CORPORATE GOVERNANCE IN THE NEW ZEALAND PUBLIC HEALTH SECTOR

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Abstract

This research report considers corporate governance within the public health sector, an area which has undergone significant changes in terms of structures, focus, and demand for service and funding. As there has been little research conducted in this specific area, the report's major findings are based on a critical examination of the literature on governance in private and public sectors along with an analysis of the changes that have occurred in the New Zealand Health sector over time.

A review of the governance literature provides evidence that good corporate governance, if it is initiated and maintained properly, has benefits that can be organisation wide. The literature review provides evidence that effective governance can enhance the outcomes in the New Zealand health organisations that are part of a sector that has undergone four major restructures since 1989. It appears that these restructures have largely been driven by post-election political ideology and in most cases the changes have had little success in improving corporate governance within this sector.

This research report concludes that some small, but significant, changes are necessary if the effectiveness of District Health Boards is to be improved. This report suggests three key changes. The first is to improve the structure by introducing new governance positions within District Health Boards. This position is based at the executive level and offers impartial advice to the board on all corporate governance issues. The second suggestion is that boards need to increase their diversity in order to improve performance, especially in geographical areas which have a large proportion of Pacific and Asian communities. The final recommendation is that board members are offered individual remuneration linked directly to their attendance and performance. These three changes, in turn, will help District Health Boards to become more effective in the way they operate.

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Table of Contents

Abstract i

Acknowledgements ii

Table of Contents iii

List of Acronyms v

Chapter One – Introduction 1

1.1 Background 1

1.2 Justification for Study 2

1.3 Research Objective 3

1.4 Structure of the Report 4

Chapter Two – Literature Review 5

2. Structure and Corporate Governance of District Health Boards 5

2.1 Introduction to Corporate Governance 6

2.1.1 Agency Theory 10

2.1.2 Board Effectiveness 12

2.1.2.1 Board Size 13

2.1.2.2 Board Composition 14

2.1.2.3 Board Structure 16

2.1.2.4 Board Remuneration 18

2.2 Corporate Governance in the Public Health Sector 20

2.3 History of the reforms in the Public Health Sector 25

Chapter Three – Discussion 36

3.1 Changes to Board Remuneration 36

3.2 Changes to Board Size 39

3.3 Changes to Board Diversity 41

Chapter Four – Conclusion **43**

4.1 Corporate Governance 43

4.2 Corporate Governance in the Public Health Sector 43

4.3 Reforms in the Public Health Sector 44

Chapter Five – Recommendations **46**

5.1 Political Involvement 46

5.2 Corporate Governance in the Public Sector 46

5.3 Board Remuneration in New Zealand 47

References 48

Reflective Journal 55

List of Acronyms

AHBs	Area Health Boards
CEO	Chief Executive Officer
CGO	Chief Governance Officer
CHEs	Crown Health Enterprises
CCMAU	Crown Company Monitoring Advisory Unit
DHBs	District Health Boards
DoH	Department of Health
DPMC	Department of Prime Minister and Cabinet
HFA	Health Funding Authority
HHSs	Hospital and Health Services
MoH	Ministry of Health
NGOs	Non Government Organisations
NZPHD	New Zealand Public Health and Disability Act 2000
OECD	Organisation for Economic Cooperation and Development
PBFF	Population Based Funding Formula
PHC	Public Health Commission
PHOs	Primary Health Care Organisations
RHAs	Regional Health Authorities
SACHSO	Special Advisory Committee of Health Service Organisation
SoEs	State Owned Enterprises
THA	Transitional Health Authority

Chapter One – Introduction

1.1 Background

The public health care sector in New Zealand is extremely fragmented and complex. The New Zealand public health care sector is subject to a minefield of political and commercial intrusions for reasons which are not directly related to the health care sector (Mathias, 2009). This means that corporate governance in the public health care sector differs considerably from other public entities and private sector organisations. Continuing pressure on boards to ensure that they are financially stable, spending within their limited budget and funding programmes which have been directed by the Ministry of Health (MoH) has forced District Health Boards (DHBs) to become more commercially sensitive, which in turn creates tension in terms of their mission set by both MoH and the boards themselves.

Decision making in this sort of environment offers much ambiguity, and is contingent on the knowledge and characteristics of individual decision makers, who make up the boards (Mathias, 2009). Lack of familiarity with the concept of what corporate governance is, also contributes to this ambiguous environment. Furthermore, the New Zealand public health care sector has been reviewed and restructured four times since 1989 (Mathias, 2009; Ingley & van der Walt, 2005; Bawden, 2008; Barnett & Clayden, 2007; Chalmers, 2008). These major structural changes have occurred when the government of the day has changed. When the government changes so do the political ideologies that structure the health policies and principles (Mathias, 2009).

Before these complex issues are explored it is necessary to gain an understanding of what corporate governance is, what corporate governance in the New Zealand public health care system is, and to examine the historical framework of the health care sector which has occurred in New Zealand. It is also advantageous to investigate the link between public health history and the precedents that exist in corporate governance decision making in today's public health care environment.

1.2 Justification for Study

Corporate Governance, or more importantly, the intent in how to make corporate governance more effective, has become increasingly important with governments, public and private organisations and individuals within the past 20 years (Bawden, 2008). In New Zealand, the Securities Commission has been the major catalyst for initiating changes in the way organisations regulate their governance practices (Mathias, 2009). According to Leblanc (2003), corporate governance is the topic of the decade for management and business journals but has been rather slow to be explored as a topic of academic enquiry. I agree with Leblanc, based on my examination of the literature where there is a steady stream of literature around establishing precedent for change, but until recently, there has been little academic research focussed on corporate governance. Corporate governance has been explored at length within the private sector; however it has not received the same level of attention or analysis in the public sector (Bawden, 2008; Howard and Seth-Purdie, 2005).

This research considers corporate governance within the public health care sector, an area which has undergone significant changes in terms of structure, focus, and demand for service and funding. There has been little research conducted in this specific area and I am hoping to address some part of these recent changes. Political involvement and political interference is also an extremely important aspect of corporate governance in the New Zealand public health care sector and very worthy of inquiry, but due to the limitations of this study I have decided to exclude this aspect.

1.3 Research Objective

The primary purpose of this current research report is to explore, in detail, the corporate governance arrangements in DHBs, and highlight any changes which I think are necessary to enhance the performance of DHBs. This research report aims to explain the workings of corporate governance within the public health care sector in order to see whether there is room for improvement. To determine this I will be reviewing the current board structure and seeing whether I can address any inefficiencies and offer ways to correcting these.

More specifically, the two main questions addressed in this research report are:

1. What changes have occurred in health governance in New Zealand?
2. What associated governance factors/issues make DHB boards more effective?

1.4 Structure of the Report

This report centres on two major themes. Chapter two focuses on these: firstly the structure of corporate governance within the public health care sector in New Zealand, which is discussed, and secondly, questions about how to make the board of directors more effective.

The literature review which follows in the next chapter will be structured with these two major themes.

In chapter three, I define corporate governance and illustrate how this relates to the public health care sector. I discuss the DHB governance model in-depth, the history of the health sector in New Zealand, the effects of the various public health care sector reforms which have taken place and the consequences that these reforms have had on the structure and makeup of corporate governance in the public health care sector. I also discuss the concept of board remuneration and the idea of performance related remuneration, board structure and board diversity.

