

ANALYZING CORPORATE GOVERNANCE IN CZECH AND NEW ZEALAND HOSPITALS

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Abstract

Business corporate governance principles have recently been discussed in the managerial literature in regards to management practice in the public sector. Health services rank among the largest public sectors in OECD countries. Efficient governance of hospitals requires the responsible and effective use of funds, professional management and competent governing structures. This paper compares and contrasts hospital governance in two plural health care systems – Czech Republic and New Zealand. Both countries have a history of economic and structural reforms that has resulted in changes of the health care sector and hospitals in particular. Similarities and differences in management ideology and practice are identified and a functional model that addresses four issues that are integral to effective governance of hospitals are discussed.

Good governance can attain better performance and better management in businesses as well as in public institutions. As Wolfensohn (1999:21) tells us “the governance of corporations is now as important in the world economy as the government of countries”. Traditionally, three groups - the board of directors, top management and creditors - govern the organisation in addition to shareholders (Post, Lawrence & Weber, 2002). The board of directors is a central factor in corporate governance as they hold the legal responsibility for establishing objectives, and reviewing management’s performance to be sure that the organisation is well run. This paper addresses the issue of governance in hospitals which are the major corporate structures in health care sectors.

Corporate governance is characterized by the supply of external funding to an organisation, a functional legal framework, and active capital markets (Shleifer & Vishny, 1997). It is based on ownership concentration, where an easily recognizable owner, such as the state in the case of publicly owned hospitals, plays a central role in taking care of the organisation and its continuous development. Good and functional corporate governance is related to adequate corporate performance. Boards of directors are responsible for governing organisations. Board size and structure average eleven members (Post, Lawrence & Weber, 2002). Some board members may be politically appointed; some may be professionally trained while others may be elected from a list of candidates. Some studies confirm that corporations with active and knowledgeable boards perform better than their counterparts with weak and uninterested boards (e.g., Millstein & MacAvoy, 1998). Cadbury (2000) speaks about the connection between a *firmer grip* of boards of directors on organisations, which forces managers to be more accountable and productive.

Corporate governance of hospitals and health care organisations is based on appropriate managerial models, distinguishing between traditional (in business sense) profit making

organisations and non-for-profit institutions. However, it cannot be assumed that such categorization would affect corporate performance *per se* because effective corporate governance is based on many different but inter related factors. These include: the overall system of health care services in a respective country, historical continuity, and preferred ownership mode. Also the relevant corporate governance literature on the public health care sector is less developed than in the business sphere (Clatworthy, Mellet & Peel, 2000) and it should be noted that corporate governance principles cannot be simply installed in public sector. Rather these have to be modified according to the sector, industry, and organisational context (Hodges, Wright & Keasey, 1996).

Three different types of health care systems are distinguished in the literature (Střítecký & Pirožek, 2002). A *liberal* health care system prefers private ownership of health care organisations; in a *plural* health care system, both private and public ownership are recognized; in a *socialistic* health care system, all the health care organisations are owned publicly. Corporate governance principles in the liberal system are applied in the same way as in the business sphere. The plural system identifies the owners and from that perspective the owners are responsible for efficiency and high corporate performance. As proposed by numerous scholars (Hodges, Wright & Keasey, 1996; Clatworthy, Mellet & Peel, 2000) corporate governance principles ought to be applied in the public sector, particularly in health care organisations, including hospitals.

However, the literature on plural and socialistic models remains underdeveloped, and it provides little guidance to practitioners and researchers in the area. Nonetheless, hospitals face similar problems to their business counterparts – how to protect owners, investors, against creditors and selfishness (and in extreme cases, of unethical behaviour) of managers

and other stakeholders, and how to develop and maintain good image and financial stability (Hashi, 2003).

This paper reviews corporate governance in hospitals in the Czech Republic and New Zealand. First we provide an overview of key features of each country's health care system. Then, we compare and contrast corporate governance in their hospitals. Finally, a functional model that addresses four key issues which may further develop corporate governance structures in both countries is proposed.

A comparative overview of Czech Republic and New Zealand health care systems

This analysis compares and contrasts the health care systems of two distant countries – the Czech Republic and New Zealand. While each country is different in nature, historical circumstances, economic performance and geographical location, several similarities between the two countries' health care systems are apparent at a macro level of analysis. Table 1 demonstrates close similarities in several key indicators between the two countries. These include health expenditure as a percentage of GDP and per capita, the number of practising medical staff - nurses and doctors, and the number discharged from hospital. Each country also has a reputation for delivering high quality health care in their respective regions (European Observatory on Health Care, 2000; Ministry of Health, Wellington, 2000).

