality of Information in Healthcare

The previous section focused on how a lack of clarity surrounding the roles and responsibilities of policy actors in healthcare policy poses a risk to democratic accountability. Attention is now turned to the ability of citizens to accurately assess the desirability of actions taken by actors within the policy process. To accurately assess the actions of policy actors, citizens must have access to a sufficient quality and quantity of

information. As presented above in Chart 7.5, while eighty-eight per cent of participants stated that Type II healthcare bodies are obligated to explain and justify their actions to the public, participants also brought forward a number of concerns regarding the effectiveness of the information provided.

The most prevalent concern voiced by participants was the format of the information provided to the public. One issue was that the reports produced to fulfill government reporting requirements and specifications where repurposed to fulfill obligations to report to citizens. While government officials assessing the information have the required expertise to accurately interpret the information, concerns were raised that most citizens lack the prerequisite knowledge to determine the appropriateness of actions. The technical nature of reports is visible in Alberta Health Services' reporting of performance measures as seen in their 2013-2014 annual report (provided in Appendix G). Concerns were also raised regarding the time constraints faced by most citizens if they wished to acquire the necessary knowledge to understand and accurately interpret the information provided to the public by Type II healthcare bodies. As argued by Abelson et al., public deliberation efforts in health policy are constrained by the time and commitment it takes for participants to learn about the issues and work through their implications (Abelson et al., 2012: 27). According to Tomblin the rhetoric for the need for civic engagement in the healthcare system is at odds with the findings that civic literacy and political knowledge are decreasing. Most citizens operate at the margins of politics and their lack of knowledge promotes attachment to existing institutions (Tomblin, 2004: 285). Furthermore, as Julie Simmons states, most citizens remain largely unaware of public reporting exercises and even Legislatures and parliaments that mandate the collection of data make little use of it when holding decision-makers to account (2011:156).

From the above discussion five factors can be identified that limit the ability of members of the public to hold Type II healthcare bodies to account:

1. Many citizens lack the level of political engagement required to seek out existing public reports.

2. Existing public reports/information are presented in a technical format that requires a high degree of background knowledge to understand.

3. Many citizens lack the technical expertise required to accurately assess the reported information.

4. Many citizens lack the time necessary to acquire the expertise necessary to accurately assess the reported information.

5. Many citizens lack the level of political engagement required to seek out the expertise necessary to accurately assess the reported information.

While each of the five factors can be viewed as interrelated, they can also be broken down into two distinct sets of problems: the first being a lack of political engagement and the second being the nature of the data provided to the public. The first problem falls outside the scope of this project, however, multiple participants claimed that citizens do become more politically engaged in health policy once either they or a loved one requires treatment for either a serious/life threatening disease or injury.

With the first problem outside the scope of the project, further consideration will be given to the second. In compiling participant responses, results show concerns were raised in each of the four provinces that the reports made available to the public were in a format that did not aid the public in assessing the performance of the Type II healthcare bodies. One participant, however, stated that when citizens were provided with the information available, they reached similar conclusions as the Type II healthcare body regarding health system decisions.

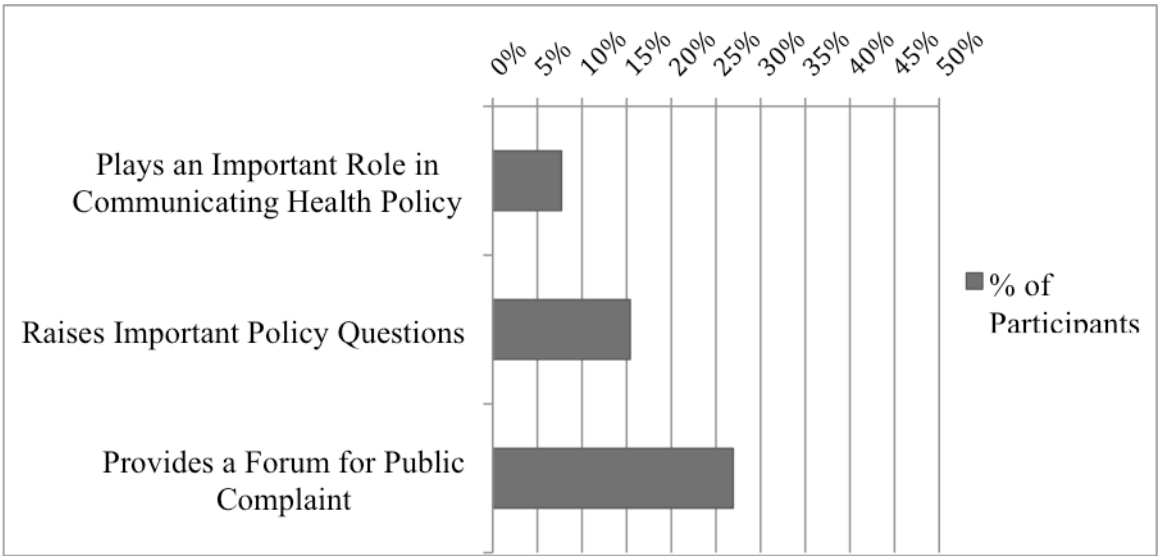
> *"If you provide the public with the same information that I have, I find that they often can reach much the same conclusions around services or proposed models of delivery and do so in a matter that is very practical and very pragmatic [sic]."*

If this is true, the problem and the solution are inherent in the two accountability relationships and by extension the two accountability chains discussed above.

In responding to the problem, what require consideration are the accountability relationships, and the actors that exist at each link in the accountability chain. First consider that healthcare professionals are recognized as having greater knowledge of what constitutes good healthcare, while citizens are recognized as being in a better position to understand local needs and the relation to health (Frankish et al. 2002: 1474). Second, lay participants who serve on health boards have little basis on which to make health care decisions and typically accept the recommendations of the healthcare professionals on staff (Björkman, 1985: 415-416). Now, within the two accountability chains healthcare professionals are located in both the Type II Multilevel Governance Bureaucracies and the ranks of Public Employees. Accordingly, it is logical that the reports provided by the Type II healthcare bodies would be technical in nature. If, as one participant suggested, you can provide the public with sufficient information to have them reach practical and pragmatic conclusions regarding the operation of the healthcare system it would appear a second set of reporting mechanisms is required. While none of the four provinces included in the study had mandated reporting that focuses on the unique informational needs of the citizen, participants from two of the four provinces discussed measures being taken to produce citizen-focused reports. In both cases the initiatives appear to have been initiated from within Type II healthcare bodies themselves.

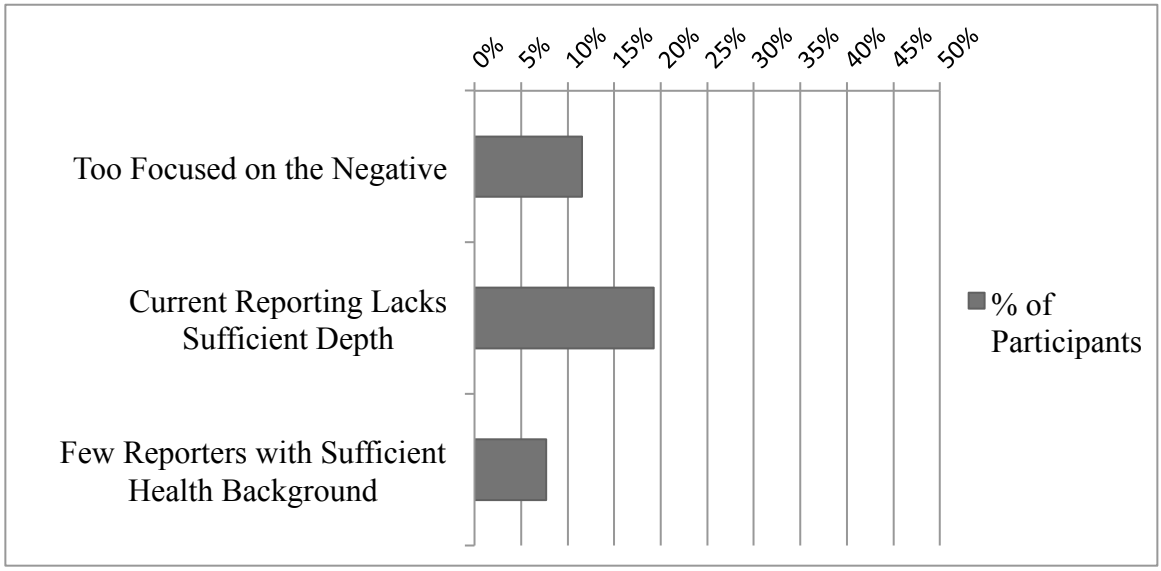
Aside from modifying report outputs, the media was identified by fifty per cent of participants as having a role to play in holding Type II healthcare bodies accountable to the public. As one participant noted, the media acts as a filter for citizen knowledge, with health policy being filtered through the media for the majority of citizens. Another participant stated that the media brought benefits to both the Type II healthcare bodies and citizens. When working well, the media serves to both distribute pertinent information as well as ask the questions that people are seeking answers to. Participant data on the media's role in holding Type II healthcare bodies to account is presented in Figure 7.7.

Figure 7.7: The Media's Role in Holding Type II Healthcare Bodies Accountable



While strong overall support existed for the media as an accountability mechanism, concerns were raised in regard to specific perceived shortcomings when reporting on healthcare. Specifically participants raised concerns regarding a disproportionally high focus on negative in comparison to positive news stories, a lack of depth when reporting on healthcare policy issues and a limited number of reporters with sufficient healthcare knowledge to be able to look into and keep track of health care policy information. Participant data on perceived media shortcomings in reporting on healthcare is presented in Figure 7.8. The results are consistent with the results of a 1996 study examining citizen participation in volunteer-based health-system governance in British Columbia. The study suggests the possibility of a larger role for the media in promoting a better understanding at the level of the citizen; however, this would require a fuller account of healthcare reform including a balance of positive and negative stories (Frankish et al., 2002a: 144).

Figure 7.8: Perceived Media Shortcomings in Reporting on Healthcare



The results presented in Figure 7.8 suggest that the potential of the media to promote a better understanding of healthcare policy to citizens has not been fully realized. The media however, continues to play an important role as they allow an issue to penetrate the public interest. As stated by one participant, it is amazing how accountable an organization or individual can become once there is media attention.

7.6 Conclusion

The findings above suggest that the legislated accountability relationships between Type II healthcare bodies and both government and society include sufficient accountability mechanisms for the public to hold Type II healthcare bodies to account. Participant responses, however, suggest that challenges, including a lack of role clarity in decision-making and citizen knowledge, lend credence to accountability concerns. Overall the accountability story that emerges is one in which sufficient accountability mechanisms exist, but the sufficient knowledge on the part of the citizen to utilize the mechanisms may not.

In looking at the accountability relationships between Type II healthcare bodies and both government and society, the results from Chapter 7 support the conclusions made in Chapter 5. First, citizens are able to hold Type II bodies either directly or indirectly

accountable. Second, of the two accountability relationships the accountability relationship between government and Type II healthcare bodies is the stronger. Moving from working strictly with formal legislation to participant perceptions, however, Chapter 7 provides interesting contradictions between formal rules and what is believed to occur. In the case of the ability to sanction, all provincial governments had the legislated ability to sanction, while the public did not. A common perception, however, was that government was unwilling to use its sanctioning power to ensure accountability while members of the public could employ informal sanctioning mechanisms to hold Type II healthcare bodies to account. In regard to the ability to ask questions and pass judgment, interview results suggested that governments had significantly greater ability to ask questions than what was legislated, while it was felt by some participants that the public was often unable to ask questions once decisions had been made. So while the accountability relationship between government and Type II bodies may be stronger, participant perceptions of how each accountability relationship works in practice suggest practical accountability benefits exist in each relationship.

More important than the existence and strength of an accountability relationship is its successful functioning. In shifting authority to new governance bodies it is not sufficient to build accountability rules into the system; sufficient knowledge must also exist to make the accountability mechanisms meaningful. While the results suggest that government is fully capable of holding healthcare bodies to account, a gap exists between the power to hold healthcare bodies to account and public knowledge. The shifting of decision-making authority horizontally has resulted in the camouflaging of responsibility, which coupled with insufficient knowledge at the citizen level continues to present challenges for democratic input and accountability. Fortunately in the field of healthcare, the responses from both board members and senior management suggest an obligation to act in the best interests of the public they serve. The challenge in healthcare is to ensure a clear delineation of roles, adequate public information, and a venue for public input that ensures the standards of democratic input and accountability are met.

Chapter 8

8 Authority Migration and Type II Multilevel Governance: Conclusions

An overarching challenge is that governance is complex. It brings together multiple actors, of whom not all are working to achieving the same objective at any given time. Furthermore, as governance patterns have altered, decision-making authority has migrated both vertically and horizontally away from the traditional political centre. New governance arrangements have emerged that no longer align with conventional government hierarchies. New governance actors are operating with autonomy from the dictates of legislatures and public agencies (Cohen and Sabel, 1997: 316). In 1999, the Auditor General of Canada observed changes in how Canadians are being governed, stating that some policy initiatives had moved beyond the traditional forms of governance to entities outside of government (Auditor General of Canada, 1999: 23-27). In 2002, the Auditor General of Canada observed that accountability relationships had become increasing complex as public objectives had become increasingly achieved through non-hierarchic relationships (2002: 4-5).

Shifts in decision-making authority have moved governance models away from a single agency model toward a multi-actor system and increased the complexity of accountability relationships. The preceding chapters focused on: 1) the extent to which Canadian provinces have opted to migrate decision-making authority horizontally in response to policy issues and what factors explain the migration of authority; and 2) the existence and relative strength of the accountability relationships that emerge once authority has been migrated, especially the accountability relationship between the new governance actors and both government and society. This final chapter will focus on reviewing the findings of the previous chapters and discuss the implications.

8.1 Review of Findings

Beginning in Chapter 4, a number of hypotheses have been evaluated regarding the migration of authority and the effect of this migration on public input and democratic

authority. Chapter 4 evaluated the historical rate of authority migration as well as the effect of fiscal capacity and political ideology on the annual rate of authority migration. These results showed that the cumulative number of Type II bodies have been increasing over time, while the annual rate of Type II body creation has remained consistent over the past sixty years. This suggests that the use of Type II bodies by government is not a recent phenomenon. Instead the evidence indicates that provincial governments in Canada have been using Type II bodies as a policy option consistently over the past sixty years. Chapter 4 yielded inconsistent support for the hypothesis that the lower the fiscal capacity of government the higher the rate of creation of Type II bodies with support being found largely in Alberta which exhibited a unique period of debt reduction. Support for the hypothesis that the further to the left-of-centre on the political spectrum a government sits the fewer the number of Type II bodies created was also inconsistent between provinces.

Building upon the results from Chapter 4, Chapter 6 looked again at the effect of fiscal capacity and political ideology on the use of authority migration to Type II bodies as a policy option by government. While Chapter 4 employed a quantitative methodology using a custom built dataset, Chapter 6 focused specifically on healthcare policy. The findings in Chapter 6 support the hypothesis that the lower the fiscal capacity of government the higher the rate higher rate of Type II body creation. In the case of healthcare reform, limited fiscal capacity to fulfill a growing demand for services was the underlying factor in each of the four provinces. How changes in healthcare were framed for the public, however, did not always align with the underlying fiscal challenges. Healthcare restructuring was frequently framed in terms of increased citizen participation and local decision-making. There is disagreement, however, as to whether greater citizen participation in decision-making has been realized (Collier, 2010: 331). As with Chapter 4, Chapter 6 yielded inconsistent support for the hypothesis that the further to the left-of-centre on the political spectrum a government sits the fewer the number of Type II bodies created.

While Chapters 4 and 6 focused on the migration of authority to Type II bodies, Chapters 5 and 7 explored the resulting accountability relationships that emerged. In Chapter 5, the

strength of the accountability relationship between the Type II bodies and both government and society were investigated. The results in Chapter 5 showed consistent support across all datasets for the hypothesis that the strength of the accountability relationship between government and Type II bodies has either increased or remained stable over time. Inconsistent support was found for the hypothesis that governing parties further to the left on the political spectrum produce stronger accountability relationships between Type II bodies and government than governing parties further to the right. No support was found for the hypothesis that the strength of the accountability relationship between government and Type II bodies will decrease as the geographic scale of the Type II body decreases. When looking at the direct accountability relationship between Type II bodies and society in Chapter 5 two hypotheses were tested: the accountability relationship between society and Type II bodies has increased in strength over time; and the accountability relationship between society and Type II bodies will increase as the geographic scale of the Type II body decreases. The results for each hypothesis were inconsistent.

