# Corporate governance of public health services: Lessons from New Zealand for the State sector

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## Abstract

*New Zealand public hospitals and related services were grouped into 23 Crown Health Enterprises and registered as companies in 1993. Integral to this change was the introduction of corporate governance. New directors, largely from the business sector, were appointed to govern these organisations as efficient and effective businesses. This article presents the results of a survey of directors of New Zealand publicly-owned health provider organisations. Although directors thought they performed well in business systems development, they acknowledged their shortcomings in meeting government expectations in respect to financial performance and social responsibility. Changes in public health sector provider performance indicators have resulted in a mixed report card for the sector six years after corporate governance was instituted.*

## Introduction

The New Zealand public health delivery system came under the governance of corporate boards of directors on 1 July 1993 after more than a century of central and local political control. The move to corporate governance was made rapidly and was associated with

other changes in the organisation of the New Zealand health system. These changes were intended to place New Zealand public hospitals on a strong and rational commercial footing. This article reviews this policy initiative from the perspective of the board directors themselves and it seeks to assess the response of directors to the expectations of government as shareholder of these enterprises. It also briefly reviews Crown Health Enterprise performance against those criteria directors considered most important to the government, and discusses a range of indicators used by government to monitor Crown Health Enterprise performance.

One view of governance is that it is responsible for ensuring policy is carried out and for maintaining organisational viability. It ensures management 'does it's job' and it holds management accountable (Shortell & Kaluzny 1993). In the public health sector, governance is sometimes required to provide accountability to the community which is served by complex, multifaceted health care organisations.

Advocates of agency theory in public sector reform hold that agents should not be accountable to more than one principal. The design of publicly-owned governance systems in health care organisations needs to take into account the competing interests of straight-line accountability on the one hand and the social objectives of the State on the other (Boston et al. 1996). The literature identifies a range of governance typologies, some with their own subsets. Some models focus on sources of income, while the distinction between market, bureaucratic and clan models (Wilkins & Ouchi 1983) allows recognition of other important considerations such as culture. The clan model, as distinct from both the market and bureaucratic models, seeks to strengthen the link between an organisation's objectives and the personal objectives of key employees (Pawar & Eastman 1997). Another view suggests a community model can represent 'the ideal of a 'foundation' organised to apply professional expertise for the benefit of the larger community or society' (Bunderson, Lofstrom & Van de Ven 1999).

## Health reforms and the move to corporate governance

The most recent health reforms in New Zealand were announced by the government in 1991 and implemented in 1993. They were intended to improve access to effective and affordable care, encourage efficiency, flexibility and innovation, reduce waiting time and widen choice (Upton 1991). The Area Health Board system was abandoned in favour of a structure that separated the purchasing of health services from their provision. It was intended that each New Zealander's entitlement to health services would be mandated by the Core Health Committee, a national committee tasked with either developing a positive list of services to which people would be entitled or a negative list to which they would not. Four regional health authorities would purchase services from public, private and voluntary agencies, and 23 Crown Health Enterprises would manage the nation's public hospital and related services.

Competition and a business-like approach were central to these reforms. The public sector providers were to generate profits for government to re-invest in health services. In 1992, the National Interim Provider Board, an agency of the Prime Minister's Department established the Crown Health Enterprises according to the following principles:

- each would have clear commercial objectives with the *Commerce Act 1986* as the cornerstone
- high-quality directors would be replaced if they were not able to perform satisfactorily
- shareholding Ministers would establish performance objectives
- an arm's length relationship would exist between the government and operational management
- a competitively neutral environment would exist with no in-built advantage to government-owned providers
- managers would have autonomy to make effective use of resources and mechanisms would be established to hold them strictly accountable for their performance in meeting the Ministers' objectives
- tax neutrality would exist with no disadvantage to the private sector
- the Treaty of Waitangi, which recognises the rights of the indigenous people of New Zealand, would continue to apply (National Interim Provider Board 1992).

Public hospitals, mental hospitals and their related community services were provided by hospital boards until 1989. These boards were controlled within a bureaucratic model of governance by elected people from a variety of backgrounds. Arrangements began to change in 1989 when Area Health Boards were established to replace the hospital boards. The Minister of Health began to appoint members with commercial expertise to add to the governance expertise on boards, however they continued to operate within a bureaucratic model. Health board members had limited autonomy and those in governance did not have the powers of directors operating under the provisions of the *Companies Act 1993*, the statute mandating the operation of private companies in New Zealand. In July 1993 the latest round of health reform placed all their services within the Crown Health Enterprises network.