Historically, two kinds of public health systems existed in Central and Eastern Europe (CEE). Before WWII, plural systems operated. These were replaced by the socialistic model until the plural system was re-established after political changes in 1990s. The Czech Republic has been labelled as a 'transition economy' since the collapse of the Soviet Block in 1989 but having recently joined the European Union in May 2004; it now should be regarded as a typical OECD market economy. Public health systems in CEE, including the Czech Republic,

are based on mandatory health insurance of each individual. Health care insurance companies invest in health organisations on the basis their declared financial performance. The state covered state budget covers the bulk of hospital's expenditure but selected medical procedures may require a small patient surcharge.

Table 1. Comparison of the Czech and New Zealand health care systems

	Czech Republic	New Zealand
Population (thousands, 2003)	10,246	3,994
Area (square km)	78,866	268,680
Capital	Prague	Wellington
GDP per capita (PPP, USD, 2003)	15,700	21,600
Health expenditure as a percentage of GDP (2002)	7.4	8.5
Health expenditure per capita (PPP, USD, 2002)	1,118	1,857
Practicing physicians per 1,000 population (2002)	3.5	2.1
Practicing nurses per 1,000 population (2002)	9.4	9.4
Discharges (all causes) per 100,000 population (2002)	21,861	20,555

Data source: Central Intelligence Unit (2004), OECD (2004)

Since the 1980s, New Zealand has undertaken substantial economic and health care reforms and has been reported as a world leader and “*success story across the globe*” (Kelsey, 1997:vii – emphasis original) in structural economic reform including the management and governance of hospitals in the health care sector. Economic changes included removing controls on prices, wages, interest rates, rents and credits were replaced by a monetarist anti-inflationary regime, operated through a policy of high interest and exchange rates. Export and domestic subsidies were eliminated. Import licenses were abolished and dramatic tariff reductions imposed. The emphasis moved from direct to indirect taxation. A universal goods and

services tax (GST) was introduced in 1986 to cover all final domestic consumption including food. The welfare state was also corporatized (Hall, 1994; Kelsey, 1997).

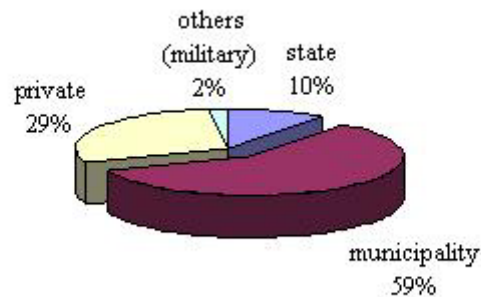
Both countries have experienced political and economic change, particularly in the last decades and now have plural health care systems with a declared universal right to free hospital health care. Each country has also experimented with greater competition among hospitals and with enforcement of their efficiency, quality and responsiveness (Docteur & Oxley, 2003).

Corporate governance of Czech hospitals

In the current Czech system, hospitals guarantee quality and accessibility of health care for everyone and to serve that purpose they have to become financially stable and efficient. However, the majority of Czech hospitals record financial losses (Střítecký & Pirožek, 2002), which are caused by a range of obligatory medical operations not covered by mandatory health care insurance. Figure 1 shows the breakdown of ownership of hospitals in the Czech Republic. Fifty-nine percent out of 201 hospitals are owned by the state and municipal government. Others, including military, state, and municipal hospitals are non-for-profit institutions; while private hospitals operate on profit-based principles. There are no private not-for-profit owned hospitals.

State hospitals are mainly university clinics and they are highly specialized facilities. State and military hospitals have usually simple organisational structures with a top manager (called a Director), who reports to and is controlled by a given state department (Ministry of Health, Ministry of Defence). Such hospitals have neither a board of directors nor a supervisory board. This raises an important issue about whether the state is a good,

responsible, and enlightened owner of any institution, but this concern is beyond the scope of this paper.



