Delivering democracy? An analysis of New Zealand's District Health Board elections, 2001 and 2004

Robin Gauld

Abstract

The district health board (DHB) system is New Zealand's present structure for the governance and delivery of publicly-funded health care. An aim of the DHB system is to democratise health care governance, and a key element of DHBs is elected membership of their governing boards. This article focuses on the electoral component of DHBs. It reports on the first DHB elections of 2001 and recent 2004 elections. The article presents and discusses data regarding candidates, the electoral process, voter behaviour and election results. It suggests that the extent to which the DHB elections are contributing to aims of democratisation is questionable.

Aust Health Rev 2005: 29(3): 345–352

What is known about the topic?

The election of board members has a long if patchy history in the public and voluntary health care sector. Concerns about the fairness of the process, and the quality of the outcomes, are sometimes outweighed by the principles of community participation and democratic values.

What does this paper add?

Less than half of the eligible voters participated in the elections of district health board members in New Zealand in 2001 and 2004, and the performance of the electoral system was problematic. Two post-election surveys revealed voter confusion and failure to ensure that all voters have the opportunity to participate. Accountability to the constituents is compromised by countervailing requirements.

What are the implications?

Enabling people to vote in board elections may not be the most effective way to democratise health care. If election of DHB members is to continue, further changes to the electoral system are required.

HEALTH CARE IS THE LARGEST public expenditure category in New Zealand, accounting for almost 20% of all government expenditure. This is equivalent to 6.8% of gross domestic product (total health expenditure is 8.7%).[1] Reflecting the size and importance of the sector (and political preferences), the governance and organisational arrangements for publicly funded health care in New Zealand have been restructured several times since the late 1980s.[2,3] The most recent set of arrangements were announced by a new Labour-led coalition government following the 1999 general election. Commonly known as the "district health board" (DHB) system, this features 21 regionally based DHBs. A primary motivation for creating the DHB system was to democratise health care governance, particularly in terms of increasing opportunities for public participation in health care planning and decision-making processes. Thus, DHBs feature various mechanisms for engaging with the public, one of which is elected membership of their governing boards. This article reports on the DHB elections of 2001 and 2004. First, it overviews the DHB system including the rationale, the regulatory framework and governance structures. Next, it considers the organisation and results of the 2001 and 2004 elections. Finally, the article reflects on the extent to which the elections have delivered on aims of democratising health care governance.

Robin Gauld, Senior Lecturer in Health Policy

Preventive and Social Medicine, University of Otago, Dunedin, New Zealand.

Correspondence: Dr Robin Gauld, Preventive and Social Medicine, University of Otago, PO Box 913, Dunedin, New Zealand. **robin.gauld@otago.ac.nz**

The DHB system

The DHB system was implemented on the tail of a decade (the 1990s) of health system restructuring

in New Zealand. As with prior restructures, the plans for the DHB system were unveiled following a general election and change of government. The health systems in place through most of the 1990s were based on a competitive business model, with health services treated as commodities, with contracting and tendering at the heart of funding and cost setting, and service governance concerned primarily with price and quality issues and accountable only to central government. This said, toward the latter part of the decade, both government policy and the health system had begun to embrace other concepts including community involvement, greater transparency in decision-making, reducing health inequalities, and improving primary care and collaboration between service providers.[4,5] Immediately preceding DHBs, the system consisted of a single national purchasing body, the Health Funding Authority, that maintained local presence in a number of regional offices, as well as 23 hospitals and Health Services which were clusters of public hospitals governed by appointed boards. Primary medical care was provided by private independent general practitioners (receiving government subsidies), many of whom were grouped into formal practitioner associations.[6]

Despite the policy evolution through the 1990s, the Labour Party, which had earmarked health system change in pre-election campaigning, viewed the health system governance structures as lacking local presence and failing to facilitate adequate public participation. Labour argued that this lack of presence and participation were the source of low levels of public confidence found in an international health-system study.[7] Creation of the DHB system was no small undertaking, involving dissolution of the Health Funding Authority and splitting its purchasing functions.[8] Some of these were transferred to the Ministry of Health; others devolved to the new DHBs.

