Health Reforms 2001 Research Project

Report No. 2

GOVERNANCE IN DISTRICT HEALTH BOARDS

Pauline Barnett

Clare Clayden

On Behalf of the Health Reforms 2001 Research Team

August 2007

Health Reforms 2001 Research Project

Report No. 2

GOVERNANCE IN DISTRICT HEALTH BOARDS

Pauline Barnett

Clare Clayden

On Behalf of the Health Reforms 2001 Research Team

August 2007

Published By
Health Services Research Centre
Victoria University of Wellington

Additional copies available at www.vuw.ac.nz/hsrc
Or from Maggy Hope maggy.hope@vuw.ac.nz 04 463 6565

Table of Contents

Introduction to the Health Reforms 2001 Research

In 2001, the New Zealand government introduced reforms to the structure of New Zealand's health and disability sector. Under the New Zealand Public Health and Disability Act 2000, the government introduced a number of overarching strategies to guide the health and disability sector and it established 21 District Health Boards as local organisations responsible for population health and for the purchasing and provision of health and disability support services at a local level.

In 2002, funding was provided to chart the progress of, and to evaluate, these reforms as they were implemented. The research took place between 2002 and 2005. This paper is one of a series reporting on findings from the research. The papers in the series focus on:

- *Health Reforms 2001Research: Overview Report*
- *Governance in District Health Boards*
- *District Health Board Strategic Decision Making*
- *Financing, Purchasing and Contracting Health Services*
- *Devolution in New Zealand's Publicly Financed Health Care System*
- *Māori Health and the 2001 Health Reforms*
- *Pacific Health and the 2001 Health Reforms*
- *Overview Report of the Research in Five Case Study Districts*
- *Print Media Reporting of the DHBs*
- *Performance of New Zealand's Publicly Financed Health Care System: A Focus on Performance Under the New Zealand Public Health and Disability Act (2000)*
- *Public Sector Management and the New Zealand Public Health and Disability Act*

The project was funded jointly by the Health Research Council of New Zealand and by the Ministry of Health, the Treasury and the State Services Commission through a grant from a Ministry of Research, Science, and Technology Departmental Contestable Research Pool. We are grateful to them for their funding of this research and for the excellent support and advice they provided during the project.

The Research Team warmly acknowledges the support of Board members, DHB staff, providers and stakeholders who have contributed to the various strands of this research. We thank all those who so willingly shared their knowledge and opinions with us.

Research Team Members

Research team members in August 2007 were:

- Dr Jacqueline Cumming, Director, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Associate Professor Toni Ashton, Centre for Health Services Research and Policy, University of Auckland
- Associate Professor Pauline Barnett, Department of Public Health and General Practice, University of Otago, Christchurch
- Dr Tim Tenbensel, Centre for Health Services Research and Policy, University of Auckland
- Professor Nicholas Mays, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington and the London School of Hygiene and Tropical Medicine
- Tai Walker, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Dr Amohia Boulton, Te Pūmanawa Hauora, Massey University
- Dr Lynne Pere, Senior Research Fellow – Māori, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Kirsten Smiler, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Larna Kingi, Research Assistant, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Marie Russell, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Sue Buckley, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Janet McDonald, Research Assistant, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Clare Clayden, Senior Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Marianna Churchward, Research Assistant, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington
- Fuafiva Fa'alau, Independent researcher, Pacific health
- Lanuola Asiasiga, Independent researcher, Pacific health
- Hilary Stace, Research Fellow, Health Services Research Centre/Te Hikuwai Rangahau Hauora, Victoria University of Wellington.

We would also like to thank the following research team members for their earlier contributions to this research: Professor Gregor Coster and Professor Michael Powell, University of Auckland; Professor Chris Cunningham, Dr Cindy Kiro, Dr Stephanie Palmer and Dr Maureen Holdaway, Massey University; Dr Lou Gallagher, Mili Burnette, Dr Megan Pledger Celia Murphy, Dr Roshan Perera, Anne Goodhead, Nicola Grace and Anna Lloyd, Health Services Research Centre; Kiri Simonsen, Stephen Lungley, Margaret Cochrane and Siân French, Ministry of Health; and Jo Davis, National Health Service Management Trainee.

Executive Summary

Introduction

There have been major changes in health governance internationally over the past two decades, with New Zealand no exception. Of importance has been the evolution of more complex 'hybrid' forms of governance that take account of multi-organisation and multi-level arrangements, both government and non-government. International research suggests that the structures of governance actually play a limited part in the effective functioning of boards, but are important for locating boards in their context, by defining expectations, accountabilities and essential relationships. The effective functioning of boards tends to be related to the extent to which boards are engaged in strategic decisions and understand their task and the vision of the organisation.

In New Zealand the changes in health governance, according to policy informants, since 1999 have been explicitly with the aims of:

Ensuring that the government achieves the population health outcomes it requires through:

- adherence to national strategy set out by the Minister of Health
- levels of devolved funding and decision-making
- accountability to the Minister of Health.

Involving the community in health decision-making through:

- the participation of community members in governance
- transparency of decision-making
- other forms of engagement with the board.

The purpose of this paper is to explore governance arrangements in district health boards, assess the extent to which these aims have been fulfilled and highlight any changes that might enhance the performance of governing boards. Māori governance issues are addressed in a separate paper.

Research methods

The research adopts an evaluation research approach by concentrating on the inputs (governance 'model'), the processes (the functioning of boards) and the outputs (performance of governance roles).

The literature used for framing the research and providing insights into the working of governance has been drawn from data base searches of refereed health management and policy journals, with some additional sources from websites of selected consultant and health organisations. Emphasis was placed on non-profit and public sector and health governance in particular.

Mindful of the criticism of Peck (1995) that too much governance research relies exclusively on the perceptions of board members, data for the analysis of DHB governance has been drawn from a range of sub-projects of the Health Reforms 2001 research. These sub-projects included:

- Interviews with national and government stakeholders
- Two interviews with CEOs of DHBs
- Two interviews with Chairs of DHBs
- Two postal surveys of Board members
- Case studies in five DHBs.

The DHB governance 'model'

Number of DHBs

The rationale for establishing 21 DHBs, based largely on existing organisations, involved a trade-off between the desire to develop a new 'model' with a focus on improving health and the wish to minimise the disruption caused by further change. While the presence of a number of small and medium sized DHBs has enhanced opportunities for community engagement, it has also created, in some areas, organisations that do not have the economies of scale to minimise infrastructure costs or guarantee good clinical services. Despite this there was no support for forced amalgamation *('No turkey ever votes for an early Christmas')* and a widespread view that strategic alliances between DHBs will minimise the negative effects of having a large number of DHBs.

DHB membership and composition

There was concern that the presence of elected members would neither provide good local representation nor ensure an adequate mix of skills. Voter turnout has been low, but a higher number of Māori and Pacific people were elected in the 2004 elections than previously. There was some concern that the number of appointed positions available did not provide sufficient opportunity for the Minister to fill both representation and skill gaps fully. Initially there was also concern over the turnover anticipated at election time and the loss of skills, but in fact nearly 65% of encumbents who stood for office were returned and neither Chairs nor CEOs appeared greatly concerned over the potential loss of continuity.

Statutory committees

The rationale for Statutory Committees was, firstly, to ensure that there was a separate focus on managing hospital assets with provision for the Hospital Advisory Committee. Subsequently, the Community and Public Health Advisory Committee and Disability Support Advisory Committee were mandated to ensure a strong

counter-focus on population health and disability issues. Boards and management have worked hard to ensure that the Committees are as effective as possible in adding value to decision-making. This was reported as time-consuming and not always easy. Individual DHBs have used their Committees in different ways, eg to manage the strategic planning process, to structure community involvement, to take pressure off the full Board. By the time of the second round of research, views on the value of the Committees were more positive, but a number of Chairs and CEOs reported that it would be preferable to have more flexibility in the committee structure of their Boards, in order to meet local needs.

Transparency and community relationships

The importance placed by the reforms of open Board meetings was widely acknowledged. There were both negative and positive views on the impact of open meetings on decision-making. Some respondents felt that open meetings constrained debate, but also encouraged the media to focus on some topical issues to the detriment of other important concerns. Some Chairs, however, felt that open meetings were helpful in managing community expectations and allowing a more pro-active relationship with the media. In general the fears that open meetings would undermine the decision-making process were reported as largely unfounded, with open meetings, by the second round of research, not being seen as an important issue. The impact on decision-making has been neutral.

Autonomy and devolution of responsibility

There is potential for tension within the DHB model between the Government's desire to implement its policies and the responsibilities of DHBs to make decisions that meet the needs of local communities. In both rounds of research a majority of Board members reported that they did not have the level of autonomy necessary to be effective and there were specific reports of 'interference'. In general the role of the centre in policy-making was regarded positively, but there was also a view that local policy decisions were constrained and that central direction extended inappropriately into operational areas.

Devolution of funds was seen as an important component of DHB autonomy, and trends in this direction were supported strongly. However, there was recognition of the importance of the role of the centre in managing public health, but concern that the full benefits of primary health organisations (PHOs) would not be realised unless there was greater devolution of both public health funding and decision-making. The devolution of disability funds for the elderly had created significant problems for DHBs, both in terms of financial risk and the management of contracts. However, there was optimism at DHB level that this devolution would allow a comprehensive approach to the aged care sector locally.

Accountability

Key informants predicted that there would be tensions for Boards that were locally elected but nevertheless clearly accountable in legislation to the Minister of Health. This proved to be the case, although only a minority of members continued to indicate that their accountability was to the community. In 2004 a strong majority of elected members indicated that they could handle this perceived dual accountability.

One readily identified source of conflict of interest was the presence of DHB employees or contracted providers on the Board, although in the 2004 elections fewer employees/providers were elected. Informants reported that conflicts of interest were becoming better understood and that the perspectives of health professionals were valued.

Board processes and functioning

Board member capability

There were concerns that members, particularly elected ones, would not be able to cope with the complexities of health decision-making. By 2004 a strong majority of members reported that they had a good understanding of their role and grasp of issues. Despite initial concerns a majority of CEOs indicated that their Boards had settled into their role well, although this had required considerable input through training, upskilling and Board development activity, and strong leadership from the Chair.

Board processes, procedures and relationships

A strong majority of Board members agreed that Boards are run efficiently and well and that there had been discussions in their DHB about Board performance. There was agreement that Boards maintained a focus on strategic direction and that enough time was devoted to such issues, although there were reports from some DHBs that it had taken time for the Board to become fully involved. Over time there was a decline in the numbers who believed their Board's time was dominated by hospital issues with a majority in 2004 reporting that the Board's priorities were based on the Health Needs Assessment. Overall relationships among Board members have been positive, with the development of a 'team' approach.

Relationships with management

In the initial stages of DHBs there were reports of problems in maintaining the proper boundaries between governance and management. Problems in relationships related to the adequacy of reporting information sent to the Board, Board member understandings of the role of governance, and not enough 'buy-in' from management on the role of an elected Board. Several Chairs reported an increasingly positive interaction between Boards and management.

Relationships with clinicians

Both Chairs and CEOs commented on the importance of clinicians for a range of high level DHB activities such as risk management and priority setting. Despite this, there is little evidence the senior clinicians are engaged with governing Boards other than through invited presentations at Board and Committee meetings. This may be appropriate as the primary relationship for clinicians is with management, but their significance to DHBs is such that there is a strong imperative for them to be more positively engaged and subscribe to organisational as well as clinical perspectives.

External relationships

Maintaining high level external relationships is an important governance role. This includes accountability relationships with the Minister/Ministry of Health and stakeholder relationships with communities of interest, as well as lateral relationships with other DHBs, including through District Health Boards New Zealand (DHBNZ).

Initially, there was concern within some DHBs about the potential of DHBNZ to usurp the decision-making autonomy of DHBs or to act beyond its brief. With time, although there still some difficult moments, DHBNZ appears to be firmly established and appreciated for its work in a number of technical areas: industrial relations, pharmaceuticals, workforce, etc. its liaison with the Ministry and the way in which it had stimulated regional approaches to collaboration. Apart from DHBNZ there are strong relationships developing between DHBs at the regional level. Although these relationships have been characterised as 'slightly competitive', most respondents see them as a way in which the infrastructure and clinical risks for small and medium DHBs can be minimised and an integrated service developed.

Performance of governance roles

Community engagement

Community engagement through governance processes, despite elected members and community appointments, has been variable. Some Boards have made exceptional efforts to encourage engagement at governance level, whereas others have seen engagement as largely being through the technical planning processes and managed by staff.

Progress on strategic issues

The strong direction from government meant that Boards saw themselves with few opportunities to demonstrate strategic leadership. However, it was acknowledged that they had worked hard on strategic plans under considerable time pressure. Board members continue to see remaining within budget and minimising deficits as their priority task. They also recognised government priorities as important for the DHB even when these did not coincide with their own preferences. Members reported less than hoped for progress on a number of issues 2002-2004, including:

- *Independence and inclusion in society for people with disabilities*
- *Involvement of the community in health sector decision-making*
- *Integration of primary and secondary services*
- *Reduced inequalities and improved health status for all disadvantaged groups*
- *Reduced inequalities and improved health status for Māori*
- *Reduced inequalities and improved health status for Pacific peoples*

Monitoring DHB performance

A key governance role is to hold management accountable for its progress in achieving Board goals. In terms of receiving adequate information for monitoring, Board members almost all agreed that they get regular, adequate reports on financial performance, with Māori members less likely to agree with this.

Case study reports were helpful in illuminating monitoring processes. In one DHB several senior managers referred to the lack of capacity to undertake the work necessary to monitor progress effectively and keep the Board informed. In another DHB it was claimed that HAC was unable to perform its monitoring role properly because management was unable to provide data with an appropriate level of analysis for assessments to be made. In one DHB Board members commented over several meetings on the inadequacy of monitoring reports to the Board, and it took some time for management to develop procedures to the satisfaction of the Board. In another case study the Board adopted seventeen clinically based indicators to augment those required for external accountability reporting and there were plans for systematic rather than anecdotal monitoring of gaps in service provision.

Accountability reporting

In order to hold Boards accountable, there must be an understanding of the criteria to be used. A majority of Board members indicated that they had a clear understanding of how their Board's performance would be assessed, and reported the main criterion on which it would be judged was financial management.

DHBs are accountable to the government and Ministry of Health through the Crown Funding Agreement and District Annual Plan, and to Parliament through the Statement of Intent. Boards appear before the House Select Committee to report on the Statement of Intent, and several DHBs reported difficult initial experiences as expectations were clarified.

With respect to the District Annual Plan and Crown Funding Agreement, DHBs report quarterly to the Ministry. There were reports of persistent problems with the monitoring regime, although there were indications that this had improved recently. Nevertheless it was reported to be still quite bureaucratic or managerialist in style, with little emphasis on outcomes.

Discussion

The DHB model

The emerging literature on health governance points to 'hybrid' type models that increasingly do not conform to strict corporate, philanthropic or other governance traditions but are created specifically for the context in which in which they operate and are 'fit-for-purpose'. The DHB model fits this arrangement, with our informants confirming that the design aimed to achieve specific goals or representation, while maintaining the role of central policy. The specific elements of the structure, designed to create transparency, community engagement and a specific ‘issues focus’ through the Committees, do not appear to make a major contribution to decision-making, although they do not undermine it in any way and create a positive community profile. This is consistent with the literature that concludes that structures have little impact on decision-making.

System relationships

The international literature emphasises system governance and linkages between organisations, and this is well demonstrated by DHB accountability and strategic relationships. In terms of ‘vertical’ relationships the balance of power between the centre and the periphery is contested, most notably in areas of strategic decision-making, including the selection of local priorities, and monitoring frameworks, two critical areas of autonomy. Part of the armoury of DHBs in maintaining their positions in relation to the centre has been the rapid evolution of DHBNZ. While this collective association of DHBs requires its own delicate balancing of governance roles, it has provided a cohesive organisation that represents the interests of DHBs and precludes individual DHBs becoming isolated in their relationships with the centre.

The presence of DHBNZ and the emergence of lateral system relationships ameliorate an important weakness identified in the DHB system: the risk to clinical and administrative viability in some small and medium sized DHBs consequent on the large number of DHBs overall and, for some, their small size. While there is strong resistance to forced amalgamation there is also a need to balance the desire for local control and equity of access with efficiency, including good outcomes which are recognised to be at risk in organisations serving smaller, dispersed populations. The strategic solution to this problem has been active inter-DHB collaboration, in some cases encouraged by the requirements of Crown Funding Agreements. While closer working relationships and strategic alliances have some problems, they are endorsed by all informants as essential and positive, securing rather than undermining the independent governance of some DHBs.

