# Hospital board structure: changing form and changing issues

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## Abstract

*Economic and social pressures are compelling many hospitals to consider their current board structure in an effort to position their hospital to meet changing demands. A national profile of the structures of hospital boards has been compiled from a questionnaire completed by hospital board representatives from both government and non-government sectors.*

*Results show that hospital board structures are a hybrid of both philanthropic and corporate models. New structures may be required to meet future challenges. In developing new structures, consideration should be given to identifying the skills and processes required to undertake board business.*

## Introduction

The placement of governing boards at the top position on models of organisational structures not only depicts their level of authority, but also the extent of their accountability for outcomes, irrespective of whether the organisations (in this case hospitals) are from the government, non-profit, or for-profit sectors. Board activities require interactions with the internal and external environments. In the case of the hospital, both are being affected by the advent of innovations, particularly those associated with technical and economic changes. Consequently, hospital boards increasingly find that they must undertake their functions under changing conditions. Many hospital boards have modified their structures or are presently considering alternative structures in order to respond to these new challenges (Hodge 1993; Witt 1993; Johnson 1994).

## Structure and restructuring

Boards of hospitals, and particularly their future structure and function, are extensively discussed in the North American literature. Views on the value of boards in organisations range from hospital boards being held up to boards of corporations as examples of best practice (Ewell 1993), to warnings that they may be on the brink of irrelevancy (Gappmayer 1994; Weiner1993). Drastic change is frequently recommended for board practices to meet the new demands brought about by changes in the economic and technical environment (Griffith 1988; Kovner 1990; Sofaer 1991; Stuart 1990; Young 1992; Zigli 1993).

The structural characteristics of a hospital board tend to follow either a philanthropic model mostly associated with the non-profit sector, or a corporate model taken from business or the for-profit sector (Delbecq 1988 Weiner 1993). These board models have been identified and characterised by and others. As shown in Table 1, Weiner (1993) compares these two types of boards according to variables which include number of members, skills, internal representation, membership turnover, selection criteria, influence of management, level of compensation to members, focus of decision making, level of participation and committee structure.

**Table 1: Characteristics of two main types of Governing Boards**

| Philanthropic | Corporate |
|---|---|
| Large board size | Small board size |
| Wide range of perspectives and backgrounds | Narrower, more focused range of perspectives and backgrounds |
| Less corporate representation on board | Greater corporate representation on board |
| Less physician representation on board | Greater physician representation on board |
| Numerous participants in new board member selection | Few participants in new board member selection |
| Constituent/community representation criteria for new board member selection | Skill /expertise criteria for new board membership selection |
| Little management influence in new board member selection | Active management participation on boards |
| No limit to consecutive terms for board members | Limit to consecutive terms for board members |
| No compensation for board service | Compensation provided for board members |
| Emphasis on asset preservation | Emphasis on strategic activities |
| Large number of standing committees | Small number of standing committees |
| Less active strategic committees | More active strategic committees |

(Weiner 1993 p 328)

Historically, hospital boards have closely resembled the philanthropic model. However Coile (1994), in two separate surveys, found that they are beginning to acquire characteristics associated with the corporate model. These changes include the increasing involvement of insiders from internal management, compensation for outsider members, the number of representatives on the board, and length of service and age of members. Adopting a new board model is influenced mainly by a hospital's unique characteristics and environmental situation rather than by any pre-defined formula (Coile 1994).

## The emerging corporate environment

The philanthropic model for hospital boards has served the organisations well (Delbecq 1988). However, the new economic environment in which hospitals are being managed is placing this model under challenge. In the past, the economic environment for hospitals was less focused on budgets, and more on community demands. However, with the escalation of health care costs, and the introduction of budget strategies focused on competition, hospitals are being forced to function in an economic climate that bears comparison with the corporate environment (Scotton 1999). Hospital boards must now provide more sophisticated input into decision-making, through the representation of a range of stakeholders including the community or customer, service providers and budgeting experts (Gautam 1996). This has been achieved by changing the skill mix of the board to include specific expertise such as accountancy, law or physician skills. The short term consequences have found some hospital boards moving away from their primary focus as agent of the community within the organisation, to looking more inwardly at internal planning needs (Young 1992).