The DHB system is conceptually similar to the Area Health Board system, in place from 1989–1991, that preceded the "competitive" era of 1992–1999. The DHB system consists of 21 DHBs centrally funded by the Ministry of Health. DHBs are responsible for planning, prioritising and purchasing health services from an appropriate range of providers for their regions' residents. They are to focus on and develop strategies to improve population health and do so in collaboration with the community and in keeping with central government policy guidelines.[9]

Each DHB has 11 members: seven elected by popular vote; the remaining four appointed by the government, including the crucial positions of board chair and deputy chair (although these two appointees may be selected from among elected members). In recognition of the Treaty of Waitangi, the founding agreement signed in 1840 between the Crown and indigenous New Zealand Maori people, the government decided that two of the 11 members should be of Maori ethnicity. Serving each DHB is a permanent secretariat including a chief executive, and various planners, managers and contract negotiators. DHBs have developed a series of inter-regional "shared service" agencies to provide support in areas such as information and contract management and financial, legal and human resource services. As noted, the government's aims for the DHB system are to improve population health, but also to increase public participation in the health system by devolving decision-making to the local level and democratising governance.

There are several tensions surrounding DHB governance.[10] First, DHB members, particularly elected members, sit in a difficult position of having dual accountabilities to both the Minister for Health and to voters. However, in recognition of this, the regulatory framework, expressed in the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, makes it quite clear that DHB members are responsible first and foremost to the government. DHB boards and individual members who fail to produce a "satisfactory performance" face a range of sanctions from funding withdrawal and government supervision through to sacking. Thus, there is limited scope for those seeking to challenge government policy. Second, DHBs differ from other local governing bodies in that they do not have a role in formulating policy. They are largely

1 2001 and 2004 District Health Board candidate information

	2001	2004
Total candidates/seats contested (*n*)	1084/146	518/147
Candidates per seat (*n*)	7.4	3.5
Male sex	55.2%	56.9%
Incumbents	6.7%	23.5%
Maori	11.7%	12.9%

responsible for implementing government policy and are restricted to developing local methods for this. Third, with a fixed budget yet unlimited service demands, combined with a requirement to prioritise and consult the public, DHBs are in a difficult position of having to seek community endorsement of choices between different services and patient needs.

The DHB elections: 2001 and 2004

Background

The inaugural DHB elections were in October 2001, in conjunction with the New Zealand local government elections. Local government elections are held every 3 years and traditionally conducted using the "first past the post" electoral system. This was also the method for the 2001 DHB elections. In 2001, DHB regions were broken into wards to ensure representation across diverse geographic and demographic areas. DHB regions were typically divided into urban and rural wards containing anything from one to five seats depending on the size of the ward population. DHB regions (built around the prior hospital cluster catchment areas) and wards were not aligned with local and regional government boundaries.

Responsibility for conducting DHB elections naturally fell to local government returning officers. Voting was by post, as has been the case for recent local government elections. Local government returning officers were also charged with educating the public about DHB elections (as well as city council, regional council and community board elections), receiving nominations and facilitating polling. Around a month before the election closing date, voting papers were mailed to all registered voters. DHB voting papers were sent alongside other local government voting papers. Voting packs also included booklets containing candidate profiles and photographs submitted by candidates.

Central government also launched a public education drive to announce that candidate nominations were open and that the elections were imminent. This included television, newspaper and movie theatre advertisements, creation of an election telephone hotline, and household letterbox mailouts. Government information consisted of overviews of the DHB system, highlighting the aim of public involvement in health care delivery as discussed above.

Arrangements for the 2004 DHB elections were largely the same as 2001, with one key difference: the single transferable voting system (STV) (preferential voting) was mandatory. STV was optional for other local-body polls, although widely employed. STV requires that voters rank candidates in order of preference. Following calculations based on the number of voters and seats, a quota is set — this being the number of votes required to be elected. Once a candidate has reached the quota and been elected, additional votes for that candidate are reassigned to the voters' next-ranked candidates until the next most preferred candidate reaches the quota. This process of transferring votes continues until the preferred candidates have reached the quota and all vacant seats are filled. The use of STV meant abolition of wards in favour of "at-large" DHB region electorates.