Chapter four presents the report's main conclusions and Chapter five encompasses recommendations to the health system and suggestions for further research.

Chapter Two – Literature Review

2. Structure and Corporate Governance of District Health Boards

This study is aiming to review and comment on the structure of corporate governance in District Health Boards (DHBs) in New Zealand and explore whether there is room for improvement in the way corporate governance in DHBs are currently structured.

This study is important for a number of reasons. Having good corporate governance is a challenge for any industry, but especially when it comes to organisations operating in the public health sector, which face many challenges through funding, political interference, and public expectations.

The intentions of this chapter are to review and highlight the available literature around corporate governance in the New Zealand public health care sector. The first section of this chapter introduces corporate governance as a concept. The second section focuses on specifically highlighting corporate governance in the New Zealand health care sector and finally, section three is a review of the consequences of the various health sector reforms which have occurred in New Zealand over the past 20 years.

A literature search was conducted using various electronic academic databases with the keywords of: Corporate Governance, Hospital, Boards, Health, and District Health Boards. I identified both theoretical and empirical articles which specifically addressed the concept of corporate governance, and the New Zealand public health care system.

There is a large amount of literature around private sector corporate governance, as well as some literature around corporate governance in a New Zealand health care setting. However the latter is somewhat limited.

2.1 Introduction to Corporate Governance

Corporate governance has become a major issue for organisations to deal with and has attracted a great deal of public interest in the past few years (Kooskora, 2006). Corporate governance is a set of procedures which boards use to direct the organisation, and it also includes ways which the organisation should use to build relationships with their stakeholders Crauford (2007). Corporate governance is important for organisations as it outlines accountability of board members and helps to lessen conflict of interests (Bawden, 2008).

Farrar, (2008) examined the history of corporate governance right back to the late 19th century. With the growth of qualified managers, the creation of potentially conflicting interests occurred between the owners or shareholders of a business and the managers who actually ran the business. Corporate governance, as a concept, had its beginning in the corporate sector (Bawden, 2008). Corporate governance is described by many commentators as a process which aids the direction, monitoring and authority of all activities within an organisation (Mathias, 2009; Leblanc & Gilles, 2005). It is also accepted that governance concerns are intrinsically complex. Both organisations and directors need to be aware of this and must start to

recognise this issue and start proposing solutions (Norgate, 2005; Mathias, 2009) In essence, corporate governance is what makes sure the right questions gets asked by the board to the management and to make sure that the right answers are given to reflect the long term strategic goal of the organisation. It is commonly understood that the position of the board is one of conscientious supervision, and that directors should not be occupied with the day to day running of the organisation (Goodman, & McPee, 2008). The obvious major challenge for directors is to get the right level of balance in decision making (Mathias, 2009). Garratt, (2005, p.30) states that 'the real role of a corporate director is balancing prudence with progress'. Farrar, (2008, p. 23) described this as the agency dilemma, 'management, in the absence of a countervailing power, have a tendency to pursue their own self-interest at the expense of the corporation'. Organisations moved swiftly to respond to such dilemmas and developed systems to help owners oversee management (Bawden, 2008). This also helped owners to observe that managers were operating within the law and maximising the wealth for themselves (Bawden, 2008; Farrar, 2008)

Governance, or more explicitly how to make corporate governance more effective, has been an issue of major concern for many board directors (Mathias, 2009). Such concerns have led to interest in corporate governance. For academics, focus of corporate governance has certainly been worthy of investigation (Mathias, 2009; Leblanc, 2003). While there is a plethora of case analysis published along with plenty of options from a legal point of view, there is very little in the way of academic research into corporate

governance in the public setting (Mathias, 2009; Clatworhty, Mellet & Peel, 2000). An independent survey into the literature shows that there are few writers outside of popular journals who explore the subject in any great depth (Cadbury, 1992; Charkham, 1994; Farrar, 2005; Garrat, 2003b; Monks & Minow, 2001). There is both a lack of research in the public sector, and a lack of research on organisations operating in New Zealand. Leblanc (2003) also reported that most research available was quantitative and was frequently associated with financial performance of an organisation. There are no studies which focus on corporate performance. So this has resulted in gaps in the literature.

There are many various definitions of what corporate governance is. Crauford (2007) explains that ‘corporate governance is the set of processes, customs, policies, laws and institutions affecting the way a corporate is directed, administered or controlled’ p.88.

Alexander, Lee, and Bazzoli (2003, p.228) state that ‘corporate governance assumes board responsibility for an organisation’s survival and well being. The act of governance is distinguished from that of management’.

The Organisation for Economic Cooperation and Development (OECD) defines corporate governance firstly as the ‘structure through which the objectives of the company are set, and the means of attaining those objectives, and monitoring performance’ and secondly, as, ‘the relationship between the board and the company’s shareholders and its other

stakeholders'. However, corporate governance has considerably more connotations, for example, its relationship with the economic and social well being of both organisations and people (Clark, 2008).

It is considered that corporate governance plays a significant part in the economic health of organisations and that when corporate governance is poorly defined this can have a detrimental effect on the organisation (Kooskora, 2006; Rayman-Bacchus, 2003). Most definitions of corporate governance embrace these major themes: accountability, probity, transparency, direction, control and the achievement of the organisations objectives (Mathias, 2009).

Corporate governance and its association with the performance of an organisation has been insufficiently studied, especially in the public sector (Mathias, 2009; Garrat, 2003a; Leblanc, 2003; Leblanc & Gillies, 2005; Clatworthy *et al,* 2000). A great deal of corporate governance literature concentrates on the traditional commercial methodology which is based on the historical origins of the corporation (Mathias, 2009; Grayburn & Garlick, 1998), and also limited liability companies in the 18th and 19 centuries (Charkham, 2005; Cumming, 2000; Smith, 1776; and Lockhart, 2006).
The latest research has claimed that political and regulatory environments have had a considerable impact on corporate governance (Firth, Fung and Rui, 2006). By the 1950's New Zealand had already started developing some early form of corporate governance under the Companies Act 1955, and this has since been further defined with the passing of the Companies Act 1993

and the Crown Entities Act 2004 (Mathias, 2009). However ‘good’ governance is not defined in either of these two Acts (Ingley & Van der Walt, 2005, p.643).

Lack of attention to corporate governance has highlighted the need for debate to occur on trying to improve corporate governance (Anderson, Melanson and Maly, 2007; Kiel and Nicholson, 2005).

2.1.1 Agency Theory

A large proportion of the available literature focuses on agency theory and how organisations need to separate ownership from the management of an organisation (Berle & Means, 1932; Eisenhardt, 1989; Anderson *et al*, 2007; Lockhart, 2006). There are other theories which you can relate to corporate governance, like stakeholder theory. However for this research I will only be looking at agency theory. Agency theory is by far the foremost concept in the literature when it comes to corporate governance (Anderson *et al*, 2007; Mathias, 2009; Lockhart, 2006). Corporate governance has been dominated by agency theory when reviewing the structure and composition of the boards, especially in publicly run organisations (Brundin & Nordqvist, 2008; Daily, Dalton & Cannella, 2003; Reoberts, McNulty & Stiles, 2005; Van der Walt, & Ingley, 2003).