Source: Institute for Health Information and Statistics, Czech Republic (2004)

Figure 1. Ownership of hospitals in the Czech Republic

Hospitals owned by municipalities (districts, towns) are regional, both non-specialized and specialized health institutions. Such hospitals do have boards of directors, consisting of employees, municipal representatives and business professionals. This composition facilitates a close relationship between owners and managers. Interests of these three groups are usually quite distinct from each other and therefore corporate performance is not always regarded as the most important objective. Accordingly, disputes among the different in-groups result in higher autonomy of management at the expense of owners. In the Czech Republic, the possibility of transforming such hospitals into publicly owned companies, i.e. changing their legal status from public hospitals into publicly owned enterprises based on profit principles, where owners would remain municipal authorities has recently been discussed. However, Střítecký and Pirožek (2003) argue that controlling of overall performance, organisational structure and division of competencies would be better, but no substantial change is expected to happen. Williamson (1999) sees a clear relationship between competence of management and governing bodies and the overall success of organisational governance.

Privately owned hospitals are divided between basic health care or on narrowly defined luxury areas such as cosmetic surgery. Ownership structures are clearly defined and such hospitals operate under standard business principles. Continental European law defines a two-level governing model, where a board of directors consists of company managers and a supervisory board represents owners. Profit orientation is reflected in an organisation's strategic goals. Overall, private hospitals are no different to other businesses and corporate governance is directly focused on issues of effectiveness and profitability.

Corporate governance in CEE hospitals is defined and determined by the owners' relationships with managers and there are unique governing structures in different types of hospitals. The recent transformation of the health care system and the resulting interactions among stakeholders has culminated in a situation where personal concerns often come before corporate performance (Nemec *et al.*, 2002). Because of the various ownership structures, the governing principles are often inconsistent and they fail to emphasize the roles and activities which are supposed to be carried out by managers and owners. Members of the governing and control bodies are not confident about owners' expectations and goals. Owners seem to be barely interested in organisations, which they were mainly gifted during the transition process, and if so they are likely to confuse the owner's role with management tasks. Hospital managers are often appointed for 3 to 5 years term by the municipality or the governmental authority according to their ownership.

There has been a lack of efficient control mechanisms and strategic planning recorded in the Czech hospitals. Nobody takes the overall managerial and owners' responsibility for the property and its development. However, it is not surprising that this is the situation in hospitals given that the governing corporate structures in business in CEE are often reported

to be insufficient or less developed in general (e.g., Mallin & Jelic, 2000; Gillies, Leimann & Peterson, 2002; Peng, 2004).

Corporate governance of New Zealand hospitals

Since the mid 1980s New Zealand's health care system, in common with those of other western countries, has been subject to continual restructuring and redesign in attempts to contain the rapidly rising costs of health care. As part of those changes public hospitals which account for a large proportion of the health care spending, have been subject to major restructuring resulting in extensive changes to the ways in which treatment and care are delivered to patients and hospitals are managed and governed (Finlayson & Gower, 2002). For example, in 1991 public hospitals were converted into 23 competitive Crown Health Enterprises (CHEs) administered by boards of directors appointed by the Minister of Health for their management skills.

Currently, public hospitals are divided into geographical areas called District Health Boards (DHBs). Funding for each of the 21 DHBs is population-based, i.e., it is done on the basis of the particular requirements of the people living in the geographical location. The primary key performance objective of the health care system and of each DHB is to attain a fair and functional health care system that is effective in contributing to the health of New Zealanders (Ministry of Health, Wellington, 2004). Board members are accountable for governing hospitals in their district. Although they have to maintain the financial stability of the hospitals, their major goal is 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, Wellington, 2004). It implies that the goal of health service delivery is superior to economic performance.

Each DHB comprises of 11 directors; seven of whom are elected through a public election system for three years term, and the rest are appointed to positions by the Minister of Health. The Chief Executive Officer of the hospital is appointed separately by the board. Care is taken to ensure representation from all of the different community stakeholder groups (there is a legal requirement to appoint at least two Maori members to represent interests of New Zealand indigenous people). A small compensation (approximately US\$ 13,000 annually) is paid to a board member. The elected DHB members are legally required to establish consultation processes whereby providers are users of health care service, and the community has an opportunity to have an input into the major decisions made by the boards. Each board is subject to monitoring and an audit of both health and economic indicators of the hospitals, which is carried out by the DHB Funding and Performance Directorate.

Whilst not expected to return profit to government, hospitals are expected to operate within pre determined fixed budgets (Hall, 1999; Ministry of Health, Wellington, 2000). The majority of hospitals are either state owned and funded, or privately owned and partially funded by the state. Although all citizens are entitled to receive state funded free medical and surgical hospital care, those who choose to go to a private hospital and who do not have medical insurance must pay for services they receive. The private hospitals are owned and managed by private medical insurance companies, individual investors or public charities. Their governing principles do not differ from those of businesses and respond to needs of their owners.