Besides the centre-periphery relationships and the links between DHBs, the literature on both individual board and network frameworks recognises the multiple accountabilities of boards to a range of local stakeholders: internal and external, formal and informal. This is made more difficult for DHBs by the provision for a majority of the Board to be elected, adding a dimension of local accountability that in some DHBs may create risk of conflict with accountabilities to the centre or collective accountability within the Board. While this conflict may be spurious in terms of the legislation, in reality it has reflected more 'local authority' style expectations where elected members directly represent local constituencies. 'At large' elections may reduce such expectations over time. The management of this expectation has fallen largely to Chairs of DHBs who are generally regarded as have been effective in this role.

Board functioning

Our research indicates that despite the handicap of Statutory Committees, some conflicts in accountability, the burden of deficits and detailed monitoring, Boards significantly improved their functioning between 2001 and 2004. The extended period of implementation required for supposedly minor restructuring and the costs of that to the system as a whole in lost productivity and momentum are acknowledged.

The research literature suggests that there are few variables that are critical in ensuring good governance performance, but that these include involvement with strategic planning and shared vision of the goals and purpose of the organisation. These were largely present in DHBs, but there are indications that this focus on strategic issues had been hard won, requiring both improved capability on the part of Board members and strong support from management. The level of management support had initially been variable, but had developed over time, in some cases at the insistence of Board members and Chairs.

International research suggests that other key factors in effective performance are the relationship between Board and management, which our research suggests has developed well over the period of the project, and critical self-review of performance, also characteristic of DHBs and led by Chairs. Skill mix, experience and time have been shown in the literature as important for effective functioning. This research, however, has shown that while Boards may not be seen to have the necessary skills and the ability to fill those skill gaps through appointment was constrained, the notion of Board development is strongly present. When accompanied by good leadership and supportive management the capability of Boards can clearly be raised to appropriate levels. Although our research stopped short of the 2004 elections, there were indications that the three-year election cycle does not necessarily create major loss of capability. However, significant investment is required to improve and maintain the performance of Boards (training, information, skill development, performance assessment). This level of investment is justifiable to the extent that government and the community value the role of local DHB members.

An assessment

Interviews with ministers, ministerial advisers and officials confirmed that the governance arrangements for DHBs were designed to facilitate two broad aims:

1 To ensure that the government achieves the population health outcomes it requires.

This was to be facilitated through centre-periphery relationships:

- adherence to national strategy set out by the Minister of Health
- levels of devolved funding and decision-making
- accountability to the Minister of Health

It is outside the scope of this project to attempt to assess population health outcomes; this is undertaken through the Minister's regular reports on *Implementing the New Zealand Health Strategy* (for example, Minister of Health 2005*)* and other special reports. However, the, the process and output elements of this aim have largely been achieved. The accountability arrangements and policy guidelines have ensured that government policy has been implemented through DHBs, although some DHBs reported that devolved decision-making had fallen short of their expectations and that accountability arrangements had not focused sufficiently on outcomes.

2 To involve the community in health decision-making.

This was to be facilitated through:

- the participation of community members in governance
- transparency of decision-making
- other forms of engagement with the Board

Our research shows that participation of community members in governance and the requirements for transparency is seen to have both costs and benefits. It was difficult to identify specific benefits to decision-making but there was a view that the culture change generated by both participation and transparency were important to the wider relationship between DHBs and their communities. Although direct engagement between Boards and local communities was highly variable, the general culture of openness was reflected in the way staff engaged with the community and providers generally and specifically through the planning process. Engagement of all types appears to be more easily achieved in smaller and medium sized DHBs than in larger ones.

The findings of this research allow reflection on the large investment of time and effort required to implement major reform of the health sector. There is no support for any significant further change, but some indication of where governance processes can be streamlined and costs taken out of the system.

- There is no support for changes in numbers and sizes of DHBs. Any inefficiencies and risks (both clinical and financial) inherent in the structure are largely being managed by DHB-DHB linkages and current community relationships are highly valued. These trends can be further supported.

- There are costs (not quantified) to DHBs in the electoral system in ensuring continuity and capability of Boards, but the relationship between DHBs and the local community is clearly enhanced by this arrangement.

- The requirements for transparency are not seen as a major barrier to Board functioning and have largely been well-managed by DHBs. Transparency is valued for promoting an open relationship with the community and has enabled improved media relations.

- There is a strong view from DHBs that the requirements for Statutory Committees should be modified to provide greater flexibility for Boards.

- Periphery-centre relationship management is improving and could be further enhanced by continued work on the monitoring framework and clarity of decision-making responsibility.

- The costs of major change need to be better recognised and provided for in any future reorganisation.

- There is significant elapsed time required for the implementation of reform, including capacity building in key areas such as governance, planning and funding and central policy and management.

- The skill, time and commitment required of Chairs of DHBs is critical to success.

- There is interest in the way in which clinicians, widely regarded as important decision-makers within DHBs, can be most effectively engaged in strategic decisions. Individual DHBs are working on a variety or arrangements; the implications of these can be monitored.

1 Introduction

1.1 What is Governance?

At the simplest level governance is the function that 'holds management and the organisation accountable, … helps provide management with overall strategic direction' (Shortell and Kaluzny 1993) and maintains viability and effectiveness (Weiner and Alexander 1993). Research into governance has historically concentrated on arrangements for private sector firms and examined the structures and systems such organisations need to maximise returns. However, there has been increasing interest in governance structures for non-profit and government sector organisations in general and health organisations in particular (Robinson and Le Grand 1993, Ferlie et al 1995), including in New Zealand (Barnett et al 2001). This interest is due partly to the importance of public trust and social accountability responsibilities and partly to the recognition that in professional (including health) organisations the style of governance is a significant indicator of organisational change (Brock et al 1999).

1.2 Overview: Changing Health Governance

1.2.1 The international context

Over the last two decades there have been significant developments in governance structures in public, private and non-profit sectors internationally. In the US approximately 1% of hospitals converted to alternative forms of governance from 1988-1993, nearly half of them from public to either private or not-for-profit status with the aim of providing more flexible and efficient processes (Needleman et al 1997). During the 1990s there were similar moves elsewhere, including the NHS and in NZ, replicating US trends towards more corporate models.

Of more recent interest has been the evolution in the US of more complex models of governance to deal with integrated systems of health organisations (Shortell et al 1993) and more complex stakeholder accountabilities (Alexander et al 1995, Savage et al 1997). In other parts of the western world there continues to be significant experimentation with governance systems, including regional approaches in Canada (Contandriopolous et al 2004) and physician inclusion in the Netherlands (Scholten and Grinten 2005). See further discussion of health governance models in Section 2, below.

1.2.2 New Zealand health governance 1983-1999

In New Zealand governance issues have been central to successive restructurings of the New Zealand health system. By 1989, publicly funded and provided health services had been restructured with previously separate hospital and public health services brought within the responsibility of 14 area health boards. For the first time, health boards had the responsibility for planning all services at a local level, although funding for and provision of primary care remained separate. While the Boards were elected, the Minister of Health was able to appoint up to five (ie a minority) additional members.

A new National government in 1990 saw such locally elected boards as inadequate to address the problems it identified, such as lack of accountability and fiscal responsibility, lack of responsiveness to the consumer, and inefficient management systems (Hospital and Related Services Taskforce 1987; Upton 1991). In the new internal market established to replace area health boards, hospitals were restructured as 23 limited liability companies (Crown Health Enterprises (CHEs)) under the Companies Act, with the government as sole shareholder. These new entities had corporate boards that functioned in a fully commercial manner with the expectation that they would produce a return on assets to their sole shareholder, the government.

In the mid-late 1990s the Coalition Government, elected in 1996, responded to public pressure and drew back partially from the fully commercial, decentralised model. It changed the governance arrangements by including appointed community representatives on boards, set a less competitive framework for resource allocation and encouraged collaboration among formerly competitive health providers. Symbolically, the CHEs were renamed Health and Hospital Services (HHSs) and multiple regional purchasers were collapsed back into one single purchasing authority. One of the critical governance features of the CHE and HHS structures was that board members were appointed by central government, with some token community representation from 1998.

1.2.3 New Zealand health governance 2000-

A newly elected, Labour-led government came to power in late 1999, promising significant change to the organisation of health care funding and provision. The resulting New Zealand Public Health and Disability Act of 2000 gave rise to a new model that was implemented from January 2001. This model includes the development of a set of over-arching national health strategies and national priorities and the establishment of 21 District Health Boards (DHBs), largely based on the former HHSs or CHEs, to fund and provide directly, or arrange for the provision of, health services for geographically defined populations.

The DHBs are governed by Boards of up to 11 members, the majority of whom (seven) are elected. The Minister of Health appoints up to four members, and also appoints the Chair and Deputy Chair (who may both either elected or appointed members). This assists with ensuring an adequate skill base and community representation, particularly Māori. Legislation provides for three statutory committees, the Hospital Advisory Committee, the Community and Public Health Advisory Committee and the Disability Services Advisory Committee, and for the business of the Board and its committees to be conducted in public.

The DHBs are bulk funded on a population basis and are then responsible for the funding and provision of hospital and community care within their regions, and for contracting with community and primary care providers as is needed. The DHBs are accountable upwards to the Minister of Health, with the Ministry of Health acting as the Minister's agent. Emphasis in the model is placed on local, cooperative, collaborative arrangements within national strategic frameworks.

1.3 Purpose and Outline of the Paper

Research into DHB governance is part of the larger Health Reforms 2001 Research Project, undertaken to chart the progress of the health reforms enacted by the New Zealand Public Health and Disability Act 2000 as they were implemented. The project is funded jointly by the Health Research Council and Ministry of Research, Science, and Technology through the Departmental Contestable Research Pool managed by the Ministry of Health, the Treasury and the State Services Commission. The Health Services Research Centre, Victoria University, is managing the project through a team of independent researchers.

One of the key themes of the research relates to governance, including identifying the strengths and weaknesses of the new governance model compared with earlier ones and providing an early indication of how the governance role has developed within the model and serves the strategic health goals of Government.

This paper aims to assess the implementation of the new governance arrangements. Specifically, the paper will:

- Outline key themes from the international literature on health governance models and discuss the DHB arrangements in the light of these.

- Review the functioning and performance of governing boards of DHBs in the light of a selection of the international literature on the functioning and performance of health and non-profit governing boards

The rest of this paper sets out a brief 'scan' of the international literature on health governance (Section 2) the research approach and methods used (Section 3); a review of the DHB governance 'model' (Section 4); an analysis of the functioning of particular elements of the model (Section 5) an assessment of the performance of DHB statutory functions (Section 6) and a final overview of DHB governance (Section 7).

2 Health Governance: an International 'Scan'

2.1 Trends in health governance: from organisations to systems

The prime purpose of governance is to support the aims of the organisation and its accountabilities. In the case of health governance, especially in the public and non-profit sector, approaches emphasise the different dimensions of the roles and responsibilities of the board, different relationships between wider stakeholders (government and the community), board members and staff.

Traditional models

Traditionally, health governance approaches have ranged from the corporate model, with its emphasis on strategy development and maximising market share, to the bureaucratic/political model with an emphasis on direct government ownership and operation of services, and the philanthropic model based largely on volunteer part time community representation and the preservation of assets (Alexander et al 1988, Shortell 1989).

These traditional approaches to governance for public and non-profit agencies no longer seem adequate, due to the increasing complexity of health organisations themselves, and the need for governance of systems rather than individual organisations. In fact, over a decade ago Weiner and Alexander (1993) reported that these models no longer appeared in their pure forms, but with health governance represented by 'hybrid' configurations with a mix of corporate and philanthropic attributes, and a pragmatic approach to decisions on structures. Savage et al (1997) acknowledged that governance of existing health care agencies exhibits particular patterns and that 'two such forms span a governance continuum from community (or philanthropic) governance at one end to corporate governance at the other end.' Like Weiner and Alexander (1993) they assert that although health service governance focuses on the two opposite ends of the community-corporate spectrum, in reality, few, if any, health organisations actually have governing boards which conform exactly to either end of the continuum.

A synopsis of the various models and approaches particularly relevant to the public and non-profit sector have been described by many commentators, including Bullen Management Alternatives (Appendix A). The most helpful models for addressing the complexity of health governance with its intricacies of external stakeholders and intra-organisational relationships are the Policy Board Model and the Tripartite model.

The **policy board model** requires the board to establish the guiding principles and policies of the organisation; to delegate responsibilities and authority to those who are responsible for enacting the principles and policies; to monitor compliance with those guiding principles and policies; and to ensure that staff and board alike are held accountable for their performance and maintain relationships with the community. There is a characteristic high level of trust and confidence in the CEO exemplified in this model, usually relatively few free standing committees, resulting in more meetings of the full board. Board development is given high priority and members are recruited for their demonstrated commitment to the values and mission of the organisation.

An alternative model, the **tripartite** model provides other dimensions. This model is described as a conventional model of governance and according to Ducca (1996), quoting Cornforth and Edwards (1998) "in many nonprofits, the responsibilities for running the organisation evolve into a three-part, interactive system-a tripartite system-comprised of a board of directors, an executive, and staff. If this system is to function effectively, its parts need to share a sense of mission. A board's central function is to keep the organisation's mission in focus, and its primary responsibility is to ensure that the other parts of the system are working toward accomplishing that mission." Emphasis on staff in this model is of interest as the engagement of clinicians, in particular, is a recurring theme of health governance, differentiating it from governance in other service sectors (Goes and Zahn 1995).

Emergent models

While the models outlined above are useful, and provide guidance to understanding elements of DHB governance arrangements, they do not reflect the complexities of governance within an integrated system or network of health organisations, as characterised by the national DHB system in New Zealand.

Internationally, there are commentaries on the more varied approaches emerging in complex systems. Alexander et al (1995) predicted that as the transition from hospitals to multi-hospital systems and community care networks proceeds, profound changes would be needed in governance. In 2003, Alexander et al reported on the governance forms emerging in 203 networks and systems in the US. They concluded that both networks and organised delivery systems attempted to 'fit' their governance forms with functional attributes of their organisation, and that there are likely to be multiple levels of governance where decision making authority depends to a large extent on the degree of centralisation of the system or network.

The degree of centralisation and devolution of decision-making provide a significant test of governance structures because they require arrangements that maximise locality interests while maintaining vertical relationships and accountabilities. The Canadian experience of extensive regionalisation in the 1990s has been characterised as a 'struggle for power' (Brunell et al 1999) between boards and governments across the country. In addition, it has been suggested that citizen or community involvement might 'derail' government intentions (Lomas 1997), although more recent research from Quebec indicates that in that province regionalisation has 'cemented' the role of the centre through its role as the source of authority for boards to act within their local areas (Contandriopolous et al 2004).

Another feature of complex public and non-profit health systems is the need for accountability to multiple stakeholders: external/internal; formal and informal. Savage et al (1997), for example, maintain that the addition of community advisory committees and task forces can make a corporate-style governance model more responsive to external stakeholders and that the addition of top management input makes the community model more responsive to internal stakeholders. They maintain

that in an increasingly complex and turbulent health environment, innovative governance structures that are responsive to internal and external stakeholder needs are particularly important.

The ability of board members to deal with these new models has been questioned, particularly if their experience has been in traditional forms of corporate governance. Orlikoff (1997) discusses the significant differences between system boards and hospital boards and maintains that many traditional system board members lack a vision of how integrated system governance is different from governance of a hospital.

2.2 Effective Boards: Notes from the Literature

A review of the extensive literature on corporate, not-for-profit or health organisation boards reveals two key points. First, much of the literature is normative, and identifies best practice governance for the guidance of practitioners. Sometimes this is explicitly based on research evidence, but this is certainly not always the case. This literature has been criticised for providing an idealised view of boards and for not being empirically grounded. (Herman 1989, Cornforth 1996, Jackson and Holland 1998).

The second key point is that there is now a growing body of research literature that explores board functioning and effectiveness, much of which is specific to public sector or not-for-profit health organisations. Even these much welcomed empirical studies have been criticised for over-reliance on one source of data, usually the perceptions of Board members (Peck 1995).

An overview of the findings of this literature suggests that there is a high level of variability and complexity in non-corporate board processes ('one size definitely does NOT fit all'). Nevertheless, some key themes emerge. The first is that structural elements of boards are not particularly important in relation to effectiveness. Bradshaw et al (1992), for example, found that the structural arrangements of a sample of non profit boards in Canada contributed only about 7-8% or variation in

perceived board performance, contradicting the normative literature which suggested that the formal arrangements for governance were critical to board effectiveness (eg Houle 1989). Similarly, Cornforth (2001), in a survey of charitable organisations in England and Wales, found that structural variables played a limited role, with only attendance at board meetings showing any importance in relation to effectiveness, as measured by fulfilment of boards' key roles.