This changing role heightens the dilemmas that arise from acting within a corporate context while at the same time representing the ideals of the non-profit sector (Seay 1989). Such conditions have found hospital boards functioning in an "... uncertain, turbulent, and hostile environment", in which the membership is faced with an extensive range of challenges of social, ethical, budgetary and control origins (Stuart 1990)

Altering the composition of a hospital board is not a universally supported change. Although it is recognised that additional expertise is required, the value of lay persons to the organisation's goals continues to be acknowledged (Wilson 1991; Judge 1992; Druker 1989). Judge (1992) found that philanthropic hospital boards achieved greater involvement of their membership in the strategic decision-making process than did

those based on a corporate model. This is a particularly important finding, as it contradicts the argument often used to underpin the need for change: that boards based on a traditional philanthropic model were less likely to be involved in activities associated with strategic planning.

One of the most recent changes to hospital structures, and likely to have a major impact on the role of the board, is the amalgamation of services (Hudson 1993). Within this type of hospital structure, boards will be required to take a more active leadership role in directing the way in which the organisations will respond and adapt. This process generally results in the organisation becoming larger and more diverse. New processes are required to incorporate a new range of inputs, and this may be achieved through extensive consultation and communication with both internal and external stakeholders of this type of organisation.

## Characteristics of membership of the hospital board

The function of a board must be defined by its purpose as a political activity, underpinned by numerous sub-texts and vested interests. How individual boards undertake their function depends on the characteristics of their members in terms of whom or what they represent, and how they enact their role.

In the past, a board's role was clear: to represent the interests of shareholders. In the non-profit sector, this meant the community. However, recent discourse on representation shows a discernible change of focus from shareholders to stakeholders. This change is significant in that it depicts an extension of the board's role to include greater involvement with the organisation's 'insiders' (Starkweather 1988) or key members of the hospital population, frequently, the Chief Executive Officer (CEO) and some form of representation from the physician group.

The position of the CEO on a board varies from full membership to attendance when required. CEOs can be viewed as integral to the functioning of the board, in that they bring valuable information to the decision making process. Alternatively, they can be considered with some suspicion, as their position on the board could be viewed as self-serving; boards should be mindful of the possibility of bias embedded in information received from the CEO (Molinari, 1997 Weiner 1993). Arising from this ambiguity are issues of power and authority between the board and the CEO (Goodwin 1992 Heuerman 1989), but these roles should become clearer with the amalgamation of services. The CEO is likely to be responsible for day-to-day management functions, while the board remains concerned with the development of long term strategies (Hudson 1993).

Similarly, support for physician representation on boards has always been high, as in this way, members gain necessary information about the internal efficiency of the hospital (Young 1992). But again it is recognised that the information provided may be biased to varying degrees - a physician's vision for the hospital may be viewed through his or her own professional perspective, rather than from a broader overall perspective of service provision (Kovner 1990).

External members were traditionally selected from the community to enhance the image of the organisation with their 'legitimacy-enhancing' and 'prestige-lending' characteristics (Fennell 1989). Organisations that have restructured their board since 1980 have mostly achieved this in two ways. First, by decreased the number of external members and applying new selection criteria based on desirable skills rather than general community representation and second by increasing the number of insiders (Molinari, 1993 Witt 1993). Other issues recently examined include length of membership term and compensation for members (Delbecq 1988 Coile 1994).

## Survey method

A survey was designed to gather information, nationally, on the structure and characteristics of hospital boards, from institutions of similar size and function, representing both the non-government and government sectors. Responses were analysed to determine the distribution of specified variables relative to board structure and type of hospital, in government and non-government sectors (Hair 1995).

Questionnaires were forwarded to the chairperson of the board of 150 hospitals; each was an acute care facility, with a bed capacity of 100 or over from the non-government sector, and 200 or over from the government

sector. From 150 hospitals surveyed, 70 questionnaires were returned, of which 47 were completed but 23 were incomplete. Some of the 23 boards who did not complete the questionnaire gave explanations. For instance, Queensland and Tasmanian Government hospitals indicated they did not have boards of management. The private sector hospitals did not have their own board but were managed through a larger company board. Hospitals from New South Wales and Western Australia were represented by regional boards, but were unsure if these boards had already undertaken the questionnaire on their behalf. Twenty of the complete returned forms represented single hospitals, while the remaining 27 collectively represented 162 hospitals.