Comparing the governance of public hospitals in the Czech Republic and New Zealand

Models of corporate governance are influenced by tradition and the notion of legality. The aim of a health care organisation is dual – medical and economical (Pirožek, Střítecký &

Dvořák, 1998). Frequently, scholars identify national models such as German, French, American, or Japanese, of corporate governance (e.g., Cobbaut & Lenoble, 2003; Sun, 2003). Therefore, it might be expected that the structural form of hospitals' corporate governance could be determined by a national corporate governance tradition. Some aspects of this can be seen in the two hospital governance systems outlined in this paper.

Table 2. Comparison of corporate governance in public hospitals in the Czech Republic and New Zealand

	Czech Republic	New Zealand
Governing bodies	State hospitals – no board of directors or supervisory board Municipality hospitals governed by board of directors. Members are hospital employees, municipal representatives and business people. Different number of members.	Public hospitals divided into 21 District Health Boards, which serve as Boards of Directors for their hospitals. 11 members - usually employees and publicly known personalities.
Becoming member of a governing body	State hospitals – no governing body. Municipality hospitals - members appointed by town and municipality officials.	7 members elected through public vote every 3 years, rest appointed by the Minister of Health. At least 2 members must be Maori.
Member's pay	Usually small fixed pay for a meeting. Data N.A.	App. 13,000 US\$ annually.
Medical and financial targets	Vaguely set by the ministry, town or district.	Set by DHB Funding and Performance Directorate.
Accountability of a governing body	Indirect.	Subject to 'public' control. Indirect.
Competence of a hospital director	High competence and high autonomy over both medicinal and financial results.	High competence and high autonomy over both medicinal and financial results.
Accountability of a director	Moderate financial involvement in potential profits. Threat of redundancy.	Moderate financial involvement in potential profits. Threat of redundancy.

Controlling body	State hospitals – ministries: low direct involvement, subject to political changes, unfocused. Municipality hospitals – town and district representations: low involvement, subject to political changes, unfocused.	DHB Funding and Performance Directorate: low direct involvement, subject to political changes, focused.
	Czech Republic	New Zealand

Table 2 summarises the key features of the two systems. The New Zealand system reflects that country’s long established democratic and liberal political system, e.g., while board members are elected, some members are appointed so that all groups in society can be represented. The Czech Republic system includes elements of a transitional developing system, for example formal appointment procedures do not exist and there is a general absence of performance goals (in contrast to the institutional support by DHB Funding and Performance Directorate in New Zealand). The lack of formal procedures and performance indicators is consistent with findings about generally poorer corporate governance in CEE (e.g., Peng, 2004). Financial rewards for members of governing bodies are not dependent on hospital performance in either country and directors have a final decision making power without being personally liable for hospitals’ performance.

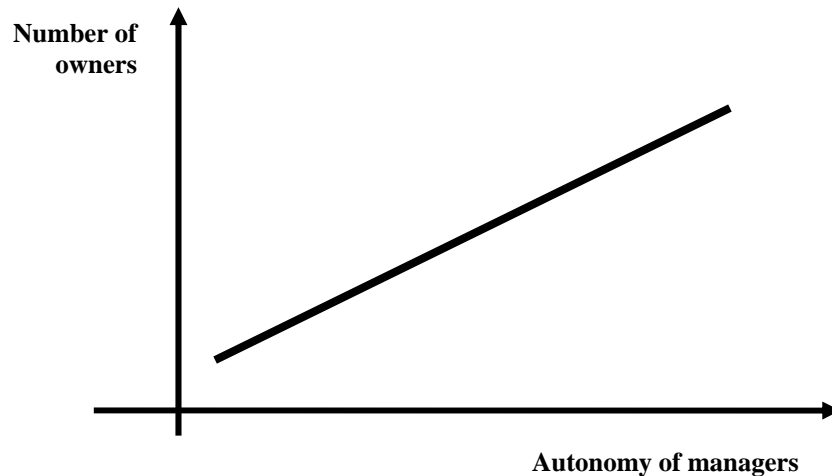
A proposed functional model for effective corporate governance in hospitals

Optimal (i.e., functional) corporate governance usually represents a compromise among the owner, owner’s representatives, managers and stakeholders. Functional models are expected to be fairly simple and to reflect owners’ expectations in regards to managers. Health organisations are expected to deliver accessible, quality health service for comparable costs. In the case of publicly owned hospitals, the emphasis on balanced books will probably remain unchanged in the future. The main distinction should be in multi-criteria set up by owners;

owners that are defined and which representatives are willing and able to emphasize owners' interests. It implies a need for higher interaction between owner's representatives and managers. The aiming at high level of responsibility means that owners feel inseparable from covering losses and participating in profits of their property (Mises, 1966).