Within the past ten years, the New Zealand public health system has changed from a cooperative/collaborative system (up to 1993), to one in which government attempted to create a market (1993–96) with a return to cooperation/collaboration (1997–99). Notwithstanding these radical changes, the system of governance of the pubic provider organisations has remained stable in a corporate model with a strong emphasis on rational decision-making within a commercial framework.

Establishment of the Crown Health Enterprises was undertaken within each region of New Zealand by advisory boards made up of five or six people, each with commercial skills and experience (National Interim Provider Board 1992). Approximately 150 people were appointed to 'shadow' boards throughout New Zealand in November 1992 and these people took responsibility for the delivery side of the public health sector in July 1993. The corporate governance model was expected:

> *…to be as profitable and efficient as compatible businesses that are not owned by the Crown [and further to] gain an acceptance that change is necessary if the enterprise is to win contracts and prosper. (Crown Health Enterprise Board Designate 1992)*

When the study began the health provider organisations were called Crown Health Enterprises but part way through the study their name was changed to Hospital and Health Services. These organisations report to government through the Crown Companies Monitoring and Advisory Unit, an agency of the Treasury.

Initially the intention was that these Crown entities would compete for contracts. In 1996, this intention was changed and Hospital and Health Services were formed. The discourse changed. Collaboration and cooperation replaced competition and contestability.

This is the background against which our study took place. An important objective of the study was to gain an understanding of how the corporate model works in professional organisations in what is essentially a political environment.

## Research design and methods

### Research design

All directors of Crown Health Enterprises were invited to complete a questionnaire and this was followed by interviews with a sample of chairpersons. Other stakeholders in the sector were also studied. This article draws on the findings from the directors' survey and chair interviews.

### Participants

The 95 directors who were the participants in this study were members of the boards of directors of the 23 New Zealand Crown Health Enterprises in 1997. Subjects were recruited by a mailed questionnaire, with a follow-up questionnaire sent to non-respondents. The total response rate was 95/149 (64%). Twenty-seven per cent of respondents had a health background (usually medicine or nursing), 41% a non-health professional background (often accounting, finance, law) with the remaining 32% from a variety of backgrounds including manufacturing, banking, retail and local government. Seventy-one per cent were men.

The 12 chairs interviewed in 1998 were from a cross-section of large metropolitan, provincial city and small Crown Health Enterprises in both the North and South Islands. These interviews were used for elaboration of the issues raised by directors and are not fully reported in this article.

### Questionnaire

Participants were asked to rate on a five-point Likert scale:

- their perception of the State's priority for performance in six areas in which it had expectations of directors:
  – business practice
  – business planning
  – financial performance
  – service/quality performance
  – change management, and
  – social responsibility
- the clarity of the State's expectations in each area, and
- whether the time spent in directors' meetings on these activities was appropriate.

The questionnaire explored the nature of the relationship between directors and the government as owner and the Crown Companies Monitoring and Advisory Unit as agent. The suitability and success of the business model was examined and the instrument to determine the nature of the Chair/Chief Executive Officer relationship compared with customary experience in a commercial organisation was sought.

### Statistical methods

Analysis was carried out with the SPSS for Windows software package. The relationship between the variables was assessed using one-way analysis of variance and multiple regression analysis.

## Results: Survey of directors

Directors considered that government placed the highest priority on performance in the business planning function. Priority was also given to 'sound business practice' and 'financial performance'. Table 1 shows the perceptions of directors of government's expectations across the range of activities. Crown Health Enterprise performance in the social responsibility area is a lower priority than other areas.

Government was understood to be clearest in its expectations in the same areas as it was perceived to have the highest priority. This is shown in Table 2. A lack of clarity was perceived in the change management and social responsibility areas.

**Table 1: Directors' perceptions of shareholder expectations**

| Area of performance of directors | Government's priority for performance in this area* |
|---|---|
| Sound business practice | 82.1 |
| Business planning | 95.8 |
| Financial performance | 86.3 |
| Service/quality performance | 58.9 |
| Change management | 50.6 |
| Social responsibility | 33.7 |

* As measured by the percentage of directors who perceived government's priority for performance in the area as high or very high on a five-point Likert scale where 1 = very low, 2 = low, 3 = neither, 4 = high and 5 = very high

**Table 2: Directors' perceptions about the clarity of shareholder expectations**

| Area of performance of directors | Clarity of government's expectations in this area* |
|---|---|
| Sound business practice | 44.2 |
| Business planning | 60.0 |
| Financial performance | 66.4 |
| Service/quality performance | 32.2 |
| Change management | 18.9 |
| Social responsibility | 23.4 |