# Results

Results from the survey focus on two main structural issues: the number of services represented by the board, and the characteristics of hospital board members in relation to skills mix, selection and tenure, performance appraisal, compensation arrangements and training provision.

## Number of Services

Of the 47 completed responses to the questionnaire, 57.4% represented the non-government sector and 42.6% represented the government sector. There was a variety in the number of hospitals represented by each board, as indicated in Table 2.

### Table 2: Number of hospitals under the direction of the board

| Number of hospitals under the direction of the board | Non-government | Government |
|---|---|---|
| 1 hospital | 66.7% | 25.0% |
| 2 hospitals | 3.7% | 20.0% |
| 3-6 hospitals | 18.5% | 30.0% |
| 7-10 hospitals | 11.1% | 5.0% |
| 10 and over | | 20.0% |

## Skills mix

Constitutional obligation for requiring specific skills mix representation on board differed between the government (80%) and the non-government (68.4%) hospitals. Table 3 shows that the most prevalent skill represented on the boards in both sectors, at 88.9% for non-government and 90% for government is the physician.

### Table 3: types of professional skill represented on boards

| Types of skills | Non-government | Government |
|---|---|---|
| CEO | 51.9% | 65.0% |
| Other from management | 40.7% | 25.0% |
| Elected staff member | 22.2% | 50.0% |
| Outside accountant | 77.8% | 55.0% |
| Outside lawyer | 85.2% | 65.0% |
| Interest group | 55.6% | 60.0% |
| Business person | 85.2% | 70.0% |
| Medical officer | 88.9% | 90% |
| Other | 29.6% | 40.0% |
| No response to question | 3.7% | 5.0% |
| Total | 57.4% | 42.6% |

The profiles for outside lawyers, outside accountants, interest groups and business persons are relatively consistent across the two sectors, though several government hospitals indicated they also had board representation from Universities. The largest variations between sectors are for elected staff, and representation from the management group, other than CEO. The non-government hospitals have less elected representation, at 22.2%, than the government hospitals, with 50%. Management is represented on 40.7% of the non-government boards, and 25% of the government hospitals. The CEOs' status on boards varied between the two sectors, though none appeared as chairperson. In the non-government sector, 44.4% were permanent members with voting rights, and 51.9% were required to attend without voting rights. Conversely, a larger proportion (65%) of government hospital boards had CEOs as permanent members with voting rights, while 35% asked CEOs to attend but with no voting rights.

## Selection and tenure

The questionnaire covered four main aspects of the selection and tenure of board members and chairperson: the overall process; representation of women on the board; status of the medical officers; and length and number of terms in office.

## Selection

Respondents were asked to identify the various methods by which board members were selected on to their board. The profile from the multiple response variables (see Table 4) shows several differences in the processes between the two sectors.

**Table 4: processes used for the selection of external board members**

| Selection processes of external representation on board | Non-government | Government |
|---|---|---|
| Individual application | 11.1% | 30.0% |
| CEO recommendation | 33.3% | 20.0% |
| Government/owner | 70.4% | 90.0% |
| Chair of board | 14.8% | 0% |
| Competitive election | 11.1% | 5.0% |
| Recommended by members of the board | 59.3% | 15.0% |
| Pre-identified skill needs of the board | 51.9% | 20.0% |
| No external representation | 7.4% | 0% |

In the non-government sector, board member selection methods (other than owner involvement) included CEO recommendation (33.3%), recommendation of other members (59.3%), and selection for pre-identified skills (51.9%). Few hospitals used individual application (11.1%), recommendation by the chair of the board (14.8%), or competitive election (11.1%).

The government sector gave high priority to external representation (90%) on their boards, but few other techniques were used. They included individual application (30%), pre-identified skills (20%), and recommendations from other board members (15%). Few hospitals used competitive election (5.1%), and none relied on selection by the chairperson .

The process of selection of the board's chairperson is similar for both sectors, with the most frequent being appointment by the owner (51.9%) or government (57.9%). In 44.4% of non-government and 31.6% of government boards, the chairperson is elected by the other board members.

With regard to female representation on boards, 81.9% for non-government and 78.9% for government reported they had no policy. Government hospitals reported 21% female board members, with 30% of the boards at 41-50% representation. 22.2% of non-government boards have no female representation, and the remainder have between 21% and 50% representation.