Beyond evaluating the five hypotheses, the results in Chapter 5 revealed that of the two relationships, the accountability relationship between the government and Type II bodies has been and continues to be the dominant one. Based on the strength of each accountability relationship the results suggest that while there are increasing levels of societal-steering, the state remains the dominant actor in the governance structure.

Like Chapter 5, Chapter 7 evaluated the accountability relationships between Type II bodies and both government and society. Consistent with Chapter 5, the results from Chapter 7 show accountability relationships between Type II healthcare bodies and government to be the stronger of the two relationships. When interview responses are taken into account, however, the results suggest that practical accountability benefits can be gained from each accountability relationship. Results from Chapter 7 also suggest that while sufficient legislation and regulations exist to hold Type II healthcare bodies to account, concerns over a lack of role clarity and limited citizen knowledge caused participants to question the ability of the public to hold Type II healthcare bodies to account. In shifting authority to new governance bodies it is insufficient to build

accountability rules into the system; sufficient knowledge must also exist to make the accountability mechanisms meaningful. While the results suggest that government has the legislated tools to hold healthcare bodies to account, a gap exists between the powers to do so and public knowledge.

When the results of the previous four chapters are considered as a whole, we see that the use of Type II bodies in response to policy issues is not new, nor is it likely to change. Moreover, when faced with financial challenges, as in the case of healthcare policy, the horizontal migration of decision-making responsibility to Type II bodies remains a policy option for government. Given the continued use of Type II bodies as a policy option, public input and democratic accountability concerns must be taken seriously. The results from Chapter 5 suggest an overall strengthening of the indirect accountability relationship between the public and Type II bodies through government. When looking at the direct accountability relationship between society and Type II bodies, however, the Ontario case showed how possible accountability gains could be lost. Also, as demonstrated in Chapter 7, the existence of sufficient accountability mechanisms, either formal or informal, does not fully alleviate accountability concerns. Interview results from Chapter 7 show role clarity among the actors involved in healthcare as challenges to accountability. As decision-making authority shifts horizontally, there is the risk of camouflaging responsibility, which, coupled with insufficient knowledge at the citizen level, presents a challenge to public input and democratic accountability.

8.2 Implications

The first implication of the thesis findings is that the use of horizontal authority migration as a policy tool is not new. While the rate of increase has remained stable, the cumulative number Type II bodies have been increasing in Canadian provinces over the past 60 years.

In Chapter 1 the argument put forward was that the demand for governance had expanded beyond the capacity of the state to the point where governance requirements cannot be fulfilled without widespread delegation (Flinders, 2006: 223). As a result the modern state no longer monopolizes the governance process, and governments are subject to

negotiations with a wide range of public, semi-public, and private actors when engaged in policy formation (Sørensen and Torfing, 2007: 3-4). The consistent use of authority migration over the past sixty years, however, suggests that such concerns, if not misplaced, are not the reason behind the use of Type II bodies by provincial governments.

The second implication of the findings is that while the number of Type II bodies created by the provinces has increased, the rate of increase has not expanded under the weight of increased governance demand as predicted in the literature. Instead, the provinces of Alberta, British Columbia, Nova Scotia and Ontario have used Type II bodies consistently as a policy tool over the past 60 years. This suggests that the reason why governments continue to the use Type II bodies may need to be reconsidered. Because government alone holds the legislative ability to set the rules of governance (Bartle and Vass, 2007: 895; Rhodes, 2007: 1244; Bell and Hindmoor, 2009: 13) government also holds a unique level of control over Type II bodies. It may yield more interesting results to look at the policy environment from which Type II bodies emerged. For instance, perhaps the creation of Type II bodies by Canadian provinces are a mechanism through which governments of all political stripes are able to deflect some of the direct attention of the public in respect to certain policy issues.

In addition to increased governance demand, Chapter 1 also raised concerns that the dispersal of authority had reshaped the governance landscape and brought into question democratic input and accountability within the governance process (Peters and Pierre, 2006: 209). While the concern remains valid, the consistent use of authority migration over the past sixty years reminds us that threats to public input and democratic accountability are themselves not a modern phenomenon.

The third implication to be taken away from the quantitative results is that while the cumulative number of Type II bodies involved in public governance continues to expand, the increased strength of the accountability relationship between Type II bodies and government and Type II bodies and society has positive implications for public input and democratic accountability. As discussed in Chapter 2, three different accountability

arrangements may exist by which citizens can hold Type II bodies to account. First, society may act as principals with Type II bodies as agents where Type II bodies are directly accountable to society. Second, citizens may act as principals with democratically elected government as agents, who in turn act as principals of Type II bodies, making Type II bodies indirectly accountable to the citizens. Lastly, both accountability arrangements may exist. The results indicate the existence of both accountability arrangements, with citizens increasingly able to hold Type II bodies both directly and indirectly to account.

The quantitative results also show, however, that while overall there has been a trend toward the strengthening of both accountability relationships the potential exists for the accountability relationship to weaken. The Ontario case, where an increase in the strength of the society accountability relationship index emerged only to dissipate a decade later, reminds us that the current levels of public input and democratic accountability are not certain going forward. In addition to the lesson learned from Ontario, the mean government and society accountability index scores demonstrate the limitations in the existing legislated accountability relationships. For both indexes, the 1996 to 2005 time period provide the highest mean scores: 2.46 for the government accountability index and 1.50 the society accountability index. Both are well below the maximum accountability score of 3, suggesting that while the strength of the accountability relationships may be improving a full accountability relationship with both government and society is not legislated for a large number of Type II bodies.

In healthcare, while sufficient legislated rules exist to hold Type II healthcare bodies fully accountable to government in each of the four provinces studied, concerns over pubic input and democratic accountability were still raised by interview participants. Moreover, while no legal sanction mechanism exists, close to half the participants interviewed felt that society, through the use of informal sanctioning techniques, had the potential to hold Type II healthcare bodies to account. The larger implications, however, are that in shifting authority to new governance bodies it is not sufficient to build accountability rules into the system, or that citizens have access to informal mechanisms of accountability. Within the new governance environment sufficient knowledge must also

exist to ensure the accountability mechanisms are accessible, understandable, and meaningful to those who are impacted by decisions. In the case of healthcare, the results suggest a gap exists between availability of accountability mechanisms by which citizens could hold Type II healthcare bodies to account and the public knowledge required by citizens to make use of those mechanisms.

As discussed in Chapter 3 vertical multilevel governance can create difficulties for citizens in attributing policy decisions to policy actors. Such information challenges can be exacerbated by the actions of governments who engage in blame shifting and credit taking for policy outcomes as authority migrated vertically from one level of elected government to another (Anderson, 2006: 450; Cutler, 2004: 19; Hamilton, 1788). The informational challenges of citizens are further clouded as authority is migrated both horizontally and vertically. The risk to public input and democratic accountability is far greater as authority migrates horizontally. As the number of non-hierarchical governance relationships increase the greater the complexity of the accountability relationship between society and public decision-makers.

8.3 Future Directions

The focus of this work has been on the extent to which Canadian provinces have opted to migrate decision-making authority horizontally in response to policy issues and the effect of horizontal authority migration on public input and democratic authority migration. From the four provinces studied, the results suggest that governments have been relying upon the use of Type II governance bodies as solutions to policy challenges for more than the past sixty years. The findings also show that differences exist across the four provinces. Contextual differences between provinces resulted in differences in outcome. Given that the work to date has only looked at Canada, it may prove useful to incorporate additional countries within the same research framework. In doing so further consistencies and differences would be explored and a fuller picture of the use of Type II bodies beyond the Canadian context would be made available.

Beyond expanding upon the scope of the existing project a further line of inquiry is the explanation behind the expectation put forward in Chapter 3 that the rate of horizontal

authority migrating is increasing while the evidence shows that it has remained constant. The question as to why the difference between the expected and actual rates of Type II body creation remains unanswered. Multiple reasons for the disjuncture are possible including: the increased use of Type II bodies in policy areas that are of high importance to citizens and traditionally viewed as the sole jurisdiction of the state; the more visible use of private actors in service delivery; and/or the result of government stepping aside so that new areas of what may have been considered public life are now regulated by market mechanisms which have stepped in to fill the void. Regardless of the exact explanation, there is the opportunity to further explore the emerging governance arrangements and why reality has not played out as expected.

While understanding governance arrangements remains important, the consistent usage of horizontal authority migration as a public policy tool combined with the challenges associated with the existing accountability relationships lead to additional research questions. The results from Chapter 5 suggest that in a great number of instances the legislated accountability obligations do not fulfill all three elements of an accountability relationship as defined by Bovens: the obligation of the accountable party to explain and to justify his or her conduct; the ability to pose questions and pass judgement on the accountable party; and to sanction the accountable party (Bovens, 2007: 450). Moreover, even when sufficient accountability rules are legislated, as was the case in the relationship between government and Type II healthcare bodies as presented in Chapter 7, concerns exist over the ability to hold such bodies accountable. Given such accountability challenges, future research can be directed toward identifying factors that promote meaningful accountability. As outlined above, when decision-making authority migrates to new governance bodies it is not sufficient to build formal accountability rules within the legislative framework. An effort must be made to ensure that sufficient knowledge and capacity exist to make the accountability mechanisms workable.

In researching the knowledge required to hold Type II bodies to account, two paths of inquiry may be taken. One area to explore is what and how information is transmitted from Type II bodies to the public. For example, when researching healthcare there was concern that the information provided to the public was produced to fulfill government

reporting requirements and was of a technical nature. The underlying questions are whether there are sufficient communication obligations and whether the information provided by the Type II body to the public is in an accessible format.

A second area of exploration is the role of the media. Strong support existed for the media as an accountability mechanism, however, the results from Chapter 7 showed concern that the media was unable to live up to its idealized role when reporting on complex policy issues. In the case of healthcare, interview participants stated that there was a lack of depth when reporting on healthcare policy issues, a limited number of reporters with sufficient healthcare knowledge, and a disproportionally high focus on the negative in comparison to positive news stories.

8.4 Closing Thoughts

Regardless of whether the practice is old or new, the dispersal of decision-making authority horizontally to actors that exist beyond the reach of the ballot box challenges public input and accountability norms within the democratic governance process. Democratic theory holds elections as a vital mechanism of accountability, through which the policy preferences of the people can influence government action (Fearon, 1999: 57). If, in a representative democracy, accountability is the principal mechanism through which mass publics exert control over their elected officials (Rudolph, 2006: 99), thought must go into how we hold to account public decision-makers that are not elected. Schattschneider hypothesized that the result of political contests is determined by the scope of public involvement in conflicts (1975: 5). Schattschneider further asked if decisions made by government empowered external bodies are as public as those that occur within elected legislatures (1975: 65). The results from Chapter 7 suggest that they are not.

With the migration of authority outside of government making decision-making less public, how do we continue to make decision-makers accountable for acts of public governance? Two accountability relationships have been considered throughout the duration of this work - the relationship with government and the relationship with society. Of the two, results from Chapters 5 and 7 suggest that the indirect accountability

relationship through government has remained the stronger of the two. Overall, while citizens have gained capacity to directly hold Type II decision-makers to account, our elected representatives are able to exercise a unique accountability mechanism on our behalf, the ability to legislate. The question remains, however, how are we to ensure that actors *are* held to account. The answer to this seems to be tied to how public the decision-making process continues to be once authority has migrated. The more public the decision-making process, the wider the scope of the political contest and the stronger the democratic accountability.

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Appendix A: Accountability Mechanism Coding – Government/Society Relationship with Type II Bodies

Accountability Mechanism	Relationship	Accountability Component
Provincial government appoints board members	Government	Sanction
Provincial government can terminate board members	Government	Sanction
Provincial government appoints board chair	Government	Sanction
Provincial members of government named to the board	Government	Explanation/Justification Questioning/Judgment
Provincial members of government named to board as ex officio members		Explanation/Justification Questioning/Judgment
Members of provincial legislature named to the board	Government	Explanation/Justification Questioning/Judgment
Provincial public service positions named to the board	Government	Explanation/Justification Questioning/Judgment
Provincial public service positions named to board as ex officio members	Government	Explanation/Justification Questioning/Judgment
Other level of government appoints board members	Government	Sanction
Other level of government can terminate board members	Government	Sanction
Other level of government appoints board chair	Government	Sanction
Member of other level of government named to the board	Government	Explanation/Justification Questioning/Judgment
Member of other level of government named to board as ex officio member	Government	Explanation/Justification Questioning/Judgment
Special interest actor appoints or elects board members	Special Interest	Sanction

Accountability Mechanism	Relationship	Accountability Component
Special interest actor can terminate board members	Special Interest	Sanction
Special interest actor appoints board chair	Special Interest	Sanction
Public elects board members	Society	Sanction
Public can terminate board members	Society	Sanction
Public appoints board chair	Society	Sanction
Board members have a fixed appointment time	N/A	N/A
Provincial government is able to reappoint board members after term is completed	Government	Sanction
Type II body must submit an annual report to the provincial government	Government	Explanation/Justification
Type II body must submit an annual report to the provincial legislature	Government	Explanation/Justification
Government can request ad hoc reports from the Type II body	Government	Explanation/Justification
Type II body must submit an annual report to municipal government(s)	Government	Explanation/Justification
Type II body subject to having its accounts audited by provincial auditor or external auditor appointed by provincial auditor	Government	Questioning/Judgment
Type II body subject to having its accounts audited by a municipal auditor	Government	Questioning/Judgment
Type II body subject to having its accounts audited by the Auditor General of Canada	Government	Questioning/Judgment

Accountability Mechanism	Relationship	Accountability Component
Type II body subject to audit by ministry officials or ministry approved auditor	Government	Questioning/Judgment
Audited financial reports sent to provincial government	Government	Questioning/Judgment
Audited financial reports submitted to provincial legislature	Government	Questioning/Judgment
Audited financial reports sent to municipal government	Government	Questioning/Judgment
Provincial government funds Type II body based on performance standards	Government	Sanction
Provincial government appoints members of an overseeing or review body	Government	Explanation/Justification Questioning/Judgment
Provincial government has the power to transfer Type II bodies power to an alternate entity	Government	Sanction
Mechanism by which public complaints against actors under jurisdiction of the Type II body are heard and investigated	Society	Questioning/Judgment
Formal process by which the public can appeal the decisions of the Type II body	Society	Questioning/Judgment
Formal process by which provincial government can appeal the decisions of the Type II body	Government	Questioning/Judgment
Type II body required to hold public consultations prior to making policy decisions	Society	Explanation/Justification Questioning/Judgment
Public may force the dissolution of a Type II body by petition or other action	Society	Sanction

Accountability Mechanism	Relationship	Accountability Component
Municipal government may withdraw from a Type II body	Government	Sanction
Type II body reports must be publically read or published	Society	Explanation/Justification
Type II body must hold an annual ratepayers meeting	Society	Explanation/Justification Questioning/Judgment
Annual general meeting (members only)	Special Interest	Explanation/Justification Questioning/Judgment
Public meeting can be initiated by the public	Society	Explanation/Justification Questioning/Judgment
Type II body committee members are elected by the public	Society	Sanction
Type II body or government appoints citizens committee positions	Society	Explanation/Justification Questioning/Judgment
Type II body board meetings are open to the public	Society	Explanation/Justification Questioning/Judgment
Type II body board meeting minutes are open to the public	Society	Explanation/Justification
Type II body board meeting minutes are sent to the provincial government	Government	Explanation/Justification
Type II body accountability agreement required by government	Government	Sanction
Type II body budget (or aspects of it) must be approved by government	Government	Sanction
Formal process exists by which government may block decisions made by the Type II body	Government	Sanction
A service plan or memorandum of understanding is required between Type II body and government	Government	Explanation/Justification Questioning/Judgment Sanction