In contrast, these, and other studies, have identified 'process' variables as important in assessments of performance of non-profit boards. In particular, involvement in strategic planning has been related to effectiveness of boards (Bradshaw et al 1992, Herman and Heimovics 1997, Green and Griesinger 1996). Cornforth (2001) used strategic planning as an output measure, but through a regression model identified four variables that explained 45% of variation in board effectiveness:

- The board has a clear understanding of its role and responsibilities
- The board has the right mix of skills, experience and time to do the job
- Board and management share a common vision of how it should go about achieving goals
- Board and management periodically review how they are working together (p.225)

In addition, several studies have identified the importance of boards engaging in strategic matters, and being fully involved in policy formation (Bradshaw et al, Herman and Heimovics 1997, Green and Griesinger 1996). In Cornforth et al (2001) board engagement in strategic planning was the single most important variable, although it became less important within the regression model. Similarly, variables related to holding a common vision or subscribing to mission and values proved important (Bradshaw et al 1992, Cornforth 2001).

3 Research Approach and Methods

'Governance Model' is a term used frequently in the organisational literature and, according to Synergy Associates, consultants in governance, consists of 'a set, cluster or constellation of structures, practices and procedures which typify a particular approach which boards of directors may use to govern, direct or oversee the operations of an organisation.' This broad definition is specified more closely for the purpose of this research. First, it is possible to separately identify the structural aspects of the governance 'model' as the prescribed set of arrangements that set the parameters for Board functioning (Table 1, column 1). Second, the functioning or process of governance reflects the ways in which the board goes about its business (Table 1, column 2) and, thirdly, the results of governance are summarised as the extent to which the Board fulfils its statutory responsibilities (Table 1, column 3).

Table 1 Dimensions of DHB process and performance

Statutory arrangements	**Board processes and functioning**:	**Performance of governance roles**
Board size and numbers	Board member role and capability	Community engagement
Board composition	Meeting processes and procedures	Progress on strategic issues
Statutory committees	Internal Board relationships	Monitoring performance of the organisation
Transparency	Relationships with management	Accountability reporting
Community relations	Relationship with clinicians	
Autonomy and devolved responsibility	External relationships	
Accountability to stakeholders		

The literature used for framing the research and providing insights into the working of governance has been drawn from data base searches of refereed health management and policy journals, with some additional sources from websites of selected consultant and health organisations. Emphasis was placed on non-profit and public sector and health governance in particular. The dimensions of the DHB model are drawn from the provisions of the New Zealand Public Health and Disabilities Act 2000 the refereed literature on health governance and governance in non-profit organisations and discussions with research funders.

Mindful of the criticism of Peck (1995) that too much governance research relies exclusively on the perceptions of board members, data for the analysis of DHB governance has been drawn from a range of sub-projects of the Health Reforms 2001 research. These sub-projects included:

- Interviews with national and government stakeholders
- Two interviews with CEOs of DHBs
- Two interviews with Chairs of DHBs
- Two postal surveys of Board members
- Case studies in five DHBs.

Full details of the research methodology used, and a preliminary compilation of data relating to governance, can be found in the *Interim Report of the Health Reforms 2001 Research Project* (Cumming et al 2003).

Note on reporting:

When attempting to integrate data from disparate sources, or interviews have been undertaken in different contexts (eg CEOs interviewed as part of case studies or as part of a stand alone survey, and at different points in the project), it may difficult to achieve a common level of specificity. For example, when all CEOs are asked the same question, it is possible to summarise responses numerically (for example, 4/19, 16/19) to give some idea of strength of feeling on the issue. Where not all were invited to comment on particular topic, or it arose uninvited in some cases, providing the numbers of respondents gives a false impression of the profile of responses. Reporting in these cases may be less specific (eg 'some CEOs...').

4 The DHB Governance 'Model'

4.1 The Aims of the Model

Our early interviews with ministers, ministerial advisors and officials confirmed that the governance arrangements for DHBs were designed to facilitate two broad aims:

1 To ensure that the government achieves the population health outcomes it requires through:

- adherence to national strategy set out by the Minister of Health
- levels of devolved funding and decision-making
- accountability to the Minister of Health.

2 To involve the community in health decision-making through:

- the participation of community members in governance
- transparency of decision-making
- other forms of engagement with the board.

4.2 The Elements of the Model

District Health Boards are Crown entities, responsible to the Minister of Health for their performance. The Minister, in turn, is responsible to Parliament for the overall performance of the health and disability sector. The elements of the governance model to support the aims set out in 4.1 include the:

- establishment of 21 DHBs with a mix of elected and appointed members (including two Māori members),
- an appropriate level of devolved responsibility,
- a Board composition and structure that is aimed at enabling effective performance,
- procedures that aim to ensure transparency,
- accountability to the Minister of Health.

These elements are reviewed below.

4.2.1 The number of DHBs

The rationale and expectations

The key feature of the reforms was the formation of 21 DHBs. In our early interviews, Ministers, ministerial advisors and some officials noted there was a preference for focusing on issues relating to promoting *health* rather than debating the number and location of DHBs. Thus the 21 DHBs were established around existing organisations, in part to reduce the potential political costs of reform. Some officials felt this was also a simple way of keeping the financial costs of implementing the new system down by expanding the existing hospital management role rather than establishing a new organisation. It was noted that, from a policy perspective, there is a trade-off between obtaining economies of scale and managing risk in order to manage within a budget, favouring larger Boards, against the closeness of Boards to a local population, favouring smaller Boards. New Zealand's social geography was seen as important, with geographical boundaries often leading to natural communities of interest. Some officials felt the establishment of 21 DHBs was a return to the previous models that reflected a deep-seated view that hospitals are central to the health system in New Zealand.

There was recognition from both ministers and officials that 21 DHBs was probably more than would have been chosen if the system were being built from scratch. One official noted there was an inclination to have fewer Boards, but that would have led to very large areas being covered by single DHBs, where there were different communities of interest and different health care needs (eg in Auckland). It would also require a cumbersome ward structure to support Board elections. Others noted that in addition to encouraging a smoother transition, establishing 21 DHBs and enabling voluntary amalgamations over time was a more sensible approach. Economies of scale could then be encouraged through co-operation between DHBs (and such co-operation would be beneficial in itself).

Reported experience

In four of the five case study reports informants identified the large numbers of DHBs and the consequent small size of some as a definite weakness of the DHB system. In our second round of interviews with Chairs of DHBs, a few Chairs volunteered that they thought that there were too many DHBs, but none suggested forced amalgamation of Boards. It was suggested that ways could be found to move towards greater rationalisation and regional activity, but without undermining current governance arrangements. The local focus was strongly endorsed*: 'a sense of community ownership again'; 'a local focus for all health services',* with *'increased public confidence'* in the system overall.

Also in the second round of interviews, 16 CEOs commented on the size and number of DHBs. All identified problems with the large number and variable size of boards. The comments on this issue were extensive, with CEOs having clearly thought about this a great deal and discussed it with their colleagues. Smaller DHBs were seen as disadvantaged by both *infrastructure costs* and *the inability sometimes to ensure good clinical services*. It was suggested that 21 separate DHBs is a barrier to achieving strategic change.

However, it was strongly argued, without exception, that amalgamation was not necessarily the solution to these problems, either by combining small boards or merging small with larger boards.

> *'...but you can't get away from the communities of interest and parochialism that exists in New Zealand. So I actually wouldn't change too much...'* (CEO 3)

> *'...size has a lot to do with being viable,... but even some medium-sized boards are struggling....but this issue is beyond administrative savings and whether we will actually make any difference to health care delivery. I would say 'no' [to amalgamation].'* (CEO 14)

There was absolutely no support for forced amalgamation and it was anticipated that no DHB would volunteer to be merged with another (*'no turkey ever votes for an early Christmas'*). There were seen to be benefits in local approaches to needs assessment and strategic planning, despite higher costs. It was pointed out that being the actual provider of services was not essential to being a DHB, with several CEOs suggesting a dual system whereby small boards undertake planning and funding roles, but with larger boards supplying hospital services. Another view was that if amalgamation did take place, funds from smaller DHBs could be ring-fenced for local areas.

There was a widespread view among CEOs from DHBs of all sizes is that there is a general move towards strategic alliances and that these will moderate the effects of having a large number of boards.

> *'There's other ways of achieving good results by amalgamating some functions...there's amalgamation of a lot of functions...there's a lot more collaboration than there used to be.'* (CEO 11)

> *'Right now, the [A] and [B] boards are busy talking about looking at regional service delivery. Now, whether that means that there will be two DHBs or one eventually - who knows? But in terms of service provision we will see a seamless entity.'* (CEO 9)

> *'You don't have to amalgamate boards. You can achieve the same things (savings, sharing expertise, etc) in a different way and still maintain the real philosophy behind DHBs, which was local responsiveness and local ownership.'* (CEO 5)

4.2.2 DHB membership and composition

Expectations of the electoral model

In the first round of interviews, all key informants acknowledged that involving local communities in decision-making is of central importance in the model. However, some suggested that the electoral process does not always provide good representation or guarantee local participation in decision-making. Some officials expressed surprise that so many people stood for election, and noted that this did seem to vindicate the reforms and the model chosen, even if elector turnout was viewed as relatively modest.

Representation

The effectiveness of voting for DHB members to ensure community representation has been questioned. According to Gauld (2005) the second election in 2004 saw a drop in voter turnout from 50% to 42%. Gauld (2005) also reported on a telephone survey of a sample of the general population that indicated that an increased proportion of people did not know why they did not vote, and reported not receiving voting papers. One third of respondents suggested that the STV system was confusing.

In the 2001 election only 2.7% of all successful candidates were Māori. Ministers and officials we interviewed in the first round of research expressed concern at the low numbers of Māori elected to Boards and concern that no Pacific members were elected. A number of people felt that a single transferable vote system would give better representation in future elections (although the reasons for this were not discussed), but they noted that it was not feasible to establish such a system in time for the 2001 elections. In fact, the proportion of Māori elected did rise to 7.5% in 2004 and three Pacific members were elected.

Following the first elections in 2001, a final analysis of Board composition by officials permitted the Minister to make appointments, mindful of the skills and experience that were considered needed on DHB governing Boards; this included Māori and Pacific skills and experience. Although the appointment process allowed gaps in representation to be addressed, in our interviews Chairs of Boards expressed a desire for greater input into the appointment process. Māori key informants also raised issues about this, with some iwi representatives expressing frustration at the lack of transparency, at the Ministerial level, about the process for appointing Board members, after the iwi's nominations have been forwarded to government.

Skill balance

In the first round of research there was concern that particularly the elected majority of members would not be well prepared for their role in the DHB. In the first survey, DHB Board members gave mixed views as to whether they felt adequately informed about relevant issues prior to election or appointment. Forty-five percent agreed/strongly agreed that they felt informed prior to election or appointment, compared with almost 30% who disagreed or strongly disagreed with the statement that they were well informed.

CEOs at that time reported that elected members tended to lack technical skills, particularly financial skills and depth of knowledge of the health sector. This was of significant concern for some, as it was perceived that the Board could not effectively challenge management. '*I feel quite exposed'* was one statement. The community knowledge and networks of elected members were highly valued by CEOs, but overall CEOs were grateful for the presence of appointed members. Initially, all the CEOs interviewed expressed a strong preference for appointed boards, although this view was not so strongly held in the second round of interviews.

In the first round of interviews, case study informants observed that although elected members can improve the breadth of decision-making, by contributing a wide range of skill and expertise, the electoral process can leave Boards with a poor mix of skills, gaps in expertise, members with variable abilities, and an imbalance of sector interests. The importance of government being able to fill these gaps and offset any imbalances with appointed members was stressed by Chairs and CEOs, but some reported that the need to appoint a chair and ensure appropriate representation meant that few appointments were available solely to redress a 'skill imbalance'. The skill imbalance was reported as of considerable concern by Chairs, although a majority of respondents to the survey of Board members in 2004 (68.1%) agreed/strongly agreed that their Board had the appropriate mix of skills.

The perceived shortage of key skills was expected to have implications for the overall functioning of Boards (see Section 5.1)

Risks around elections

Chairs were asked to comment on the impact of the then forthcoming (2004) elections on the Board's functioning. Half (7) of the respondents noted that they had some concerns about the impact of elections (*'a little apprehensive', 'not worried about the outcome, but they are already running!' 'Some disruption expected'*). However, these Chairs, like their seven colleagues who reported no particular concerns, appeared quite relaxed about the consequences of any changes (*'We'll live with it', 'We'll have to do the work to get it working as an entity', 'Who knows?'*) One CEO reported: *' But I look at the board as a hand of cards that you are dealt and you play the hand as best you can.'* (CEO 9)

The prospect of 'good' elected Board members being voted off the Board and consequent loss of competency, expertise and institutional knowledge was raised as a concern in one case study Board, and by CEOs. In fact nearly 65% of incumbent candidates from 2001 who ran in 2004 were returned in 2004. There was a perception in one case study DHB that elected members who are also staff can be a barrier to progress; and in another Board it was felt that the Ministry should not be involved in Board member appointments.

4.2.3 Statutory Committees

Rationale for the Statutory Committees

In the first round of research, a number of officials discussed the background to the Statutory Committees. They noted that once it was decided that DHBs would own public hospitals, it was suggested that there should be a Hospital Advisory Committee (HAC) to maintain a separate focus on the proper management of hospital assets. However some government policy makers were then concerned that this created excessive focus back on to the secondary and tertiary sector, when a strategic re-orientation to population health was desired. The literature notes some support for the role of advisory committees (Savage et al 1997) in helping maintain an alternative focus or power centre to management or other special interests, and this view is consistent with the decision to establish another Committee, the Community and Public Health Advisory Committee (CPHAC), as a counter-balance to HAC, even though some officials felt the broader community focus was in fact the role of the Board itself. This was followed by the decision to require the Disability Support Advisory Committee (DSAC) in each DHB.

The mandatory Statutory Committees and their functioning have been important and contentious issues within DHBs, as set out below.

The value of Committees

In the first round of research, the survey of Board members showed that many (just under three-quarters) considered the Board Committees played a significant role in the work of the Board overall. Several case study Boards reported that much of the debate and decision-making occurs at the committee level rather than at full Board meetings. However it was also noted by informants that it was important that the Committees should not operate independently of the Board.

A strong majority of CEOs in the first round of research reported that the governance structure, with three mandatory committees, was excessive. The HAC was seen as filling an important role. However, both DSAC and CPHAC were reported to have little meaningful work once DHB Strategic Plans were completed. Overall the costs of servicing the committees were considered greater than the benefits accrued. Only a few CEOs reported the committees were useful: one CEO noting that the committees were useful for actively structuring community involvement (by drawing in people from the community with desired knowledge and skills); another found it valuable to have all issues fully discussed at committee prior to a Board meeting.

In the second round of research Board members maintained a positive view of Committees overall (Table 2), but when asked specifically about whether the 'real work and decision-making' took place in Committees they were less affirming (28.9% agreed or strongly agreed).

Table 2 Board members' views on Statutory Committees

Responses to questions:	2002	2004
'Committees play a significant role in the work of the Board' - Strongly agree or agree?	73.2%	74.8%
'The real work and decision-making takes place in Committees' - Strongly agree or agree?		28.9%

Of the CEOs interviewed in the second round, seven were very enthusiastic about their Statutory Committees, and believe that they are working well. Boards are using the committees in different roles: to take pressure of the full board by doing detailed preliminary work or by engaging with the community on particular issues. Some comments from CEOs:

> *'They work well because we have come up with a defined work programme for them and we feed issues through to the Board and try not to duplicate activity. '* (CEO 16)

> *'Ours are really getting into some very meaty stuff, and I certainly think they are connecting with the community and informing the Board and providing a lot of guidance.'* (CEO 13)

Eight CEOs reported that the committees were working quite well, and five still held negative views.

The trend to a more positive perspective on the statutory committees was expressed by one CEO who had initially been extremely unenthusiastic:

> '*I must admit I was probably more sceptical to start with, but I think having been doing it for a while, I quite like the committee process. I think, on balance, they are worthwhile....We do more of the routine stuff in committees and we've allowed up to half the Board meeting for thinking and talking about one big issue....Too much time can get taken up with dross and routine stuff, without the real engagement on issues. Without the committee structure that would force the Board in to a 'machine' type process which doesn't help the organisation.'* (CEO 3)

Of the 14 respondent Chairs in the second round, eight were unreservedly positive about the roles and performance of their statutory committees. For example:

> *'The committees have worked wonderfully well, I think....I don't think the Board can operate without them. The Board can't go into the same detail or spend as much time. Management uses the committees as a resource, no question, and we don't re-do the work of committees in the Board - that's a waste of time. The committees are value added; they recommend to the Board but there's no authority in the committees.'* (C 12)

> *'The committees have worked well, although initially I was uncertain. They can't make decisions but we certainly expect them to make strong recommendations through to the Board and they have all played a strong role in that. A lot of the hard work, analysis, evaluation, going back to management for more information - all that is done by the committees. They know they are making a meaningful contribution to Board decision-making.'* (C 6)

Six Chairs expressed reservations about the levels of effectiveness of committees, but there was a clear consensus that committees 'added value' to the work of the Board.