Agency theory started to take shape in the 1932 seminal work of Berle and Means on the separation of owners and managers. Tosi (2008, p.163) argues that ‘From both a theoretical and a practical perspective, the base of

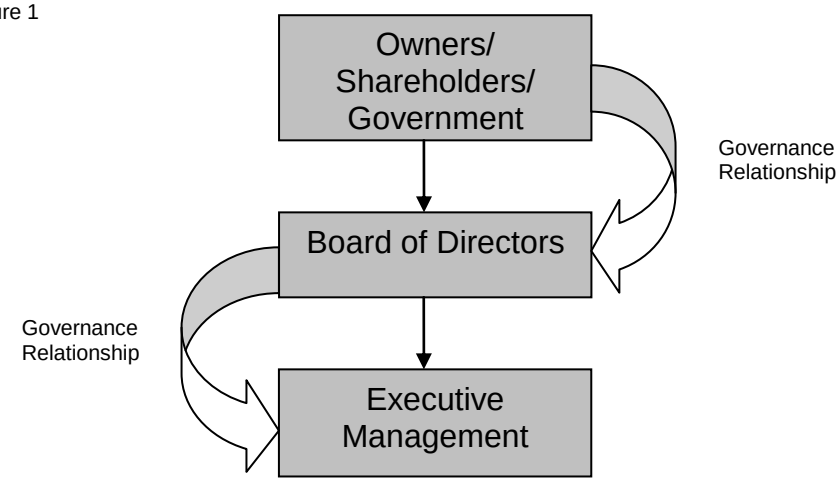
corporate governance issue is the separation of ownership from the control of the firm'. The agency relationship is defined by Tosi (2008, p.160), as 'a contract user which one or more persons (the principal(s)) engage with another person (the agent) to perform some service on their behalf which involves delegating some decision making authority to the agent'.

In terms of organisations today, the literature around agency theory centres on the internal management structure of the firm, and the characteristic observation is that shareholders and the board of directors are the principles while the managers and more explicitly the CEO are the agents (Tosi, 2008; Van der Walt *et al*, 2003). Kooskora (2006, p.27) states that 'Corporate governance is most often viewed as both the structure and the relationships that determine corporate direction and performance. With agency theory the control is in the hands of the managers who act as "agents" for the owners. Since this control is in the hands of the managers then these agents do not always act in the interest of the owners (Anderson *et al*, 2007; Eisenhardt, 1989; Agarwal, 2010). To counter this, owners need to have checks and balances in place which help to monitor the managers, as well as offering incentives to managers. This is done are done to increase the amount of information which is passed on to the owners.

The problem of agency occurs due to the basic tenets of economic theory in which all individuals are motivated by self-interest (Anderson *et al*, 2007).

Branston, Cowling and Sugden, (2006, p.199) state that ‘most literature on corporate governance considers the exact nature of the controlling group by centring the debate on the relationship between shareholders and managers’. Agency theory is the base which corporate governance developed from.

Figure 1



There have been many instances whereby corporate governance structures in the private sector have been duplicated into the public sector with drastic results (Howard and Seth-Purdie, 2005). Howard *et al* (2005, p.56) say that ‘the context in which they [public sector organisations] make decisions is complicated by factors not found in the private sector, such as the role of government ministers, the necessity of taking into account government policy and/or community service obligations’.

2.1.2 Board Effectiveness

Much of the debate around corporate governance has been directed towards the size, structure and makeup of the board (Lehn, Patro and Lhao, 2004). Boards of directors serve two primary functions: firstly they give directions to the managers about the organisation’s strategy (Lehn *et al,* 2004) and

secondly, they monitor the implementation of these strategies by the managers (Monks & Minow, 2001).

Strach, Hall, and Pirozek, (2004, p.3) state that ‘good governance can attain better performance and better management in businesses as well as in public institutions’. Another important statement is made by Wolfensohn, (1999, p.21), ‘governance of corporations is now as important in the world economy as the government of countries’. New Zealand has experienced its share of political and economic transformation. We have experimented with competition in the sector to try to make the sector more efficient (Docteur and Oxley, 2003). Now there is more of a cooperation approach (Quin, 2009).

2.1.2.1Board Size

Lehn *et al (*2004, p.1) points out that ‘many scholars, investors, and regulators argue that corporate boards should be small and comprised largely of independent directors’. There is not a vast amount of literature around what is the optimal size of a board. Much of the literature that theorises or addresses optimal size states that small boards function more effectively (Lehn *et al,* 2004; Coles, Daniel and Naveen, 2004; Yang, Linck and Netter, 2004). For example, the position of Lipton and Lorsch (1992) on board size is that boards with 10 or more members become more difficult to operate, and it is harder for members to express their opinions more freely. Furthermore, Jenson (1993) maintain that having small boards can help boost the performance of the board and that when boards exceed eight members it is doubtful that they function effectively. Lehn *et al,* 2004, point

out that large boards are weak and that the ‘major advantage of large boards is the collective information that the board possesses about factors that affect the value of firms...however the major disadvantages of large boards are the coordination costs and ‘free rider’ problems’. This free rider difficulty is associated with large boards in which the average level of influence that a board member has, or is perceived to have, fluctuates depending on the size of the board (Lehn *et al,* 2004). The problem with this argument is that board members have reduced influence then they may also have decreased enticement in monitoring management (Lehn *et al,* 2004; Agarwal, 2010).

2.1.2.2 Board Composition

Another factor that can impact board effectiveness is board composition. However this factor is also inadequately researched and there is also an inadequate amount of literature which summarises the determinants of what a good board composition would be (Lehn *et al,* 2004; Agarwal, 2010; Blackham, 2007).

Why board composition is so important is that many board members might not have the required skills to perform the task of governing and organisation (Clark, 2008). This can have a detrimental effect on the board. Dube and Slattery, (2007) discuss creating an important position within an organisation. This position is called the “Chief Governance Officer”. This position is an executive manager who offers impartial advice to the board on all governance related matters (Dube *et al,* 2007). This position helps the board

in developing good corporate governance policies and helps to educate the board on governance issues (Dube *et al,* 2007). This position would help immensely when it came to board members who needed extra education on governance issues.

Lipton and Lorsch (1992), propose a ratio of two independent directors for every internal director. Jensen (1993) disputes this idea and states that the only internal director sitting on the board should be the CEO. This is due to the fact that no inside directors can critically evaluate the CEO.

The quality of decisions made by a board should imitate the capabilities of its members (Lockhart, 2006). Members need to have the right amount of experience, work ethic and relevant skills to enable them to make the right decisions in an effective way. Most boards normally meet for a few hours a month, and in this time they must absorb and evaluate complex information. It is extremely important to select directors who have outstanding capabilities and are capable of handling this knowledge in an appropriate way (Lockhart, 2006; Blackham, 2007).

In the first part of 2003 a review was conducted by Higgs. This review looked at the roles of independent directors and focused on their role, contribution, remuneration, selection and duration (Higgs, 2003; Garratt, 2003).

Board composition is also likely to change if a board is either elected or appointed by the government (Van der Walt, Ingley, & Diack, 2002). With

corporate governance, the concept of diversity on the board is associated with board composition (Van der Walt, & Ingley, 2003).

2.1.2.3 Board Structure

The focal point when one describes corporate governance should be to review an organisation's structure, processes, managerial and board control and most importantly in my mind, strategic direction.

Crauford (2007, p.88) argues most organisations have 'focused on the structure of boards including their size, composition, independence of directors...but what is the role of the board and is there a relationship between board structure and corporate performance?'