Appendix B: Type II Bodies

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	ABC Benefits Corporation	ABC Benefits Corporation Act	1996	
Alberta	Agricultural Products Marketing Council	The Marketing of Agricultural Products Act	1965	
Alberta	Agricultural Relief Adjustment Board	Municipal Government Act		1994
Alberta	Agriculture Financial Services Corporation	Agriculture Financial Services Act	1963	
Alberta	Alberta Agricultural Research Institute	Alberta Science and Research Authority Act	1970	2000
Alberta	Alberta Alcoholism and Drug Abuse Commission	Alberta Alcoholism and Drug Abuse Commission	1970	
Alberta	Alberta Apprenticeship and Industry Training Board	Apprenticeship and Industry Training	1991	
Alberta	Alberta Art Foundation	Alberta Foundation for the Arts	1972	1991
Alberta	Alberta Assessment Equalization Board	The Municipalities Assessment and Equalization Act	1957	1994
Alberta	Alberta Association of Architects	The Alberta Architects Act		
Alberta	Alberta Association of Dental Technicians	Health Professionals Act	1961	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Alberta Association of Midwives	Health Professionals Act	2001	
Alberta	Alberta Association of Registered Nurses	Health Professionals Act		
Alberta	Alberta Association of Registered Occupational Therapists	Health Professionals Act	1987	
Alberta	Alberta Association of Registered Social Workers	Health Professionals Act	1969	
Alberta	Alberta Cancer Foundation	Alberta Cancer Foundation Act	1984	
Alberta	Alberta Chiropractic Association	Health Professionals Act		
Alberta	Alberta Colleges Commission	The College Act	1969	1973
Alberta	Alberta Cultural Heritage Foundation	Alberta Cultural Heritage Act	1984	1987
Alberta	Alberta Dairy Control Board (Formerly Milk Control Board)	The Dairy Industry Act	1969	1999
Alberta	Alberta Dental Association	Health Professionals Act		
Alberta	Alberta Drama Board	The Cultural Development Act	1946	1966
Alberta	The Alberta Educational Communications Corporation	Alberta Educational Communications Corporation Act	1973	1996

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Alberta Electric Energy Marketing Agency	Electric Energy Marketing Act	1981	1997
Alberta	Alberta Energy and Utilities Board	Alberta Energy and Utilities Board Act	1994	
Alberta	Alberta Environmental Research Trust	Alberta Environmental Research Trust Act	1971	1995
Alberta	Alberta Foundation for the Arts	Alberta Foundation for the Arts Act	1991	
Alberta	Alberta Foundation for University Research and Education in Alcoholism and Drug Abuse	Alcoholism and Drug Abuse Foundation Act	1972	1993
Alberta	Alberta Gaming and Liquor Commission	Gaming and Liquor Act		
Alberta	The Alberta Hail and Crop Insurance Corporation	Agriculture Financial Services Act		1993
Alberta	Alberta Handicraft Board	The Cultural Development Act	1946	1966
Alberta	Alberta Health Care Insurance Commission	Department of Hospitals and Medicare Act	1969	1977
Alberta	Alberta Heritage Foundation for Medical Research	Alberta Heritage Foundation For Medical Research Act	1979	
Alberta	Alberta Heritage Foundation for Science and Engineering Research	Alberta Heritage Foundation for Science and Engineering Research Act	2000	
Alberta	Alberta Hospital Districts	Hospitals Act		1996

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Alberta Industrial Corporation	Business Development	1946	1972
Alberta	Alberta Institute of Agrologists	The Agrologists Act	1947	
Alberta	Alberta Land Survivors' Association	Land Surveyors Act		
Alberta	Alberta Library Board	The Cultural Development Act	1946	1966
Alberta	Alberta Library Board	Libraries Act	1983	1998
Alberta	Alberta Mortgage and Housing Corporation	Alberta Mortgage and Housing Corporation Act	1970	1984
Alberta	Alberta Motor Transportation Safety Board	Traffic Safety Act	1977	
Alberta	Alberta Municipal Financing Corporation	The Alberta Municipal Financing Corporation Act	1956	
Alberta	Alberta Music Board	The Cultural Development Act	1946	1966
Alberta	Alberta Oil Sands Technology and Research Authority	Alberta Science and Research Authority Act	1974	2000
Alberta	Alberta Opportunity Company	Agriculture Financial Services Act		2002
Alberta	Alberta Opticians Association	Health Professionals Act	1965	
Alberta	The Alberta Optometric Association	Health Professionals Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Alberta Petroleum Marketing Commission	Petroleum Marketing Act	1973	
Alberta	Alberta Pharmaceutical Association	Health Professionals Act		
Alberta	Alberta Physical Recreation Board	The Cultural Development Act	1946	1966
Alberta	Alberta Podiatry Association	The Podiatry Act	1952	
Alberta	Alberta Power Commission	Hydro and Electric Energy Act		1971
Alberta	Alberta Racing Corporation	Horse Racing Commission Act	1962	
Alberta	The Alberta Registered Dietitians Association	Health Professionals Act	1959	
Alberta	Alberta Registered Professional Foresters Association	Forest Professionals Act	1985	
Alberta	Alberta Science and Research Authority	Alberta Science, Research and Technology Authority Act		
Alberta	Alberta Securities Commission	Securities Act	1967	
Alberta	Alberta Teachers' Association	The Teaching Profession Act		
Alberta	Alberta Tourism Education Council	Tourism Education Council Act	1988	1996
Alberta	The Alberta Veterinary Medical Association	Veterinary Profession Act	1953	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Alberta Visual Arts Board	The Cultural Development Act	1946	1966
Alberta	Ambulance Advisory and Appeal Board	Ambulance Services Act	1990	
Alberta	The Association of Professional Engineers, Geologists and Geophysicists of Alberta	The Engineering, Geological & Geophysical Professions Ac	1955	
Alberta	Board of Administrators of the Teachers Retirement Fund	Teachers' Pension Plans Act		
Alberta	Board of Reference	School Act	1988	
Alberta	Board of Trustees for each school district	The School Act		
Alberta	Calgary Municipal Heritage Property Authority	Calgary Municipal Heritage Property Authority	1984	
Alberta	The Calgary Research and Development Authority	The Calgary Research and Development Authority Act	1981	
Alberta	Certified General Accountant Association of Alberta	Regulated Accounting Profession Act	1984	
Alberta	Child and Family Services Authority	Child and Family Services Authorities	1996	
Alberta	College Boards (Public Colleges)	The College Act	1969	1973

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	College of Acupuncturists of Alberta	Health Professionals Act	1999	
Alberta	College of Physicians and Surgeons of the Province of Alberta	The Medical Profession Act		
Alberta	Combined Laboratory and X-ray Technicians	Health Professionals Act	2005	
Alberta	Community Library Boards	Libraries Act	1948	
Alberta	Consulting Engineers of Alberta	Consulting Engineers of Alberta Act	1992	
Alberta	Council of the Society of the Management Accountants of Alberta	Regulated Accounting Profession Act		
Alberta	The Crimes Compensation Board	The Criminal Injuries Compensation Act	1969	1996
Alberta	Debtors' Assistance Board	The Debtors' Assistance Act		
Alberta	Dental Assistants Association	Health Professionals Act	1990	
Alberta	Dental Hygienist Association	Health Professionals Act	1990	
Alberta	The Disabled Persons Act (Creation of body specified in legislation	Assured Income for the Severely Handicapped Act	1955	1979
Alberta	The Disabled Persons' Pension Act (Creation of Board Specified)	Assured Income for the Severely Handicapped Act	1952	1979

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	District Ambulance Boards	Ambulance Services Act	1990	
Alberta	Drainage District Boards	The Drainage Districts Act		
Alberta	Eastern Rockies Forest Conservation Board	The Forest Reserves Act	1955	1976
Alberta	Edmonton Convention and Tourism Authority	Edmonton Convention and Tourism Authority	1982	1993
Alberta	Edmonton Economic Development Authority	Edmonton Economic Development Authority	1982	
Alberta	Edmonton Research and Development Park Authority	Edmonton Research and Development Park Authority Act	1980	
Alberta	The Education of Service Men's Children	The Education of Service Men's Children Act	1946	1997
Alberta	Energy Resources Conservation Board	Energy Resources Conservation Act Hydro and Electric Energy Act		
Alberta	Geographic Board of Alberta	The Alberta Heritage Amendment Act	1949	1974
Alberta	Hazardous Chemical Advisory Committee	Environmental Protection Act	1978	1992
Alberta	Health Occupations Board	Health Occupations Act	1980	1986
Alberta	Health Unit Board	Public Health Act	1951	1994
Alberta	Hearing Aid Practitioners	Health Professionals Act	2002	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Horse Racing Appeal Tribunal	Horse Racing Commission Act	2002	
Alberta	Institute of the Chartered Accountants of Alberta	Regulated Accounting Profession Act		
Alberta	Irrigation Council	Irrigation Districts Act		
British Columbia	Labour Relations Board	Labour Relations Code	1947	
Alberta	Land Compensation Board	Expropriation Act	1974	
Albert	Law Enforcement Review Board	Police Act	1973	
Alberta	Law Society of Alberta	The Legal Profession Act		
Alberta	Library System Boards	Libraries Act	1948	
Alberta	Licensed Practical Nurses Profession	Health Professionals Act	2003	
Alberta	The Local Authorities Board	The Local Authorities Board Act	1961	1994
Alberta	M.S.I. Foundation	M.S.I. Foundation Act	1970	
Alberta	Medical Laboratory Technologists	Health Professionals Act	2001	
Alberta	Medical Radiological Technicians Board	Radiation Protection Act	1963	1985
Alberta	Municipal Government Board	Municipal Government Act	1994	
Alberta	Municipal Library Boards	Libraries Act	1948	
Alberta	Municipal Police	Police Act	1973	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
	Commission			
Alberta	Natural Resources Conservation Board	Natural Resources Conservation Board Act	1990	
Alberta	Naturopathic Association of Alberta	The Naturopathy Repeal Act	1948	1986
Alberta	Persons with Developmental Disabilities Foundation	Persons with Developmental Disabilities Foundation Act	1996	
Alberta	Physical Therapy Profession Act	College of Physical Therapists of Alberta		
Alberta	Private Colleges Accreditation Board	Post-Secondary Learning Act	1983	2003
Alberta	Profession of Denturists	Health Professionals Act	1961	
Alberta	Provincial Cancer Hospitals Board	Cancer Programs Act	1967	
Alberta	Provincial General Hospital Boards	The Provincial General Hospitals Act	1959	1995
Alberta	Provincial Universities. Board of Governors	The Universities Act		1973
Alberta	Psychiatric Nurses Association	The Psychiatric Nurses Association Act	1963	1986
Alberta	Psychologists Association of Alberta	Health Professionals Act	1967	
Alberta	Public Health Advisory and Appeal Board	Public Health Act	1984	
Alberta	Public Utilities Board	The Public Utilities Board Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	Real Estate Council of Alberta	Alberta Real Estate Act	1995	
Alberta	The Recreation, Parks and Wildlife Foundation	Recreation, Parks and Wildlife Foundation Act	1976	
Alberta	Regional Airport Authorities	Regional Airport Authorities Act	1989	
Alberta	Regional Health Authorities	Regional Health Authorities Act	1994	
Alberta	Regional Health Foundations	Regional Health Foundations Act	1996	2003
Alberta	Regional Service Commissions	Municipal Government Act	1994	
Alberta	Registered Music Teachers' Association Repeal Act	The Alberta Registered Music Teachers Association	1947	1983
Alberta	School Buildings Board	The School Act	1952	2001
Alberta	Small Producers Assistance Commission	Small Producers Assistance Commission	1987	1989
Alberta	Speech-Language Pathologists	Health Professionals Act	2002	
Alberta	Students Finance Board	Students Finance Act	1953	1998
Alberta	Surface Reclamation Council	Land Surface Conservation and Reclamation Act	1963	1973
Alberta	Surface Rights Board	Surface Rights Act	1952	
Alberta	The Assessment Appeal Board	Municipal Government Act		1994

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Alberta	The Old Age Assistance Act (Board not named in the Act)	The Old Age Assistance Act	1952	1976
Alberta	Sexual Sterilization Act (Board appointed under the Act)	The Sexual Sterilization Act		1972
Alberta	Universities Co-ordinating Council	The Universities Act	1964	
Alberta	Universities Commission	The Universities Act	1964	1973
Alberta	Widows' Pension Act (Board not named in Act)	The Widows' Pension Act	1952	1967
Alberta	Wild Rose Foundation	Wild Rose Foundation Act	1984	
Alberta	Workman's Compensation Board	The Workman's Compensation Act		
British Columbia	Alcohol and Drug Commission	Alcohol and Drug Commission Act	1973	
British Columbia	Applied Science Technologists and Technicians of British Columbia	Applied Science Technologists and Technicians Act	1985	
British Columbia	Architectural Institute of British Columbia	British Columbia		
British Columbia	Arts Council of British Columbia	Arts Council Act	1995	
British Columbia	Association of British Columbia Foresters	Foresters Act	1947	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	The Association of Professional Engineers and Geoscientists of the Province of British Columbia	Engineers and Geoscientists Act		
British Columbia	The Barbers Association of British Columbia	Barbers Act		2003
British Columbia	BC Ferry Authority	Coastal Ferry Act	1976	
British Columbia	Blind Persons' Allowance Board	Blind Persons' Allowances Act	1951	1980
British Columbia	Board of Brand Commissioners	Livestock Brands Act (1979)		1997
British Columbia	Board of Eugenics	Sexual Sterilization Act		1973
British Columbia	Board of Governors	University Act		
British Columbia	Board of Hearing Aid Dealers and Consultants	Hearing Aid Act	1971	2002
British Columbia	Board of Industrial Relations	Male Minimum Wage Act (Employment Standards Act)		1983
British Columbia	Board of School Trustees	School Act		
British Columbia	British Columbia Assessment Authority	Assessment Authority Act	1974	
British Columbia	British Columbia Broiler Hatching Egg Commission	Natural Products Marketing (British Columbia) Act	2004	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	British Columbia Buildings Corporation	Public Agency Accommodation Act	1976	2006
British Columbia	British Columbia Chicken Marketing Board	Natural Products Marketing (British Columbia) Act	1961	
British Columbia	British Columbia College of Social Workers	Social Workers Act	1968	
British Columbia	British Columbia Cranberry Marketing Commission	Natural Products Marketing (British Columbia) Act	1968	
British Columbia	British Columbia Dyking Authority	Dyking Authority Act	1965	1999
British Columbia	British Columbia Egg Marketing Board	Natural Products Marketing (British Columbia) Act	1967	
British Columbia	British Columbia Energy Commission	Energy Act	1973	1980
British Columbia	British Columbia Harbours Board	Harbour Board Act	1967	1983
British Columbia	British Columbia Heritage Trust	Heritage Conservation Act	1977	
British Columbia	British Columbia Human Rights Tribunal	Human Rights Act	1984	
British Columbia	British Columbia Hydro and Power Authority	Hydro and Power Authority Act		
British Columbia	British Columbia Institute of Argologists	Agrologists Act	1947	
British Columbia	British Columbia Milk Marketing Board	Natural Products Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	British Columbia Petroleum Corporation	Petroleum Corporation Act	1973	1994
British Columbia	British Columbia Police Commission	Police Act	1974	1997
British Columbia	British Columbia Racing Commission	Gaming Control Act	1959	2003
British Columbia	British Columbia Safety Authority	Safety Authority Act	2003	
British Columbia	British Columbia Society of Landscape Architects	Architects (Landscape) Act	1968	
British Columbia	British Columbia Systems Corporation	System Act	1977	1998
British Columbia	British Columbia Turkey Marketing Board	Natural Products Marketing (British Columbia) Act	1966	
British Columbia	British Columbia Utilities Commission	British Columbia Utilities Commission	1980	
British Columbia	British Columbia Vegetable Marketing Commission	Natural Products Marketing (British Columbia) Act	1980	
British Columbia	Building Officials Association	Building Officials Association Act	1997	
British Columbia	Bull Control Committee	Animals Act		
British Columbia	Business Practice and Consumer Protection Authority	Business Practice and Consumer Protection Authority Act	2004	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Cattle Industry Development Council	Farming and Fishing Industries Development Act	1973	
British Columbia	Certified General Accountants' Association of British Columbia	Certified General Accountants Act	1951	
British Columbia	Child and Family Review Board	Child, Family and Community Services Act	1994	
British Columbia	Children's Aid Societies	Child, Family and Community Services	1943	1994
British Columbia	Coal and Petroleum Products Control Board	Coal and Petroleum Products Control Board		1953
British Columbia	College of Applied Biology	College of Applied Biology Act	2002	
British Columbia	College of Chiropractors of British Columbia	Health Professions Act		
British Columbia	College of Dental Hygienists of British Columbia	Health Professions Act	1994	
British Columbia	College of Dental Surgeons	Health Professions Act		
British Columbia	College of Dental Technicians of British Columbia	Health Professions Act	1958	
British Columbia	College of Denturists of British Columbia	Health Professions Act	2000	
British Columbia	College of Dietitians of British Columbia	Health Professions Act	2002	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	College of Message Therapists of British Columbia	Health Professions Act	1994	
British Columbia	College of Midwives of British Columbia	Health Professions Act	1995	
British Columbia	College of Naturopathic Physicians	Health Professions Act		
British Columbia	College of Occupational Therapists of British Columbia	Health Professions Act	1998	
British Columbia	College of Opticians	Health Professions Act	1994	
British Columbia	College of Optometrists of British Columbia	Health Professions Act		
British Columbia	College of Pharmacists	Health Professions Act		
British Columbia	College of Physical Therapists of British Columbia	Health Professions Act	1946	
Nova Scotia	College of Physicians and Surgeons of Nova Scotia	Medical Act		
British Columbia	College of Podiatric Surgeons of British Columbia	Health Professions Act		
British Columbia	College of Practical Nurses of British Columbia	Health Professions Act	1951	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	College of Psychologists of British Columbia	Health Professions Act	1977	
British Columbia	College of Registered Nurses of British Columbia	Health Professions Act		
British Columbia	College of Registered Psychiatric Nurses of British Columbia	Health Professions Act	1951	
British Columbia	College of Speech and Hearing Health Professionals of British Columbia	Health Professions Act	2008	
British Columbia	College of Teachers	Teaching Professionals Act	1987	
British Columbia	College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia	Health Professions Act	2000	
British Columbia	Columbia Basin Trust	Columbia Basin Trust Act	1995	
British Columbia	Commission for the Education of Soldiers' Dependent Children	Education of Soldiers Dependent Children Act		1973
British Columbia	Community Living Authority	Community Living Authority Act	2004	
British Columbia	Community Resources Board	BC Benefits (Income Assistance) Act	1974	1996
British Columbia	Corporation of Land Surveyors	Land Surveyors Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Disabled Persons' Allowance Board	Disabled Persons' Allowance Act	1954	1980
British Columbia	Drainage and Dyking Districts	Drainage, Dyking and Development Act		
British Columbia	Emergency Health Services Commission	Emergency and Health Services Act	1974	
British Columbia	Emergency Medical Assistants Licensing Board	Emergency and Health Services Act	1974	
British Columbia	Employment Standards Tribunal	Employment Standards Act	1995	
British Columbia	Environmental Appeal Board	Environmental Management Act	1981	
British Columbia	Farm Industry Review Board	Natural Products Marketing (British Columbia) Act		
British Columbia	Fence Viewers	Line Fences Act		1971
British Columbia	Financial Institutions Commission	Financial Institutions Act	1989	
British Columbia	Forest Appeals Commission	Forest Practices Code of British Columbia Act	1994	
British Columbia	Gaming Control Act	Lottery Corporation Act	1985	
British Columbia	Grasshopper-control Committees	Grasshopper-control Act		1998
British Columbia	The Hairdressers Association of British Columbia	Hairdressers Act		2003

