



The New Zealand Centre for Political Debate

Governments, Governance and Trust

The recent finding by Justice Asher in the Auckland High Court that a group of District Health Boards (DHBs) failed to adequately manage both a conflict of interest invoked by one of their board members being a senior party in a contract let by the board and a fair consultation process throws into doubt the efficacy of many of the processes undertaken by a very large number of 'quasi-autonomous non-governmental organisations' (quangos) established in the health care sector under the health reforms implemented since 2000. These agencies – principally 21 DHBs and over 80 Primary Health Organisations – are charged with disbursing practically all of New Zealand's \$10.4 billion taxpayer-funded annual health spend. At 21% of government spending, the health vote constitutes the largest single government spending category, and has been the fastest-growing, averaging annual growth of 8% per annum in the last 10 years[1].

Underlying the Asher decision is the principle that board members (directors) of any institution – be it a for-profit shareholder-owned firm, a nonprofit society or trust, or even a state-owned enterprise – owe their primary duty of decision-making care to the institution itself. These duties, known as fiduciary duties, reflect the degree of trust that shareholders, donors and beneficiaries have collectively placed in the board to act in their interests (the technical term is an 'agency responsibility' – the board members are agents of the shareholder/donor/beneficiary principals). The risk that any shareholder, donor or beneficiary faces when entrusting directors to make decisions in their interests is that the directors fail to discharge their fiduciary duties to the entity, instead opting to place their own personal interests[2] above those of the institution, and by extension, the interests of the shareholders, donors and beneficiaries. Wise shareholders, donors and beneficiaries will not entrust boards with resources and decision-making responsibility where there are insufficient means of detecting breaches of trust, or inadequate processes for dealing with breaches when they are detected.

The real challenge facing shareholders, donors and beneficiaries is determining what will be the best set of rules (governance system) both to discourage self-

interested director actions in the first place, and to detect them when they occur. As shareholders, donors and beneficiaries cannot monitor every decision themselves, they face an information disadvantage. A good starting point would be for principals to avoid appointing directors who will likely be compromised by personal interests in the first place. The old adage of not placing the fox in charge of the henhouse serves as a good principle for corporate governance as well as for animal welfare.

However, it is not always possible to avoid all conflicts. Disclosure of conflicts, and the removal from any part in the decision for any directors with potential conflicting interests, as recommended in the Securities Commission governance guidelines, and laws governing the use of insider information and tipping, provide some assurances.

Lesson 1: The farmer can hardly blame the fox for engaging in self-interested actions if he knowingly put the fox in charge in the first place. If only foxes are available to guard the hens, then a wise farmer will shackle the foxes with credible and reliable restraints.

An important counterbalance in governance systems is the ability for the principals, having been informed of the conflict or breach by their agent, to take prudent remedial action. Nonetheless, the problem remains of detecting a risk or breach in the first place. A partial solution is the joint and several liability of directors.

If all directors are individually liable for the costs and consequences of the actions of any one of their number, there is greater assurance that all directors will actively monitor each other, take responsible actions that allow breaches to be detected, and act swiftly to discipline any director who acts in breach of trust. But the penalties for failing to act in his manner must be severe – for example, immediate exposure of the breach and the loss of personal reputation, leading ultimately the loss of current and future income streams from working as a director, as directors in breach will be unlikely to be trusted again by any potential principal. The efficacy of the threat of sanctions in ensuring compliance is, however, only as good as their credibility. If the sanction is difficult or costly to carry out, or principals have little willingness to enforce it when

breaches occur, then the threat is hollow. The likelihood of breaches occurring and principals' interests being impaired increases markedly. Whilst it is beholden upon the board members to monitor each other, take appropriate actions to manage conflicts, and report breaches immediately to the parties with the power to sanction the members concerned, ultimately, it is the responsibility of the originating principals to ensure that the systems in place are satisfactory before handing over resources and/or responsibility.