Of the 85.1% of the sample that responded, 45.5% of non-government and 61.1% of government boards reported that medical officers were mainly appointed to the board by the owner/government. The next most prevalent method (non-government, 31.8% and government, 33.3%) was through election from the hospitals' medical officers.

### Tenure

Policies on length of a board members term was commonly between 3 and 4 years (58.3% for non-government and 75% for government); a few had no limits to the length of term. The permitted number repeat terms per member, ranged from 2-4 to 7 and over, and varied between the two sectors. Non-government policies ranged from a set limit of 2-4 (47.6%), to 7 terms and over (47.6%). The government sector placed fewer restrictions on tenure with 72.2% of the boards allowed terms of 7 and over. The response '7 years and over' may also imply that no policy exists on the number of terms per member.

Length of term for a chairperson differs between the two sectors; the most common length for a non-government board is 'no set time' (40.7%), followed by 1-2 and 3-4 years, each at 29.6%, and the number of repeat terms varies between 2-3 terms (47.1%) and 6 or more (35.3%). In the government sector, the most common length for a term is 3-4 years; a smaller proportion (26.3%) of hospitals designate no fixed term, and 92.3% hospitals allow the number of repeat terms of 6 and over. This high number and the relatively low response rate to this question (63.8%) could indicate that the government hospitals did not hold a policy on length of tenure for the chair.

### Performance appraisal and 'staff development'

Performance appraisal of board members and chairperson was an issue canvassed in the survey. Respondents were asked who performed such a review, and whether resources were allocated to "general staff development" of board members.

Over half the respondents (53.8% non-government and 57.9% government) indicated that performance appraisals were conducted, often on an annual basis (30.8% non-government and 21.1% government). The most prevalent processes in the non-government hospitals were self-evaluation (53.8%) and a review by the chairperson (30.8%). In the government hospitals, it was more likely that the chairperson would undertake the review (60%), though 20% employed a process of peer review.

Few boards (about 42% from each sector) formally evaluated their chairperson's performance; where chairperson appraisal was conducted, this was most commonly undertaken by the owner (28%) or government (23.5%).

### Training provisions

On the issue of "staff development" for board members, more than half the hospital boards (55% non-government and 53.8% government) identified no allocated budget for this purpose. Where resources were provided, there was no consistent specified purpose for the allocated funds.

### Compensation

Compensation provided to board members varied between the two sectors. Of the non-government hospitals, 55.6% provided for out-of-pocket expenses and 33.3% did not provide any form of remuneration. In the government sector, 50% of hospital boards claimed to provide compensation at a salaried rate, and 25% indicated that no remuneration was provided.

## Discussion

For both sectors, the survey revealed an extensive number of amalgamated services under the umbrella of one board. As argued by Hudson (1993), this inevitably has an impact on how boards function. Although it is argued that hospital boards establishing new structures employ principles closely associated with those of corporations (Coile 1994), researchers have identified that, in reality, they do not classically represent either form. Rather, there is a tendency towards hospital boards being hybridised between the corporate and the philanthropic models (Weiner 1993 Griffith, 1987).

Hospital boards involved in this survey showed a consistency with this position. Most of the hospitals surveyed did not have a policy on skills' mix, or on matching new members to pre-identified required skills. The dominant skills selected, mostly by the owner/ government, were from groups outside the hospital, such as the law, business, accountancy and (to a lesser extent) interest groups. From insider groups, the most highly represented were medical officers, selected either by owner/government appointment or by peer election. Just over half the hospitals included the CEO on the board. Although the skill mix of the board is relatively consistent with the corporate model, the policies on tenure, performance appraisal, training provision and, to a lesser degree, compensation remain consistent with those associated with philanthropic boards.

## Skills mix and selection

The change of hospital boards to a corporate model structure is based on a perceived need for more sophisticated and specific knowledge to be brought to the decision-making process. It has been suggested that a hospital board should comprise a small, elite group of people, holding the desired expertise, who have past experience in governance, and whose skills are aligned through needs analyses and skills audits (Hageman 1993 Witt 1993). However, a review of the professional and academic literature on the changing structures and functions of hospital boards found little correlation between corporate model boards and improved hospital performance (Sofaer 1991). One alternative to such wholesale adoption of the corporate model would be to contract the relevant expertise when required (Wilson 1991). This would have the advantage of overcoming any skill deficit, while maintaining the benefits of board membership with a broader focus.