Empirical findings on the degree to which the board has influence on strategic participation continue to be largely miscellaneous (Brauer, and Schmidt, 2008). What is clear about this is that the board is not that involved in the formulation of strategies (Crauford, 2007). The board needs to be involved in more than just "rubber stamping" management's strategic suggestions and needs to be developing the strategic future of their organisation (Brauer *et al,* 2008; Blackham, 2007).

Strategy is an important characteristic which boards need to cope with (Sioncke & Parmentier, 2007; Nwabueze, & Mileski, 2008; Maharaj, 2009). An unambiguous and distinct strategy formulation and implementation are just as important as any other corporate governance issue (Sioncke *et al*, 2007; Nwabueze *et al,* 2008). There are, however, numerous causes which

make it difficult for organisations to reach these performance expectations (Verweire and van den Berghe, 2004; Nwabueze *et al,* 2008).

One theory which Emslie, Oliver, and Bruce, (2006) observe is what is known as “Policy Governance”. Policy governance is an integrated concept which describes how to govern a board (Emslie, *et al,* 2006). There is increasing recognition that good corporate governance and the role the board takes in overseeing an organisation do make a difference in the performance of that organisation (Emslie, *et al,* 2006; Agarwal, 2010). However, Barnett, and Clayden, (2007, p.vii) argue that: ‘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’.

Boards need to make sure that their structure is to serve their needs and the needs of the organisation and community (Van der Walt, Ingley, Shergill, and Townsend, 2006). Barnett *et al*, (2007, p.xvii) illustrate that ‘skill mix, experience and time have been shown in the literature as important for effective functioning’. Considerable investment is necessary to improve and maintain the performance of boards (Barnett *et al*, 2007; Agarwal, 2010).

Rao, and Hossai, (2002) believe that board composition and the performance of an organisation in cooperation with each other respond in a positive manner. Boards are wholly accountable to the shareholders for performance of their organisation. The only issue with this is that members are normally

only a part time mechanism and have rather complex tasks and it is impossible for them to have knowledge of all the happenings within the organisation.

2.1.2.4 Board Remuneration

The subject of board remuneration has attracted much academic and media attention within the past few years (Lee, 2009; Blackham, 2007). There are many authors who consider linking board remuneration to performance (Lee, 2009; Core, Holthausen, and Larcker, 1999; Denis, 2001; Kakabadse, Kakabadse, and Kouzmin, 2001). Pervost,

Board remuneration is an issue which has attracted much academic, political and media debate throughout the world, with the exception of New Zealand (Cahan, Chua, & Nyamori, 2005; Agarwal, 2010). Academic research on board remuneration is extensive but mainly based within the private sector (Cahan *et al,* 2005; Murphy, 1998; Swagerman, and Terpstra, 2009). Brickley, van Horn, and Wedig, (2003) acknowledge that most research is based on private organisations and that there is little research on public sector entities; this is also backed up by Cahan *et al, (*2005). Nevertheless, it is still a very critical issue since boards in the public sector play a more important role than those based in the private sector due to the extensive use of tax payers' money. There is a considerable amount of literature that supports the belief that governments should arrange public sector boards to be more like boards within the private sector.

Board members need to attend more than just meetings; board membership involves a significant dedication of time, a dedication which increasingly requires better remuneration (Goodman *et al*, 2008).

Core, Holthausen and Larcker, (1999) believe that board remuneration can help to address board effectiveness as remuneration decisions are an important way of managing the board more effectively.
Kubo, (2005) found that the effect of performance related board remuneration did have an effect on the performance of an organisation, and that organisations which have higher remuneration rates for their board members are more likely to achieve better results.

Goodman *et al*, 2008, illustrated that the majority of payments are made through “meeting fees”. However, more and more organisations are paying their directors through annual retainers. Agarwal, (2010, p.28) argues that ‘compensation should be predominantly cash based on short term performance’. Most corporate governance authors recommend that board remuneration consists of both cash and equity based payments (Goodman *et al*, 2008; Cook, 2009).

There is a vast amount of literature around corporate governance. Most of this literature is based on International, and the private sector model.

There is some public sector literature but a lot of this is not relevant to this study. This literature is limited in what it addresses and cannot be easily adopted into the New Zealand public sector as it is mostly based in the United States of America.

Again there are a number of different definitions of corporate governance, but they all have the same defining characteristics.

There are a number of studies which show that having good corporate governance is good for the organisation. Most of this literature also comments about board size, structure and remuneration which I will elaborate on in the discussion section.

2.2 Corporate Governance in the New Zealand Health Sector

The government is the foremost supplier of funding and provision of the health care service in New Zealand (Quin, 2009; Bawden, 2008; Ashton, Cumming, and McLean, 2004). Governance in the health sector has changed with every past election restructure. In New Zealand, corporate governance issues have been fundamental to the restructurings of the health sector within the last 20 years (Barnett *et al*, 2007).

Organisations in the public sector have more functions to perform than just maximising shareholder value and are unable to trace their performance via the share market or through any other purely financial means. Corporate governance is much more complex for public sector organisations. This is

mainly due to increasing political interference at the board level as well as the need to support the requirements of the local community.

Cornforth, (2003) recognises this concern and states: ‘oversimplifying the problems, underestimating the conflicting demands and pressures that board members face, and presenting solutions that are difficult to implement in practice’.

In terms of corporate governance, DHBs need to focus on defining their function, identifying the organisation’s interest and identifying how they will achieve all of these objectives (Bawden, 2008). However, although these objectives are not new, it is important to note that the achievement of these objectives is often more difficult due to DHBs having different source of revenue and a vast number of obligations to perform under various legislation and regulations (Ashton *et al*, 2004).

The reforms which have taken place in New Zealand aimed to provide better fiscal and management autonomy to DHBs, in order for them to improve the quality of the health care that they were providing, as well as making it more cost effective (Mordelet, 2008).

DHBs have a legal status under corporate law. However this does not by itself mean that they operate as a corporate organisation, with corporate principles and a corporate mindset (Ashton *et al*, 2004).

Efficient governance of DHBs requires responsible use of funding, professional management of the organisation and good competent corporate governance (Strach *et al,* 2004).

The health care system in New Zealand is similar to that of many other western countries (Strach *et al*, 2004) and has been subjected to numerous forms of restructure (Barnett *et al*, 2007). When the majority of the health care system is funded via the government then extensive changes need to be made to ensure that the tax payer is receiving the best health care system for the money invested. Restructuring was a way that government could make change. These changes have resulted in alterations in the way public hospitals have been funded, changes to the services they offer and how they offer the services (Finlayson and Gower, 2002).

At present, public hospitals are separated into geographical areas called District Health Board catchment areas. The way DHBs are funded is through the PBFF, which basically means that they are funded on the basis of the ‘particular requirements of the people living in the geographical location’ (Strach *et al.*, (2004, p.10). The main performance functions of DHBs are to ‘attain a fair and functional health care system that is effective in contributing to the health of New Zealanders’ (Ministry of Health, 2004). The DHB members are responsible for governing the health services within their district. A board needs to preserve financial stability and needs to ‘improve, promote and protect the health of those within its district and to promote the

independence of people with disabilities within its district' (Ministry of Health, 2004).

The shift to corporate governance was rather rapid in New Zealand (Perkins, Barnett and Powell, 2000). It was coupled with various other public sector reforms which were taking place with the National government in the early 1990s. These changes were anticipated to place the public health sector on a strong and logical commercial footing (Perkins, *et al.*, 2000).