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Health Insurance Commission	Health Insurance Act		1973
British Columbia	Health Professionals Review Board	Health Professions Act	1990	
British Columbia	Improvement District	Water Act		
British Columbia	Industry Training Authority	Industry Training Authority Act	1977	
British Columbia	Institute of Chartered Accountants of British Columbia	Chartered Accountants Act		
British Columbia	Insurance Corporation of British Columbia	Insurance Corporation Act	1973	
British Columbia	Insurance Council of British Columbia	Financial Institution Act	1969	
British Columbia	Land Settlement Board	Land Settlement and Development Act		1968
British Columbia	Land Title and Survey Authority of British Columbia	Land Title and Survey Authority Act	2004	
British Columbia	Law Society of British Columbia	Legal Professions Act		
British Columbia	Legal Services Society	Legal Services Society Act	1975	
British Columbia	Liquor Control Board	Liquor Control and Licensing Act		1977
British Columbia	Medical Services Commission	Medical Protection Act	1967	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Municipal Finance Authority	Municipal Finance Authority Act	1970	
British Columbia	Municipal Police Boards	Police Act	1974	
British Columbia	Municipal Public Libraries' Public Library Board	Libraries Act		
British Columbia	Ocean Falls Corporation	Ocean Falls Corporation Act	1973	1986
British Columbia	Oil and Gas Commission	Oil and Gas Commission Act	1998	
British Columbia	Old-age Assistance Board	Old-Age Assistance Act	1951	1980
British Columbia	Passenger Transportation Board	Passenger Transportation Act	2004	
British Columbia	Pesticide Control Appeal Board	Integrated Pest Management Act	1977	2003
British Columbia	Pollution Control Board	Pollution Control Board	1956	1981
British Columbia	Property Assessment Appeal Board	Assessment Act	1953	
British Columbia	Provincial Adult Care Facilities Licensing Board	Community Care and Assisted Living Act	1969	2002
British Columbia	Provincial Agricultural Land Commission	Agricultural Land Commission Act	1973	
British Columbia	Provincial Capital Commission	Capital Commission Act	1956	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Provincial Child Care Facilities Licensing Board	Community Care and Assisted Living Act	1969	2002
British Columbia	Provincial Council of British Columbia Music Teachers Association	Registered Music Teachers Act	1947	
British Columbia	Public Library Associations	Public Libraries Act		
British Columbia	Public Library Commission	Public Libraries Act		1978
British Columbia	Public Utilities Commission	Public Utilities Act		1973
British Columbia	Real Estate Council	Real Estate Services Act	1958	
British Columbia	Real Estate Foundation	Real Estate Act	1985	
British Columbia	Regional Health Boards	Health Authorities Act	1993	
British Columbia	Rent Review Commission	Residential Tenancy Act	1977	1984
British Columbia	Royal British Columbia Museum	Museum Act	2003	
British Columbia	Securities Commission	Securities Act	1962	
British Columbia	Seed-control Committee	Seed-growers' Protection Act		2003
British Columbia	Society for the Prevention of Cruelty to Animals	Society for the Prevention of Cruelty to Animals Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
British Columbia	Society of Management Accountants	Accountants (Management) Act		
British Columbia	South Cost British Columbia Transportation Authority	South Coast British Columbia Transportation Authority	1998	
British Columbia	Steam-boiler Inspection Committee	Boiler and Pressure Vessel Act		1949
British Columbia	Surface Rights Board	Petroleum and Natural Gas Act	1954	
British Columbia	Trade and Development Corporation	Development Corporation Act	1973	2007
British Columbia	Travel Assurance Board	Business Practice and Consumer Protection Authority Act	1977	2004
British Columbia	Universities Council	University Act	1974	1987
British Columbia	Urban Transit Authority of British Columbia	British Columbia Transit Act	1979	
British Columbia	Veterinary Association of British Columbia	Veterinary Act		
British Columbia	Workmen's Compensation Board	Workmen's Compensation Act		
Nova Scotia	Advisory Council on the Status of Women	Advisory Council on the Status of Women Act	1977	
Nova Scotia	Agricultural Marshland Conservation Commission	The Agricultural Marshlands Conservation Act	2000	
Nova Scotia	Art Council of Nova Scotia	Art Council Act	1995	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Art Gallery of Nova Scotia	Art Gallery of Nova Scotia Act	1775	
Nova Scotia	Association of Interior Designers of Nova Scotia	Interior Designers Act	1990	
Nova Scotia	Association of Nova Scotia Land Surveyors	Land Surveyors Act		
Nova Scotia	Association of Professional Engineers of the Province of Nova Scotia	Engineering Profession Act		
Nova Scotia	Association of Professional Geoscientists of Nova Scotia	Geoscience Profession Act	2002	
Nova Scotia	Atlantic Institute of Education	Atlantic Institute of Education Act	1969	
Nova Scotia	Atlantic Provinces Special Education Authority	Handicapped Persons' Education Ac	1960	
Nova Scotia	Bedford Waterfront Development Corporation	Bedford Waterfront Development Corporation Act	1983	
Nova Scotia	Board of Commissioners of Public Utilities	Public Utilities Act		1992
Nova Scotia	Board of Dispensing Opticians	Dispensing Opticians Act	1968	
Nova Scotia	Board of Examiners for Scalers	Scalers Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Board of Examiners for Stationary Engineers	Stationary Engineers Act	1980	
Nova Scotia	Boards of Health	Health Act		2004
Nova Scotia	Board of Registration of Embalmers and Funeral Directors	Embalmers and Funeral Directors Act	1955	
Nova Scotia	Canada-Nova Scotia Offshore Petroleum Board	Canada-Nova Scotia Offshore Petroleum Resources Accord Implementation Act	1987	
Nova Scotia	Canadian Information Processing Society of Nova Scotia	Canadian Information Processing Society of Nova Scotia Act	2002	
Nova Scotia	Cancer Treatment and Research Foundation of Nova Scotia	Cancer Treatment and Research Foundation	1980	
Nova Scotia	Certified Engineering Technicians and Technologists of Nova Scotia	Applied Science Technology Act	1999	
Nova Scotia	Certified General Accountants	Certified General Accountants Act	1998	
Nova Scotia	Clean Nova Scotia Foundation	Clean Nova Scotia Foundation Act	1988	
Nova Scotia	College of Licensed Practical Nurses of Nova Scotia	Licensed Practical Nurses Act	1988	
Nova Scotia	College of Paramedics of Nova Scotia	Paramedics Act	2005	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	College of Registered Nurses of Nova Scotia	Registered Nurses Act		
Nova Scotia	Cosmetology Association of Nova Scotia	Cosmetology Act	1962	
Nova Scotia	County Health Boards	Public Health Act		1962
Nova Scotia	Criminal Injuries Compensation Board	Compensation for Victims of Crime Act	1975	
Nova Scotia	Cultural Foundation	Cultural Foundation Act	1978	
Nova Scotia	Cumberland Development Authority	Regional Community Development Act	1988	1996
Nova Scotia	Denturist Licensing Board	Denturist Act	1973	
Nova Scotia	District Health Authorities	Health Authorities Act	2000	
Nova Scotia	Drug Dependency Foundation	Drug Dependency Foundation Act	1959	
Nova Scotia	Energy and Mineral Recourses Conservation Board	Energy Conservation Act	1980	2001
Nova Scotia	Family Benefits Review Board	Family Benefits Act	1977	2000
Nova Scotia	Farm Practices Board	Farm Practices Act	2000	
Nova Scotia	Film Nova Scotia	Film Nova Scotia	1990	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Fire Protection Districts	Rural Fire Districts Act	1963	
Nova Scotia	Forest Practice Improvement Board	Forest Enhancement Act	1965	1986
Nova Scotia	Foresters Association	Foresters Association Act	1999	
Nova Scotia	Halifax-Dartmouth Port Development Commission	Halifax-Dartmouth Port Development Commission	1984	
Nova Scotia	Health Research Foundation	Health Research Foundation Act	1998	
Nova Scotia	Health Services and Insurance Commission	Health Services Insurance Act	1958	
Nova Scotia	Institute of Chartered Accountants of Nova Scotia	Chartered Accountants Act		
Nova Scotia	Labour Relations Board of Nova Scotia	Trade Union Act		
Nova Scotia	Licensed Professional Planners Association of Nova Scotia	Professional Planners Act	2005	
Nova Scotia	Liquor License Board	Liquor Control Act	1961	2001
Nova Scotia	Louisbourg District Planning and Development Commission	Louisbourg District Planning and Development Commission	1963	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Maritime Provinces Harness Racing Commission	Maritime Provinces Harness Racing Commission Act	1946	
Nova Scotia	Maritime Provinces Higher Education Commission	Maritime Provinces Higher Education Commission Act	2004	
Nova Scotia	Marsh Body	The Agricultural Marshlands Conservation Act	1949	
Nova Scotia	Marshland Reclamation Commission	The Agricultural Marshlands Conservation Act	1949	2000
Nova Scotia	Municipal Board of Police Commissioners	Police Act	1974	
Nova Scotia	Nova Scotia Association of Architects	Architects Act		
Nova Scotia	Nova Scotia Association of Occupational Therapists	Occupational Therapists Act	1970	
Nova Scotia	Nova Scotia Association of Physiotherapists	Physiotherapy Act	1958	
Nova Scotia	Nova Scotia Association of Real Estate Appraisers	Real Estate Appraisers Act	1998	
Nova Scotia	Nova Scotia Association of Social Workers	Social Workers Act	1963	
Nova Scotia	Nova Scotia Barristers' Society	Legal Profession Act		
Nova Scotia	Nova Scotia Board of Censors	Theatres and Amusements Act		2000

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Nova Scotia Board of Examiners in Psychology	Psychologists Act	1980	
Nova Scotia	Nova Scotia Boxing Authority	Boxing Authority Act	1973	
Nova Scotia	Nova Scotia Business Incorporated	Nova Scotia Business Incorporated Act	1986	2000
Nova Scotia	Nova Scotia Chiropractic Association	Chiropractic Act	1972	
Nova Scotia	Nova Scotia College of Medical Laboratory Technologists	Medical Laboratory Technologists Act	2000	
Nova Scotia	Nova Scotia Crop and Livestock Insurance Commission	Crop and Livestock Insurance Act	1968	
Nova Scotia	Nova Scotia Dairy Commission	Dairy Industry Act	1967	2000
Nova Scotia	Nova Scotia Dental Technicians Association	Dental Technicians Act	1965	
Nova Scotia	Nova Scotia Dietitian Association	Professional Dietitians Act	1973	
Nova Scotia	Nova Scotia Economic Council	Economic Council Act		
Nova Scotia	Nova Scotia Environmental Assessment Board	Environment Act	1994	
Nova Scotia	Nova Scotia Farm Loans Board	Agriculture and Rural Credit Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Nova Scotia Fisheries and Aquaculture Loan Board	Fisheries and Coastal Resources Act		
Nova Scotia	Nova Scotia Gaming Control Commission	Gaming Control Act	1994	
Nova Scotia	Nova Scotia Gaming Corporation	Gaming Control Act	1994	
Nova Scotia	Nova Scotia Housing Commission	Housing Act		1983
Nova Scotia	Nova Scotia Human Rights Commission	Human Rights Commission Act	1967	
Nova Scotia	Nova Scotia Innovation Corporation	Innovation Corporation Act	1994	
Nova Scotia	Nova Scotia Institute of Agrologists	Agrologists Act	1953	
Nova Scotia	Nova Scotia Legal Aid Commission	Legal Aid Act	1977	
Nova Scotia	Nova Scotia Liquor Corporation	Liquor Control Act		
Nova Scotia	Nova Scotia Lottery Commission	Gaming Control Act	1976	1994
Nova Scotia	Nova Scotia Municipal Board	Utility and Review Board Act	1981	1992
Nova Scotia	Nova Scotia Municipal Finance Corporation	Municipal Finance Corporation Act	1979	
Nova Scotia	Nova Scotia Museum of Science	Nova Scotia Museum Act	1947	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Nova Scotia Optometrical Association	Optometry Act		
Nova Scotia	Nova Scotia Pharmaceutical Society	Pharmacy Act		
Nova Scotia	Nova Scotia Police Commission	Police Act	1974	2004
Nova Scotia	Nova Scotia Police Review Board	Police Act	1985	
Nova Scotia	Nova Scotia Power Finance Corporation Act	Nova Scotia Power Finance Corporation Act		
Nova Scotia	Nova Scotia Primary Forest Products Marketing Board	Primary Forest Products Marketing	1972	
Nova Scotia	Nova Scotia Registered Barbers Association	Registered Barbers Act		
Nova Scotia	Nova Scotia Resources Development Board	Business Capital Corporation Act	1971	1986
Nova Scotia	Nova Scotia Securities Commission	Securities Act	1987	
Nova Scotia	Nova Scotia Society of Radiological Technicians	Medical Radiological Technicians Act	1965	
Nova Scotia	Nova Scotia Veterinary Association	Veterinary Medical Act		
Nova Scotia	Nova Scotia Water Authority	Water Act	1963	1972
Nova Scotia	Pay Equity Commission	Pay Equity Act	1988	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Prescription Monitoring Board	Prescription Monitoring Act	2004	
Nova Scotia	Provincial Apprenticeship Board	Apprenticeship and Trades Qualifications Act	1988	
Nova Scotia	Provincial Community Pastures Board	Agriculture and Marketing Act	1957	2004
Nova Scotia	Provincial Dental Board	Dental Act		
Nova Scotia	Provincial Grain Commission	Provincial Grain Commission Act	1977	
Nova Scotia	Public Accountants Board of Nova Scotia	Public Accountants Act	1952	
Nova Scotia	Regional Health Boards	Regional Health Boards	1993	2000
Nova Scotia	Regional Library Boards	Libraries Act		
Nova Scotia	Rent Review Commission	Rent Review Act	1975	
Nova Scotia	Research Foundation of Nova Scotia	Research Foundation Act	1946	
Nova Scotia	School Boards	Education Act		
Nova Scotia	Shipbuilding Commission	Shipbuilding Commission Act		1967
Nova Scotia	Small Business Development Corporation	Small Business Development Act	1981	2001