In contrast to the rhetoric surrounding community representation, selection was largely based on a candidate's association with a power base, rather than their ability to represent the needs of the broader community. It was expected that the board member's political and/or financial associations would contribute to maintaining the hospital's dominance in the provision of services (Hageman 1993). However, with higher educational standards and access to information, community expectations of their hospital's board to represent their needs have grown. In New Zealand, for example, all hospital boards must now have two community members. Similarly, in the case of a very public conflict between Berkshire Medical Centre Board and its community, the outcome clearly articulated the community's expectation of the board's role as "responsible first and foremost to their community as those responsibilities were defined by the community" (Pryor 1993).

Meanwhile, the decision of many hospitals to increase the number of insiders on their board, as in the corporate model, must be examined. Insiders bring invaluable information about how the hospital is functioning; however, it must be recognised that such information will not be value free (Hageman 1993 Kovner 1990). Specifically, information from nurses or physicians requires critical review prior to adoption, since their allegiances are necessarily divided between the hospital and their own professional norms (Delbecq, 1988). Membership of a CEO on the board of their hospital can equally be argued for and against. The argument in support of their inclusion is based on the CEO's presumed commitment to the organisation's goals (Delbecq 1988). Against this is their vested interest in outcomes (Pointer 1994), especially when information directly relates to the CEO's role, or to outcomes arising from their actions (Molinari 1997).

## Educational need, performance appraisal and compensation

A major difficulty for a board consisting of lay-people from outside the organisation, is their lack of knowledge about the health care system (Delbecq 1988). As a result, most information, particularly regarding the internal functioning of the hospital, is gained through the insiders on the board, frequently, the CEO and representative(s) from the physician group (Molinari 1993 Starkweather 1988). Because of the rise in pressures brought on by the changing economic environment, it is increasingly important for all board members to be able to fully participate. A considerable education program is needed to overcome knowledge gaps that could prevent informed decision-making. Such a program should provide knowledge based on the role and responsibilities of the board, quality assurance, finance, physician relations, strategic planning, the CEO-board relationship, and executive evaluation (Coile 1994; Delbecq 1988; Dolan 1993; Witt 1993).

Concerns over the length of a member's tenure relate more to the effectiveness of their contribution to board's business than simply to the length of time served. Renewal of tenure needs to be linked with outcomes from performance appraisal that is designed to measure members' commitment, their level of comprehension of the

role, participation in decision making, analytical skills, dependability and personal traits (Coulson-Thomas 1993; Johnson 1994; Pointer 1994; Witt 1993). While renewal of board membership should be based on performance criteria, consideration should also be given to the importance of continuity, 'corporate culture' and its contribution to board stability, in seeing through long term strategic goals. However, if specific skills are required, and where greater expectation of output by board members is recognised, then compensation may need to be considered as an incentive to attract the best people to the position and as an incentive for high performance (Coile 1994).

### Hospital amalgamations

As in other countries, the recent amalgamation of hospitals and other health services requires subsequent changes to hospital board structures. For instance, of the 47 boards that participated in the survey, 27 were responsible for two or more hospitals.

Amalgamations result in larger and more diverse organisations, whose planning processes must incorporate a convergence of input. To achieve this, extensive consultation and communication is necessary between both internal and external stakeholders. Once amalgamated, the governance of the organisation becomes more clearly defined; the board can again focus on long term planning strategies and the CEOs on implementing policy.

## Conclusion

Rather than hospital boards becoming irrelevant to the future of their organisations, as in some Australian States, this study suggests that they will increasingly be integral to the development of a contemporary health care service, particularly within the context of amalgamations. Nonetheless, to be responsive to the new challenges brought on by the demands of a changing economic environment along with an informed customer base, careful consideration should be given to current board structures.

Any changes to selection criteria will require a balance between the desire for specific skills, information about the internal environment, and a perspective on broader community needs. The adoption of a corporate model, with a smaller number of representatives who are either from inside the organisation or who have highly specialised skills, could result in a narrow perspective for the organisation's plans. Alternatively, keeping a large and outmoded board structure will also inhibit the future of the organisation. In developing a new structure, the focus should be on those elements that currently obstruct a board in fulfilling its charter. In particular, consideration should be given to identifying the skills required to undertake board business, inclusive community representation, a compensation plan to attract the best people, the establishment of a 'staff development' plan, and a performance appraisal strategy.

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