The Labour-led government in 1999 announced the current shake up of the health service. The first move was to change the focus on the corporate rationalist model of governance, reinstating locally elected boards and eliminating the provider/purchaser divide (Devlin, *et al,* 2001). The strategies which the Labour-led government adopted was built upon strategies which already existed (Devlin, *et al,* 2001). This was good for the newly formed government as it meant that they did not attract a large amount of criticism. Even though the health strategies did not change a great deal, the actual structure of the health system did (Devlin, *et al,* 2001; Ashton *et al*, 2004). It was so radical that new legislation had to be drafted and passed by parliament. The new structure was seen by most as a positive change. Some still argued that the extensive reform was excessive (Devlin, *et al,* 2001).

The current health system reinstates a form of the local governance which was similar to the AHBs in the 1980s to early 1990s (Devlin, *et al)*.

The DHB structure which the Labour government wanted with having more of a local autonomy in the decision making of the boards has now taken shape. However, just because the governance has been given to DHBs does not

mean that they do not have to have accountability to the Minister of Health. Strict accountability has been developed and the Minister of Health has the means to review and control the actions of DHBs (Devlin, *et al,* 2001). One notable difference with DHBs and AHBs is the number of DHBs. There are 21 DHBs compared to 14 AHBs. This was beneficial as DHBs can concentrate on their populations as there are many areas which have small populations with challenging needs; for example Northland and the Gisborne areas. There have been many commentators who argue that 21 DHBs is not sustainable and a reduction or amalgamation may need to occur (Devlin, *et al,* 2001).

Like the private sector, the health sector needs to have good corporate governance principles in place, and needs to function like a well oiled wheel. This section of the literature has explained why changes have occurred in the past and reiterates ideas to focus on during my discussion.

The public health sector is such an important part of our daily lives. Health takes a large proportion of our tax dollars and we need to make sure that our current health structure functions efficiently. There is not a lot of research around corporate governance in the public health sector which means that research does need to be conducted.

From the literature we can gage that good governance does make organisation improve their performance. The health system in New Zealand

has had some radical changes, and each of these changes has resulted in a different governance structure. None of these were perfect, or even near perfect.

2.3 History of the Reforms in the Public Health Sector

When the Labour movement took off around the world in the 1930s it defined the way governments looked at addressing inequalities in social services which had occurred as a result of capitalism (Chalmers, 2008; Castles & Shirley, 1996). After both World Wars people were becoming more aware and concerned with the economic and social issues when it came to health, old age and unemployment (Chalmers, 2008; Gustafson, 1997). When the first Labour government under Michael Joseph Savage was elected in 1935 they introduced wide changes in social security and the start of a publicly funded health care system emerged (Gustafson, 1997; Mathias, 2009; Ingley & van der Walt, 2005; Bawden, 2008; Barnett & Clayden, 2007; Chalmers, 2008).

Since 1983 the public health care sector in New Zealand has undergone four major structural changes (Quin, 2009; Perkins, *et al*, 2000). Each structural change has seen new organisations set up to fund and deliver health services to the New Zealand public (Quin, 2009; Perkins, *et al*, 2000).

Along with the four changes to the public health care sector came four major legislative changes, these being:

1. Area Health Boards Act 1983;
2. Health and Disability Act 1993;
3. Health and Disability Services Amendment Act 1998; and
4. New Zealand Public Health and Disability Act 2000

The Area Health Boards Act 1983 created the gradual establishment of the 14 Area Health Boards (AHBs) which were based on the population based funding formula (PBFF) (Quin, 2009; Barnett, Perkins, & Powell, 2001). The Health and Disability Act 1993 created four Regional Health Authorities (RHAs). This meant that the purchasing and supply of health care service was detached from one another and the AHBs were structured into 23 for-profit 'Crown Health Enterprises' (CHEs) and were now subject to company law like any other company operating in New Zealand (Quin, 2009; Perkins, *et al*, 2000; Barnett *et al,* 2001).

The Health and Disability Services Amendment Act 1998 was a result of the coalition agreement between National and the New Zealand First parties. The agreement stated that a reform of the health system should occur. This resulted in another restructure and the RHAs became one national purchasing agency called the Health Funding Authority (HFA). The 23 CHEs were then reconfigured as 24 non profit crown owned companies and renamed 'Hospital and Health Services' (HHSs). (Quin, 2009; Barnett *et al,* 2001).

At the end of 1999 the newly elected Labour-Alliance coalition government went about with the fourth and final restructure with the introduction of the New Zealand Public Health and Disability Act 2000 (NZPHD) (Quin, 2009; Ashton *et al*, 2004). The NZPHD established 21 DHBs and had provisions to develop Primary Health Organisations (PHOs) whose task it was to manage the primary health care strategy (King, 2001).

All of these changes were intended to enhance health outcomes, increase accountability within the public health sector as at the time it was seen to have been lacking and to reduce the increasing pressure on health expenditure (Quin, 2009).

New Zealand was not alone and has faced similar problems with other countries when it came to the need or the desire to restructure health care (Quin, 2009; Barnett *et al*, 2007). The population was ageing; technology was becoming more advanced and more expensive for hospitals to purchase (Quin, 2009; Ashton *et al*, 2004) and the public's expectations of what they expected for their tax dollars increased.

Inconsistencies in health service is not a new phenomenon, and is not something that will be corrected overnight. Concerns about the quality and unequal access to health care caused great public and political debate for many years prior to 1983 (Gauld, 2001; Quin, 2009; Perkins, *et al*, 2000). Even so it was not until the newly elected 1975 National Government that a realistic attempt to reform the health sector actually started to take form

(Quin, 2009). The National government established a Special Advisory Committee of Health Service Organisation (SACHSO) to review which restructuring approach would be best (Quin, 2009). The committee recommended that locally elected AHBs be established (Quin, 2009). The National government piloted the AHB model in both Northland and Wellington before rolling it out nationwide (Quin, 2009; Ashton *et al*, 2004)

By a snap election in 1984 the fourth Labour government came into power (Gauld, 2001). Considerable reform across the whole state sector occurred (Gauld, 2001; Quin, 2009; Ashton *et al*, 2004). Many advisors at the time recommended that the government take more of a 'commercial' stance when it came to the health sector. However the government continued on with the AHB model.

The significant changes were that 14 locally elected and appointed AHBs were formed between 1983 and 1989 (Quin, 2009; Perkins, *et al*, 2000). PBFF was being developed so that each region was funded for their population needs more than their actual population (Perkins, *et al*, 2000). The Department of Health (DoH) was becoming more decentralised with planning, funding and responsibilities falling to AHBs (Quin, 2009; Ashton *et al*, 2004). With this first reform a more preventative approach was seen to be occurring as in the past it was more curative (Quin, 2009).

The AHBs themselves varied in size, from serving a population of 35,000 to serving a population of 900,000 people. Until 1991 board members were elected through local body elections and the Minister of Health was able to appoint up to four further members to make up any deficiencies, for example

in board diversity, business skills, or cultural skills (Quin, 2009; Perkins, *et al*, 2000). In 1991 the National government announced that they would be appointing ‘Commissioners’ to run AHBs while the next intended reforms were being sorted out (Quin, 2009; Perkins, *et al*, 2000).