The owners' responsibilities for performance efficiency cannot be easily delegated to managers. Managers usually contribute to and share organisational profits with owners. However, their liability for losses is limited. A loss-making business will not always directly affect the welfare of a manager. A manager can never take over the role of the owner. It is absolutely necessary to make a distinction between a manager and an owner, not only because of the capital allocation but mainly due to the different levels of responsibility (Hayek, 1948). As the needs of the public stakeholders are unknown, largely because they are not communicated and there are diverse groups of people with variety of interests. Therefore, it is impossible to address each individual need. Representatives in the governing bodies or a director may promote their own individual goals or those of their hospitals instead of the community's. More attention may be paid to the delivery of health services than to its economic efficiency.

Figure 2 demonstrates that hospital's managers may utilize a higher level of autonomy when handling the property of numerous owners and stakeholders. Because the public hospitals' owners appear to be anonymous, controlling and monitoring is not supposed to be carried out by another public authority but rather by the independent auditor appointed on the principle of competition.



Source: Pirožek & Střítecký (2003):26

Figure 2. The relationship between the number of owners and the autonomy of managers

It is suggested that a model for effective hospitals' governance should reflect the universal principles introduced by Hayek (1938, 1947) and Mises (1966), similar to businesses' governance models. Our model has two important characteristics - an owner's representative has to share the responsibility for development of capital infrastructure with the owner and with the manager, and the appointed manager must be capable of making a selection based on best alternatives and be ready to accept accountability for that decision. We propose a functional model to address the following four key issues:

1. Identification of the structure, competence and tasks for governing bodies and their members.

By structural identification, we mean a precise definition of governing bodies (owners' representatives, a board of directors, and a supervisory board) and of executive bodies (management). Their roles should be clearly identified and delineated (initiation, ratification, implementation, and monitoring - Jensen & Fuller, 2003). Molinari *et al.* (1993) confirm that hospitals with governing bodies comprising medical staff, a director and representatives

external to the organisation perform financially far better than hospitals whose governing bodies accommodate only people external to the hospital.

The New Zealand system meets this goal as it has a formal structure and requirement for election of seven of the eleven board members. Some clearly defined tasks are specified in that the board is required to consult with stakeholders before major decisions about the use of funds are made. Individual board members are accountable to their community and also to the Ministry of Health; however this accountability is neither personal nor financial. In the Czech Republic, there is no similar governing structure – a director carries out some defined tasks but is not required to consult with stakeholders. Thus the role of governing boards in the Czech Republic could be described as rather symbolic.

2. Professionalisation of governing bodies.

This is an important yet often overlooked part of effective organisational performance. Hiring of experienced, reliable, and accountable professionals in the areas of medical economics is a difficult task, especially when only few members of a governing body and management actually know the real impact of effective resources allocation (Hayek, 1937). Hospitals should prevent a common business practice of having large boards, or situations where people become ‘governing professionals’, serving on numerous boards simultaneously. Young, Buchholtz and Ahlstrom (2003) point out that serving on multiple boards reduces attention paid to each board meeting which undercuts the possibility of effective monitoring, pressure on management and potentially lowers corporate performance. Two ways for achieving professionalisation of governing bodies might be considered:

- Involvement of bodies’ members in the direct organisational responsibility through personal financial liability.

- Contracting a professional governing firm for a hospital with contracted unlimited corporate liability to owners.

Each way requires a person to perform the demanding, and responsible job of a board member in an efficient way. Organisational governing should be seen as high skilled and accountable work. Monetary reward may be offered in terms of a fixed or performance based bonus, accumulated and paid to a body member after the term of appointment. Clatworthy, Mellet, & Peel (2000) remark that without threat of instigating sanctions the minority of organisations would perform satisfactorily. Therefore in case of impaired results, the accumulated bonus would be preferentially used for covering losses of a hospital. Through that mechanism, the member of the governing body would remain highly involved in the economical output of the organisation. A small annual salary is paid to board members in New Zealand but no punitive measures exist.