In the case study boards, there was much less questioning of the value of Committees in the second round, but still some uncertainty over their place overall. Although all case studies reported improvements and some very productive Committee experiences, overall they indicate the diversity of experience, summarised as follows:

Very positive: CS1- Committees demonstrate democracy and allow Board more time for strategic thinking

CS2 – Committees enable Board to clear its own agenda for strategic thinking

Moderately positive:

CS3 – Committee review in 2003 streamlined process and pathways to Board; but closer relations between Committees, and between Committees and the Board still needed

CS4 - Some lack of clarity around Committee roles and need to be better aligned with services; strong contribution to community input

Mildly positive:

CS5 Ongoing tensions around Committee-Board relationships; one Committee Chair resigned due to this.

Management of Committees

Considerable effort was reported as necessary to provide a framework for effective Committee performance. Some CEOs reported putting considerable effort into developing a framework through which the Committees could operate, including modifying meeting times, changing terms of reference, developing work plans etc.

Some Chairs reported that they had had to work hard to clarify roles and streamline the work of the Committees. While it was reported that the Committees absorbed a large burden of work that would otherwise fall on the Board and represented 'best practice governance', several Chairs also felt that the Committees are not performing to their potential or being used effectively. One Chair explained this:

'I think their contribution has been significant, but I'm not sure that we are using them properly. That's not necessarily a shot at the concept, but now we know what the rules are, I think we can do better...So you refer something to committees for advice and comment, and if it's clear cut it will comeback quickly to the Board. But frequently it's complex, and the original Board request gets lost in the all the work. We've lost the continuity, we fire it to the committee and it all goes haywire. So we have to control the agendas better and communicate better.' C 3)

Case study data showed that Boards have adapted committee structures to suit local needs. For example, onew case study Board combined the Community and Public Health Advisory Committee and Hospital Advisory Committee. Both have the same membership and meetings are held on the same day. The rationale given for this is that the provider arm should be treated the same way as other providers in terms of purchasing services if the Board is to refocus from a hospital orientation to a health Board.

An emerging theme from case studies in the second round is the more assertive role of Board members in the Committee process. One DHB initially had brief staff reports to the Board on the work of the Committees, now the Committee Chairs report more fully and meet regularly together. In two case study Boards there are reports of more systematic appointments processes in order to gain greater benefit from Committees. In only one case study DHB did Committee members report not feeling particularly well-supported by management.

Additional committees have been established in most Boards. These include various management committees (eg finance and/or audit committees, site or facility development committees, human resources or remuneration committees, quality and risk management committees), but also service based committees for areas such as primary care, mental health and Māori health as the DHB sees the need.

Perspectives from Committees

Interviews with CEOs and Chairs provided limited detail on individual Committees, but case study reports permitted some overview of their progress.

Hospital Advisory Committee

In the first round of research HAC was seen as filling an important role and this perception has continued. There is greater clarity around the role of HAC than for the other Committees and it was generally seen to be performing well, with good relationships with management. In one DHB it was noted that the full benefits from HAC had yet to be realised and this was partly to do with the need to improve the sophistication of analysis of the information presented to it.

Community and Public Health Advisory Committee

In the first round of research there was considerable uncertainty about CPHAC's role and it was thought that it might have little meaningful work once Strategic Plans were completed. This uncertainty has continued in some case study DHBs, but there has been increasing attention to clarifying the role of CPHAC, which is highly variable across DHBs. For example, one case study DHB uses CPHAC for active engagement with the community on a number of issues, and in another it was noted that Committee members had *'brought in voices that would not otherwise come through any other governance arrangements.'* In another case study DHB CPHAC operates at a higher policy level and has little involvement with the community, and even no community members.

Disability Support Advisory Committee

In the first part of the research Disability Support Advisory Committees generally reported being frustrated by the lack of a role and somewhat 'marginalised'. Nevertheless one DSAC developed a DHB Disability Action Plan and others were keen to take up their tasks once funding for disability support services was devolved. In the second round several Chairs reported DSAC as still having a low level of activity, but two identified it as valuable because *'we are weak in that area'* and *'it is dealing with practical issues very successfully'.* In several case study DHBs it was reported that DSACs had developed their own 'niche' of activity, contributing in practical ways through advocacy and raising the profile of disability issues within DHBs. Largely, however, they were seen as somewhat separate from the mainstream of Board level thinking and not well-engaged in strategic planning.

Resourcing and supporting Committees

There continues to be a range of views about the Statutory Committees. In the first round of research reports from almost all CEOs and case study Boards indicated that Committees were very costly from an administrative and management perspective and were a complication to governance-management-operations boundaries. In the second round five CEOs still held negative views of their statutory committees, regarding them as time-consuming and costly, and definitely not adding sufficient value to the work of the DHB. In contrast, no Chair agreed that the costs of the committees outweighed their benefits, and it was commented that they fulfilled a wider role: *'the price of democracy and public confidence'*.

In the second round there continued to be concern about duplication of effort and information across the committees and the costs of supporting committees, especially for small DHBs. A number of CEOs (including some who thought their committees were working well) volunteered that they would prefer NOT to have statutory committees, but would rather develop committee or working party arrangements appropriate to their own DHBs. This view is consistent with those of Board members, with a strong majority (71%) reporting that they would like to see the adoption of Committees as a DHB level function. One Chair also queried whether prescribed committees were the most appropriate structure, with some Boards reporting establishing additional committees for specific purposes. One Chair noted that it is up to the Board to make sure that the committees function effectively and in the wider interest.

In case study DHBs there were early attempts to minimise the time and administrative burden associated with the Committees. These included 'tight management', combining Committees, or holding Committees on the same day as Board meetings. Over time, however, more positive perspectives have encouraged case study DHBs to make Committees more useful and relevant to the work of the Board rather than seeing them just as 'necessary evils'. This has involved reorganising Committee membership, streamlining processes, linking more closely with the Board, allowing more time for the Board to consider strategic issues. Overall case study DHBs reported an improvement in the value and functioning of Committees over time, with only one DHB reporting some ongoing tensions. Case studies emphasised the pivotal role of the committee responsible for finance, audit and risk management in each DHB.

4.2.4 Transparency and community relationships

Rationale

In our early interviews, Ministers, ministerial advisors and officials noted that the government wished to open the health system up, 'warts and all' in the words of one Minister (KII 2). This would occur by allowing the media to attend meetings, allowing members of the public to sit in on meetings and to appear before the DHB, putting their views forward, i.e. the DHB model would operate with as much information as possible. The aim was to make the system open and transparent. The comment was made that '*the public actually can be quite sensible about what's going on if they don't think there's a conspiracy that's in secret'* (KII 2). One Minister felt that early impressions suggested the DHBs are doing much more in public than occurred with the HFA and RHA models.

Open meetings

In the first round of interviews and case studies, respondents acknowledged the centrality of community involvement in the legislation. Some CEOs observed that the governance system of elected members and open meetings was not seen as contributing as much to community involvement compared with the more structured processes many Boards had used for their strategic planning. Some, however, found open meetings to be helpful in managing community expectations and allowing a more positive engagement with the media, thereby increasing transparency.

Some negative points relating to open meetings were noted by CEOs. Public meetings were seen to constrain the debate necessary for good decision-making, due to the time available and members not wishing to be exposed through the frankness of discussion. Some DHBs use informal workshops and closed parts of Board meetings as mechanisms to cope with this. In general, in the second round of research, CEOs did not report open board meetings as posing major problems.

All respondent Chairs reported that their Boards worked within the spirit of the legislation and kept as much business in public as possible. 'Public excluded' times at Board meetings were reported as used only when essential for commercial or personal privacy reasons, although this placed pressures on the Board. Some Chairs acknowledged that there were risks attached to this where sensitive issues were on the agenda or when Board members may be compromised by speaking openly.

> *'...what we've tried to do is make as much as possible in the public domain. But there are times when, because reporting can be so awful and inaccurate, it causes many problems....So while we accept what the Minister's trying to do, there are times when you just can't afford to do it any other way than with the public excluded.'* (C 4)

> *'I've felt strongly that as a public body we should do as much as possible in a public setting. One of the changes that our Board had to go through was to learn how to be a public body as opposed to following the private company board model. And there's always been a tension in that. Part of the problem is that in our work there are so many areas where we are not free to make decisions, or where these need to be tested with the Minister and Ministry. So it's more difficult to do that in public until it's clear what the parameters are, and they are set outside the Board.'* (C 3)

Several Chairs indicated that their Boards did not use workshops for Board members, or that any workshops were used for information purposes, upskilling Board members, meeting community providers, etc, rather than reviewing Board business.

Although Board meetings are open, researchers have observed that generally few members of the public attend Board meetings, apart from the occasional media representative. Data from the case studies suggest that those that attend are seen to frequently have a particular agenda item that is of concern to them. Some Boards invite participation in discussions, others allow the public only as observers. One HAC member from a case study board reported that people get used to open meetings and *'just get on with it'*.

Though Boards report trying to hold more business in public there are difficulties if Board members discuss confidential issues at public meetings. Once case study reported that an analysis of the Board minutes confirmed that public were excluded when documents were still under negotiation with the Ministry of Health, when there were matters of commercial sensitivity, performance reviews and matters of personal privacy. In another one case study DHB it was reported that decision-making is slower in Committees because of the public being present, where Board members feel the need to give reasoning for their points of view and to reiterate their values base. Apart from specific, sensitive matters, any initial anxiety about being exposed to press or public scrutiny appears to have been allayed, and several Chairs reported a pro-active relationship with media.

A small majority of members (53.3%) in 2004 disagreed/strongly disagreed that open meetings constrained the debate necessary for good decision-making, with elected members more likely to support this view (p=.027). A small majority (54%) in 2004 reported that they disagreed/strongly disagreed that most decision-making took place in closed meetings of the Board or Committees.

Community engagement

Although few members of the public attend Board or Committee meetings, many respondents to the Survey of Board members report that nevertheless their Board had established procedures for seeking community input (with 71.8% strongly agreeing/agreeing in 2002 and 69.6% in 2004). In 2004 79.9% agreed/strongly agreed that the Board had established procedures for seeking input from whānau/hapū/iwi and Māori communities, but Māori however, were less likely to agree with this (p=0.024). There were mixed views on whether Boards have effective ways of reporting to the community, with just over one third of respondents agreeing/strongly agreeing at each time period. In 2004 just over half (54%) of respondents agreed that community input made a difference to decision-making.

The case studies demonstrate that the ways in which the Board itself engages with the community are highly variable. Some Boards had specific strategies to ensure greater direct Board member engagement with the community (eg public right to speak at committee meetings, 15 minutes set aside before the Board meeting for members of the public to speak, taking Board meetings 'on the road', Board members attending meetings of representative groups in the community).

4.2.5 Autonomy and devolution of responsibility

Rationale

Under s. 23 of the Act, each DHB is charged with ensuring the provision of services for its resident population and to undertake the planning, community involvement, prioritisation, decision-making, contracting and monitoring to achieve this. In these ways, the reforms transfer decision-making to a sub-national level of government. On the other hand, DHBs' strategic plans are not to be inconsistent with the NZHS and the NZDS; and one of the principles of the NZHS is '…equitable access for all New Zealanders to a comprehensive range of health and disability services…' where '…the health sector much ensure that New Zealanders with similar health conditions are able to achieve similar outcomes' (King 2000).

A number of key informants, both ministers and officials, indicated that decision-making would be devolved over time, but they always stressed that this would occur within national frameworks, eg taking into account national strategies and priorities and service coverage frameworks. Some felt that this would cause conflict between local, regional, and national decision-making processes, and some officials felt that decision-making would continue to be dominated by national priorities.

It was also argued by ministers and officials that the phased hand-over was intended to give the DHBs time to establish capacity and capability, and to protect health funding and provision as capacity and capability developed in DHBs.

Autonomy of decision-making

In the first round of research there was a strong perception from CEOs of DHBs of a reluctance on the part of the Ministry to devolve, and too great an involvement in operational matters. There were also comments from case study informants that suggested concerns about the autonomy of DHBs, for example:

- The unwillingness of the Minister to sign off the annual plan caused tension, when the Board considered its plan both reasonable and feasible.

- Central government still dictates what has to be done and paid for, eg fertility and surgical services.

- Unclear locus of decision-making. DHBs are charged with needs assessment and prioritisation and yet funding decisions are constrained by national frameworks and (on occasions) interference in local decisions by the centre.

Board member views

In both 2002 and 2004 clear statements on devolved decision-making come from surveys of Board members. A majority of members in 2004 (67.4%) agreed/strongly agreed that their Board was able to address important health issues, about the same proportion as in 2002 (67.4%). There was some increase in levels of agreement/strong agreement between 2002 (82.6%) and 2004 (86.7%) that Government strategy played an important part in DHB decision-making. In 2004, there were mixed views on Board autonomy, 40% of Board members disagreed/strongly disagreed that their Board had sufficient autonomy to spend their resources, with 30.1% of Board members agreed/strongly agreeing that they did have such autonomy. This reflects a view that the Ministry of Health was seen to interfere inappropriately in the work of the DHB (71% agreeing/strongly agreeing in 2004, compared with 61.8% in 2002).

In the 2004 survey of Board members a series of items addressed the question of where decision-making is *currently seen to lie*. Board members responded as follows:

Minister or Ministry of Health: A strong majority of respondent Board members reported central decision-making functions to be

- the appointment of members to the DHB (72.1%) and
- selecting the Board Chair (81.4%).

A bare majority of respondents reported central decision-making functions as

- determining the priority between public health issues to be addressed (52.8%)
- negotiating user charges in primary care (53.5%)

District Health Board: A majority reported the following as decision areas for DHBs:

- consulting with the public on priorities (76.5%)
- selecting providers to contract with (78.9%)
- monitoring provider organisations (73.5%)
- determining PHO (primary health organisation) approval and selection (59.2%)

There were no decisions that a majority saw as regional, nor any that a majority saw as shared between the centre and the DHB. However, there were a large number of decision areas where the responsibility for the decision was reported as either dispersed or unclear (Table 3).

Table 3 Board member views on current responsibility for decision making where responsibility is dispersed or unclear

Decision area dispersed, or unclear	Central	DHB	Shared
	Identified currently as responsible for the decision (%)		
Determining priorities over next 5 years		32.8	45.0
Determining priorities over the next year		33.6	49.6
Decision making in relation to the Treaty of Waitangi	26.9	45.4	24.6
Setting salaries for DHB staff		40.2	29.1
Determining the price to pay providers		40.0	30.8
Which NZHS objectives to concentrate on	32.7	35.7	27.9
How much funding to put into different programmes	34.1	25.8	32.7
Range of services to be covered		37.2	34.1
Reconfiguring services		37.2	34.1
Volume of services to be purchased	35.9	36.7	34.4
Advisory Committees adopted by DHB	38.7	37.4	23.7
Assessing DHB provider arm performance	34.1	25.8	35.6

Of interest are the areas where DHB members feel that they **should** have a greater decision-making than currently. Table 4 sets out the areas where members reported that greater responsibility is desirable **and** where the Kappa coefficient, used to measure agreement across an entire group, is low, indicating poor agreement between current and desired role allocation across respondents.

Table 4 Board member views on areas where a greater role for DHBs in decision-making is preferred

Decision area	Respondents currently identifying DHBs as responsible (%)	Respondents indicating DHBs <u>should</u> be responsible (%)
Deciding which NZHS objectives to concentrate on	36	54
Determining the public health issues to address	-	39
Appointing members to the DHB	-	23
Selecting the Board Chair	-	81
Deciding which advisory committees to adopt	37	71
Selecting providers to contract with	79	88
Negotiating user charges for primary care	23	43

Chairs' views

Chairs tended to have a positive view of the role of the centre. In 2004 they recognised that the role of Government as funder and policy strategist could limit the decision-making of individual DHBs, but characterised this as part of the normal public sector relationship and 'a fact of life'.

Five Chairs reported no real constraints from the centre on their decision-making:

> *'I think we've got adequate flexibility to make a difference. I think we have to keep our feet on the ground. The central policy-makers do set the core direction but I think there's plenty of room to make a difference at local level.'* (C 11).

Nine Chairs, however, indicated restrictions, although not all of these were considered serious barriers. For example:

> - sometimes new (usually good) ideas or other requirements (eg the restraint policy in hospitals) come from the centre that have not been budgeted for but which were expected to be incorporated into the DHB's services. One Chair described this: *'we have surprises dropped on us all the time...that we hadn't budgeted for in DAP'.* (C 2)
>
> - Minister's 'start here' list limits local flexibility
>
> - Break-even requirement pre-empts even the 'start here' list
>
> - Still not quite the right balance and Ministry must be challenged from time-to-time.

CEOs' views

CEOs spoke more strongly about the constraints of the centre with respect to both policy and operational decisions. Seven CEOs specifically indicated that they felt that there was definitely too much central control of policy decision-making. It was suggested that the Ministry was now more centrist than previously and that the ability to make local decisions, 'without the political 'tick'', was uncommon, with this compromising DHBs' ability to rationalise services and meet local needs.