As shown in Box 1, in 2001, 1084 candidates contested 146 seats out of a total of 147 (one seat had only one candidate), meaning there were 7.4 candidates per contested seat. Some wards attracted high candidate numbers. For instance, voters in the Waitakere ward, one of three composing the Waitemata DHB, had a choice of 50 candidates contending for three seats. In the Christchurch ward, 75 candidates contested five

2 2001 and 2004 District Health Board election results

	2001	2004
Voter turnout	50%	42%
Male sex	55.5%	57.1%
Incumbents elected	35.6%	55.8%
Maori elected	2.7%	7.5%
Blank or invalid votes	5.6%	15%

seats. The 1084 candidates were 55.2% male. In all, 54 candidates (5%) were DHB employees, 73 (6.7%) were incumbent board members, and 127 (11.7%) were of Maori ethnicity. Perhaps predictably, given the different objectives and potential for greater politicisation inherent within the DHB system, many incumbents did not present themselves for election.

In 2004, the number of candidates dropped to 518, or 3.5 per seat. The gender split was roughly similar to 2001, as was the proportion of Maori candidates. There was a substantial increase to 23.5% in the proportion of incumbent candidates (around 83% of incumbents stood for election). There were again large numbers of candidates in some DHB electorates. The Capital Coast and Counties Manukau DHBs had 40 and 41 candidates, respectively, and several DHBs had over 30 candidates. However, the at-large electorates meant candidates were vying for seven seats.

Election results

Box 2 summarises the results of the 2001 and 2004 DHB elections. In 2001, voter turnout was 50%, with a considerable reduction to 42% in 2004. This low polling level is in keeping with New Zealand's recent local government elections, with a turnout of only 48.5% in 2001, dropping to 45.2% in 2004. North American research suggests that postal voting increases participation, particularly in local government polls.[11] Following this, turnout could have been worse if a traditional polling-station method requiring voters' physical presence had been used. This said, the 2004 results were further undermined by the fact that 15% of voting papers were either returned blank (7.9%) or incorrectly filled out (7.1%), rendering them invalid.

Similar proportions of males and females were elected to DHBs in 2001 and 2004. There was a significant increase in the number of incumbents elected in 2004, with the proportion of incumbent candidates also considerably higher (Box 1). More Maori candidates (11 [7.5%] of all elected members) were elected in 2004, compared with only four (2.7%) in 2001.

Candidates from a wide range of professions and backgrounds were elected in 2001. For instance, 55 (37.4%) had experience in the health professions including medicine, nursing, midwifery and pharmacy; 45 (30.6%) had worked in business or law or had company director/analysis experience; and at least 16 (10.9%) had backgrounds in community work and advocacy. In 2004, 11.6% of those elected were employed by the DHBs they were elected to. Almost 35% had prior experience in local government.

The high candidate volume in many wards in the 2001 poll meant that most DHB members were elected with a very small percentage of total votes and backed by a small minority of voters. For example, in the Tauranga ward (33 candidates; three seats) 87 485 votes were received from 45% of eligible voters, each of whom was able to vote for up to three candidates. The three successful candidates received between them 23 160 votes (26.47 % of the total). The situation in 2004 is difficult to compare, owing to the introduction of the STV voting system and at-large electorate. It may have been marginally improved, although again only a small proportion of the low numbers of participating voters backed each of the seven successful candidates in each DHB electorate. The Bay of Plenty DHB (which absorbed the Tauranga ward), for example, had a turnout of 44.9%, just above the national average. A total of 49 294 valid voting papers were received, with each voter able to cast up to seven ranked votes. Mirroring the situation in other DHBs, the quota that successful candidates were required to reach was 5515 votes. Only one

3 Reasons why respondents did not vote in the District Health Board elections

	2001 (*n*=173)	2004 (*n*=183)
Don't know	20%	27.9%
Didn't know about elections	15%	16.4%
Didn't receive voting papers	11.5%	17.5%
No interest in elections	27%	30.1%

4 Reasons for voters' choice of candidates in the District Health Board elections

	2001 (*n*=327)	2004 (*n*=345)
Used candidate profiles	60.5%	53.5%
Looked for someone I knew	25.7%	35.2%
Took a guess	4.2%	3.2%

5 Main candidate qualities sought by voters in the District Health Board elections

	2001 (*n*=327)	2004 (*n*=345)
Experience in health service	57.4%	61.2%
Experience in community work	20%	21.6%
Experience in management or financial matters	6.8%	6.7%

candidate gained enough first preference votes to reach the quota.