3. Arrangements for key competence of governing bodies of hospitals.

In every organisation, management must be competent, i.e. must have abilities, skills, and the power to fulfil their responsibilities in relation to hospitals' both economic and service performance ((Taylor & Taylor, 1994; Weiner & Alexander, 1993). Managers must possess the knowledge to switch to alternative plans and to drive organisational development (Reinke, 1988). Care also must be taken not to ensure that people are not appointed to positions because of political influence or favouritism which often happens in public hospitals in CEE (Střítecký & Pirožek, 2003), and can occur in the appointment mechanism in New Zealand (Ministry of Health, Wellington, 2000).

4. Independent check of financial statements.

Hospitals' annual financial results have to be checked by independent auditors who are not appointed by health authorities, but externally selected based on market principles (Clatworthy, Mellet, & Peel, 2000). An independent check by an auditor will ensure that health organisations provide a true record of their financial situation. New Zealand DHBs are subject to a regular audit process to ensure funded services are being delivered and that they are financially viable, clinically safe and of a high quality, but the auditors are not appointed independently or externally to the public health care system (Ministry of Health, Wellington, 2000). In the Czech Republic, the control function should be undertaken by municipalities and ministries, but for governing bodies the control is not financial performance oriented.

Implementing effective corporate governance in public hospitals

We have contrasted two countries hospitals' governing systems. This analysis demonstrated that neither system complies with the general governing principles outlined in the literature. While public hospitals arguably are different to typical business organizations, they are probably not different in nature from private hospitals. Therefore public hospitals ought to be capable of delivering similar financial and medical returns as their private counterparts. This paper suggests a model and practically oriented recommendations that should result in more efficient and effective hospital governance (see Table 3).

Key issues for public hospitals to financially succeed are: identifying and delineating of competences among members of a governing body, and between a director and a governing body; appointing professionals to boards; establishing personal accountability of each board member and a Managing Director for hospital performance; and appointing an independent auditor to check financial statements.

Table 3. Suggestions for the implementation of corporate governance in public hospitals

Key issues	Suggested implementation
1. Identification of the structure, competence and tasks for governing bodies and their members.	Governing bodies appointed by authority (ministry, town, or district) on the basis of selection process. Medical and financial targets set by authority.
2. Professionalisation of governing bodies.	Boards of Directors with odd numbers of members ranging from 5 to 9. Equal proportion between medical and economic professionals – hospital staff, a director and external professionals. No person can serve on multiple boards.
3. Arrangements for key competence of governing bodies of hospitals.	Direct personal liability of governing bodies and a director for both profits and losses. Members’ pay based on meeting the targets. High competence of a Managing Director with duty to consult with the governing body.
4. Independent check of financial statements	Independent externally appointed professional auditor. No subject to political changes focused and financially involved.

The proposed functional model of effective hospitals’ governance is based on the plural health care system. It is inevitable that highly specialized and basic broad health care institutions will remain publicly owned, because they are a public good. However, due to the high cost and limited demand, ‘luxury’ specialized health care will continue to be carried out in private hospitals. For all ownership structures, reliable and professional corporate governance is desirable. Amateurism and objectionable political interests must be avoided. Preventing individuals promoting their self-interest may be accomplished through defined contracts and through participation in the economic realities of hospitals.

The current state of hospitals’ governance in both countries might be attributed to a lack of public knowledge about efficient governing principles. The present situation may result in declining quality of health service. As Williamson (1999) suggests governance implies a performance-based approach to comparative assessment of organisations. Managing hospitals

inevitably has to be both economically responsible and viable in order to produce health services efficiently and in desired quality.

Conclusion

The transformation from current governing systems to the proposed one would require the change in socialistic (Czech Republic) and egalitarian (New Zealand) ideological perspectives. Changes in legal frameworks as well as in public perception of the role of a board member are topics for further research. In case of the Czech Republic, the recent EU accession may speed up the possible transformation. The possibility of change in New Zealand would be rather speculative.

According to the suggestions made in the functional model the most important characteristics of governing board members and managers are as follows: they have required competencies to govern or to manage; they have been professionally trained in the areas such as medicine and medical economics; they serve on one board only; and they are accountable, responsible and financially liable for their decisions. The model should also allow legitimate interests of the owner such as cost efficiency, maximizing performance and developing of infrastructure to be attained.

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