> *'The reality is that the Minister has a lot more under statute than existed under the old model. The extent of control coming out of the centre is much stronger than it was'* (CEO 20)

> *'It's now 2004 and we are District Health Boards. We now know who we are, what we are and what we should be doing. There should be much less direction and monitoring from the Ministry, it shouldn't be such a big player'.* (CEO 12)

Several CEOs also reported that in the Ministry was too concerned with operational matters within DHBs, including working directly with PHOs, NGOs, and in mental health. CEOs expected a more 'hands-off' approach and indicated that such involvement could cause difficulties locally. Within this context the DHB model was referred to as 'devolved in appearance but not in reality', and there was frustration with the central constraint on decisions that were seen to be more appropriately made locally. Once case study DHB reported that the Ministry's request for proposals for primary care mental health could set a trend for funding providers through PHOs which may run counter to the DHB's policy.

Case study experience

Case study informants expressed a tension over the perceived lack of willingness by the Ministry to devolve decision-making: *'They've said on the one hand the DHB must make all these decisions but then they've proceeded to make some decisions for us, definitely they've interfered.'* Case studies consistently reported on the Ministry's inability to stick to policy matters, with too much involvement in operational areas, including details of contracting.

In one case study an informant noted:

> *'The expectation of Government for community organisations and DHBs to work together without some time and to make changes when they're already keeping a very tight grip on things is sometimes frustrating and impossible.'*

There were numerous examples cited of excessive involvement in operational areas, with the high level of detail required for DAP reportedly detracting from the planning process. One case study DHB reported that there was no disagreement with the Minister over priorities, but that the DHB did not want *'to be told how to do it.'*

Devolution of funding

In the first round of research there were comments about the slow pace at which disability support, public health and mental health funds were devolved; and this was seen that the Ministry was *'hanging onto the funding'*. Although DHBs acknowledged a limited capacity to take on extra work in the early days, most informants expressed a preference for, ultimately, greater devolution. Ring-fencing of funding, while seen as a pragmatic approach for a period of time, was not considered a good long-term strategy.

Disability funds

By the time of the second round of research, disability funds had been devolved. This was not an entirely successful process. Only three CEOs made positive comments about the actual handover process, indicating that this had gone more smoothly than earlier devolution of personal health and mental health contracts. Two CEOs expressed very strong views that the process had been exceptionally poor*: 'appalling', 'a disgrace...a hospital pass,'* and most others commented strongly on the frustrations of the lack of information on the contracts and uncertainty over the financial implications.

> *'We were disappointed in the amount of information available from the Ministry prior to the contracts, but this was a transitional issue. A major issue for us was the level of funds devolved to manage the contracts.'* (CEO 1)

All respondent CEOs (19) contributed information to an overall assessment of the issues and problems involved in the devolution process:

Incomplete information on contracts handed over. CEOs were particularly concerned that contracts were handed over with incomplete correspondence files, and without any indication of performance history.

Financial risk incurred. All CEOs commented on the financial risks to their DHBs and the uncertainly of the effectiveness of the national risk pool in addressing this. It was suggested that greater discussion of risks should have occurred prior to devolution.

Of the 13 Chairs commenting on the devolution of funds for people over 65, four noted that there had been no particular issues or problems, other than the need to commit more resources to ensuring proper future management. Most Chairs, however, expressed concern over financial risk. They reported inheriting a large new amount of over-funding, attributing this to inappropriate decision-making and monitoring on the part of agencies formerly responsible (RHAs, HFA, the Ministry of Health). Some Chairs expressed annoyance that outstanding issues had not been resolved prior to devolution and concern about the impact on the DHB's relationships with providers as work continued on 'cleaning up' previous decisions.

> *'It's creating a major difficulty for us because on the one hand we are expecting to take costs out of the system...and on the other, the Ministry that says we are over-funded has been writing all these approvals. It was perfectly OK until they handed over to us and now it's $x million over-funded!'* (C 8)

> *'...the detailed material we received from the Ministry was pretty chaotic and so there was a high level of guesswork operating and quite a high level of anxiety within the board. ...In some senses the real test will be our planning for the coming year.'* (C 4)

Despite the widespread irritation with the process and concern about the funding implications, both Chairs and CEOs volunteered comments about the positive implications of devolution for their DHB, including the opportunities to work with providers, to find efficiencies, and to consider service improvements across the entire aged care sector. Several indicated that they were continuing to work closely with the Ministry on a range of issues.

In general case study DHBs were moderately optimistic about the opportunities presented by devolution of disability funds, expected that local monitoring would ultimately be more effective, and that pro-active planning would address most risks. Comments from case studies where a wider range of informants were involved tended to be less temperate than Chair and CEO assessments.

One case study reported on perspectives from local providers who were concerned that DHBs would not be able to maintain the national overview held by the Ministry. In the national stakeholder study, in the first round of interviews, informants reported similar ambivalence to devolution. On the one hand they were optimistic about local partnerships and the opportunity for innovation. On the other they feared loss of consistency, costs of contracting and funds being diverted to other services. The second round of interviews was only nine months after devolution and too soon to assess progress, but a variety of reports were emerging, both positive and negative.

Public health funds

There was greater ambivalence on the part of DHBs regarding the devolution of public health funds. Sixteen CEOs commented on the issue of complete devolution of public health funding to DHBs. A clear majority (13) indicated that they wished to see greater devolution, some (7) expressing strong views about the importance of being able to make decisions locally in support of PHOs. Among those expressing support for greater devolution there was also recognition of the need for some national public health initiatives and that there were definite efficiencies through regional collaboration. The three CEOs not particularly concerned about devolution expressed strong support for the regional arrangements of which they were a part. Others expressing similar satisfaction nevertheless would have preferred the funds to be devolved, even with ring-fencing.

Case study reports reflected this range of views.

4.2.6 Accountability

In our key informant interviews, we asked a number of questions about the issues raised by the mix of accountabilities signalled in the legislation. Ministers and officials stressed that '*...district health Boards are very, very clearly accountable to their Minister*' (KII 14). One Minister viewed the DHB accountability to central government as essential, given that the funding comes from central government and that central government is directing overall health policy. Within this context, it was expected that elected members would represent their district and bring local knowledge into decision-making.

A number of those we interviewed, including officials, predicted that this perception of a mix of accountabilities, and the desire for local decision-making at a local level while DHBs are also operating within national frameworks, would generate tensions.

One key informant raised a further concern around the accountability arrangements. If DHBs did not have a reasonable scope of budget and responsibility for a reasonable range of services, then it would be impossible to hold them properly to account for anything. They would simply be able to argue that what they were doing was influenced by a wide range of constraints. This key informant noted that if New Zealand was going this far to develop a devolved model, then we should *go 'the whole hog and devolve responsibility to DHBs'.*

Dual accountabilities

In the two surveys (2002; 2004) Board members were asked about competing accountabilities. Despite the clarity of the legislation and guidelines, there was a feeling on the part of some elected members that they had accountability to their communities as well as the Minister. In 2002 42.3% of respondents agreed/strongly agreed that their primary accountability was to the Government, not the community, with 20% disagreeing/strongly disagreeing. By 2004, 50% agreed/strongly agreed and only 16.3% disagreed/strongly disagreed.

In 2002 56.3% or respondents agreed/strongly agreed that part of their role was to represent a geographical area, a view held particularly amongst elected members (p=0.02). By 2004 this had dropped to 47.4% of elected respondents, with appointed members (p=0.001) and Māori respondents (p=0.009) less likely to see themselves as representing geographic areas. There was a similar decline from 2002 (41.6%) to 2004 (34.9%) in the proportion of members strongly agreeing or agreeing that their role was to represent special interests in the community.

In 2002, among elected respondents, 54.4% agreed or strongly agreed that they could handle this perceived dual accountability, this rising to 74% in 2004. The number of respondents in 2004 choosing to identify themselves as principally accountable to the Minister of Health rose to 65.3% (greater than the proportion of appointed members) compared with 50.4% in 2002.

Pacific respondents were less likely to report feeling accountable principally to the Minister of Health. Among Māori members, only 30% in 2004 agreed or strongly agreed that accountability to their whānau/hapū/iwi was a source of personal tension, the same level as 2002, although the proportion strongly disagreeing/disagreeing in 2004 had risen to 65% compared with 30.7% in 2002.

The implications of the accountability as a **Board** to the Minister of Health created practical difficulties for some members and some DHBs. In one case study DHB there had been extensive debate about the extent to which individual members could speak out on decisions with which they disagreed. There was a clear division in that Board over the issue, with a group of elected members strongly espousing this view. The issue surfaced strongly at the time of the 2004 election with a clear tension between what the Chair identified as 'modern governance accountabilities' and a more traditional 'local authority' view of how elected representatives do their work, particularly a closer involvement with constituents and advocacy roles. In other case studies this tension was less apparent.

Conflict of interest

The most readily identified source of conflict of interest was the presence of DHB employees or other health professionals or contracted providers on the Board. This was identified by CEOs in the first round of research and in the second round of research generally informants reported that members understood and declared conflicts of interest.

Most case study DHBs reported that conflict of interest issues were clear. In one case study DHB members with involvement in the health sector were seen as a strength, although with the need to ensure that alternative views were also incorporated. In another DHB, where four local health professionals were elected to the Board, conflict of interest was seen as important for both the Board and the Committees. An obvious area of conflict was for GP Board members where PHOs were under discussion. One DHB member noted that fairly large conflict issues arose at almost every board meeting but "*generally it's dealt with good naturedly and I think most people are starting to understand how critical* [conflict of interest issues] *they are".* However, this interviewee went on to note that fellow board members *"don't always work out for themselves when they're possibly conflicted."* From 2003 this Board used guidelines for dealing with conflict of interest drawn largely from the NZPH&D Act itself, mainly addressing specific conflicts when material benefits may flow to Board members. The broader issue of more generalised biases was assessed as more difficult to manage and monitor.

In 2002 73% of respondents agreed/strongly agreed that conflicts of interest were well managed, with Māori members less likely to agree (p=.05), rising to 81.4% in 2004, with males more likely to agree than females (p=.011).

5 Board Processes and Functioning

5.1 Board Member Capability

Board members' preparedness for their role

In 2002 nearly half (45%) of Board members felt adequately informed about the issues before joining the Board, with a similar proportion (45.2%) in 2004. By 2004 33.3% agreed/strongly agreed that they would like more training for their role as a Board member, compared with 40% in 2002, reflecting the build up of experience on the part of returning members. Board members grew in confidence in their role, with 82.2% agreeing/strongly agreeing in 2004 that they would probably choose to serve another term. In 2002 Māori members were less likely to agree that they would do so ($p=0.04$), but there was no significant difference between Māori and others in 2004.

In 2002 87% of members agreed/strongly agreed that they had a clear understanding of their role as a Board member, with elected respondents less likely to agree ($p=0.007$). In 2004 94.8% members reported a good understanding of the role. A minority of Board members (19.3% in 2004) strongly agreed/agreed that their workload was excessive.

Functioning of the Board

There were high levels of agreement/strong agreement in both 2002 (83.3%) and 2004 (88.9%) among members that they had a good grasp of issues facing the Board. Board members tended to have a positive view of their influence. In both 2002 and 2004, 75% agreed/strongly agreed that they were able to influence Board decisions.

Of the 20 CEOs interviewed in the second round of research six were very positive about the functioning of their Boards:

> *'I can't speak highly enough of my Board....to be honest, I was looking for some cracks...but I couldn't ask for more.'* (CEO 15)
>
> *'I've got a very good Board...I consider myself very fortunate.'* (CEO 14)
>
> *'...from the last time round to this time...it's been an extremely good Board. The maturity, the growth, the understanding has grown in quantum leaps.'* (CEO 7)

Thirteen CEOs indicated that the Board had settled into a well functioning mode, although this had required considerable input, in particular from the Chair. Despite some specific skill gaps, these CEOs reported a progressive improvement in functioning over the life of the board. They reported improved understanding of the complexities of the sector and more cohesive approaches. Most boards had engaged in specific training initiatives and paid attention to the boundaries between governance and management.

A number of CEOs volunteered the fact that they would prefer a fully appointed Board, but there was a greater acceptance of the current arrangements than in earlier interviews and a positive and flexible approach to maximising the performance of their boards. This was characterised by CEOs:

> *'Boards are going to come and go and I don't see this as a major issue. Sure, trying to bring them up to speed is time-consuming and energy sapping. But I look at the Board as a hand of cards that you are dealt and you play the hand as best you can.'* (CEO 9)
>
> *'[success]..depends on the willingness of the CEO to communicate with Board members, especially elected members, so that they have the information they need...for example, if we get the resignation of a senior doctor I ring [the Board member] right away before she hears it from someone else'.* (CEO 2)
>
> *'...almost without exception, from a management perspective, we have seen the decisions we would expect a Board to make. Sometimes the route there is a little tortuous, but the board does get there...'.* (CEO 1)

Only one CEO reported that the board had not been able to fulfil its role and appeared to lack understanding of both the complexities of health and the accountability processes.

All 14 Chairs reported progressive improvement over the three-year cycle, following some initial problems. Chairs reported on some of the roles that they had assumed in helping develop Board functioning, including education, mentoring and supporting members, acting as a bridge between members and management and leading the Board's evaluation of its own performance. Chairs were probably being modest and understated this role as interviews with CEOs indicated how critical the leadership of Chairs has been. Several Chairs noted how demanding the role is and how high are the expectations both in the DHB area and nationally.

Contributions of Board members

Elected and appointed members

In the first round of interviews CEOs had expressed considerable reservations over the capability of elected members, particularly their understanding of board-management boundaries and accountability relationships. In the second round CEOs reported much more positively.

As noted above, nineteen CEOs (see above) indicated that their boards were working well, or reasonably well. Five confirmed that the appointed members had filled important skill gaps. A further 5 reported that use of appointments to ensure appropriate community representation or appoint a Chair may have reduced the opportunity to target skill gaps. The inability to ensure additional skills through the appointment process was an important issue for some CEOs:

> *'we don't have financial skills on our Board...this is a big risk for any governance organisation, and for an organisation our size not to have a chartered accountant on the Board is a big risk.'* (CEO 9)

> *'I'm holding out for STV because I think that it will actually improve things. I believe Māori will be represented through STV so that it will free up appointed positions to be more closely targeted to skill needs.'* (CEO 5)

Seven CEOs reported that it was hard to distinguish between the performance of elected and appointed members but, as noted above, the capability of Boards overall had required considerable work from members, CEOs and, particularly, Chairs. There were concerns reported over delays in appointments being made.

In the second round of interviews, CEOs did not report such major concerns over the understanding of accountability issues on the part of elected members, although they noted that these issues were still present.

> '*On occasion you will have members that forget that they are representative of all residents of the DHB and tend to look to their own district or area. So we do have those issues coming into play at times.'* (CEO 1)

While they reported difficulties for individual members from time to time, in general this was dealt with via the Chair. Some CEOs reported that as the 2004 elections approached they noted 'electioneering' behaviour from some elected members and expected some destabilisation of the board as a result of the elections.

Not surprisingly, 73.9% of DHB members reported in 2002 agreeing/strongly agreeing that Board members bring 'added value' to decisions (71.9% in 2004), with elected members more likely to agree than appointed members.

Case study reports

Case study reports, particularly where researchers attended meetings regularly, allowed additional insights into Board member functioning. Two extracts from case study reports are presented in Appendix 2.

Case study A shows that Board members grew in confidence through out the period, demonstrated by an increase in constructive debate and challenge at Board meetings. In terms of decision-making, the first period of research did not occur at a time of intense decision-activity by the Board, but nevertheless the Board acted in a 'high level' statutory role, referring and amending recommendations and monitoring strategic direction. The Board also engaged in detailed questioning or challenge of management and presenters. This level of activity persisted in 2004, with only one third of the agenda items coming to the Board being 'received' or 'noted' without challenge or action.

Case study B reports that meetings were 'lively and at times tense and conflictual'. The majority of contributions (55.5%) at the Board table (including the CEO) were providing information or comment, with a smaller proportion questioning, challenging or critiquing (12%). Five per cent of contributions were to suggest or initiate action or amendment. There was a variety in speakers' overall contributions, with one participant (probably the Chair) contributing 23% of all comments. Four other participants contributed 13%, 13%, 11% and 7% of comments. Other Board members spoke much less.