* As measured by the percentage of directors who perceived that the government was clear or very clear in its expectations on a five-point Likert scale where 1 = very unclear, 2 = unclear, 3 = neither, 4 = clear and 5 = very clear

**Table 3: Directors' perceptions as to their success in meeting shareholder expectations**

| Area of performance of directors | Success in achieving expectations* |
|---|---|
| Sound business practice | 74.7 |
| Business planning | 75.7 |
| Financial performance | 44.2 |
| Service/quality performance | 66.3 |
| Change management | 53.7 |
| Social responsibility | 45.2 |

* As measured by the percentage of directors who perceived that they had been successful or very successful in meeting the expectations of government on a five-point Likert scale where 1 = very unsuccessful, 2 = unsuccessful, 3 = neither, 4 = successful and 5 = very successful

Table 3 shows that directors believed they had been more successful in meeting some shareholder expectations than others. They did not rate themselves highly in the area of financial performance.

Half the study participants (50.5%) found the level of reporting to the Crown Companies Monitoring and Advisory Unit was more or much more than they had expected. They viewed the role of the unit to be analogous to that of a control agency (80.4%), with only 28.6% perceiving it to be in the role of market analyst. Although 55.4% believed that there was a tendency for shareholders to by-pass directors and deal directly with management, only 17.9% considered that this was a problem. However 69.6% agreed or strongly agreed that the relationship between directors and government is compromised by the fact that the government is both a shareholder in the Crown Health Enterprises (Hospital and Health Services) and the dominant funder of public health services.

Eighty-two per cent of the respondents supported the business model. More specifically, 75% disagree or strongly disagreed that the nature of health care is such that the business model is inappropriate in a publicly-funded system. However 89.3% considered that the model would be improved if the Crown Health Enterprises had been established with stronger balance sheets and realistic revenue flows. Notwithstanding this, support for the model was qualified. Directors were likely to consider the business model unsuitable when they found themselves spending more time discussing management and efficiency issues [$t(71) = 2.52$; $p < 0.05$] and when they felt they were unsuccessful in meeting social responsibility goals [$t(71) = -2.242$; $p < 0.05$].

Fifty-two per cent agreed or strongly agreed that the relationship between the Chair and the Chief Executive Officer is more of a partnership than is customary in a commercial organisation. Those directors with a health background agree more strongly with this proposition than directors with non-health backgrounds (who comprised 73% of the participants).

## Discussion

Directors were clearest about their role in financial and business affairs. Nevertheless, there was and remains a statutory requirement on directors to act with social responsibility. A Chairperson of a Crown Health Enterprise in a provincial city explained the obligation to be socially responsible this way:

> *Certainly all of us feel a moral obligation to the community but without question the government has financial constraints on health and the provision of health and we have some very, very strict criteria in which we've got to perform. So our actual focus tends to be on efficiencies, that is, lowering our costs, getting more for the buck out of the organisation.*

Several chairpersons of large city Hospital and Health Services referred to their lack of identity within the community in which they served. Further, they said all directors in their cities had a low profile. This is in contrast with the situation in smaller centres where the directors have a much higher standing and where they find it is realistic to relate to major community organisations such as Rotary and iwi (local Maori authorities which can speak and act on behalf of their members). A quid pro quo here is that in small towns and cities local directors are less likely to be effective in driving structural change. As one chairperson of a small hospital and health service observed, '…if the Minister wants this local hospital closed down, he'd have to come and do it himself because we sure as hell aren't going to do it'. Another said, in reference to the problem of inefficient and (arguably) ineffective small hospitals, '…boy, it's hard being the 'axe murderer' in the small towns'. So while the corporate governance model operates comfortably in the metropolitan areas, directors who live in the smaller cities and districts are mindful of the political realities of survival in small-town New Zealand.