In February 1992 the government announced that AHBs could introduce user charges. The motivation for this was to try to discourage people using hospitals for treatment of primary health care, as this had major effects on health expenditure (Ashton, 1992; Quin. 2009; Perkins, *et al*, 2000). However this policy was abandoned a year later due to negative publicity and the financial cost which AHBs had to bear (Gauld, 2001).

The newly elected National government progressed with the previous Labour government’s widespread restructuring of the health sector but embarked on a more aggressive format. A ministerial task force was set up to review the perceived deficiencies within the health system (Gauld, 2005). The task force announced their recommendations on Budget night, July 1991. Their report repeated much of what was reported in the 1988 Gibbs report *Unshackling the hospitals* and also the report by Scott, 1986 *Choices for health care: report of the Health Benefits Review*. Both of these reports were published in the 1980s (Quin, 2009). The task force’s report advocated that the health purchaser and health provider become independent of each other and that the health system should operate under a competitive, quasimarket approach for all services relating to the provision of health (Quin, 2009; Gauld, 2001; Perkins, *et al*, 2000). However there is evidence that the quasi market approach was not successful (Devlin *et al,* 2001). From this report the

government initiated four RHAs which were designed to purchase health services from a range of providers who operated in the competitive market (Quin, 2009; Ashton *et al*, 2004). AHBs were changed to 23 CHEs which had the proviso to operate as commercial organisations and with boards who had been appointed by the Minister of Health (Gauld, 1999).

The government announced that the new system would not take effect for two years, and the scheduled start date was 1 July 1993, which allowed for more consultation to occur (Quin, 2009; Ashton *et al*, 2004). However work began immediately with AHB members being substituted for commissioners who were government appointed. The execution of this process was managed not by the DoH but by the Department of Prime Minister and Cabinet (DPMC).

An additional transformation was the relocation of funding to the new RHAs, and the DoH became the MoH (Quin, 2009).

The Public Health Commission (PHC) was created to be an independent voice from the MoH (Quin, 2009). The PHC's main function was to advise the Minister of Health on a range of health, public health, monitoring and purchasing of health services (Blank, 1994; Quin, 2009). The PHC entered into agreements with CHEs and other health providers for various services. However, the PHC was decommissioned in 1995 as the government realised that the PHC offered additional structure to a public health service which was already burdened with enough red tape. Gauld, 2001 also states that the

PHC was decommissioned because much of their policy and advice to the Minister was at odds with other government policy at the time.

With the establishment of the Health and Disability Services Act 1993 the four RHAs were launched to purchase health care services for the 23 CHEs who were now classed as providers (Quin, 2009; Ashton *et al*, 2004). One of the main responsibilities that the RHAs had was to monitor the health needs of the populations in which they served and purchase the appropriate services for the population (Bloom, 2000). The four RHAs were: Northern, Midland, Central and Southern (Quin, 2009). Each RHA was accountable for between 750,000 and 1,000,000 people and had the added responsibility to purchase not only primary, secondary and continuing care, but also accident related health services both from the government and private providers (Quin, 2009; Coster & McAovy, 1996; Ashton *et al*, 2004).

Like AHBs, RHAs were funded by the MoH via PBFF (Blank, 1994). The selection of directors on the whole was from people outside the health sector, primarily from business backgrounds (Barnett & Barnett, 2000). Now that the health system had a purchase/provider division, public hospitals no longer had the benefit of full access to public funding (Quin, 2009). The intention was to have RHAs introduce competitive competition around the whole health sector, including with private providers. However this never occurred and this policy was never implemented as the government once again changed (Ashton, Mays & Devlin, 2005).

CHEs were intended to make public health care more efficient. They were shaped to be autonomous, publicly owned organisations which typically included a main hospital, or various hospitals supporting a region. CHEs were established to be similar to State Owned Enterprises (SOEs) and could operate as a registered limited liability company under the Companies Act 1993 (Quin, 2009).

With the first election under MMP a National-New Zealand First coalition agreement was written. Advice from Treasury, MoH and the Crown Company Monitoring Advisory Unit (CCMAU) resulted in the two parties negotiating that the current health system needed to be reviewed (Gauld, 2001). Ashton, 1997 stated that this agreement was meant to signal a shift from a more competitive approach, to more of a cooperative approach to health care. The major changes identified in the agreement were that both the Ministers of Health and Crown Health Enterprises would be amalgamated into the position of Minister of Health (Quin, 2009). The four RHAs were amalgamated into one central health funding authority (HFA) which was tasked with having more of a focus on building better relationships with service providers (Gauld, 2001). CHEs were renamed and were now known as Hospital and Health Services and were made to be more businesslike and set out to make profits (Perkins, *et al*, 2000).

Almost immediately after the 1996 election work started on integrating the four RHAs into one HFA (Quin, 2009). In 1997 the Transitional Health Authority (THA) was established to review the previous purchasing system

and to administer the merger of the four RHAs into the HFA (Gauld, 2001). The government passed the Health and Disability Services Amendment Act in 1998. This is when the HFA officially replaced the THA and assumed full accountability for the purchase and monitoring of the public health system. Even though the main functions of the HFA were the same as the RHAs the underlying principle for a single entity was to help reduce the cost within the health sector (Gauld, 2001; Quin, 2009; Ashton *et al*, 2004).

However this new reform developed quite a number of disagreements between officials and politicians. Gauld, 2001 says that only "elements of the coalition polices were promoted; other changes indicated attempts to repackage ideas introduced in 1993". The coalition government eventually collapsed in August 1998 and the minority National government then focused on establishing the changes and working towards adding consistency to services and establishing a world class health system (Gauld, 2001).

With the election in1999 saw another round change for the health sector. Labour's health policy released in 1999 emphasised their commitment to restructure the health system for the fourth time in nearly 20 years (Gauld, 2001). The Labour-led government considered that the HFA structure was exceedingly competitive, have very little community participation and lacked accountability (Quin, 2009). So the Labour-led government set about to change this with the introduction of the New Zealand Public Health and Disability Act 2000 (NZPHD). With the NZPHD the HFA was disestablished and the MoH became the principal organisation responsible for policy advice, funding and monitoring accountabilities for the health sector (Quin, 2009;

Gauld, 2001). Twenty one DHBs replaced the Hospital Health Services and took over the responsibility for providing health services to their local communities, and once again the boards of the DHBs were mainly elected via the community which they served (Ashton *et al*, 2004).

DHBs are crown entities and through this are responsible to the Minister of Health and are also funded via PBFF by the MoH. DHBs are responsible for a wide range of planning, funding and ensuring that the health services are geographically designed for their population (MoH, 2006; Ashton *et al*, 2004). By law, DHBs are obliged to concentrate on reducing inequalities around their populations, prioritising health services within a predetermined budget set by the MoH, and providing a range of services including, disability support, mental health, primary health and of course secondary health services (Gauld, 2006). DHBs populations range from 30,000 to nearly 500,000 (MoH, 2005).

DHBs are governed by a board of 11 members. Seven of these are elected via the local body elections held every three years (Quin, 2009; Ashton *et al*, 2004) and up to four board members are appointed by the Minister of Health. Each board is required to have at least two Maori members. These members can either be elected or appointed.

The Crown Entities Act 2004 states that DHBs are to produce a Statement of Intent and an annual report which gets tabled in Parliament (Quin, 2009). This ensures a high level of accountability of individual DHBs.