How did voters select candidates?

How voters made their choices is an important question, given the numbers of candidates in both elections. For the 2001 poll, an added difficulty was the small proportion of incumbents and the fact that most candidates lacked any experience in DHB governance. To investigate voter behaviour, a fixed-response survey of voters was conducted by the author immediately following the 2001 (500 voters) and 2004 (529 voters) elections. Respondents were randomly selected from telephone directories. In 2001, 100 respondents were sampled from each of five wards with large candidate numbers, representing rural and urban areas in the North and South Island of New Zealand; in 2004, five DHB electorates were targeted again with 100 respondents from each, and with rural, urban, North and South Island representation (the 529 respondent total is the result of oversampling).

In the 2001 and 2004 surveys, 65.4% and 65.3% of respondents, respectively, had voted in the DHB elections. This suggests the survey sample was not wholly representative of the general voting population. Those who had not voted were asked why. The most frequently cited reasons are listed in Box 3. There is a notable increase in 2004 in those who did not know why, and those who failed to receive voting papers.

Respondents were asked how they made their choices from among the multiple candidates presenting themselves for DHB election. As shown in Box 4, the candidate profiles supplied with voting papers proved a useful information source for many. A proportion looked for candidates they knew. A small number resorted to guess work.

Respondents were also asked what main candidate qualities they looked for in making their choices. Results are in Box 5. There was a slight increase in 2004 in the numbers seeking health service experience, a similar level of support for community work and comparably low preference for candidates experienced in management and finance.

Finally, in the 2004 survey, respondents were asked whether they found the STV system confusing. One third (33.2%) agreed that it was.

Appointed DHB members

Shortly after the October 2001 elections, the government unveiled its list of DHB chairpersons. It announced the additional appointees in January 2002. Appointees were selected in

accordance with a number of criteria, including prior experience in health sector governance. Among the 84 appointees, 53 had been pre-election incumbents and 46 fulfilled the criteria of being Maori. A number of appointees stood as candidates but had failed to win seats. In all, 79 (34.1%) of the 231 elected and appointed DHB members had served as board members before the elections.

In 2004, DHB chair appointments were again announced following the elections. In all but two cases, current chairs were reappointed to provide, as suggested by the Minister for Health, "continuity and stability". Remaining appointees were added in December 2004, although there remain seven "vacant" positions as the Minister for Health retains the right to appoint up to four members of each DHB board. In contrast with 2001, there were only five incumbents among the 75 appointees; 49 self-identified as Maori. There were a total of 87 incumbents (38.8%) among the 224 elected and appointed DHB members.

STV and vote counting

There was an unanticipated fiasco that enveloped the 2004 DHB vote counting and release of election results. STV vote counting requires a complex series of computer-assisted calculations. Vote counting for New Zealand's local government bodies and DHB elections was subcontracted to private providers who, in collaboration with the government, had designed computer programs for the task. Election results were expected within hours of the deadline for returning voting papers. Instead, there were considerable delays in processing owing to software problems, mislaid data and a general failure to foresee the extent of work required to process STV votes. To the ire of candidates and delight of the media and opposition politicians, 18 of the 21 DHBs (as well as several city and district councils) had to wait for over 4 weeks for announcement of results. In response, the government has requested a full parliamentary inquiry into all aspects of the elections. This will most likely report in late 2005.

Discussion

New Zealand's DHB elections raise a range of important questions, given that an original intention of the DHB system, and particularly the electoral component, is to increase public participation in health care governance and decision-making. The first is whether the two elections have succeeded in delivering on the aim of democratisation. Clearly, there are doubts about this. In both elections, there were a considerable number of non-voters, an outcome which undermines the legitimacy of the electoral process and system. If anything, an increase in voter participation, not a substantial decrease, may have been expected in the 2004 poll, given that there would have been more knowledge of the DHB system than in 2001.