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Nova Scotia	Society of Management Accountants of Nova Scotia	Certified Management Accountants of Nova Scotia Act	1950	
Nova Scotia	Sydney Steel Corporation	Sydney Steel Corporation Act	1967	
Nova Scotia	Sydney Waterfront Development Corporation	Sydney Waterfront Development Corporation	1988	1994
Nova Scotia	Tidal Power Corporation	Government Restructuring Act	1971	2001
Nova Scotia	Utility and Review Board	Utility and Review Board Act	1992	
Nova Scotia	Workmen's Compensation Board of Nova Scotia	Workmen's Compensation Act		
Ontario	AgriCorp	AgriCorp Act	1996	
Ontario	Agricultural Research Institute of Ontario	The Agricultural Research Institute of Ontario Act`	1961	
Ontario	Agricultural Societies	Agricultural Societies Act		1988
Ontario	Alcohol and Gaming Commission	Alcohol and Gaming Regulation and Public Protection Act	1996	
Ontario	Alcoholism and Drug Addiction Research Foundation	The Alcoholism and Drug Addiction Research Foundation Act	1965	
Ontario	Algonquin Forest Authority Act	Algonquin Forestry Authority Act	1974	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Art Gallery of Ontario	The Art Gallery of Ontario Act	1966	
Ontario	Association of Ontario Land Surveyors	Surveyors Act		
Ontario	Association of Professional Engineers of Ontario	The Professional Engineers Act		
Ontario	Board of Funeral Services	Funeral Directors & Establishments	1947	
Ontario	Board of Parole	Department of Correctional Services		
Ontario	Boards of School Trustees	Education Act		
Ontario	Burlington Beach Commission	The Burlington Beach Act		1956
Ontario	Centennial Centre of Science and Technology	The Centennial Centre of Science and Technology Act	1965	
Ontario	Child and Family Services Review Board	Child and Family Services Act	1978	
Ontario	Children's Aid Societies	Child and Family Services Act		
Ontario	Co-operative Loans Board of Ontario	Co-operative Loans Act	1956	1994
Ontario	College of Audiologists and Speech-Language Pathologists of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Chiropractors of Ontario	Regulated Health Professions Act	1991	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	College of Dental Hygienists of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Dietitians of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Medical Laboratory Technologists of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Message Therapists of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Midwives of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Occupational Therapists of Ontario	Regulated Health Professions Act	1991	
Ontario	College of Medical Radiation Technologists of Ontario	Regulated Health Professions Act	1962	
Ontario	College of Nurses of Ontario	Regulated Health Professions Act	1951	
Ontario	College of Opticians of Ontario	Regulated Health Professions Act	1960	
Ontario	College of Optometrists of Ontario	Regulated Health Professions Act		
Ontario	College of Psychotherapists and Registered Mental Health Therapists of Ontario	The Psychologists Registration Act	1960	
Ontario	College of Physiotherapists of Ontario	Regulated Health Professions Act	1991	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	College of Respiratory Therapists of Ontario	Regulated Health Professions Act	1991	
Ontario	Collision Repair Advisory Board	Collision Repair Standards Act	2002	
Ontario	Commercial Registration Appeal Tribunal	Ministry of Consumer and Commercial Relations	1968	1999
Ontario	Commission for the Investigation of Cancer Remedies	The Cancer Remedies Act		1997
Ontario	Community Care Access Corporations	Community Care Access Corporation Act	2001	
Ontario	Consent and Capacity Board	Health Care Consent Act	1996	
Ontario	Conservation Authorities	Conservation Authorities Act	1946	
Ontario	Criminal Injuries Compensation Board	Compensation for Victims of Crime Act	1967	
Ontario	Crop Insurance Commission of Ontario	AgriCorp Act	1966	1996
Ontario	Custody Review Board	Child and Family Services Act	1984	
Ontario	Deposit Insurance Corporation of Ontario	Credit Unions and Caisses Populaires Act	1994	
Ontario	District Social Services Administration Boards	District Social Services Administration Boards Act	1962	
Ontario	Drugless Practitioners Board of Regents	The Drugless Practitioners Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Eastern Ontario Development Corporation	Development Corporations Act	1973	
Ontario	Education Quality and Accountability Office	Education Quality and Accountability Office Act	1996	
Ontario	Electrical Safety Authority	Electricity Act	1998	
Ontario	Environmental Review Tribunal	Environmental Assessment Act	1975	2000
Ontario	Environmental Appeal Board	Environmental Protection Act	1975	2000
Ontario	Farm Income Stabilization Commission	Farm Income Stabilization Act	1976	1996
Ontario	Farm Practices Protection Commission	Farm Practices Protection Act	1988	1998
Ontario	Farm Products Appeal Tribunal	Ministry of Agriculture and Food Act	1978	
Ontario	Farm Products Payment Boards	Farm Products Payments Act	1967	
Ontario	Governing Board of Dental Technicians	The Dental Technicians Act	1946	
Ontario	Health Disciplines Board	Regulated Health Professions Act	1974	1991
Ontario	Health Facilities Appeal Board	Ministry of Health and Long-Term Care Appeal and Review Boards Act	1974	1998

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Health Protection Appeal Board	Ministry of Health and Long-Term Care Appeal and Review Boards Act	1983	1998
Ontario	Health Professions Appeal and Review Board	Ministry of Health and Long-Term Care Appeal and Review Boards Act	1998	
Ontario	Health Services Appeal Board	Ministry of Health and Long-Term Care Appeal and Review Boards Act	1972	1998
Ontario	Hospital Services Commission of Ontario	Health Insurance Act	1957	1972
Ontario	Hydro One Inc.	Electricity Act	1998	
Ontario	Independent Electricity System Operator	Electricity Act	1998	
Ontario	Land Compensation Board (Board of Negotiation)	Expropriations Act	1968	
Ontario	License Appeal Tribunal	License Appeal Tribunal Act	1999	
Ontario	License Suspension Appeal Board	Highway Traffic Act	1973	1999
Ontario	Liquor License Appeal Tribunal	The Liquor License Act	1975	1990
Ontario	Liquor Control Board of Ontario	The Liquor Control Act		
Ontario	Liquor License Board of Ontario	Alcohol and Gaming Regulation and Public Protection Act (and Liquor License Act)	1946	1996

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Local Boards of Health	Health Protection and Promotion Act		
Ontario	Local Roads Area Board	The Local Roads Boards Act	1964	
Ontario	Local Services Boards	Northern Services Board Acts	1979	
Ontario	Long Point Park Commission	Long Point Park Act		1954
Ontario	Metro Toronto Convention Centre	Metropolitan Toronto Convention Centre Corporation Act	1988	
Ontario	Milk Industry Board of Ontario	The Milk Act		1965
Ontario	Milk Commission of Ontario	The Milk Act	1965	1988
Ontario	Milk Industry Commission of Ontario	Milk Industry Act	1954	1957
Ontario	Milk Products Board of Ontario	Milk Industry Act	1954	1957
Ontario	Milk Products Producers' Co-ordinating Board	The Milk Act	1954	1965
Ontario	Moosonee Development Area Board	Town of Moosonee Act	1966	
Ontario	Municipal Police Services Boards	Police Services Act	1964	
Ontario	New Homes Warranty Plan Corporation	Ontario New Home Warranties Act	1976	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Niagara Escarpment Commission	Niagara Escarpment Planning and Development Act	1973	
Ontario	Niagara Parks Commission	The Niagara Parks Act		
Ontario	Northern Ontario Development Corporation	Development Corporations Act	1970	
Ontario	Northern Ontario Grow Bonds Corporation	Northern Ontario Grow Bonds Corporation Act	2004	
Ontario	Northern Ontario Heritage Fund Corporation	Northern Ontario Heritage Fund Act	1988	
Ontario	Nursing Homes Review Board	Ministry of Health and Long-Term Care Appeal and Review Boards Act	1972	1998
Ontario	Old Age Pension Commission	Old Age Pension Act	1948	1951
Ontario	Ontario Association of Architects	The Architects Act		
Ontario	Ontario Cancer Treatment and Research Foundation	The Cancer Act	1957	
Ontario	Ontario Certified General Accountants Association	Certified General Accountant Act	1983	
Ontario	Ontario Civilian Commission on Police Services	Police Services Act	1961	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Ontario Clean Water Agency	Capital Investment Plan Act	1993	
Ontario	Ontario College of Pharmacy	Regulated Health Professions Act		
Ontario	Ontario College of Social Workers and Social Services Workers	Social Work and Social Services Act	1998	
Ontario	Ontario Deposit Insurance Corporation	The Ontario Deposit Insurance Corporation Act	1967	1997
Ontario	Ontario Development Corporation	Development Corporations Act	1966	
Ontario	Ontario Education Communications Authority	The Ontario Education Communications Authority Act	1970	
Ontario	Ontario Energy Board Act	Ontario Energy Board Act	1960	
Ontario	Ontario Energy Corporation	Ontario Energy Corporation Act	1974	1998
Ontario	Ontario Farm Products and Marketing Commission	The Farm Products Marketing Act	1946	
Ontario	Ontario Film Review Board	Film Classifications Act		
Ontario	Ontario Financing Authority	Capital Investment Plan Act	1955	
Ontario	Ontario Food Terminal Board	The Ontario Food Terminal Act	1946	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Ontario Heritage Foundation	Ontario Heritage Act	1967	
Ontario	Ontario Highway Transportation Board	The Ontario Highway Transportation Board Act	1956	
Ontario	Ontario Housing Corporation	The Ontario Housing Corporation Act	1964	
Ontario	Ontario Human Rights Commission	Human Rights Code	1958	
Ontario	Ontario Hydro	Electricity Act		1998
Ontario	Ontario Labour-Management Arbitration Commission	Labour Relations Act	1968	1979
Ontario	Ontario Labour Relations Board	Labour Relations Act		
Ontario	Ontario Land Corporation	Capital Investment Plan Act	1974	1993
Ontario	Ontario Library Services Board	Public Libraries Act	1984	
Ontario	Ontario Lottery Corporation	Ontario Lottery and Gaming Corporation Act	1974	
Ontario	Ontario Municipal Board	Ontario Municipal Board Act		
Ontario	Ontario Municipal Health Services Board	Municipal Health Services Act		
Ontario	Ontario Northland Transpiration Commission	Ontario Northland Transpiration Commission Act		

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Ontario Parks Integration Board	Ministry of Natural Resources Act	1956	1972
Ontario	Ontario Place Corporation	Ontario Place Corporation Act	1972	
Ontario	Ontario Power Authority	Electricity Act	1998	
Ontario	Ontario Power Generation Inc.	Electricity Act	1998	
Ontario	Ontario Racing Commission	Racing Commission Act	1950	
Ontario	Ontario Rental Housing Tribunal	Tenant Protection Act	1997	
Ontario	Ontario Securities Commission	Securities Act		
Ontario	Ontario Stock Yards Board	Stock Yards Act		1999
Ontario	Ontario Teachers' Federation	Teaching Profession Act		
Ontario	Ontario Telephone Development Corporation	Ontario Telephone Development Corporation Act	1955	1999
Ontario	Ontario Transportation Capital Corporation	Capital Investment Plan Act	1993	
Ontario	Ontario Veterinary Association	Veterinarians Act	1958	
Ontario	Ontario Waste Management Corporation	Ontario Waste Management Corporation Act	1981	

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Ontario Water Resources Commission	Government Reorganization Act	1957	1972
Ontario	Operating Engineers Board of Examiners	The Operating Engineers Act		1965
Ontario	Ottawa Congress Centre	Ottawa Congress Centre Act	1988	
Ontario	Pay Equity Commission of Ontario	Pay Equity Act	1987	
Ontario	Pension Commission of Ontario	Financial Services Commission of Ontario	1965	1997
Ontario	Planning and Implementation Commission	Education Act	1986	1997
Ontario	The Presqu'lle Parks Act	The Presqu'ile Park Act		1954
Ontario	Professional Geoscientists of Ontario	Professional Geoscientists Act	2000	
Ontario	Province of Ontario Arts Council	The Arts Council Act	1962	
Ontario	Public Accountants Council for the Province of Ontario	The Public Accountancy Act		
Ontario	Public Library Boards	Public Libraries Act		
Ontario	Public Library Associations	Public Libraries Act		1966
Ontario	Public Utility Commission	Public Utilities Act		2001

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Regional Growth Councils	The Regional Development Councils Act	1966	1973
Ontario	Registered Insurance Brokers of Ontario	Registered Insurance Brokers	1980	
Ontario	Rent Review Hearings Board	Ontario Rent Control Act	1986	1992
Ontario	Research Foundation	Research Foundation Act		
Ontario	Residential Rental Standards Board	Ontario Rent Control Act	1986	1992
Ontario	Roads Commissioners	Statute Labour Act		
Ontario	Royal College of Dental Surgeons of Ontario	Regulated Health Professions Act		
Ontario	Royal Ontario Museum	The Royal Ontario Museum Act	1968	
Ontario	Sheridan Park Corporation	The Sheridan Park Corporation Act	1964	1979
Ontario	Social Assistance Review Board	Ministry of Community and Social Services Act	1975	
Ontario	Social Benefits Tribunal	Ontario Works Act	1997	
Ontario	Soldiers Aid Commission	Soldiers Aid Commission		
Ontario	St. Clair Parkway Commission	St. Clair Parks Commission Act	1966	
Ontario	St. Lawrence Development Commission	St. Lawrence Development Commission Act	1958	
Ontario	Stallion Enrolment Board	The Stallions Act		1966

Province	Most Recent Type II Body Name	Most Recent Act	Creation (before 1946 blank)	End
Ontario	Suburban Service Board	Suburban Area Development Act		1952
Ontario	Technical Standards and Safety Authority	Technical Standards and Safety Ac	2000	
Ontario	Technology Centres	Technology Centres Act	1982	1999
Ontario	The Financial Corporation	Electricity Act	1998	
Ontario	The Law Society of Upper Canada	The Law Society Act		
Ontario	Toronto Area Transit Operating Authority Act	Toronto Area Transit Operating Authority Act	1974	2011
Ontario	Toronto Futures Exchange	Toronto Futures Exchange Act	1983	2009
Ontario	Toronto Stock Exchange	The Toronto Stock Exchange Act		
Ontario	Toronto Waterfront Revitalization Corporation	Toronto Waterfront Revitalization Corporation Act	2002	
Ontario	Wine Authority	Vintners Quality Alliance Act	1999	
Ontario	Workplace Safety and Insurance Appeals Tribunal	Workplace Safety and Insurance Act	1997	
Ontario	Workplace Safety and Insurance Board	Workplace Safety and Insurance Act		

Appendix C: Government Healthcare Document Collection

Province	Document Name
Alberta	1989. Premier's Commission on Future of Health Care for Albertans. *The Rainbow Report: Our Vision of Health, Volume 1.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	1989. Premiers's Commission on Future Health Care for Albertans. *The Rainbow Report: Our Vision of Health, Volume 2.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2000. Legislative Assembly. "Regional Health Authorities Act, Revised Statutes of Alberta 2000, Chapter R-10." Edmonton, AB: Queen's Publisher for Alberta.
Alberta	2001. Premier's Advisory Council on Health. *A Framework for Reform: Report of the Premier's Advisory Council on Health.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2004. Alberta Health and Wellness. *Tracking Health Refrom in Alberta: Alberta Health Reform Implementation Team Final Report January 2004.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2005. Alberta Health and Wellness. *Guide to Health Authority Accountability Documents.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2006. Alberta Health and Wellness. *Health Authority Accountability in Alberta's Health System.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2007. Alberta Health and Wellness. *Aligning Health Authority Accountability in Alberta's Health System.* Government, Edmonton: Queen's Printer for Alberta.
Alberta	2008. Alberta Health and Wellness. *Provincial Service Optimization Review: Final Report.* Government, Edmonton: Queen's Printer for Alberta

Province	Document Name
British Columbia	1991. Royal Commission on Health Care and Costs. *Closer to Home: The Report of the British Columbia Royal Commission on Health Care ad Costs Volume 2.* Government, Victoria: Queen's Printer for British Columbia.
British Columbia	1993. Ministry of Health. *New Directions for a Healthy British Columbia.* Government, Victoria: Queen's Printer for British Columbia.
British Columbia	1996. Legislative Assembly. "Health Authorities Act, Revisesed Statutes of British Columbia 1996, Chapter 180." Victoria, BC: Queen's Printer for British Columbia.
British Columbia	2001. *A new Era for Patient-Centred Health Care: Building a Sustainable, Accountable Structure for Delivery of High-Quality Patient Services.* Government, Victoria: Queen's Printer for British Columbia.
British Columbia	2001. Office of the Provincial Health Officer, Policy and Practice: A Report on the Use of British Columbia's Health Goals. Government, Victoria: Queen's Printer for British Columbia.
British Columbia	2008. Office of the Auditor General of British Columbia. *Public Sector Governance: A Guide to the Principles of Good Practice. How are We Doing? The Public Reporting of Performance Measures in British Columbia.* Government, Victoria: Queen's Printer for British Columbia.
British Columbia	2012. Ministry of Health. Safe Reporting/Whistleblowing Policy Standards. Government, Victoria: Queen's Printer for British Columbia.
British Columbia	2012. *Office of the Auditor General of British Columbia. Crown Agency Board Governance.* Government, Victoria: Queen's Printer for British Columbia.
Nova Scotia	1990. Royal Commission on Health Care. *Health Strategies for the Nineties: Managies Better Health.* Government, Halifaz: Queen's Printer for Nova Scotia.
Nova Scotia	1999. Minister's Task on Regionalized Health Care in Nova Scotia. *Final Report and Recommendations.* Government, Halifax: Queen's Printer for Nova Scotia.