5.2 Board Processes and Procedures

Managing the Board

In 2002 80% of Board member respondents agreed/strongly agreed that Board meetings were run efficiently and well, although this dropped to 73.4% in 2004, with statistically significant differences between DHBs. A majority of members (53.3%) in 2004 disagreed/strongly disagreed that open meetings constrained the debate necessary for good decision-making, with elected members more likely to support this view (p=.027)

A majority of members in 2004 (61.4%) reported that there had been discussion within their Board about Board performance. A number of CEOs, particularly those enthusiastic about their boards, commented on the importance of the Chair in managing the Board. Besides personal and group evaluation, effective Chairs have also mentored individuals and provided leadership both at meetings and outside. CEOs commented:

> *'the whole functioning of the Board around elected and appointed members is dependent on the skills and capability of the Chair.'* (CEO 2)

> *'I have a knowledgeable, astute, intelligent Chair who...can get all Board members involved. So even those members elected on 'single issues' now look at the big picture and understand the complexities of that.'* (CEO 7)

Chairs themselves, in both rounds of interviews confirmed the high workload associated with their role.

Between 2002 and 2004 there was a decline in the proportion of respondents who agreed/strongly agreed that diverse points of view are valued in Board discussions, down from around 75% to 63%.

Strategic focus

Responses from Board members indicate that a majority see the Board as maintaining a strategic focus. In 2002 and 2004 similar proportions (just over half) of respondents agreed/strongly agreed that their Board provided a clear vision for local health developments. The proportion of Board members agreeing/strongly agreeing that there is normally adequate time for discussion of major issues increased between 2002 and 2004 to just over half of respondents. Similarly, there was an increase in the proportion of respondents between 2002 and 2004 who agreed/strongly agreed that their Board spent enough time on policy and strategic planning matters (from 59.8% to 65.9%). There was also a decline to 28.2% in the proportion who agreed/strongly agreed that their Board's discussion is dominated by hospital issues. In 2004 68.1% or respondents agreed/strongly agreed that the Board's priorities were based on the Health Needs Assessment.

It was noted by a range of informants that the strong direction from government meant that there were few opportunities to demonstrate local leadership. In fact most Board member survey respondents agreed/strongly agreed that government strategies played an important role in Board decision-making (82.6% in 2002; 86.7% in 2004). In the first round of research most CEOs reported that the level of strategic leadership demonstrated by Boards was relatively limited. Several noted an over-reliance on management that they were concerned might lead to too narrow a focus and even resentment at management 'dominance'. However, nearly all acknowledged that Boards had worked hard on their strategic plans under severe time pressures, and that they had been able to reach agreement.

By the time of the second round of research CEOs reported their Boards had a much better understanding of the complexities of the health sector. Chairs also noted the need to maintain a strategic focus, with issues arising from both management and members. In the second round of research one Chair reported on the initial reluctance of management to involve the Board early enough or adequately in the process.

> *'I've struggled to change the way they've done it here. We have made some progress but not as much as I think we should. I think we [the Board members] are not brought in early enough, and the Board did not have enough control.'* (C 13)

Four Chairs reported that good progress had been made to address problems with the functioning and capability of their Boards in strategic areas, for example:

> *'We need to keep the critique at the strategic level. It was a huge problem at the beginning and it's a recurring problem. But there's been a great improvement. It's a matter of providing leadership to progress the understanding, mentoring your colleagues.'* (C 12)

The case studies reported in more detail how the strategic focus of the Board had developed. One case study indicated that there was a view that strategic issues were 'not opened up enough' at Board level and that issues came to the Board 'a bit sewn up'. The recently elected Board (2004) appears less accepting of this situation. In another case study DHB the Board devotes half a day per month exclusively to considering strategic matters in addition to the formal Board meeting. Members clearly felt frustrated that their attempts to provide strategic leadership by planning to disinvest in some services not considered critical to public health were halted by the Minister.

5.3 Internal Board Relationships

Overall Board members strongly agreed/agreed in 2002 (87.9%) and 2004 (90.3%) that they had a good relationship with Board colleagues, with elected members more likely to agree (p=.042) and Māori less likely to agree (p=.003).

Several Chairs reported positively on the development of a 'team' approach on the part of the Board, indicating greater collaboration between members and better understanding of collective decision-making over time.

Case studies confirmed that generally Board member and Board management relationships were harmonious. In one case study DHB the Board was described as a 'strong, cohesive group.' In another DHB informants confirmed that the Board works well together: 'the mix seems to work'. In another, informants described an '*open culture', 'it's very supportive, there's nobody judging you.*' In only one case study DHB was there an indication of any difficulties, with a reported reluctance on the part of Board members to undertake self-review in association with the Chair.

5.4 Relationships with Management

In 2002 59.8% of respondents to the survey of Board members agreed/strongly agreed that the Board and management shared a common vision, rising to 76.2% in 2004. Furthermore, in 2002 68.5% of Board members agreed/strongly agreed that Board and management work well together, with statistically significant differences across DHBs. This rose to 81.4% in 2004. Also in 2004 less than a quarter of respondents agreed/strongly agreed that the Board is a rubber stamp for management, with elected members more likely to agree than appointed Board members.

In the first round of the research most CEOs commented that there had been difficulties in maintaining proper boundaries between governance and management.

This was felt to be because elected members in particular had not understood the role clearly, but as time progressed there was more clarity. About half of the CEOs commenting on this issue reported particular strategies for dealing with it, formal education of boards, the chair working with members, a letter from the CEO or a chat with members.

In 2004 92.6% of members agreed/strongly agreed that they ask for more information if they need it. From CEO interviews and the case studies it is apparent that requests for information often place a considerable burden on management, with sometimes an apparently reluctant response which may be misunderstood by members as wishing to limit their access to information. Several DHBs had put procedures in place to ensure that requests for information are properly channelled and assessed.

Half of the respondent Chairs (7/14) reported some difficulties with Board-management relationships, often minor and sorted out over time. These included the adequacy of reporting and information sent to the Board, Board member understandings of the role of governance, and not enough 'buy-in' from management on the role of an elected Board. Several Chairs noted that the interaction between Board and management had changed:

> *'Overall we've changed the interaction of the Board with management....With the previous Board the closeness of the Chair and CEO meant that the Board had very little influence and that is quite turned around now so that the Board has the influence and the CEO and management work with the Board.'* (C 1)

> *'We didn't have much buy-in from senior management that an elected Board could be any good, or any buy-in from the Board that management were actually working with them. So the biggest progress we've made in the last year is to get the best from each other to get the best results.'* (C 13)

In both 2002 and 2004 there were mixed views on the part of Board members regarding the need to become involved sometimes in 'management' issues. Through the case studies it was also possible to identify genuine 'grey areas' or circumstances where Board members needed to know more about management issues in order to fulfil their governance role properly. PHO development was given as an example; an operational issue that had strategic implications for the DHB.

All five case studies confirmed the experience of clarification and strengthening of Board-management relationships over time. In one DHB the initial suspicion that management was trying to constrain Board decisions was alleviated as it became clear that certain decisions were actually made in the Minister's office.

5.5 Relationships with Clinicians

Both Chairs and CEOs commented on the importance of clinicians for a range of high level DHB activities such as risk management and priority setting. Sixteen CEOs specifically mentioned the importance of clinicians to overall financial sustainability. In 2002 44.3% of Board members agreed/strongly agreed that their Board had a positive relationship with senior clinicians, rising to 51.1% in 2004, with statistically significant differences between DHBs.

Despite these comments, there is little evidence the senior clinicians are engaged with governing Boards other than through invited presentations at Board and Committee meetings. This may be appropriate as the primary relationship for clinicians is with management, but their significance to DHBs is such that there is a strong imperative for them to be more positively engaged and hold organisational as well as clinical perspectives. In some DHBs there are opportunities for greater engagement of clinicians through organisations such as Clinical Boards, and in one case study Board there is a standing invitation for Board members to attend Clinical Board meetings. An informant in another case study Board reported that the 'anti-doctor' culture was changing and that the DHB tended to listen to senior clinicians.

5.6 External Relationships

Maintaining high level external relationships is an important governance role. This includes accountability relationships with the Minister/Ministry of Health and stakeholder relationships with communities of interest. It also includes important lateral relationship with manawhenua (discussed in another report) and relationships with other DHBs. Relationships with DHBs are managed either through the collective organisation of DHBs, District Health Boards New Zealand (DHBNZ) or in bi-lateral or regional ways.

DHBNZ

District Health Boards New Zealand was not set up as part of the statutory framework for the 2000 health reforms, but arose out of the need for DHBs collectively to develop national perspectives on health matters. The Crown Health Association (CHA) had preceded it under the previous structure, and Chairs had moved quickly to develop DHBNZ in a similar role. At the time of the first round of interviews DHBNZ had only recently been established. It had little to show in terms of its contribution and there was concern on the part of some CEOs about the potential for it to usurp the decision-making autonomy of DHBs or to act beyond its brief (*'the tail wagging the dog'*). A number of CEOs indicated that they anticipated some tensions developing between individual DHBs and DHBNZ.

In the second round of interviews 18 CEOs responded to a question about DHBNZ. Although there might have been some tensions and difficult moments, DHBNZ is firmly established and well-regarded by CEOs. Its position as a 'servant of the DHBs' and not an independent voice was been confirmed, and there were appreciative comments from CEOs on its work in a number of technical areas: industrial relations, national issues such as pharmaceuticals, workforce, etc. its liaison with the Ministry and the way in which it had stimulated regional approaches to collaboration.

From a governance perspective, some caveats remained, particularly with regard to ensuring that DHBNZ does not present itself as representing DHBs without a proper mandate, although several CEOs noted that other health agencies tended to misunderstand DHBNZ's role and ascribe to it powers or responsibilities it does not have. CEOs reported that some Board members with concerns about DHBNZ did not fully understand its agreed role.

> *'There are a number [of members] of our Board who believe that DHBNZ is usurping some control of governance, and it's got quite testy at times.'* (CEO 1)

> *'There are tensions within DHBs over DHBNZ. Those tensions are from the uninitiated ...or people who are not fully engaged at regional or national level....You hear people talking about DHBNZ as if it's running its own agenda. So it frustrates me a bit. If we don't like the agenda, we reset it...and we don't and shouldn't view it as a problem.'* (CEO 8)

All Chairs spoke very positively about the role of DHBNZ. Its operations were reported to have become more streamlined since 2002/3. Overall DHBNZ was seen as improving the 'connectability' of the sector and giving confidence and stability through times of change. Specific areas where DHBNZ was seen to be working well were in facilitating relationships with the Minister,- industrial relations, analytical and policy work on sector-wide issues (eg pharmaceuticals, IT, referred services) and facilitating regional collaboration. Chairs spoke very positively about the regional groupings fostered by DHBNZ, with regular meetings of Chairs and CEOs considered important for developing regional approaches to issues, including capital developments, service configurations, regional clinical issues.

In the earlier round of interviews Chairs had expressed some concern about the need to maintain an effective governance relationship within DHBNZ to ensure that the autonomy of individual Boards would be preserved. In the second round of interviews this was seen as less of an issue, with some Chairs indicating that the organisation was evolving appropriately: *'the Chairs are more comfortable now'; 'there is a good relationship between the DHBNZ board and the executive group*'.

However, a significant minority of Chairs still expressed some reservations about DHBNZ's way of working, for example:

> *'I am broadly comfortable, except DHBNZ needs to be in better communication with Chairs';*
>
> *'I have a concern that it is leading DHBs, not following';*
>
> *'It has a long way to go at governance level to work properly;*
>
> *'Still a danger of becoming an elite group'.*

Relationships between DHBs

A number of Chairs and CEOs reported on the evolving relationships with other DHBs in the same region, and this was a notable development since the time of the first round of research. While much of the activity was driven by CEOs, Chairs were actively involved in meeting with regional colleagues.

Chairs noted that, overall, relationships between DHBs were described as 'cordial' or 'very good' although several Chairs noted that there are still 'slightly competitive' elements inhibiting collaboration. For example:

> *'We have one tertiary hospital in the region. I think there is some tension there. They like to be in control so we have some tensions. But that doesn't mean that we don't work well together. But I think they see themselves as going out and doing our work instead of truly providing a regional service into which everyone has input. So I think there needs to be some change of attitude, although that is often at a clinical rather than CEO or board level.'* (C 1)

Some Chairs saw their DHBs as having very close relationships with their neighbours *('we now have a memorandum of understanding'; 'we stand and fall on our relationship with each other').* Although it was acknowledged that collaboration 'is required of us', most acknowledged the benefits of such an approach.

CEOs take the major role in managing DHB-DHB relationships. One CEO remarked that 'strategic alliances' are the only way forward, and the local relationships were

seen by both Chairs and CEOs as a way of minimising the issues arising from having some DHBs that are seen as only marginally viable either clinically or financially.

Sixteen CEOs commented very favourably on the development of positive relationships with other DHBs in their region and noted that these had been enhanced by DHBNZ regional groupings. Relationships had tended to develop in two broad areas:

Non-clinical and administrative services

There was a trend reported towards increasing co-operation in support and administrative areas in order to derive greater efficiencies and increase capability. Human resources, industrial relations, IT and a joint venture laundry service as well as the shared services agencies were examples of such joint activities.

Clinical services

Several CEOs commented that the main risk to the New Zealand health sector is the non-viability of clinical services in some areas, and there is a need to develop relationships to sustain these. This was seen to be in the interests of both smaller boards, where recruitment and the achievement of critical mass might be problematic, and larger boards which needed certainty in terms of the demands placed on them from elsewhere. Examples of collaboration of services included mental health, surgical and medical specialities, and laboratory services. Some CEOs commented on the importance of clinical leadership in developing the necessary relationships and networks to further collaboration in service areas, and the variability of progress because of this. Good clinical coverage was seen as the important outcome, rather than efficiencies.

Case studies provided useful insights into collaboration between DHBs, particularly the use of the shared service agencies, which were largely endorsed. DHB relationships with shared service agencies were evolving, with some DHBs wishing to derive greater benefits and others seeking to do more work themselves. No case study DHB reported its autonomy compromised by more formal lateral relationships. Some tension are still apparent, particularly related to the perceived dominance of larger DHBs, lack of resolution of inter-district flow payments, and residual competition from previous reform.

6 Performance of Governance Roles

The expectations of the outcomes from district health boards are high, with DHBs charged with improving the health of the community, addressing inequalities and ensuring quality health services. This research has not aimed to assess the outcomes of DHBs, but the processes that they are using to achieve these. This paper has been devoted to the structure of governance and the functioning of Boards, but it is important to assess how DHBs have discharged the key outputs of governance as required by the New Zealand Public Health and Disabilities Act; community engagement, strategic decision-making, monitoring the performance of the DHB, and reporting to the government.

In 2002 nearly two-thirds (63.1%) of Board members agreed/strongly agreed that the Board was performing effectively, increasing to 69.6% in 2004. Pacific respondents were more likely to agree with this assessment (p=.04).

6.1 Community Engagement

Community engagement through governance processes is intended to occur through the presence of elected representatives and the provision for open meetings. These have been discussed above (section 4.2.2 DHB membership and composition; and section 4.2.4: Transparency and community relationships) The section on representation suggests that the presence of elected members is a neutral factor in ensuring community engagement on behalf of DHBs, providing both benefits and costs. It appears that the architects of the reform over-estimated the extent to which elected members could contribute unique community perspectives, and management over-estimated the problems inherent in elected arrangements.

Section 4.2.4 indicates that DHBs have faithfully implemented the requirements for open meetings and transparency of decision-making as part of the contribution to maintaining relationships between the health services and the community as a whole. There is general agreement that these arrangements have not compromised decision-making.

The extent to which open meetings have actively allowed community engagement appears limited, with some exceptions. One case study report, for example, indicated that Board meetings are run in an open and inclusive manner:

> *'The style of chairing we observed to be very inclusive with both Board members and public encouraged to contribute if they indicated that they had something to say. There was no formal demarcation in seating arrangements between members and the public'*

This appears to be an exceptional case, with other case studies reporting greater levels of formality and separation. Nevertheless, other case studies reported good mingling of Board members and the public at tea breaks, and a welcoming approach from Chairs. Chairs may permit the public to speak; in some DHBs this requires prior 'notice of motion', in others the Chair has used discretion to permit advocacy groups to speak, but this is relatively rare. In some DHBs the Statutory Committees are flexible in engaging with community members who attend. In general, neither the presence of elected members nor the open meetings appear to have directly enhanced the contribution of the community to DHB decisions.

6.2 Progress on Strategic Issues

As has been noted, the level of strategic leadership demonstrated by boards was relatively limited in the early days of DHBs. Several CEOs noted an over-reliance on management. However, nearly all acknowledged that boards had worked hard on their strategic plans under severe time pressures, and that they had been able to reach agreement The strong direction from government meant that there were few opportunities to demonstrate local leadership.

As time went by a number of CEOs seemed pleasantly surprised by the ability of their Boards to undertake decision-making tasks:

> *'...almost without exception, from a management perspective, we have seen the decisions we would expect a board to make. Sometimes the route there is a little tortuous, but the board does get there...'.* (CEO 1)

If Boards, then, as is suggested, are able to make decisions, what are the areas of priority and concern?

Priority issues

In 2002 65.8% of all Board respondents agreed/strongly agreed that the Board's main imperative is to remain within budget and minimise the deficit. In 2004 this had risen to 74.8%. In 2002 Board members were asked to rate a range of health issues identified through government policy documents in terms of the priority for them personally, the priority for the DHB, the expected progress in the next few years, and, in 2004, the actual progress on the issues.