At the very least, it might be suggested that the electoral process allows for members of the community to present themselves as prospective board members, as opposed to a select few being hand-picked by government as was the case with the corporate system preceding DHBs. The sizeable number of candidates at both the 2001 and 2004 elections might be viewed as a strong measure of support for, and therefore positive outcome of, the democratic process. This stated, there are strong financial incentives for candidates: at around NZ$24 000 per annum for an estimated 30 days' work, plus additional pay for sub-committee work, DHB members are remunerated at much higher rates than most other New Zealand local-body representatives. Offsetting the lack of public participation in the DHB electoral process are other regulatory requirements of DHBs. As outlined above, these include considering the needs and preferences of the entire community (not just those who voted), and ensuring community consultation in planning and decision-making. In other words, while the elections have failed to achieve widespread public support, the DHBs are still required to engage with the community.

Second is the question of why close to 60% of voters did not participate in the 2004 DHB elections. The survey reported in this article provides some insights here. Many may have

been confused. Not only did voters have to deal with a new voting system, they also were voting for multiple elections and, in some cases, facing a mix of first past the post and STV. Notably, a proportion of voters did not receive voting papers, effectively stripping them of their opportunity to participate, while the number of those who had no interest or did not know about the elections must be of concern to the government and DHBs.

The longer-term implications of the vote counting debacle remain unclear. It may be that, following the 2005 parliamentary review, the method of voting will be simplified. It may also be that voter confidence has been irreparably damaged. Of course, it is possible, given the restrictive operating environment of DHBs outlined in this article, that some voters simply see little point in voting. Members of at least one DHB have spoken out about the high levels of government intervention in DHB governance matters and tight constraints within which they work, while others have implied that they are simply government messengers. Public involvement in DHB meetings and consultation efforts has been limited. Again, this has been a concern to DHB members.

Third, Maori continued to be under-represented in the 2004 elections, as they were in 2001, requiring a substantial number to be added via the appointments process. This said, all Maori appointees were selected in accordance with several criteria and bring multiple skills and experience in community and health care service and governance. Nonetheless, were these DHB members elected, it may enhance their legitimacy and perhaps connect Maori people more closely with their representatives. It may be that, as in the New Zealand parliament, contestable Maori-specific seats need to be created for DHBs.

Finally, it is not clear that the STV system introduced in 2004 has promoted the democratic process. As a proportional representation system, STV is ostensibly fairer.[12,13] However, it is possible that STV confused voters, as was the case with one-third of respondents to the survey discussed in this article. It is possible that STV contributed to the drop in voter turnout, as well as the large proportion of blank and invalid voting papers, all of which undermines the democratic process. There have been post-election allegations that the at-large STV electorates have left some communities with no local representative. The previous ward system of the 2001 elections ensured representation in specific remote and rural areas within DHB boundaries. There have also been suggestions that STV produces results that are no different, nor a ballot any more fair, than first past the post would have. As noted in this article, few of those elected in 2004 received strong voter endorsement.

Conclusion

The material and data presented in this article show that the electoral component of the DHB system is failing to make a substantial contribution to democratisation of health care governance in New Zealand. Considerable shortcomings were evident in both the process and outcomes of the 2001 and 2004 polls. These include voter confusion, failure to ensure that all voters have the opportunity to participate, questions over electoral system performance, and low voter turnout.

With the electoral component now established, it would be difficult, at least for the present government which is likely to be re-elected in late 2005, to simply abandon DHB elections and go back to an appointment system. This is despite the fact the government could argue that there are many other ways that DHBs ensure public participation in decision-making. Much work, therefore, is needed to improve the electoral process. With the next DHB elections in 2007, there is opportunity in the interim to consider different polling methods such as traditional polling booths; revert to first past the post and smaller wards as in the 2001 elections; engage in much more public education about DHBs, the voting system and the importance of voting; rigorously test vote-counting mechanisms to ensure that the debacle of 2004 is not repeated; and consider staging the DHB elections at a different time from those of other local bodies. Short of such meas-

ures, another substandard electoral performance may be expected.

Acknowledgements

I am grateful to the New Zealand Ministry of Health and Department of Internal Affairs for provision of DHB election data; the Dunedin School of Medicine, University of Otago, for funding the DHB voter survey discussed in this article; Associate Professor Peter Herbison, Department of Preventive and Social Medicine, University of Otago, for statistical advice and assistance; and the two anonymous referees for comments on a prior draft.

Competing interests

None identified.

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(Received 15 Feb 2005, accepted 13 Jun 2005) □