Province	Document Name
Nova Scotia	2000. Legislative Assembly. “District Health Authorities Act, Chapter 6 of the Acts of 2000.” Halifax, NS: Queen's Printer for Nova Scotia.
Nova Scotia	2003. Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal. *Primary Health Care Renewal Action for Healthier Nova Scotians.* Government, Halifax: Queen’s Printer for Nova Scotia.
Nova Scotia	2006. Department of Health. A Primary Health Care Evaluation System System for Nova Scotia. Government, Halifax: Queen’s Printer for Nova Scotia.
Nova Scotia	2012. Health and Wellness. 2012-13 Statement of Mandate between Health and Wellness and the District Health Authorities.
Nova Scotia	2012. Health and Wellness. *Annual Accountability Report for the Fiscal Year 2011-2012.* Government, Halifax: Queen’s Printer for Nova Scotia.
Ontario	1974. Ontario Health Planning Task Force. *Report of the Health Planning Task Force.* Government, Toronto: Queen's Printer for Ontario, Toronto.
Ontario	1975. Ministry of Health. *Report, Reactions Response: The Health Care System in Ontario.* Government, Toronto: Queen's Printer for Ontario.
Ontario	1987. Health Review Panel. *Toward a Shared Direction for Health in Ontario: Report of the Ontario Health Review Panel, June 1987.* Government, Toronto: Queen's Printer for Ontario.
Ontario	2004. Minister of Health Health and Long-Term Care. *“Ontario's Health Transformation Plan Purpose and Progress. Speaking Notes for: The Honourable Minister of Health and Long-Term Care September 9, 2004.”* Government, Toronto: Queen's Printer for Ontario.
Ontario	2005. Health Results Team. *Health Reslths Team First Annual Report 2004-05.* Government, Toronto: Queen's Printer for Ontario.
Ontario	2005. Health Results Team. “Bulletin No. 6.” *Local Health Integration Networks: Building a True System.* Toronto, ON: Queen's Printers for Ontario.

Province	Document Name
Ontario	2006. Legislative Assembly. 2006. *"Local Health System Integration Act, Statutes of Ontario, 2006, Chapter 4."* Toronto, ON: Queen's Printers for Ontario.
Ontario	2009. Minister of Health Health and Long-Term Care. *2007-2010 Accountability Agreement between the Ministry of Health and Long-Term Care and the Local Heath Integration Networks.* Government.
Ontario	2010. Ombudsman of Ontario. *The LHIN Spin: Investigation into the Hamilton Niagara Integration Network's Local Health Integration Network's use of community engagement in its decision-making process.* Government, Toronto: Queen's Printer for Ontario.

Appendix D: Interview Questions

Health Care System Case Study: Interview Question Guide

The Interview process will combine standardized questions as well as unstructured questions. This semi-structured approach is intended to allow for elaboration on responses to standardized questions and to allow for interviewees to express opinions that may not have been captured by the standardized questions. Standardized questions are number, while possible probes are listed in the bullet points below each question. Not all standard questions may be applicable to each interviewee or may be superseded by answers to previous questions.

Interview Topic Areas:

- What it means to be accountable and the role of the non-governmental organization, government, and society in ensuring accountability
- The nature of the accountability relationship between the non-governmental organization and government
- The nature of the accountability relationship between the non-governmental organization and society.

Interview Script

Thank you for agreeing to be interviewed. The focus of the research project is on how organizations that have been given the authority to make policy decisions, but sit outside the structure of traditional government are held accountable. The questions that I will be asking you today deal with your perception of the accountability of <organization name>.

Before we get started, do you have any questions for me?

Are you okay with me recording our conversation?

In cases where either the role of the organization or individual is not know one or both of the following questions may be asked prior to proceeding with the standardized questions

6. In what capacity are or were you would you describe the role of your organization within the health care system?

7. How would you describe the part you play or played in helping your organization fulfill its role?

Section 1: Accountability (as defined by the interviewee)

1.1 The focus of this research is to gain an understanding of how organizations like the <organization name> are held accountable. As accountability can mean different things to different people I would like to start with how you would define or describe accountability.

- What do you think it means for <organization name> to be accountable?

1.2 Based on your definition of accountability, to whom do you feel <organization name> is most accountable to?

- How do you feel <organization name> is held accountable by <insert response>?
- Are there specific accountability requirements that must be met?
    - What are they?
    - How effective do you feel them to be?

1.3 Whose interests do you feel the decisions of <organization name> most represent?

- How do you feel <organization name> is held accountable by <insert response>?
- Are there specific accountability requirements that must be met?
    - What are they?
    - How effective do you feel them to be?

If the provincial government is not mentioned then ask question 1.4.

1.4 How would you describe the accountability relationship between <organization name> and government?

If the general public not mentioned then ask question 1.5.

1.5 How would you describe the accountability relationship between <organization name> and members of the public?

Section 2: Accountability (as defined by Mark Bovens)

One way to look at accountability is to break it down into three components:

1) The obligation the organization to explain and justify action

2) The ability of those outside the organization to question and pass judgment

3) The ability for those outside the organization to impose sanctions

For each of the three aspects of accountability I am interested in your perception of the relationship between the < organization name > and both government and society.

To start lets focus on the accountability relationship with government.

2.1 To what extent do you feel that the <organization name> has an obligation to explain and justify its actions to government?

- How successful do you believe the <organization name> has been at explaining and justifying its actions?
- What more if anything could or should be done to make <organization name> explain and justify its actions?

2.2 To what extent do you feel the provincial government is able to question and pass judgment on the decisions and actions of <organization name>?

- How successful do you believe the provincial government has been at asking questions and passing judgment in relation to the actions of <organization name>?

- What more if anything could or should be done to allow for the province to question the <organization name> and pass judgment.

2.3 To what extend do you believe the provincial government is able to sanction <organization name> for actions that it does not approve of?

- When, or if, required, how successful has the provincial government been at sanctioning <organization name>?

- What more if anything could or should be done to allow the provincial government to sanction <organization name> more effectively?

Now lets focus on the accountability relationship with society.

2.4 To what extent do you feel that the <organization name> has an obligation to explain and justify its actions to society?

- How successful do you believe the <organization name> has been at explaining and justifying its actions?

- What more if anything could or should be done to make <organization name> explain and justify its actions?

2.5 To what extent do you feel society is able to question and pass judgment on the decisions and actions of <organization name>?

- How successful do you believe society has been at asking questions and passing judgment in relation to the actions of <organization name>?
- What more if anything could or should be done to allow for society to question the <organization name> and pass judgment.

2.6 To what extend do you believe society is able to sanction <organization name> for actions that it does not approve of?

- When, or if, required, how successful has society been at sanctioning <organization name>?
- What more if anything could or should be done to allow society to sanction <organization name> more effectively?

Section 3: Alberta Only

Alberta moved multiple regional authorities to one single organization. I am interested in what, if any, impact this change has had in your view on the accountability relationships for both government and society.

3.1 From your perspective, what impact has the shift from regional authorities to a single provincial health board had on the ability to hold decision-makers accountable?

Wrap up

Is there anything else you would like to add in regard to <organization name> how it is accountable for its decisions?

Appendix E: Introductory E-mail Script

Dear _____,

I am a Doctoral student in the Department of Political Science at The University of Western Ontario working under the supervision of Dr. Cameron Anderson.

The purpose of this e-mail is to invite you to participate in a research study that looks to better understand how organizations external to the traditional structure of government that have been delegated the authority to make public policy decisions are held accountable.

Case studies across four provinces have been selected for study including *insert their specific organization name here*. You are being contacted because of your role as *insert their role here.* For each case I would like to interview people from the organization being studied, the public service, elected officials and interest groups. All interviews are confidential and no information that discloses the identity of the interviewee will be released or published without their specific consent.

Participation would entail an interview of no longer than one hour in length that would cover the following topic areas:

1. The function or purpose of the organization and the role government and society play in the organization fulfilling that purpose
2. What it means to be accountable and the role of the organization, government, and society in ensuring accountability
3. The nature of the accountability relationship between the organization and government
4. The nature of the accountability relationship between the organization and society

Thank you for considering this request. I look forward to hearing from you.

Robert

Appendix F: Interview Consent Form

Research Consent Form

Accountability and Non-governmental Decision Making in Multi-level Governance

Title of Research: Accountability and Non-governmental Decision Making in Multi-level Governance

Investigator: Robert W. Waterman

Supervisor: Dr Cameron D. Anderson

Introduction:

I am a Doctoral student in the Department of Political Science at The University of Western Ontario working under the supervision of Dr. Cameron Anderson.

You are being invited to participate in a research study that looks at the accountability of non-governmental organizations that have been authorized or created by government to make public policy decisions. The purpose of this letter is to provide you with the information you require to make an informed decision on participating in this research.

Purpose of Research and Interviews:

The purpose of the research project is to better understand how organizations external to the traditional structure of government that have been delegated the authority to make public policy decisions are held accountable. In addressing this question the project includes four case studies selected across four provinces. Each case study includes interviews used to obtain the insights of individuals within the non-governmental organization, government, and society.

Interview Procedure and Questions:

Interviews will last a maximum of 1 hour. Interviews will be completed over the phone, with the interviewer calling you at the number specified by you, or over the internet through Skype or an alternative software package. With your permission an audio recording of the interview will be made. Declining to have an audio **recording** of your interview created does not disqualify you from participation in the study.

The interview process is divided into 5 topic areas: 1) How you associated with the organization; 2) The function or purpose of the organization and the role government and society play in the organization fulfilling that purpose; 3) What it means to be accountable and the role of the organization, government, and society in ensuring accountability; 4) The nature of the accountability relationship between the organization and government; and 5) The nature of the accountability relationship between the organization and society.

Participants Initials: _____

THE UNIVERSITY *OF* WESTERN ONTARIO
FACULTY OF SOCIAL SCIENCE • DEPARTMENT OF POLITICAL SCIENCE
ROOM 4154, SOCIAL SCIENCE CENTRE • LONDON, ONTARIO • CANADA – N6A 5C2
TELEPHONE: 519-661-3266 • FAX: 519-661-3904 • WWW.UWO.CA

Research Consent Form

Accountability and Non-governmental Decision Making
in Multi-level Governance

After the interview has been completed you will be given the opportunity to review the material collected. At your request a copy of the material transcribed from your interview and review of available audio recordings will be provided. You will have the opportunity to provide corrections or clarifications to the information, as well as the opportunity to withdraw from the study at this time.

Participants interviewed as society representatives must have no previous employment with either the non-governmental organization or government.

Possible Risks and Benefits:

The risks of the proposed research are minimal. You may feel some psychological or emotional discomfort answering questions about the organization's level of accountability if you have concerns over how the organization or those working for or with the organization will be perceived.

The direct benefit to you, as a participant, is the opportunity to put forward your view of the accountability of non-governmental decision-makers. Broader benefits to society include developing an understanding of the use of non-governmental actors in public decision-making and how such actors are held accountable.

Withdrawing From the Study or Omitting Certain Questions:

Participation in this study is voluntary. You may refuse to participate, refuse to answer any question or withdraw from the study at any time. You have the right to be given important information about the study and what will be asked of you. You should only agree to take part if you feel confident that enough information has been given. Participation is voluntary; you do not have to take part in the study if you do not want to.

Confidentiality and Storage of Personal Records

You do not waive any legal rights by signing the consent form. Your confidentiality will be respected. No information that discloses your identity will be released or published without your specific consent to the disclosure. It is importing to note, however, that due to the small sample size and the inclusion of organization names, speculation on the identity of participants may occur and it may be possible for individual participants to be identified. If you are not comfortable with this possibility then you should not participate.

Your research records will be encrypted and stored digitally. Copies of the encrypted audio recording and associated transcripts will be stored on the investigator's personal computer, backup device, and CD. Audio recordings will be destroyed 5 years after the completion of the research. Transcripts of your interview will be kept indefinitely.

Participants Initials: _____

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ROOM 4154, SOCIAL SCIENCE CENTRE • LONDON, ONTARIO • CANADA – N6A 5C2
TELEPHONE: 519-661-3266 • FAX: 519-661-3904 • WWW.UWO.CA

Research Consent Form

Accountability and Non-governmental Decision Making
in Multi-level Governance

It is also important to note that representatives of the Research Ethics Board at the University of Western Ontario may access the original signed research consent form and the data obtained from your interview for the purpose of monitoring the research. The Research Ethics Board at The University of Western Ontario may contact you directly to ask about your participation in the study.

Request for Results

If you would like to receive a copy of the results of this study please inform the interviewer at the time of the interview.

Contact Information:

If you have any questions about this study please contact:

Robert Waterman
Department of Political Science
The University of Western Ontario
London Ontario N6A 5C2
[redacted]

If you have questions about your rights as a participant you may contact:

Office of Research Ethics
The University of Western Ontario
London Ontario N6A 5C2
519-661-3036

Participants Initials: _____

Research Consent Form

Accountability and Non-governmental Decision Making in Multi-level Governance

Title of Research: Accountability and Non-governmental Decision Making in Multi-level Governance

I consent to having an audio recording of my interview created:

Accept ☐ Decline ☐

I have read the Letter of Information (or Information/Consent document), have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Name of Participant (Printed)	Contact Phone Number or Skype Address of Participant
Signature of Participant	Date
Signature of Investigator Reviewing Research Consent Form	Date

Participants Initials: _____

THE UNIVERSITY *OF* WESTERN ONTARIO
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Appendix G: Performance Measures Reporting Example (From AHS Annual Report 2013-1014)

PERFORMANCE MEASURES

In collaboration with Alberta Health, Alberta Health Services established 16 performance measures in January 2014 to help us continue to build and strengthen our health care system. We will continue to monitor other measures to help support the health and well-being of all Albertans and the support of our front-line health care providers.

We've streamlined performance measures to ensure they represent the broad spectrum of health care, including targets for community-based care and patient outcomes. We've added measures that align with national standards where possible, so Albertans can easily compare the performance of our health system with other health systems across Canada. Having measures aligned with national and Western Canadian benchmarks improves the transparency of our reporting by putting our accomplishments into a broader context.

The Alberta Quality Matrix for Health provides a way of organizing information and thinking around the complexity of the health system.

The matrix has two components:

1. Dimensions of quality, which focus on aspects of the patient/client experience

2. Areas of need, which divides the range of services offered by the health system into four distinct, but related, categories.

    i. Being Healthy: Achieving health and preventing occurrence of injuries, illness, chronic conditions and resulting disabilities.

    ii. Getting Better: Care related to acute illness or injury.

    iii. Living with Illness or Disability: Care and support related to chronic or recurrent illness or disability.

    iv. End of Life: Care and support that aims to relieve suffering and improve quality of living with or dying from advanced illness or bereavement.

The Quality Matrix allows the public, patients, providers, and organizations to see how levels of quality and areas of need might intersect. It has been used in numerous ways, including policy development, strategic planning, and as a way to educate the public about quality in healthcare.

Our performance measures are organized by the Alberta Quality Matrix for Health, which describes six dimensions of quality.

Acceptability	Health services are respectful and responsive to user needs, preferences and expectations.
Accessibility	Health services are obtained in the most suitable setting in a reasonable time and distance.
Appropriateness	Health services are relevant to user needs and are based on accepted or evidence-based practice.
Effectiveness	Health services are provided based on scientific knowledge to achieve desired outcomes.
Efficiency	Resources are optimally used in achieving desired outcomes.
Safety	Mitigate risks to avoid unintended or harmful results.

Targets have been created for the new 16 performance measures for 2014-15 and 2015-16; since the new measures were released near the end of 2013-14, targets were not established for 2013-14. The performance targets for 2014-15 and 2015-16 are challenging but achievable. At present, we are on track to achieve the targets set for 2014-15. These performance targets will help us measure our progress and improve the health system.

PERFORMANCE MEASURES (continued)

The following chart demonstrates trending of Alberta Health Services' system performance measures. Six out of 16 measures have 2013-14 data. Seven measures reflect the third quarter year-to-date data (April 1, 2013 to December 31, 2013); once 2013-14 data is available for these seven measures; the chart below will be refreshed and published. Two measures are only reported annually (i.e., satisfaction with long-term care and early detection of cancer). One other measure – "Emergency Department Wait to See a Physician", is currently under development.