The New Zealand experience with corporate governance is in contrast with the United Kingdom experience with National Health Service trust governance in that the New Zealand boards appear to have played a stronger role. Ferlie, Ashburner and Fitzgerald (1995) report that non-executive (or non-employee) directors in the National Health Service trust setting, 'probed and sought further information but seldom shaped strategic decisions and only rarely confronted the executive'. The experience of chief executives in the New Zealand Crown Health Enterprise sector suggests the corporate governance model has had a more direct impact on business operations than this. One Chief Executive Officer (from 1993 until 1998) observed:

> *Boards brought a particular way of asking questions and discussing issues and they came from another paradigm which meant that management either had to shape up or in most cases they shipped out.*

The *Companies Act 1993* places a legal requirement upon company directors to act in company interests rather than in the interests of a broader group of stakeholders. One consequence of the purchaser–provider element of the health reforms is that there is no ambiguity about who is responsible for allocating resources to meet health needs. In the reformed health system in New Zealand it is the purchaser, not the provider, who is responsible for resource allocation to meet health need. One consequence of the commercial model concerns values. In any health system the potential exists for a clash of values among directors and staff involved in the provision of health services. Ferlie, Ashburner and Fitzgerald (1995) refer to this potential among executive and non-executive members of National Health Service trust boards. However, since New Zealand Hospital and Health Service boards operate under the *Companies Act 1993*, issues such as whether a Hospital and Health Service should expand facilities for private patients does not arise as an ethical dilemma. If establishing such a facility was to make commercial sense, a New Zealand Hospital and Health Service would require a strong reason for resisting such an initiative. Likewise, a decision to close a support services operation, resulting in a loss of local employment in favor of a more efficient option

able to be provided elsewhere would be encouraged under New Zealand-style corporate governance. In this connection, the Chair of a Hospital and Health Service in a small town remarked with respect to one such decision:

> *We'd be irresponsible if we didn't discuss the consequences of actions before we take them, but we still take them, although the odd director will say 'oh [expletive], we shouldn't do that because, because…'*

Under the old Area Health Board system, it would have been difficult to manage the politics of getting private beds in public hospitals and virtually impossible to close anything.

While half the participants agreed or strongly agreed that the relationship between the Chair and the Chief Executive Officer is more of a partnership than is customary in a commercial organisation, a disproportionate number of these study participants came from a health background. Those directors most likely to know about the relationship in the non-health or commercial setting were less convinced. Among those directors who considered that the relationship involves more of a partnership, there was a clearly expressed view that health is somehow 'different'. Health was identified as 'new territory', with more complex demands from the government as shareholder. There was a consensus among Chairs that the political sensitivities required a different approach. Chairs who were interviewed had a range of views. Most identified politics as a factor. The Chair of a metropolitan Crown Health Enterprise explained the difference this way:

> *…the only difference would be that the politics of it requires a different relationship…and understanding the vagaries of Wellington was not one of [the Chief Executive Officer's] strengths and I had worked in that for years…'*

Williamson (1989), Stewart (1991) and Ferlie, Ashburner and Fitzgerald (1995) consistently report on the special relationship in health organisations between the Chief Executive Officer and the Chair. The suggestion from these writers is that the Chair probably plays a more significant role than s/he would in a comparable company in the private sector and that there is a depth to the relationship which often develops into something akin to a partnership. The results from our study are consistent with international findings.

## Performance of the corporate model

While the purpose of this chapter is not an evaluation of the health reforms or their provider component, we include some discussion of how the corporate enterprises have performed because expectations of corporate governance were high. In fact, in some quarters, it was believed that corporate governance would deliver substantial savings in operating revenue.

Evaluating the model is difficult for a number of reasons. The introduction of corporate governance was one of several major changes that took place in 1993.

When it was introduced it was the government's intention that public providers of health services operate in a competitive environment. Indeed it was the State's belief that efficiencies in the sector would be generated as a result of this competition. The model was seen as both natural and necessary given the other elements of the reform program. Although the Coalition government in late 1996 mandated a shift to a cooperative culture, the corporate governance model has been retained. The language of management discourse has altered during the past six years from a harsh commercial discourse (competition, profits, agent-principal relations) to a discourse which acknowledges cooperation and working together for health gain as legitimate aims. For example, patients are no longer referred to as revenue-generating units by staff in the Health Funding Authority. However, despite this shift in language and expectations, the government still monitors Hospital and Health Service activity by using a number of financial and non-financial performance indicators. These are contained in a quarterly report that summarises Hospital and Health Service performance in league tables across 18 measures.

Table 4 shows changes in a selection of financial and non-financial indicators during a 15-month period ending March 1999.

Inpatient throughput has improved with an overall reduction in length of stay and an increase in bed occupancy. Consumer satisfaction shows over half of all patients consider that overall the treatment or care they received was very good or better. Financial performance is mixed. Some indicators show improvement, others do not. Overall the financial position of the sector has deteriorated. In December 1997, the Crown Companies Monitoring and Advisory Unit advised the Ministers of Health and Finance that the Hospital and Health Services sector was planning to maintain costs around current levels over the 1998–2001 period which, if achieved, would 'represent a significant improvement over past performance' (Weeks 1998). There is no evidence that this has happened and the deficit for the sector has deteriorated.