In 2002, Board members rated *Improved health status in the community* and *Quality health services* as the most important objectives for them personally. Low ranking objectives included *Recognising the importance of the Treaty of Waitangi in decision-making* and *DHBs being environmentally responsible*. However, Board members ranked issues differently from their DHB's perspective. Top ranked issues for the DHBs were *Reduced health inequalities and improved health status for Māori,*

Recognising the importance of the Treaty of Waitangi in decision-making, and *Tackling high priority public health issues.* Similarly there were differences in ranking between individual and DHB issues and expected progress: *Tackling high priority public health issues, Primary care, Recognising the importance of the Treaty of Waitangi in decision-making* and *the Integration of primary and secondary services* were seen as areas where greatest progress was expected. Progress was not anticipated for highly rated personal and some DHB priorities

In 2002 a top-rated item for DHB members personally was *Improved health status in the community*. In 2004 this item was given the highest mean score in relation to importance it was given over the previous two-three years by the DHB. This was followed by: *Tackling high priority public health issues; Quality health services; Reduced inequalities and improved health status for Māori; Better mental health services; and Recognising the importance of the Treaty of Waitangi in decision-making.* The lowest score for importance over the previous 2-3 years was for *Reduced health inequalities and improved health status for Pacific peoples;* the second lowest was *DHBs being environmentally responsible.*

In terms of progress reported in 2004, across DHBs it was reported that there was more progress on *Recognition of the importance of the Treaty of Waitangi in decision-making; Tackling high priority public health issues; Giving greater priority to primary care;* and *Better mental health services.* The lowest scoring area in terms of perceived progress was *Reduced health inequalities for Pacific peoples.*

In terms of expected progress, it is suggested that it had not been as good as anticipated (as measured in 2004) especially in the following areas:

- *Independence and inclusion in society for people with disabilities*
- *Involvement of the community in health sector decision-making*
- *Integration of primary and secondary services*
- *Reduced inequalities and improved health status for all disadvantaged groups*
- *Reduced inequalities and improved health status for Māori*
- *Reduced inequalities and improved health status for Pacific peoples*

From the data available from case studies it is unclear how many identified areas, in reality, made progress. Several case studies identified priority population health issues (eg cardiovascular disease, diabetes) as priorities and reported adherence to national strategies and the Minister's 'start here' list.

Chair interviews in 2004 provided perspectives on dominant issues facing DHBs. Financial matters, not unexpectedly, were noted by a majority of respondents (11/14), although there were various perspectives on this, depending on local circumstances. Some Chairs, from DHBs with deficits, reported deficit reduction/breaking even as a dominant issue, with a typical response:

> *'The ongoing one is financial. The commitment to the Minister to break-even. That's always the number one priority.'* (C 5)

Several Chairs referred to the continuing problems of restraining hospital expenditure:

> *'...we see the big health dollars being driven into hospital growth. And we see bugger all going into the community and primary care sector, the non-hospital side.'* (C 2)
>
> *'Traditionally hospital services get more money but don't produce more.'* (C 13)
>
> *'Like most DHBs, our hospital services are struggling to break even and produce the volumes we need.'* (C 5)

Chairs also acknowledged the wider issues underpinning hospital expenditure, such as demand management and the overall configuration of services. Some Chairs (5) described their financial issues in terms of strategic approaches to service change and 'reconfiguration', for example, addressing multiple service sites and planning for appropriate local services as a means of securing financial sustainability. One informant reported 'reconfiguration' as a 'codeword' for re-allocation of resources from hospital to community.

Other dominant issues reported by Chairs fell into two groups: those related to health and service direction, and those related to effective resource management. Service issues included addressing health outcome inequalities, development of the primary care sector, implementing service reviews, population growth and ageing. Resource management issues included industrial relations and recruitment.

6.3 Monitoring Board Performance

A key governance role is to hold management accountable for its progress in achieving Board goals. In terms of receiving adequate information for monitoring, Board members almost all agreed that they get regular, adequate reports on financial performance

In 2002 87.3% of Board members agreed/strongly agreed that they received regular, adequate reports on financial performance, rising to 94.8% in 2004, with Māori Board members less likely to agree/strongly agree (p=.0.45). A lesser proportion in 2003 (78.5%) agreed/strongly agreed that they received regular and adequate reports on service performance. In 2004 this increased to 82.2%, although comments from DHB informants and some local providers spoke strongly about the need for more 'output' and 'outcome' based measures.

Case study reports were helpful in illuminating monitoring processes, which had taken some time to develop. In one DHB in the first round of interview several senior managers referred to the lack of capacity to undertake the work necessary to monitor progress effectively and keep the Board informed. In another DHB it was claimed that HAC was unable to perform its monitoring role properly because management was unable to provide data with an appropriate level of analysis for assessments to be made. In the same DHB Board members commented over several meetings on the inadequacy of monitoring reports to the Board, and it was some time before management was able to develop procedures to the satisfaction of the Board.

In yet another case study the Board had adopted seventeen clinically based indicators to augment those required for external accountability reporting and there were plans for systematic rather than anecdotal monitoring of gaps in service provision.

6.4 Accountability Reporting

In order to hold Boards accountable, there must be an understanding of the criteria to be used. In 2002 over 50% of respondents agreed/strongly agreed that they had a clear understanding of how their Board's performance would be assessed, increasing to 68.1% in 2004. When asked about the three main criteria on which the performance of their Board would be judged, 93.5% volunteered that it would be on financial management. This was expressed in a number of ways ('finances', 'financial performance', 'living within budget', 'managing funds', with 30% or respondents specifying 'deficit management'). Although respondents were not asked to rank issues, financial management was overwhelmingly the first item listed. Some respondents listed only financial management.

DHBs are accountable to the government and Minister of Health through the Crown Funding Agreement and District Annual Plan, and to Parliament through the Statement of Intent. Boards appear before the House Select Committee to report on the Statement of Intent, and several DHBs reported difficult initial experiences as expectations were clarified.

With respect to the District Annual Plan and Crown Funding Agreement, DHBs report quarterly to the Ministry. A majority of CEOs reported persistent problems with the monitoring regime, with eight reporting improvements over the last year or two. The regime was reported as rationalised somewhat, but still quite bureaucratic or managerialist in style with little focus on outcomes. CEOs expressed continuing frustration, suggesting that requirements needed to be focused on more meaningful indicators, that feedback to DHBs was needed, and that more progress had been expected in this important area.

> '*They haven't moved to the new sector structure in their philosophy and thinking. They have not yet come to grips with the fact that they should be monitoring at a higher level....it's imposing huge additional costs on the sector.'* (CEO 5)

Informants from all case studies indicated that the quarterly reporting requirements were excessive and often at a 'micro-level' not required by DHBs themselves. Informants endorsed the refining of accountability frameworks and early moves towards monitoring for outcomes.

7 Discussion

7.1 The DHB Model

The emerging literature on health governance points to 'hybrid' type models that increasingly do not conform to strict corporate, philanthropic or other governance traditions but are created specifically for the context in which in which they operate and are 'fit-for-purpose'. The DHB model fits this arrangement, with our informants confirming that the design aimed to achieve specific goals or representation, while maintaining the role of central policy.

The design has strong elements of the 'policy board' model (Appendix A) where the Board role is to establish guiding principles and policies, delegate responsibilities and monitor performance. Both staff and Board are accountable for maintaining relationships with external stakeholders. The partially elected nature of DHBs and the requirement for open meetings provide particular opportunities for direct local stakeholder relationships. These have been present in highly variable ways in DHBs, with some success, particularly in smaller DHBs. Despite the difficulties sometimes of establishing governance level engagement with the community, the strength of the identification of DHBs with the local community is marked, and is carried forward through planning and other processes and well supported by Boards and management.

Policy boards are reported as tending to have few standing committees, with DHBs diverging from this model in their requirement for Statutory Committees. The research literature suggests that such structural elements may add little to a board's effectiveness (Bradshaw et al 1992, Cornforth 2001) with the Statutory Committees serving political rather than practical ends. Chairs and CEOs have worked extremely hard to ensure that the Committees add some value and feel keenly that the legislation removes local discretion in this area. In the policy board model, as with DHBs (see section 7.3, below), board development is given a high priority and members recruited for their commitment to the values and mission of the organisation.

The tripartite board model (Appendix A) is of interest in a DHB context because of its perspective that governance is a partnership between board, executive and staff. In health services the focus on the engagement of health professionals, particularly medical staff, in decision-making is crucial, with some research indicating that the involvement of clinicians in governance level decisions is associated with better financial performance (Goes and Zahn 1995). The DHB model itself makes no provision at governance level for this, but clearly individual DHBs have worked hard to find appropriate ways of bringing clinicians closer to strategic decision-making and more integrated in to the chain of accountability. The extent to which this will be formalised and linked more closely to DHB governance remains to be seen.

7.2 System Relationships

Centre-periphery

Unlike traditional governing boards, DHBs do not stand in isolation but are part of an integrated system, with formal accountability to the government and Ministry of Health. Recognition of the tension between various levels of decision-making in complex networks and systems is acknowledged in US research (Alexander et al 2003) and in Canada (Lomas 1997) where the balance of power between the centre and the periphery continues to be contested. This 'vertical' accountability was provided for in legislation in New Zealand, and our research suggests that these national-local interfaces are most tested in areas of strategic decision-making, including the selection of local priorities, and monitoring frameworks, two critical areas of autonomy.

In terms of decision-making there is a strong view that key decisions are still made in Wellington and that decentralised decision-making is more illusory than real. Monitoring arrangements, however, seem to becoming more streamlined although there were frequent reports of the need for greater emphasis on outcomes.

Part of the armoury of DHBs in maintaining their positions in relation to the centre has been the rapid evolution of DHBNZ. While this collective association of DHBs requires its own delicate balancing of governance roles, it has provided a cohesive organisation that represents the interests of DHBs and precludes individual DHBs becoming isolated in their relationships with the centre. There is evidence that the emergence of DHBNZ and its regional groupings not only provides opportunities to reduce the vulnerability of small and some medium sized DHBs, but also supports the maintenance of a balance of power on behalf of the 'periphery' (Barnett, Powell and Cumming 2006).

Size and viability if DHBs

The presence of DHBNZ and the emergence of lateral relationships ameliorates an important weakness identified in the DHB system: the risk to clinical and administrative viability in some small and medium sized DHBs consequent on the large number of DHBs overall and, for some, their small size. Our research indicates that the universal recognition of this problem is accompanied by strong resistance to forced amalgamation and the view that voluntary amalgamation unlikely in the short-term (*'no turkey ever votes for an early Christmas'*). However, there is also an need to balance the desire for local control and equity of access with efficiency, including good outcomes which are recognised to be at risk in organisations serving smaller, dispersed populations.

Our research indicates that the strategic solution to this problem has been, in the last three years, active inter-DHB collaboration, in some cases encouraged by the requirements of Crown Funding Agreements. While our research indicates that closer working relationships and strategic alliances between DHBs have some problems, they are endorsed by all informants as essential and positive, securing rather than undermining the independent governance of some DHBs.

Multiple accountabilities

Besides the centre-periphery relationships and the links between DHBs, both policy board and network frameworks recognise the multiple accountabilities of boards to a range of local stakeholders: internal and external, formal and informal. This is made more difficult for DHBs by the provision for a majority of the Board to be elected, adding a dimension of local accountability that in some DHBs has been shown in our research to be in conflict with accountabilities to the centre or collective accountability within the Board. While this conflict may be spurious in terms of the legislation, in reality it has reflected more 'local authority' style expectations that elected members directly represent local constituencies. 'At large' elections may reduce such expectations over time. The management of this expectation has fallen largely to Chairs of DHBs who are generally regarded as have been effective in this role.

7.3 Board Functioning

General functioning

While there have been notable and well publicised conflicts in some DHBs, Boards appear to be functioning relatively harmoniously even though there are periodic under-currents of frustration, and occasional public conflict, based on the differing perspectives and operating styles of management, Board members and Chairs.

However, much of our research indicates that despite the handicap of Statutory Committees, some conflicts in accountability, the burden of deficits and detailed monitoring, Boards significantly improved their functioning between 2001 and 2004. Chairs and CEOs in particular acknowledge the progress between the two research rounds and are largely satisfied with the performance of their Boards. This indicates the extended period of implementation required for major restructuring and the costs of that to the system as a whole in lost productivity and momentum.

The emergence of close relationships between Chairs and CEOs is noted. In some cases this has evolved over time, and reflects the expectations of the relationship between these roles in modern governance models, both corporate and non-corporate. Boards in all sectors carry risk from dominance by the 'Chair-CEO axis', but this does not appear to have been a major issue for Board members.

Strategic vision

The research literature suggests that there are few variables that are critical in ensuring good governance performance, but that these include involvement with strategic planning and shared vision of the goals and purpose of the organisation. These were largely present in DHBs with confirmation from Chairs and CEOs, and through the case studies, of Boards' engagement in strategic planning and sharing the common vision. Board members themselves also indicated common views on DHB priority objectives, even when these did not necessarily align with their personal views.

There were indications that this focus on strategic issues had been hard won, requiring both improved capability on the part of Board members and strong support from management. The level of management support had initially been variable, but had developed over time, in some cases at the insistence of Board members and Chairs.

Member capability

International research suggests that other key factors in effective performance are the relationship between Board and management, which our research suggests has developed well over the period of the project, and critical self-review of performance, also characteristic of DHBs and led by Chairs. Skill mix, experience and time have been shown in the literature as important for effective functioning.

This research, however, has shown that while Boards may not always be seen to have the necessary skills and the ability to fill those skill gaps through appointment was constrained, the notion of Board development is strongly present. When accompanied by good leadership and supportive management the capability of Boards can clearly be raised to appropriate levels.

Although our research stopped short of the 2004 elections, there were indications that the three-year election cycle does not necessarily create major loss of capability. In fact there was good continuity of elected membership, with 65% of encumbent candidates from 2001, who ran again, returned in 2004 (Gauld 2005). Our research suggests, however, that significant investment is required to improve and maintain the performance of Boards (training, information, skill development, performance assessment). This level of investment is justifiable to the extent that government and the community value the role of local DHB members.

7.4 An Assessment

7.4.1 Have the governance aims been achieved?

As noted in section 4.1, interviews with ministers, ministerial advisers and officials confirmed that the governance arrangements for DHBs were designed to facilitate two broad aims:

1 To ensure that the government achieves the population health outcomes it requires.

This first aim, according to our informants, was to be facilitated through centre-periphery relationships:

- adherence to national strategy set out by the Minister of Health
- levels of devolved funding and decision-making
- accountability to the Minister of Health

It is outside the scope of this project to attempt to assess population health outcomes; this is undertaken through the Minister's regular reports on *Implementing the New Zealand Health Strategy* (for example, Minister of Health 2005*)* and other special reports. However, the, the process and output elements of this aim have largely been achieved. The accountability arrangements and policy guidelines have ensured that government policy has been implemented through DHBs, although some DHBs and Board members reported that devolved decision-making had fallen short of their expectations and that accountability arrangements had not focused sufficiently on outcomes.

2 To involve the community in health decision-making.

This second aim was to be facilitated through:

- the participation of community members in governance
- transparency of decision-making
- other forms of engagement with the Board

Our research shows that participation of community members in governance and the requirements for transparency is seen to have both costs and benefits. It was difficult to identify specific benefits to decision-making but there was clearly a view that the culture change generated by both participation and transparency were important to the relationship between DHBs and their communities. Although direct engagement between Boards and local communities was highly variable, the general culture of openness was clearly reflected in the way staff engaged with the community and providers generally and specifically through the planning process. Engagement of all types appears to be more easily achieved in smaller and medium sized DHBs than in larger ones.

7.4.2 Are Changes Required to Governance?

The findings of this research allow reflection on the large investment of time and effort required to implement major reform of the health sector. There is no support for any significant further change, but some indication of where governance processes can be streamlined and costs taken out of the system.

- There is no support for changes in numbers and sizes of DHBs. Any inefficiencies and risks (both clinical and financial) inherent in the structure are largely being managed by DHB-DHB linkages and current community relationships are highly valued. These trends can be further supported.

- There are costs (not quantified) to DHBs in the electoral system in ensuring continuity and capability of Boards, but the relationship between DHBs and the local community is clearly enhanced by this arrangement.

- The requirements for transparency are not seen as a major barrier to Board functioning and have largely been well-managed by DHBs. Transparency is valued for promoting an open relationship with the community and has enabled improved media relations.

- There is a strong view from DHBs that the requirements for Statutory Committees should be modified to provide greater flexibility for Boards.

- Periphery-centre relationship management is improving and could be further enhanced by continued work on the monitoring framework and clarity of decision-making responsibility.

- The costs of major change need to be better recognised and provided for in any future reorganisation.