The trend column indicates comparison of the most recent data over the earliest data available for each measure. An upward arrow (↑) indicates improvement; a horizontal arrow (→) indicates stability and a downward arrow (↓) indicates areas that require additional focus.

Performance Measures	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Early Detection of Cancer: Are we diagnosing cancer in its early stages? *The percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.*	64.9% (2007)	64.6% (2008)	65.4% (2009)	66.6% (2010)	66.3% (2011)	pending	pending	↑
Mental Health Readmissions: Are mental health patients returning to hospital unexpectedly? *The percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.*	not available	9.4%	9.2%	9.5%	9.4%	9.8%	9.3% (Q3 YTD)	→
Access to Radiation Therapy: How long do most patients wait for radiation therapy? *The length of time or less that 9 out of 10 patients wait to receive radiation therapy (in weeks).*	not available	5.0	5.3	3.6	3.1	3.0	3.0	↑
Emergency Department Length of Stay for Admitted Patients (hours): How long does a patient stay in the emergency department before moving to a hospital bed? *The average patient's length of time in the emergency department before being admitted to a hospital bed at the 16 busiest emergency departments.*	not available	10.8	10.3	9.8	8.8	8.7	8.9	↑
Emergency Department Length of Stay for Discharged Patients (hours): How long does a patient stay in emergency department before going home if they don't need to stay in hospital? *The average patient's length of time in the emergency department before being discharged at the 17 busiest emergency departments.*	not available	3.2	3.1	3.1	3.1	3.1	3.0	↑
Satisfaction with Hospital Care: Are patients satisfied with their hospital care? *The percentage of adult patients who rated their overall care in hospital as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.*	not available			81%	84%	81%	81% (Q3 YTD)	→

Performance Measures	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Actual Length of Stay Compared to Expected Stay: Are patients in hospitals longer than needed? *The actual length of stay in hospital compared to the expected length of stay in hospital. Every .01 drop in this ratio means we can treat more than 3,200 more patients in hospital every year.*	not available	1.04	1.02	1.01	1.00	0.98	0.97	↑
Surgery Readmissions: Are surgery patients returning to hospital unexpectedly? *The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.*	not available	5.8%	5.9%	6.0%	6.3%	6.5%	6.6% (Q3 YTD)	↓
Satisfaction with Long-Term Care: Are families satisfied with the long-term care their loved ones received? *The percentage of families of long-term care residents who rated the overall care as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.*	71%	This measure is updated every two years.		73%	This measure is updated every two years.		pending	↑
Continuing Care Placement: How many people are placed in continuing care within 30 days? *The percentage of people placed into continuing care within 30 days of being referred.*	not available			55%	64%	67%	69%	↑
Stroke Mortality: Are patients dying in the hospital following a stroke? *The percentage of patients dying in hospital within 30 days of being admitted for a stroke.*	16.1%	12.6%	11.7%	13.2%	13.5%	15.0%	14.3% (Q3 YTD)	↓
Heart Attack Mortality: Are patients dying in the hospital following a heart attack? *The percentage of patients dying in hospital within 30 days of being admitted for a heart attack.*	7.1%	6.5%	6.3%	6.2%	6.5%	5.9%	7.2% (Q3 YTD)	→
Hospital Mortality: Are more patients dying in the hospital than expected? *The actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths. In Alberta, a rate of 84 means 850 fewer deaths in hospital than expected each year.*	104	104	99	93	88	84	85 (Q3 YTD)	↑
Hand Hygiene: Are health care workers cleaning their hands to avoid spreading infections? *The percentage of times health care workers clean their hands during the course of patient care.*	not available				50%	59%	66%	↑
Hospital Acquired Infections: Are patients acquiring infections while in the hospital? *The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 days of care. A rate of 4.1 means approximately 100 patients per month acquires C-diff infections in Alberta.*	not available				4.3	4.1	4.4 (Q3 YTD)	↓

Under development: **Emergency Department Wait to See a Physician:** How long are patients waiting to see a physician in the Emergency Department? The average patient's length of time in emergency department before being seen by a physician at the 17 busiest emergency departments.

PRIMARY AND COMMUNITY CARE

Alberta Health Services supports all Albertans in having access to a primary health care team with a range of providers no matter where patients enter the system. AHS is:

- Working with Alberta Health (AH) to increase the number of Family Care Clinics and enhance the services provided by primary care networks.
- Redesigning how we deliver care more appropriately to specific complex, high-needs populations.
- Developing an integrated primary health care service model, which will focus on linking many existing services to provide support to identified population groups.
- Developing collaborative team care models for populations with similar needs. Those groups will include the frail elderly, the vulnerable, complex high-needs children and youth, and those at the end of life.

With an aging population and the prevalence of chronic disease on the rise, it is imperative that we offer Albertans access to the best primary care system, and in turn, the best opportunity to maintain good health and access to the services they need, when they need them.

PRIORITY ACTIONS	PROGRESS/RESULTS
Complex High Needs Population: Develop innovative community-based service model(s) to address complex, high needs individuals/ populations.	• Edmonton Zone currently has five projects underway to address the health of complex high needs populations to improve their care, with a focus on: the inner-city team, addictions and reproductive health, Boyle McAuley Home Care team, high risk pre/ post-natal care, and EMS community-level services. The learning and approach used in Edmonton will be leveraged to support developmental work in other zones. • Calgary Zone has identified users of emergency department and inpatient services at the Peter Lougheed Centre that might benefit from integrated services at the Calgary East Family Care Clinic. • North Zone is working in Grande Prairie to assess utilization of complex, high needs populations with mental health issues.
Family Care Clinics (FCC): Further develop AHS FCCs and work with AH to increase the number of FCCs within the province.	• AHS continues to work with AH to increase the number of Family Care Clinics (FCCs) within the province. FCC's provide comprehensive primary health care services and connections to social/community services that align with the health needs of those areas. • 24 communities have been identified where there is a need for better access to primary health care. Three pilot projects were implemented in 2012 in Calgary, Edmonton and Slave Lake. • Albertans and community groups have been engaged to support the development of FCCs in targeted areas. • Business planning process is currently underway, but Alberta Health has extended the timeframe for FCC setup, business planning, and grant agreement development to allow FCC proponents time to undertake all the required work. • Work is also underway with the Complex High Needs Patients initiative to ensure needs for those populations within communities can be met through the development of new service models such as FCCs.
Primary Care Networks (PCN): Work with AH to enhance the work of PCNs through further development of common standards and expansion of the range of services where needed.	• The Primary Care Alliance (PCA) of the Alberta Medical Association (AMA) completed a draft blueprint for an enhanced Primary Care Network Program in Alberta (PCN Evolution). The blueprint incorporates input from PCA, AMA, Alberta Health, AHS and Alberta College of Family Physicians. • The Primary Health Care Evaluation Expert Advisory Group, led by AH, released the evaluation framework in November 2013 for the primary health care system. The evaluation framework focused on measures that lead to improved access, greater attachment, higher quality patient-centred care, better health outcomes and patient experiences, healthier choices, efficiency and accountability. • Thirteen PCNs are engaged in the Measurement Capacity Initiative, to build capacity for collaborative development of common quality and outcome measures in primary care. • Work continues with the Complex High Needs Patients initiative to define complex high needs population to ensure needs for those populations within communities are met through integration between AHS and PCNs. • Currently, there are a total of 42 primary care networks: South Zone - 2; Calgary Zone - 7; Central Zone - 12; Edmonton Zone - 9; North Zone - 12.

PRIORITY ACTIONS	PROGRESS/RESULTS

Community Service Delivery Alignment: Develop transformation plans to support the implementation of integrated community and primary care services, enhancing primary care, chronic disease management and other community based options.	• Worked with zones and communities to assess service needs and develop plans to address those needs, taking into account services that are available locally and within the surrounding area.
	• Developed Rural Service Access Guidelines including educational presentations; map guidebooks and interactive maps were posted on the AHS internal website.
	• Established the Rural Surgical & Obstetrical Guideline Advisory Committee with key zone and strategic partner membership. Final guideline documentation is currently in development.
	• Initiated other provincial chronic disease management activities including:
	  ◦ Better Choices Better Health™ Online (self-management) License Agreement between AHS and the National Council on Aging.
	  ◦ Working with Strategic Clinical Networks on clinical decision support tools to support standards in the supervised exercise program.
	  ◦ Completed emotional eating patient education resource facilitator training in the South Zone.
	  ◦ Formed provincial MEND (Mind, Exercise, Nutrition… Do-it!) working group with representation from all zones.
	  ◦ Completed diversity workshop facilitator training in the Edmonton Zone.

In Summary: Alberta Health Services continues to work on improving the health and wellness of Albertans by improving access to and the quality of primary health care services. We are:

- Strengthening integration and collaboration across community-based services and primary health care providers by developing appropriate service delivery models to address the specific health needs of Albertans.
- Delivering innovative service delivery models to address the complex, high needs populations.

MyHealthAlberta and HEALTHLink Alberta

Significant work is underway to enhance access for all Albertans to health information and advice through MyHealthAlberta and Health Link Alberta. The staff, physicians and volunteers of AHS are also key partners in health and their voices will help us build a system that makes best use of their talents and improves the quality, outcomes and value of our health system.

PRIORITY ACTIONS	PROGRESS/RESULTS
Personal Health Portal (PHP): Work with Alberta Health to support the development of a personal health record for Albertans that can contain both self-entered and clinical reports from the provincial electronic health record, Alberta Netcare.	• The Personal Health Portal program is a collaborative provincial health system initiative that provides online personalized health information and services to Albertans through the MyHealth.Alberta.ca (MHA) portal. • On-line visits to the MyHealth.Alberta.ca website increased significantly over the year, reaching just under 1 million visits in 2013-14. • In 2013-14, the portal added a video library and search, a "Health and Alberta" library, learning modules with quiz tools, patient care information handouts on more than 3,000 different topics, Medication Safety pages, as well as consumer appropriate drug monographs for all prescribed, over the counter and herbal drugs available in Canada. • The portal also provided emerging content during the Southern Alberta floods and Alberta Influenza. • The Organ Tissue Donor Registry has been developed, and is made available through MHA. The registry allows Albertans to register their intent to become and organ and tissue donor. • MHA continues to form new partnerships with other AHS departments for subject matter and expert review of clinical content. Recent partnerships include the Pelvic Floor Clinic, Medication Reconciliation, Goals of Care, Physiotherapy, Chronic Kidney Disease, Enhanced Recovery After Surgery, Acute Pain Service and Fall Prevention.

PRIORITY ACTIONS	PROGRESS/RESULTS
Health Link Alberta (HLA)	• Health Link Alberta (HLA) has added two new services through partnerships with the Poison & Drug Information Service and AHS Nutrition Services, enabling convenient access to medication information and nutrition advice for callers. • HLA supported the development, posting and highlighting of flood related health information on MyHealth.Alberta.ca during the flooding in Calgary and Southern Alberta to enable easy access to accurate and timely information for the volunteers at the Flood Welcome Centres and the public. • HLA is partnering with the Bone and Joint Strategic Clinical Network to implement a new program called "Catch-a-Break", which identifies patients who have suffered a low impact fracture and are at risk for osteoporosis. HLA follows up with the patient and their physician to support appropriate screening, diagnosis and intervention. • HLA participated in the Calgary Zone Surge Capacity committee to plan for the diversion of appropriate patients who present to the emergency departments to Primary Care Network clinics. HLA support included the use of expanded triage criteria to the After-Hours Primary Care Network Clinics. • HLA experienced significant call volume related to influenza beginning in December and peaking in January 2014. HLA added information on the Influenza Immunization Clinic "look up tool" which provided accurate and up-to-date information to the public on immunization clinic locations across the province for the duration of the influenza season.

In Summary: MyHealth.Alberta.ca, Health Link Alberta and InformAlberta are growing by adding new content and functions that will help more Albertans to manage their own health. In January 2014, Alberta Health Services launched the "Know Your Options" campaign to help Albertans understand what their health care options are and when to use them, so that they get the right care, in the right place. This multimedia, multilingual campaign helps provide direction to the public to call HealthLink Alberta, or visit their family doctor as the starting point for health advice, or to visit the AHS website for more information about health care options.

EMERGENCY MEDICAL SERVICES

When Alberta was hit by historic flooding in June 2013, AHS Emergency Medical Services (EMS) was on the front lines of flood relief efforts. From sending its Multi Patient Unit – a big bus capable of transporting multiple patients at a time – to relocating patients in High River and Drumheller, to using community paramedics to assist patients access basic health care needs such as medication, minor wound care, prescriptions and housing – AHS EMS was there to ensure Albertans received the care they needed.

FOCUS	PROGRESS/RESULTS
EMS: Develop a provincial EMS system fully integrated within the overall health system.	• EMS is involved in an ongoing study with the University of Calgary's Ward of the 21st Century in the Ambulance Design Research Project, the first of its kind in Canada. Its findings on how to best use the limited space in the back of an ambulance could influence the safety, layout and functionality of future ambulances in AHS and across the country. • In May 2013, EMS announced the innovative Community Paramedic Program, which has teams of paramedics and EMTs dedicated to providing community care to patients. Focusing mainly on seniors, these health care professionals provide care in the patient's residence. The program is currently operating in Lethbridge and Calgary. It is estimated that this program has prevented about 700 emergency department visits in its first year of operation. • Critical Care Medical Control Protocols to support air medical personnel in treating patients were completed. This will ensure safe, consistent care for patients across the province as well as enhancing training and safety for staff. • EMS has worked on ways to improve processes for third-party and out of province patient billings for air ambulance. It is using a Patient Care Record database to identify billable clients and also engaging with providers to assist in identifying billable parties/patients. • To make sure service plan strategies are more connected at the local community level, EMS initiated a more proactive approach to engaging communities regarding service plan modeling. • The development of electronic Patient Care Record (ePCR) specific to the air ambulance environment will improve accuracy and completeness of clinical information during transport, facilitate data collection, reporting, medical review and oversight. The ePCR system design and clinical content was completed. ePCR implementation is scheduled for early Summer 2014 for all contracted Air Ambulance providers.

In Summary: Saving lives and improving care is a vital goal for Alberta Health Services. Whenever EMS is called upon, lives are potentially on the line. Ensuring we are providing the right care, at the right time, by the right provider, will save lives. As we strive to improve overall system performance, we have implemented a co-ordinated series of initiatives across the province to improve patient care. Protocols to support EMS personnel in treating patients and avoiding hospitalization will continue to be implemented.

CONTINUING CARE

It is estimated, that by 2030, one out of five Albertans will be more than 65 years old and the average age of Alberta's population will continue to increase. Many seniors will be more independent and healthier than in previous generations. Others, including those with multiple chronic illness and disabilities, will need health care and will want options that allow them to receive care while continuing to live in their own homes and communities. With more options available and better access to caregivers, seniors will be able to live independently as long as possible.

PRIORITY ACTIONS	PROGRESS/RESULTS
Home Care Standardization: Streamline and standardize home care services.	• A Request for Proposals (RFP) was issued and concluded in Edmonton and Calgary Zones which resulted in a significant reduction in both the number of contracts and cost of services. All operators are now on standard contract terms with consistent accountabilities and funded rates. • Planning began in the zones to address equity between urban and rural zones, particularly with respect to personal care, respite care and caregiver support and Adult Day Program access. • Work is underway to expand existing adult day programs and to launch new adult day programs in both Calgary and Edmonton in early 2014-15. This will benefit more than 500 additional seniors.
Continuing Care Options and Capacity: Further development of continuing care spaces, options and capacity.	• A total of 335 net spaces were staffed and placed into operation in the 2013-14 fiscal year. • From April 1, 2010 to March 31, 2014, 3,369 net new continuing care and palliative spaces have been staffed and placed into operation. • As anticipated, 2013-14 has been a challenging year for net capacity increases. The unavoidable loss of space related to the southern Alberta flood and contract issues further decreased net new capacity. • Work continued to expand implementation of the Advance Care Planning Goals of Care across the province.

In Summary: Seniors have told us they want to remain safe and independent in their own homes, for as long as possible. In response, AHS is expanding services, and providing more home care to Alberta's seniors than ever before.

AHS continues to expand home care by adding more hours for those requiring short-term care, in order to prevent hospitalization or an emergency situation. There is a 2.8 per cent increase (3,043 clients) between 2012-13 and 2013-14 volume of home care clients served. In total for 2013-14, AHS had 112,227 home care clients across the province. All zones will continue to implement the new service guidelines and to educate staff to the new guidelines. In order to manage increased referrals from acute care, AHS implemented enhanced home care capacity to seven days a week with evening access to home care. Destination Home continues to increase home care services to clients with complex needs in Calgary and Edmonton.