Under this current system many Non government organisations (NGOs) have also been encouraged. Many health services are delivered by NGOs, especially in primary health care (Quin, 2009).

This section has reviewed the key literature on the history of reforms in the public health sector in New Zealand. The main purpose of this section was to conclude that the New Zealand health sector has under gone four rigorous changes within the past 20 years, mainly due to changes in the ruling political parties of the day, and that these changes have meant that the health system still does not have an effective governance structure in place and that there is still room for improvement.

In conclusion, there are a small number of research articles available which clearly explain that it is fundamental to District Health Boards to have a fully functioning corporate governance structure. In the next section I will outline what I see are fundamental changes which need to be addressed.

Chapter Three - Discussion

Based on the literature that I have reviewed there are three main areas which I would like to address in helping to make DHBs become more effective. The three areas are: board remuneration, board structure and board diversity.

The reason that I have chosen these three areas is because I see that if DHBs implement my proposed changes then they will be able to operate more effectively. I realise that my changes to board remuneration could be seem as controversial, especially when reviewed in the New Zealand public sector context. But I think that this is essential to get the “right” individual onto the board. Board size could be another controversial proposal. Many people see that having fewer people on a board gives members too much power and control. In this instance, the literature backs up my proposal, and that decreasing the current number of board members is essential. Board diversity is important, especially in a multi-cultural country like New Zealand. This is why I think that slightly enhancing diversity on DHBs is also encouraging, especially in the main areas where we see greater Pacific and Asian communities.

3.1 Changes to Board Remuneration

One area which is significantly covered in the literature is board remuneration. Based on the literature that I have reviewed I am going to propose a new system for board member remuneration in DHBs. This new

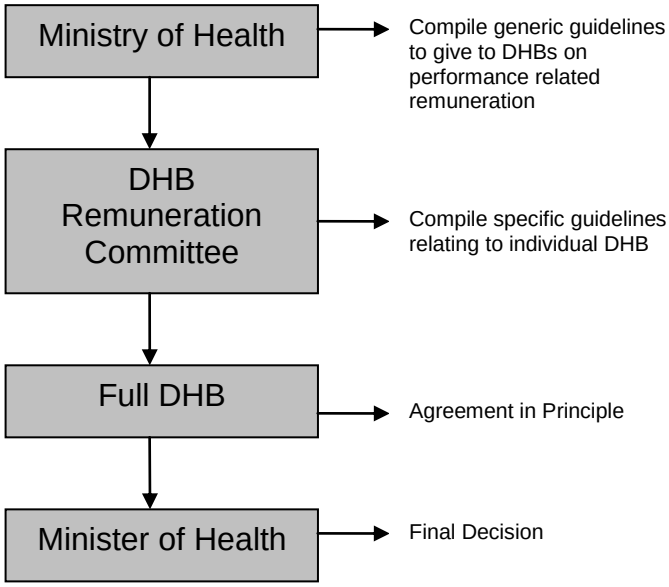
system is comprised of compulsory remuneration and a performance based remuneration design.

There are many authors who consider linking board remuneration to performance as a positive mechanism for an organisation (Lee, 2009; Core, Holthausen, & Larcker, 1999; Denis, 2001; Kakabadse, Kakabadse, & Kouzmin, 2001).

In my proposed model, the board is still fully accountable to the Minister of Health. The Minister also has the final say on performance related remuneration (see Figure 2, p 38).

In the first step of this process, the Ministry of Health compiles generic guidelines to all DHBs on performance-related remuneration. This information would explain the rationale behind the policy, and state guidelines which DHBs must follow. The second step of this process is that DHBs create a remuneration committee made up of at least four board members. This committee then compiles specific guidelines relating to the individual DHB. The third step is that the full board must then vote on the committee's recommendations. This must be passed by an outright majority.
The final step in this process is that the performance-related remuneration then goes to the Minister of Health for their approval.

Figure 2



One difficulty in this proposed plan is to define what parameters the board must achieve to improve the DHBs performance. This is why I would recommend that the performance related remuneration is targeted on the board completing 80% or above on their “Performance Related Targets”. These targets are set by the MoH. These targets are worked out individually for each DHBs population and would take into account the differing demographics, location and existing services offered by that DHB.
The compulsory fees would include full board meetings, and any committee meetings that the member may be sitting on. The compulsory fees would increase if the member was the Chairperson, deputy Chairperson of the board or Chairperson of a committee.

It is important to note that although the compulsory fees would be lower than what members are currently receiving, the performance-related remuneration would then be worked out in the process above and based on the outcomes

of the DHBs performance-related targets. My rationale behind this is that with members receiving less compulsory payments it might make them think more objectively in their decision making, and want to become more efficient in the way they operate due to the extra performance pay that they are likely to receive if they reach their targets. Which comes back to a major principle of agency theory.

Payment of this remuneration is based on the discretion of the Minister of Health and can be fully or partially paid if the Minister thinks that this is appropriate when the board does not comply with the target range.

3.2 Changes to Board Size

Board size is another issue which has dominated the literature. However, although this issue is given a great deal of attention in the international literature, it has not been looked at in a New Zealand sense in any great detail. It is also interesting to note that the current number of board members sitting on DHBs is 11. The number of board members has not changed a great deal with the various public health structures that we have had since 1983.

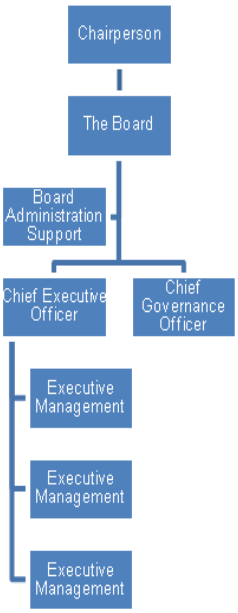
Much of the debate around corporate governance has been directed towards the size, structure and makeup of the board (Lehn *et al,* 2004). A large amount of the literature talks about the optimal size of boards, and that smaller boards function more effectively than larger boards (Lehn *et al,* 2004; Coles *et al,* 2004; Yang *et al,* 2004).

Currently the DHBs are allowed 11 members, with up to four members being appointed by the Minister of Health. My proposed solution is to limit this to nine members. Lipton *et al*, 1992 state that 'when a board has more than 10 members it becomes more difficult for them to express their ideas and opinions'. There is some literature which states that seven or eight members should be the ideal size (Jenson, 1993; Lehn *et al,* 2004). In my proposed structure, nine members enables the board to have five elected members which allow adequate community representation, with the additional members being appointed with skills which might be lacking from the elected representatives on the board.

In my proposed structure, I would have five members elected through local body elections as they are in the current system, and have up to four members appointed by the Minister of Health. I would also state that the appointed members should be appointed based on skills, experience and prior knowledge and not on political leanings or bias which can be the case in the current structure.

In the new proposed structure I would recommend that all DHBs create a position which is known as the "Chief Governance Officer". This position is based at the executive level on the management structure, but the officer sits in on board and committee meetings and offers impartial advice to the board on all corporate governance issues, and can also offer advice and education to board members who might not necessarily have the experience or skills to perform their jobs to a high standard.

The new proposed structure would look like this:



3.3 Changes to Board Diversity

Board diversity is another hotly debated topic in the literature. However there is very limited literature on what actually constitutes good board diversity (Lehn *et al,* 2004; Agarwal, 2010; Blackham, 2007).