- There is significant elapsed time required for the implementation of reform, including capacity building in key areas such as governance, planning and funding and central policy and management.

- The skill, time and commitment required of Chairs of DHBs is critical to success.

- There is interest in the way in which clinicians, widely regarded as important decision-makers within DHBs, can be most effectively engaged in strategic decisions. Individual DHBs are working on a variety or arrangements; the implications of these can be monitored.

References

Alexander J, Lee S Y, Bazzoli G. (2003). Governance Forms in Health Systems and Health Networks. *Health Care Management Review* 28 (3): 228-242.

Alexander J, Weiner B. (1998). The Adoption of the Corporate Governance Model by Nonprofit Organizations. *Nonprofit Management and Leadership* 8(3): 223-242.

Alexander J, Zuckerman H, Pointer D. (1995). The challenges of governing health care systems. *Health Care Management* 20(4):69-81.

Alexander J, Morlock L, Gifford B. (1988). The effects of corporate restructuring on hospital policy making. *Health Services Research* 23(2): 311-327.

Alexander J, Zuckerman H, Pointer D. (1995). The challenges of governing health care systems. *Health Care Management* 20(4):69-81.

Barnett P, Perkins R, Powell M. (2001). On a hiding to nothing? Assessing the corporate governance of hospital and health services in New Zealand 1993-1998. *International Journal of Health Planning and Management* 16:139-154.

Barnett, P, Powell, M, Cumming, J. (2006). The Limits of restructuring: A decade of health reform in New Zealand. In *Innovations in Health Care: A Reality Check,* A.Casebeer, A. Harrison, A.Mark (eds). (Palgrave Press, 2006).

Bradshaw P, Murray V, Wolpin J. (1992). Do boards make a difference? An exploration of the relationships among board structure, process and effectiveness. *Nonprofit and Voluntary Sector Quarterly.* 21(3):227-248.

Brock, D., Powell, M, Hinings, R. (1999). *Restructuring the Professional Organisations: Accounting, Health Care and Law.* Routledge, London.

Brunelle F, Leatt P, Leggat S. (1998/99). Healthcare Governance in Transition: From Hospital Boards to System Boards…a National Survey of Chairs of Boards. *Hospital Quarterly* Winter 2(2): 28-34.

Contandriopoulos D, Denis JL, Langley A, Valette A. (2004). Governance Structures And Political Processes In A Public System: Lessons From Quebec. *Public Administration* 8(3): 627-655.

Cornforth C. What Makes Boards Effective? (2001). An examination of the relationships between board inputs, structures, processes and effectiveness in non-profit organisations. *Corporate Governance*. 9 (3):217-227.

Cornforth C. (1996). *Governing Non-profit Organisations: Heroic Myths and Human Tales. Researching the UK Voluntary Sector.* London: National Council for Voluntary Organisations.

Cornforth C, Edwards E. (1999). Board Roles in the Strategic Management of Non-profit Organisations: theory and practice. *Corporate Governance.* 7(4): 346-362.

Cornforth C, Edwards E. (1998). *Good Governance: Developing Effective Board-Management Relations in Public and Voluntary Organisations*. CIMA Publishing, London.

Ducca D. (1996). *Nonprofit Boards: Roles, Responsibilities and Performance***,** John Wiley, New York.

Ferlie E., Ashburner, L. and Fitzgerald, L. (1995). Corporate governance in the public sector: some issues and evidence form the NHS. *Public Administration* 73: 375-392.

Gauld R. (2005). Voter participation in New /Zealand district health board elections. *Australian Health Review*, 29: 345-452.

Goes JB, Zahn C. (1995) The effects of hospital-physician integration on hospital financial performance. *Health Services Research*, 30: 506-530.

Green JC, Griesinger DW. (1996). Board performance and organizational effectiveness in nonprofit social services organizations. *Nonprofit Management and Leadership.* 6(4): 381-402.

Health Reforms 2001 Research Team (2003). *Interim Report of the Health Reforms 2001 Research Project.* Wellington, Health Services Research Centre, Victoria University.

Herman R. (ed). (1989). *Nonprofit Boards of Directors: Analysis and Applications.* New Brunswick, N J: Transaction Press.

Herman RD, Renz DO, Heimovics RD. (1997). Board practices and board effectiveness in local nonprofit organizations. *Nonprofit Management and Leadership.* 7: 373-386.

Hospital and Related Services Taskforce (1987). *Unshackling the Hospitals.* Report. Wellington.

Houle CO. (1989). *Governing Bodies: Their Nature and Nurture*, Jossey-Bass, San Francisco.

Jackson D, Holland T. (1998). Measuring the effectiveness of non profit boards. *Nonprofit and Voluntary Sector Quarterly*. 27(2):159-182.

Lomas J. (1997). Devolving authority for health care in Canada's provinces: 4: Emerging issues and prospects. Past concerns and future roles for regional health boards. *Canadian Medical Association Journal* 156 (6): 817-23.

Needleman J, Chollet D, Lamphere J. (1992). Hospital conversion trends. *Health Affairs,* March-April: 187-195.

Orlikoff, J. (1997). From hospital to health system governance. *Health Care Executive*, 12(5): 14-18.

Peck, E. (1995). The Performance of an NHS Trust Board: Actors' Accounts, Minutes and Observation, *British Journal of Management*, Vol 6, pp135-156.

Robinson R, LeGrand, J. (1993). *Evaluating the NHS Reforms* King's Fund, London.

Savage G, Taylor T, Rotarius T, Buesseler J. (1997). Governance of Integrated Delivery Systems/Networks: A Stakeholder Approach. *Health Care Management Review* 22(1): 7-20.

Scholten GR, and Grinten T. (2005). The integration of medical specialists in hospitals. Dutch hospitals and medical specialists on the road to joint regulation. *Health Policy* 72: 165-73.

Shortell S. (1989). New directions in hospital governance. *Hospital and Health Services Administration* 34(1): 7-23.

Shortell S, and Kaluzny A. (1993). *Health Care Management: Organization Design and Behaviour.* 3rd ed. Delmar Pub. New York.

Shortell S, Gillies R, Anderson D, et al. (1996). *Remaking Health Care in America.* Jossey Bass: San Francisco.

Shortell, S, et al (1993). Creating organizational delivery systems: The facilitators and barriers. *Hospital and Health Services Administration*, 38 (4): 447-65.

Synergy Associates-
http://www.synergyassociates.ca/publications/synopsisofmodels.htm.

Upton S. (1991). *Your Health and the Public Health.* Minister of Health, Wellington.

Weiner B, Alexander J. (1998). The Challenges of Governing Public-Private Community Health Partnerships. *Health Care Management Review* 23(2):39-55.

Weiner B, Alexander J. (1993). Corporate and philanthropic models of hospital governance. *Health Services Research* 28: 325-355.

Appendix 1 Selection of Governance Models Characteristic of Non Profit Organisations

There are many models of governance described in the prescriptive literature. The models are described in terms of their essential characteristics. It is generally agreed that 'no one size fits all' but that each board requires a shared view of its roles and responsibilities and an agreement on a model or framework which will best support the organisation or business. There appears to be extensive variation in how models are adopted and operationalised both in the corporate and not for profit world. Each approach emphasizes the different dimensions of the roles and responsibilities of the board and each arises out of a different relationship between board members and staff members. The adoption of particular approaches also reflects the differences in size, purpose, and history of an organisation. A synopsis of the various models and approaches have been summarised and described by many commentators, including both Garber and Associates and Bullen Management Alternatives. They have labelled the models variously as the tripartite model, the agency or stewardship model, the political model, the managerial model, the advisory board model, the patron model, the co-operative model, the management team model, and the policy board model.

Tripartite Model

This model is described as a conventional model of governance and according to Ducca, quoting Cornforth and Edwards 1998 the model "in many nonprofits, the responsibilities for running the organisation evolve into a three-part, interactive system-a tripartite system-comprised of a board of directors, an executive, and staff. If this system is to function effectively, its parts need to share a sense of mission. A board's central function is to keep the organisation's mission in focus, and its primary responsibility is to ensure that the other parts of the system are working toward accomplishing that mission."

Agency or stewardship model

The agency view presumes that managers have a tendency to act in their own interests rather than in the interest of the 'owners' of an enterprise. Board members see their function as being to control the behaviour of managers. They primarily have a stewardship role in making sure that the resources of the organisation are safeguarded.

Political Model

The political or democratic model is categorised as a board which assures that board members represent the interests of one or more stakeholders in the organisation and to express and resolve differences between these interest groups.

Managerial Model

The managerial model regards the board as the apex of a management hierarchy. Ideas and practices from management are considered appropriate to governance also. Board members are therefore chosen on the basis of their expertise and contacts, in order to add value to the organisations decision making processes.

(Above three models outlined by Fishel 2003).

Advisory Board Model

This model emphasises the helping and supportive role of the board and frequently occurs where the CEO is the founder of the organisation. The board's role is primarily helper/advisor to the CEO. Board members are recruited by the CEO for their professional skills which are aligned with organisational need. The board members help to establish the credibility of the organisation for the purposes of fundraising and public relations. Board meetings are informal and task oriented with agendas developed by the CEO. This model has a short life span as it exposes the board members to significant liability in that it fails to provide the accountability mechanisms that are required of boards of directors.

Patron Model

This model is similar to the Advisory Board Model only the board of directors in this model have even less influence over the organisation than the Advisory Board. Such boards meet infrequently as the real work is done outside the board meetings. Many organisations maintain a Patron Board in addition to their governing boards.

Management Team Model

This model is characterized by a board with a high degree of involvement in the operational and administrative activities of the organisation. It fits in well with the widely held view of non profits as volunteer driven or at least non professional organisations. The model arises out of modern ideas about team management and democratic structures in the work place. It normally takes the form of a high directive supervision of the CEO and staff at all levels of the organisation with many committees and sub committees. The selection of board members is ideally on knowledge and experience in a specific field or a special interest group or sector that the board considers to be stake holders. The model appears to work well for all-volunteer organisations but has proven to be less well suited to organisations with professional management and full time employees. Difficulties in this field have led to thinking in the field of the differentiation between 'governance and management". A major criticism of the model is that it degenerates into micro management in which board members refuse to delegate authority.

Co-operative Model

In this model all responsibility is shared and there is no CEO. Decision making is usually by consensus and the board consists of official board members, staff members, volunteers and sometimes clients. Seen by its advocates as the most democratic style of management but is also the most difficult of all models to maintain. The two major areas of concern of the model are the ability to compromise and the difficulty of implementing accountability structures.

Policy Board Model

The originator and most influential proponent of this model is John Carver. The board's job in the view of this model is: to establish the guiding principles and policies of the organisation; to delegate responsibilities and authority to those who are responsible for enacting the principles and policies; to monitor compliance with those guiding principles and policies; and to ensure that staff and board alike are held accountable for their performance.

The model arose from the need to differentiate the **boards' role from the managers' role** and an examination of the role of the board, relations between the board and the CEO and the relations between the board and the community. There is a characteristic high level of trust and confidence in the CEO exemplified in this model. There are usually relatively few free standing committees, resulting in more meetings of the full board. Board development is given high priority and members are recruited for their demonstrated commitment to the values and mission of the organisation.

In the Carver Model the board is responsible for:

1. Linkage to ownership-board acts in a trusteeship for 'ownership' i.e. members.
2. Explicit governing policies-board explicitly enunciates the values and perspectives of the whole organisation and the proper categorisation of broad policies.
3. Assurance of executive performance-board ensures staff members performance meets the criteria the board has set and is accountable for the fulfilment of that performance.

Source: Carver J. (1991). Boards *That Make a Difference: A New Design for Leadership in Non-Profit and Public Organisations.* San Francisco: Jossey-Bass. Compiled by Paul Bullen, Management Alternatives PTY Ltd http://www.mpl.com.au/governance

Appendix 2 Case Studies

Case study A

(thirteen meetings observed)

From analysis of Board meetings it is clear that members draw on their personal background to offer information and ask questions on issues where they have a detailed knowledge or interest. Such issues included prioritisation, service budgeting, outcome monitoring, fluoridation, ethnicity recording, pay equity for community health care workers, health promotion and intersectoral alliances.

We noted a growth in Board member confidence and knowledge throughout 2003-4, demonstrated by an increase in constructive debate and challenge at the Board meetings. There has been a willingness to address a full range of issues and to initiate action across a number of areas e.g. prioritisation, outcome monitoring, future funding pressures, service budgeting.

Informants reported that generally the Board was developing well with members working together, although it had taken some time for the members to gain confidence and the understanding necessary to 'really govern the organisation.' The leadership taken by Board members in addressing the strategic monitoring function is noted elsewhere. Informants reported that resignations from the Board and time lapses in appointing new members had reduced the overall performance of the Board, particularly with respect to Māori, with a lack of vigorous questioning that had previously been present. It was reported that there were good relationships between individual Board members. One of the biggest threats to the Board in terms of destabilisation was reported to be the 2004 elections. From our observations and reports from early meetings of the new Board it appears that the four newly elected members are well-informed on governance and health issues and bring essential skills to the table.

In terms of leadership in strategic decision-making, it has been reported that some strategic decisions do not 'get opened up well enough' at the Board level and that issues come to the Board 'a bit sewn up'. The recently elected Board appears already to be less accepting of this situation.

Decision-making in meetings

During the two phases of this research we observed Board meetings for two periods: December 2002-July 2003 (5 meetings) and February-September 2004 (8 meetings).

Table 1 Analysis of decision-making at Board meetings

Time period	No of meetings	Agenda items	Average per meeting	'Decision' items	Decision' items per meeting
Dec 2002-July 2003	5	50	10	4	1.25
February-September 2004	8	70	8.8	25	3.13

Table 1 indicates that during the second period the Board made many more 'decisions' than in the earlier phase. However, the earlier period was outside some key times for strategic and annual planning and for financial decision-making. Not only did the second phase incorporate such periods but, as the final year of the three-year Board term, it also represented a period of accumulated Board activity requiring decisions prior to the 2004 election, including important capital expenditure decisions.

Despite the lack of formal decisions in the first period, we note (Table 2) that an additional eleven items required the Board to act in its high level statutory role, referring and amending recommendations or monitoring strategic direction. For 16 of the remaining 35 items we also noted a significant level of detailed questioning and challenging of management or presenters (beyond seeking simple clarification and additional information), indicating a critical approach on the part of Board members to the material presented. This appears to have persisted during 2004, with only 23 (33%) of items 'received' or 'noted' without challenge and action during the second period, compared with 19 (38%) in the earlier time period.

Table 2 Patterns of responses to agenda items

	Agenda items	Decisions	*'High level' action	Challenging and questioning	Noting and receiving only
Dec 2002-July 2003	50	4	11	16	19 (38%)
February-September 2004	70	26	6	16	23 (33%)

* High level action includes amending, referring elsewhere for action and active monitoring.

Case study B

(three meetings observed)

Board meetings appeared to the observers during the three formal observations in 2003 to be lively and at times tense or conflictual. Several of the Board's protocols for behaviour at Board and Committee meetings were breached repeatedly in meetings, in particular those relating to:

> *polite and respectful manner; not interrupt each other or talk while another member is speaking; only make a point if it has not already been raised and is relevant; and endeavour to clarify questions, issues, requests before taking actions or responding.*

The Board observations in 2003 recorded the nature and frequency of Board members' contributions during the public part of Board meetings. Not all of the contributions noted were contributed by the Board members or CEO. The nature of the contributions was noted in 14 categories, as Table 3 shows:

Table 3 Frequency of Board members' activity

Activity	Meeting 1	Meeting 2	Meeting 3	Totals
Seeking clarification, further information	45	70	40	155
Questioning	63	40	26	129
Challenging, critiquing	29	24	23	76
Representing, advocating specific interests	13	37	39	89
Initiating	20	2	0	22
Providing information or comment	158	493	307	958
Summarising	15	1	1	17
Eliciting information	0	2	0	2
Praising, endorsing	18	0	7	25
Suggesting action	38	4	5	47
Giving opinion	59	8	7	74
Raising procedural/ process issues	16	0	2	18
Shutting down a speaker/ agenda item	24	1	0	25
Amending recommendations	12	1	5	18
Other	17	19	30	66
Totals	527	702	492	**1721**

There was wide variation in the frequency of members' spoken contributions as observed in the public part of Board meetings in 2003, as Table 4 shows:

Table 4 Frequency of Board member contribution in three Board meetings

Board member/ and CEO	Meeting no. 1	Meeting no. 2	Meeting no. 3	Total contributions in three meetings
1	45	83	91	219
2	43	52	20	115
3	15	15	27	57
4	18	46	22	86
5	36	44	17	97
6	116	161	108	385
7	78	82	60	220
8	8	0	36	(two meetings) 44
9	66	75	34	175
10	17	57	13	87
11	52	0	22	(two meetings) 74
12	0	49	0	(one meeting) 49
Total				**1608**