AHS continues to expand seniors' health options to respond to our changing demographics and to provide quality care and support to Albertans and their families and caregivers. In 2013-14, 335 beds were added to the system which now totals 3,369 additional beds since 2010. Home care and adult day programs expanded in 2013-14 with 95 new adult day program spaces to meet the needs of Albertans. AHS has increased the unique number of home care clients by 12 per cent since 2010-11.

Unexpected or sudden medical events can leave us unable to communicate our wishes. Other medical conditions can slowly take away our ability to communicate or make decisions about our health care. Goals of Care and Advanced Care Planning are two initiatives which recognize the importance of understanding an individual's values regarding care choices and serves as a communication tool for individuals and health care professionals. In times of crisis, health care providers are enabled to provide timely care that is medically appropriate and meets the family's personal values and wishes. AHS will continue to ensure Albertans have an opportunity to document an at-a-glance summary of the focus of care and what the patient and family will and will not permit, preventing unwanted interventions especially during a medical crisis.

POPULATION HEALTH

In working to improve the health of all Albertans, we also recognize the need to promote better health and reduce health inequities. Enabling people to stay well and to minimize their need to access health services will improve both the quality of life for Albertans and enable the system to be more sustainable. This focus on health promotion and wellness underlies all of what we do across the continuum of care within AHS and requires full partnership with the public, government and a variety of stakeholders. This year, AHS worked with partners across Government of Alberta Ministries including Health, Education and Human Services to deliver greater coordination and integration for initiatives such as the Early Childhood Development Strategy.

PRIORITY ACTIONS	PROGRESS/RESULTS
Children and Youth – Nutrition, Activity and Mental Health: Partner with schools, school jurisdictions and community organizations to plan and carry out initiatives that increase availability of healthy foods and beverages, expand opportunities to be physically active, and improve mental health for children and youth.	• Comprehensive School Health (CSH) is an evidence-based approach to building healthy school communities. AHS collaborates with schools, school jurisdictions and community organizations to develop knowledge and skills; create supportive environments; and facilitate healthy policy development to support healthy eating, active living and positive mental health. • Completed report summarizing work between AHS, education sectors and community organizations to achieve the goals of promoting healthy eating, active living, and positive well-being to support healthy weights in school-aged children and youth. The report highlights that 90 per cent (target was 75 per cent) of school jurisdictions are partnering with AHS. • An external website **www.everactive.org/shaping-the-future** was established. Fifteen new CSH educational resources were added to the website which was further promoted through emails to AHS staff, schools, school jurisdictions and submissions to relevant school health newsletters.
Early Childhood Development: Work with the Ministries of Health, Education, Justice and Solicitor General, and Human Services to implement the Regional Collaborative Service Delivery Model (RCSDM) in support of early childhood development.	• AHS collaborated with the Ministries of Health, Education, Justice and Solicitor General, and Human Services to better integrate programs, services and supports for children and youth. This is an Alberta Education led initiative supported by AHS Primary and Community Care, Addiction and Mental Health. This initiative is intended to improve supports for children and youth in schools, including early childhood programs, and those between the ages of 0-20 years with complex needs and/or requiring extraordinary care. • Regional Collaborative Service Delivery merged the Student Health Partnerships, Children and Youth with Complex Needs and Regional Educational Consulting Services programs into 17 regional groups. Strategic plans were developed and approved by the 17 regional groups. • Implementation of the Regional Collaborative Service Delivery model is underway.
Infant and Pre-School Screening and Follow-Up: Work with AH to implement the Infant and Preschool Screening and Follow-Up Services Framework and the Early Childhood Development Priority Initiative.	• The Newborn Metabolic Screening (NMS) Program Initiative (2010-2015) will ensure all infants born in Alberta receive timely access to safe and effective newborn blood spot screening to support Newborn Metabolic Screening. • AHS completed NMS Program clinical policy suite implementation and evaluation plans. • 99.4 per cent of all newborns in the province are currently screened. Planning underway with Alberta Health regarding the implementation of the Infant and Preschool Screening and Follow-up Services Framework.
Child Injury Prevention: Develop guidelines and training resources and implement A Million Messages for child injury prevention (aimed to prevent abuse and injury for that age group).	• A Million Messages (AMM) standardizes the child injury prevention messages given to parents and caregivers and is designed to provide simple, consistent and targeted messaging to parents and caregivers as part of the core business of AHS health care professionals. • The AMM Online Learning Module went live on My Learning Link in January 2014 for provincewide use by AHS staff. It supports staff orientation to AMM program content and delivery. The module remains available to non-AHS health providers on the AHS public website at **www.albertahealthservices.ca/7607.asp**.
Healthy Parents and Children: Disseminate and begin evaluation of Healthy Parents, Healthy Children resources.	• Alberta Health and AHS media launch of Healthy Parents Healthy Children resources took place in November 2013, including the launch of the nine week Social Media campaign. • There have been a total of 56,867 visits to the website and distribution of printed material includes 91,100 redemption cards, 469,400 promotional cards and 40,420 book sets. • An evaluation plan for the Healthy Parents, Healthy Children initiative was developed.
Tobacco Reduction Strategy: Work with Alberta Health and other Ministries to implement the Alberta Tobacco Reduction Strategy.	• AHS worked with Alberta Health and other organizations to implement the Alberta Tobacco Reduction Strategy. • Tobacco Free Futures, an integrated health systems tobacco cessation model was implemented at 29 sites across AHS with continued expansion planned for 2014. Planned and proposed expansions include clients of Addictions & Mental Health and Cancer Control services. • The AHS Tobacco and Smoke free policy (site-based) was established and a tool to measure AHS compliance was implemented. • The "Keep Trying" marketing campaign targeting female smokers, 25-44 years of age, was launched. • The Nicotine Replacement Therapy research project has been implemented at four mental health and addiction sites across three zones.

PRIORITY ACTIONS	PROGRESS/RESULTS
Suicide Prevention: Work in partnership with the AHS Provincial Steering Committee on suicide prevention to increase the availability of prevention programs.	• Developed a system to track the number of partnerships that Aboriginal Youth and Community Empowerment Strategy (AYCES) communities establish with surrounding non-AYCES communities. • Nearly 650 people have received training to prevent suicide in Aboriginal communities through an AHS initiative. Four AHS staff members from the Aboriginal Health Program are certified to deliver Applied Suicide Intervention Skills Training (ASIST), an internationally recognized program for people who live and work with individuals at risk of self-harm. Since the AHS initiative was launched in late 2011, these ASIST-certified staff members have led two-day workshops for 36 aboriginal groups in First Nations and Métis communities across the province. ASIST participants learn how to discuss suicide with a person who might be at risk, identify risks and signs of self-harm, and develop a safe plan to address them, develop skills required to intervene with a person at risk, connect people to available resources and improve community resources and networking to better prevent suicide.
Alberta Alcohol Strategy (AAS): Work with Alberta Health and other Ministries in support of the Alberta Alcohol Strategy.	• AHS worked with Alberta Health, other Ministries and non-government stakeholders in support of the Alberta Alcohol Strategy to build shared leadership commitment to the strategy and build capacity to reduce alcohol-related harm. • Governance and leadership structures were put in place with Alberta Health, AHS and Alberta Gaming and Liquor Commission. In addition, the development of Alberta Alcohol Strategy Shared Action Plan for 2013-14 was completed and implementation of the actions is underway. • Consultation with 25 community coalitions to support local efforts to reduce alcohol-related harm (i.e. knowledge exchange strategy implementation for community coalitions, webinars, social network forums, formal learning events and individual consultation) is ongoing; 37 Community Coalitions participated at the March 2014 Coalitions Connect. • Canada's Low Risk Drinking Guidelines (LRDG) communication plan was approved. LRDG was promoted in AHS staff and public communications (i.e. National Addiction Awareness Week, social media feeds, myhealth.alberta.ca, Chief Medical Officer of Health blog). As well, seven education events and 30 consultations were delivered.
Environmental Public Health: AHS continues its efforts in support of environmental public health, including inspections of restaurants. The goal of the Safe Food Program is to contribute to the reduction of the incidence of food-borne illness. This is accomplished by inspecting food establishments, by education and enforcement.	• In June 2013, the investigative work by AHS with the 2012 E. coli outbreak associated with mechanically tenderized Costco beef steak traced to XL Foods was commended in the report of an Independent Expert Advisory Panel appointed by the Government of Canada. An excerpt from the Expert Advisory Panel's report: *"The investigation team at Alberta Health Services (AHS) quickly identified the link between human cases and the [mechanical beef tenderization] process at the North Costco store near Edmonton. With the collaboration of company management, AHS staff was able to take rapid action to minimize further exposure of the public to the threat, as well as bring the [mechanical beef tenderization] issue to the attention of CFIA and other provinces and territories."* AHS Environmental Public Health's identification of mechanical beef tenderization as a public health risk in Canada elicited a high profile, national-level discussion on the issue. • In September 2013, AHS Environmental Public Health officers identified an outbreak of E. coli illnesses associated with unpasteurized gouda cheese produced. AHS Environmental Public Health was the first agency in the country to link outbreak cases to cheese produced at the implicated facility, which eventually included 28 cases among five provinces. Identification of the outbreak elicited national-level discussion on requirements for raw milk gouda cheese production in Canada.

In Summary: AHS is working with Alberta Health (AH) to implement a long-term plan to promote wellness. However, the health system alone cannot make people healthier. We must partner with Albertans, other government departments, health service providers, communities, businesses and others to support individuals in taking personal responsibility for their health and Albertans in turn need to understand how to manage their own health and that of their families.

In 2013-14, AHS conducted more than 95,000 food safety inspections which is an increase of 10 per cent (9,064) from 2010-11. Also, AHS conducted more than 175,000 public health inspections which is a nine per cent increase from 2012-13. AHS delivers inspections and interventions in seven program areas: Safe Food, Safe Drinking Water, Safe Built Environments, Safe Indoor Air, Healthy Environments, Safe Recreational Water and Disease and Injury Control. The increase was largely due to AHS quick response to businesses and rental housing during the flooding in southern Alberta.

AHS annual seasonal influenza immunization program contributes to individual and population-level influenza prevention, including prevention of outbreaks in our facilities. AHS aimed to immunize half of its workforce in 2013-14. Health care worker immunization rates increased from 41 per cent in 2012-13 to 54 per cent in 2013-14. AHS continues to develop new strategies to provide enhanced communication and service delivery initiatives.

We helped prevent further spread of measles by undertaking a coordinated approach to assessment and immunization through Zone Emergency Operations Centres, and by activating the Provincial Emergency Coordination Centre. Thousands of individuals around Alberta were assessed, immunized and advised.

MENTAL HEALTH

The provincial Addiction and Mental Health Strategy is supported through the development of innovative community-based service models to address individuals with complex addiction and mental health needs and the further development of coordinated and consistent access for children and adolescents to addiction and mental health services.

PRIORITY ACTIONS	PROGRESS/RESULTS
Children's Mental Health Plan Implementation: Further development of coordinated and consistent access for children and adolescents to addiction and mental health services.	• Supported implementation of the provincial Addiction and Mental Health Strategy through further development of coordinated and consistent referral and access for children and youth to Addiction and Mental Health Services across the continuum. • Developed an inventory of the types of services provided locally, regionally (zone) and provincially. • AHS continues to participate in a cross-ministerial strategic planning process for "Children, Youth and Families Addiction and Mental Health" led by Alberta Health with Government of Alberta (GOA) Ministries of Education, Human Services, Justice and Solicitor General, as well as the Chief Medical Officer and community partners. • Completed a work plan for the Integrated and Collaborative Care Model for Complex Youth Project that was announced January 2014 in the Calgary Zone. The project will build on previous and current shared cross-ministerial services and will provide recommendations for a best practice model. • Shared support, tools and information with the GOA Ministry of Human services as it relates to planning and preparation for their new grant-funded children's mental health projects. • As part of the Children's Bed Plan Initiative, work continues to advance a Community of Practice that will create support and information to improve access for children and youth moving between programs and across health care sectors.

In Summary: Over the past year, significant work has been implemented to improve addiction and mental health delivery systems for all age groups. AHS has begun work on a care model for the support of seniors in continuing care environments who have been diagnosed with an addiction and/or mental health condition.

Examples of future work in mental health include the development and implementation of a sustainable model for addiction and mental health service delivery for Family Care Clinics throughout Alberta, to allow for provincial standardization with local adaptation to meet community needs.

CANCER

AHS worked with Alberta Health to implement the new provincial cancer strategy. This strategy focuses on accelerating the implementation of evidence-informed clinical pathways (how patients optimally flow through the system), best practices and standards in cancer surgery (beginning with lung cancer); prevention and early detection through breast, cervical and colorectal cancers screening; and support for cancer survivors and provision of palliative care.

PRIORITY ACTIONS	PROGRESS/RESULTS
Cancer Plan Implementation: Begin actions in support of the phased implementation of "Alberta's Cancer Plan to 2030".	• CancerControl Alberta brings together cancer facilities and programs under one umbrella to create a comprehensive and coordinated system of cancer prevention, screening, care and research for Alberta. • The provincial accountability framework that addresses alignment and integration to support provincial operational standards and equity of care is in place and aligns with AHS Health Plan, CancerControl Alberta Operations Plan and Changing Our Future: Alberta's Cancer Plan to 2030. • A comprehensive health information cancer-specific management unit, C-MORE was developed and implemented. • Three provincial councils (Radiation Medicine, Systemic Therapy and Supportive Care) and 12 tumour teams were created to support quality improvement and integration of services across the province. Significant quality improvement initiatives were initiated including a 10-year replacement plan. • In November 2013, the Red Deer Cancer Centre opened and offers radiation therapy and dedicated dietician and nutritional counselling. This complements the existing chemotherapy program. There have been more than 25 new staff hired or in the process of being hired to support the centre. As of the end of March, more than 140 patients have been treated with radiation therapy and have completed nearly 1,772 treatment sessions. Red Deer is the latest addition after Lethbridge, with Grande Prairie to follow in 2017. • In 2013-14, AHS launched the Enhanced Access to Cancer Screening Project. This project is sponsored by federal, provincial, zone and community partners to increase access to cancer screening for rural and remote communities. • The Alberta Breast Cancer Screening Program (ABCSP) initiated a trial to support women in rural and remote areas in having timely knowledge of their ability to access mobile screening services close to home or fixed site service (usually at a greater distance). The ABCSP will work to address any gaps which may result in inaccurate estimation of both breast cancer screening participation rates, and wait time for resolution of abnormal screening results. The Screen Test Program continued to provide mobile mammography services without disruption despite the displacement of the Screen Test south office. In addition, despite the closure due to flooding of the Screen Test fixed mammography clinic in Calgary, the Screen Test Program continued to provide screening mammography services to Calgary clients through the use of the south mobile unit which has been set up in Calgary. • The Alberta Cervical Cancer Screening Program made the following key accomplishments in the past year: Completed initial phase of development and testing of the Colposcopy electronic synoptic reporting system that includes all the essential data elements for this clinical procedure, as approved by a provincial committee and the Canadian Partnership against Cancer. Achieved 100 per cent implementation of all client correspondence for eligible women in Alberta (including invitation letters, results letters, and screening reminder letters). • Fecal Immunochemical Test (FIT) was implemented provincewide in November 2013. FIT is a new screening test targeting colorectal cancer, it is an easy, at-home test that can eliminate the need for average-risk Albertans to have a colonoscopy. Initial utilization of FIT is being closely monitored. An Alberta Colorectal Cancer Screening Program performance management framework including FIT related indicators is currently being developed.

In Summary: The long-term, strategic plan for cancer control in the province outlines a vision for 2030, where more cancers are prevented, more cases of cancer are cured and the suffering from cancer is greatly reduced. Changing Our Future will make better use of existing facilities and staff, and build or expand cancer facilities in Edmonton, Calgary, Red Deer and Grande Prairie.

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"Accountability and the Migration of Authority in Provincial Health Care," the 85th Annual of the Canadian Political Science Association, Victoria, June 2013

"Assessing the Accountability of Non-governmental Actors in Canadian Public Governance," the 84th Annual Meeting of the Canadian Political Science Association, Edmonton, June 2012

"Accountability and Non-governmental Actors in Canadian Public Governance," the 83rd Annual Meeting of the Canadian Political Science Association, Waterloo, May 2011

"Non-Governmental Actors in Public Governance: Accountable to Whom?," the Political Science Graduate Student Conference on Canadian Democracy, Carleton University, February 2011