Jenson, 1993 expresses that the CEO should be the only internal director to sit on the board. I agree with this because I believe that internal directors are unable to critically evaluate the CEO and management of a DHB when they are staff members themselves. For example, this can create an issue when a staff member has been elected to the board as is the case in some current DHBs. This solution has the potential to create a conflict of interest.

I think that having clinical or allied health experience on the board is an excellent idea and should be encouraged. However if an elected member is also a member of staff for that particular DHB, then they would have to resign

from their position to take a seat on the board as this could create an conflict of interest . This would not affect clinical or allied health professionals if they were not employed by the DHB. But they may also have a related interest in the private sector, and this could also create a conflict of interest which would have to be addressed.

At the current time there has to be a minimum of two Maori members sitting on the board. These members can either be elected or appointed. Under my proposed structure I would keep this policy, but change the requirements to say that the board must have a minimum of “two cultural minority members”. This is due to the large Pacific and Asian communities now based in New Zealand. I think that these ethnic minorities also need to be represented at board level, especially in the highly populated areas. New Zealand is obliged under the Treaty of Waitangi to have bi-cultural representation, and I would not deviate from this. But because New Zealand is becoming more of a multi-cultural country I think that it is also important that minority cultures are also represented at the board level.

Chapter Four - Conclusion

4.1 Corporate Governance

The strongest theme that emerges from this research report is that corporate governance, if it is initiated and maintained properly, has benefits that can be organisation wide. Good corporate governance provides for accountability between the board and its shareholders, and between the board and executive management.

There is a vast amount of literature available around corporate governance, and especially corporate governance based in the private sector. Most of this literature is internationally based and cannot be easily adopted into New Zealand organisations.

Governance research in the private sector contains a substantial amount of academic research investigations on three main areas: board size, board diversity and board member remuneration. These are important aspects for organisations to consider because boards need to get the right “fit” between the board and their particular company. Each company needs to carefully consider structure and size as these are critical factors for the performance of the organisation. This report concludes that great care should be taken when organisations review their structure and I believe such a review is necessary.

4.2 Corporate Governance in the Public Health Sector

Although the amount of literature around corporate governance in the New Zealand health sector is not substantial, there are a number of key

documents which provide key evidence that can be applied to governance in the New Zealand health setting. But there is little in peer viewed academic research that offers good, practical advice for today's health structure.

Like the private sector, both DHBs and the public sector at large need to have good corporate governance principles in place if they are to succeed and be efficient. Efficiency in this environment is vital because DHBs are responsible for around nine billion tax payers dollars each year and are not only accountable to the Minister of Health, but also to their local communities, who elect the majority of the members sitting on the board.

Although this report recognises that many changes have occurred within the health sector, DHBs to become more effective, they need to review their size, structure, and diversity of their board. Such changes will improve corporate governance and, in turn, improve organisation performance, both in the public and private sector, and the health sector is not immune to these changes.

4.3 Reforms in the Public Health Sector

Since the Labour movement in the 1930s started to take off, the government began to look at addressing inequalities in health. At the same time, the general public were becoming more concerned about health care, and other social issues, due to the fall of capitalism, when the lower and middle socioeconomic classes in New Zealand started to develop.

The first public health services in New Zealand stared to emerge in 1935 with Michael Joseph Savage's Labour government. There was not a great deal of change till 1983, and since this time we have experienced four major structural changes to our health system. Each structural change has resulted in new organisations being established and/or disestablished.

This current report provides evidence that the current structure, in general terms, is adequate but does recommend some key changes. Is the current structure adequate? I think so. Obviously it does need some adjustments to make it more efficient but quality improvement is something that DHBs, or any organisation should be always looking to improve. No organisation can obtain 100%. I think that the introduction of my proposed changes, of introducing the position of 'Chief Governance Officer', changing the way board members are remunerated, having more performance-related remuneration and decreasing the size and diversity of boards are ways in which DHBs can become more efficient.

This report concludes that some minor, but key changes are needed to the health structure that we have at present. More importantly, such changes should be developed independently of the government of the day. Health reforms should be free of political ideology and should instead be based on analytical approaches of current government literature.

Chapter Five - Recommendations

5.1 Political Involvement

One area which I see great potential for further research is to look at the political involvement or political interference which DHBs as organisations, and board members as individuals may experience.

When it comes to corporate governance and DHBs should there be political interference? DHBs are government funded, but does the Minister of Health and MoH have too much power over DHBs and their communities? New Zealand is only a small country, but has great diversity in its population. Each DHB has a vast makeup, which is unique to their specific district, and perhaps more community involvement on the structure of the local health system is necessary? Or perhaps there is too little involvement by the government and MoH?

5.2 Corporate Governance in the Public Sector

What comes through in the literature is a general lack of academic research into corporate governance in the public sector, both internationally but especially in a New Zealand context.

An important piece of research would be to review the corporate governance of the New Zealand public sector to see what efficiencies can be identified.

5.3 Board Remuneration in New Zealand

A major theme in this research and especially in my discussion section is the notion of performance-related remuneration for board members. I have proposed a simple structure which could easily work in the health sector in New Zealand. However I do think that performance-related remuneration should be explored in more depth and with greater emphasis on boards being more strategic in their thinking, and being responsible for the consequences of their actions (both positive and negative). I think further research into both the public and private sectors would be worthwhile. I really feel that if boards are given incentives to put their best efforts in then boards will be able to function much better.

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Reflective Journal

I can honestly say that I have enjoyed researching and writing this report more than any other University programme that I have undertaken to date.

I was rather nervous about conducting this report due to my limitations when it comes to grammar and expressing my thoughts into some form of written language. However, I feel that since completing this report I am much more confident in tackling these issues.

One reason which made me feel a little at ease was the fact that I could choose my own area of research. District Health Boards or the public health system in general has interested me for a very long time. I have worked in DHBs since completing my Bachelor's degree in 2003, and hope now that now my Master's degree is completed I will get back into this field again (unless I continue on with my University education?).

One of the key areas which I think is absolutely imperative to grasp when completing a research report of this nature is time management. It is so important that you manage and plan your time in an effective way as there is a lot of information to process within a short period of time.

Another important aspect is to pick a topic which you are either interested in, or would like to become interested in. You do live and breathe the topic while you are conducting this report, so something that you are passionate about is very important.

The reason why I chose Corporate Governance is that I am extremely interested in learning about the inner workings of organisations, but especially the workings at the board level. I think that it is tremendously important that boards function efficiently as this does have a flow on effect in organisations, and if the boards are not effective then the organisation also suffers.

I have learnt an array of new skills while conducting this research report. These are mainly:

- The ability to think critically when reading a vast amount of literature;
- The ability to formulate and expand on other people's ideas and concepts to evolve these into ideas and concepts which would fit into a New Zealand perspective;
- The ability to take notes in a logical manner, so that when I review these notes some weeks later I can easily recall the knowledge that I had learnt.

All of these skills are an essential skill for any manager to have. The ability to recall information, the ability to critically analysis information and to create your own thoughts and feelings on particular topics are also important for any manager.

Managers need to be able to tackle multiple tasks at once, and I feel that this research report has helped me to build my skills in this regard.

Once again, I really enjoyed researching and writing this report, and I hope that you also find it interesting and informative.

Corporate governance in the New Zealand public health sector: a 152.785 research report presented in partial fulfilment of the requirements of the degree of Master of Management (Management) at Massey University, Albany, New Zealand

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