It has been clear for some time that government was not going to be able to obtain a return on health assets comparable with the return it obtained on other State assets entrusted to State-owned enterprises. The Crown Companies Monitoring and Advisory Unit reported in 1997 that '…the return is well below the return that would be expected of a commercial company, reflecting both pricing and efficiency issues'. Elsewhere in the same letter, it was noted that:

> *…during the same period the average length of stay for the sector has decreased, the occupancy rates have increased to an average of just under 90%. Personnel costs per unit of output were stable and there was an increase in the return on assets. (Weeks 1997)*

The sector is costing more to operate that it was in 1993 but more work is being performed. The complexity of the workload has increased.

**Table 4: Changes in public health sector provider performance, December 1996 to March 1999**

| Indicator | Sector average December 1996 | Sector average March 1999 | Diff | Per cent change | Direction of change |
|---|---|---|---|---|---|
| Average length of stay[1] | 4.76 | 3.86 | 0.9 | 18.9 | Positive[2] |
| Inpatient bed occupancy rate | 76.96 | 79.31 | 2.35 | 3.0 | Positive |
| Direct personnel salaries per inpatient day equivalent[3] | $262.42 | $327.38 | $64.96 | 24.8% | Negative[2] |
| Percentage casemix-weighted elective day-stay surgery[4] | 52.77 | 52.02 | 0.72 | 1.4 | – |
| Staff turnover[5] | 5.16 | 5.72 | 0.56 | 10.9 | Negative |
| Customer satisfaction questionnaire, percentage of 'very good' replies | 56.40 | 57.54 | 1.14 | 2.0 | Positive |
| Year-to-date net income ratio[6] | –6.57% | 2.11% | 8.68 | 133 | Positive |
| Year-to-date return on equity | –10.57 | 7.44 | 18.01 | 170 | Positive |
| Debt-to-debt plus equity ration | 41.89 | 46.23 | 4.34 | 10.4 | Negative |
| Acid test[7] | 0.88 | 0.76 | 0.12 | 13.6 | Negative |
| Year-to-date debt service coverage ratio[8] | 1.14 | 5.21 | 4.07 | 357 | Positive |

*Notes:*
1. Diagnosis Related Group-based casemix-weighted average length of stay for inpatients and day patients
2. 'Positive' means improvement across the sector, 'negative' means deterioration
3. This is the average cost of doctors and nurses per inpatient day
4. This indicator is adjusted for casemix complexity
5. This is the ratio of total staff departures to total employed whole time equivalent (WTE)
6. Year-to-date net income before extraordinaries, asset sales and tax as a percentage of total revenue
7. Cash and temporary investments divided by total current liabilities
8. Year-to-date net income, excluding depreciation, interest expense and extraordinaries over interest expense. This is a measure of the sector's ability to service borrowings

*Source:* Crown Companies Monitoring and Advisory Unit 1999

## Conclusion

Evaluating health policy is especially difficult when changes in policy are continually being made as lessons are learned. The corporate governance model has remained intact although the health reform program that commenced in 1991 has been amended significantly since that time. We believe that to evaluate corporate governance in the New Zealand public health sector would require a multiple stakeholder analysis that is beyond the scope of this article. However, we do comment on the operational/commercial performance since it was in this area that government had high expectations of directors. Of the 11 measures of performance reported on by the Crown Companies

Monitoring and Advisory Unit over the past 15 months, six indicate performance improvement, four indicate a deterioration and one remains the same. This is a rather mixed report card for the Hospital and Health Services sector.

Directors of Crown Health Enterprises were clear in their understanding of what government wanted from its reform program and from them. They gave themselves good marks for performance in business systems development (see Table 3) but acknowledged their shortcomings with respect to being able to meet government's expectations in the areas of financial performance and social responsibility. In this respect, corporate governance has not delivered all it promised.

It was expected that corporate governance would deliver good commercial results at the beginning of the decade, with the experience gained it continues to be expected that corporate governance and good management will drive efficiencies and deliver effective services for the New Zealand public.

Ferlie, Ashburner and Fitzgerald (1995) note that there has been a tendency by government to ignore or conveniently forget previous experience and that maybe there is a case for slowing down rates of change to allow time for reflection and learning from the recent past. Perhaps now is the time to reflect on experience of corporate governance.

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