Lesson 2: The farmer sets the rules that govern the henhouse before handing it over to the foxes. When he discovers mayhem in the henhouse, he shoots the fox that broke the shackles, and shoots the other foxes because they failed to either stop her or alert him. For if they had stopped her or alerted him in the first place, there would be no mayhem to discover. But if the farmer fails to shoot any of the foxes, they can cause mayhem again. Foxes learn fast that the farmer won't shoot even when they break the rules. This knowledge assists them in their choices when they guard the sheep as well as the hens.

Citizen/Government Farmers and Healthcare Quango Foxes

In light of these principles of governance design, it is apposite to examine the rules and processes that have been put in place to protect the interests of taxpayers and patients in respect of the management of the fifth of the tax take spent in the health sector. Whilst some of this money is managed directly by the Ministry of Health, the bulk of it is transferred on a per capita basis immediately to DHB and PHO quangos. These entities are charged with purchasing and/or providing health and disability services to New Zealand citizens (beneficiary-principals). In the case of DHBs, some services are provided by the entities themselves (e.g. services provided from DHB hospitals) and some are contracted from private sector providers (e.g. the Auckland contract for laboratory services). The primary responsibility of PHOs is to enter into contracts for the provision of co-ordinated primary care services – at the current point of time principally general practitioner and nurse services.

The members of DHB boards are comprised of two types – individuals appointed by the Minister of Health, and individuals elected by the relevant communities on a three-yearly basis during the local body election process. It is quite conceivable that individuals with vested interests may be either elected or appointed. For example, a DHB employee or someone associated with a firm with whom the DHB either has, or may in the future, enter into a contract may be elected. The individual may also be associated with, or even in direct commercial competition with, parties who have or may in the future have contracts. At the very least, such interests should be disclosed at the time of nomination for election, or if the conflict arises after

election, as soon as the potential conflict is identified. It would appear to be negligent for the Minister to appoint an individual with a prima facie conflict of interest, without specifically taking some responsibility for identifying and declaring the nature of the conflict, and ascertaining that processes are in place to preclude the ability for the conflict to be exploited. It would also appear to be appropriate for the Minister to commission reasonable monitoring in order to be assured that no liberties are taken, and to facilitate the swift imposition of credible sanctions. Should a declared conflict or breach be untenable to voters, the declaration allows the electorate to voice its opinion at the next election. The Minister has the power to remove an appointed board member at any time.

The recent case before Justice Asher reveals inadequate processes in relation to at least one contract and one board member of the DHBs involved. The especially telling point of the Asher judgement is that the DHB governance processes were insufficient to either prevent a breach occurring or invoke action when it did. Quite simply, the governance processes designed by the entities who entrusted the DHBs with resources and decision-making powers (i.e. political agents of taxpayers and citizens) failed. The relevant conflict was revealed not by the board members themselves, a vigilant Minister exercising prudent oversight or even a concerned taxpayer, patient or constituent assessing board performance, but by an unsuccessful tenderer. It is extremely fortunate that, as a consequence of DHBs being statutory government bodies, their processes and decision-making are subject, under the wider governance arrangements in the New Zealand legal process, to the scrutiny of judicial review. This element of governance design enabled the exposure of not only a flawed set of decisions and processes, but also the ability to scrutinise the efficacy of the governance arrangements under which such a significant amount of taxpayers' funds are disbursed. Whilst there are clearly individual accountabilities for the individual board members concerned, there must also be some accountability for the design of the system itself. The design responsibility lies clearly with the Minister and the Ministry of Health, who oversaw the implementation of the DHBs from 2000.

The inability of the DHB governance arrangements to adequately handle the conflicts associated with the Auckland laboratory contract must therefore raise concerns about the governance design efficacy of other entities created to disburse the ever-growing amounts of taxpayer funds in the health sector. PHOs have also been established with the explicit purpose of administering all contracts for the provision of government-subsidised primary health care. In the absence of providing any treatment themselves, the only substantial activity undertaken by PHOs is the administration of contracts with a variety of health care providers (albeit that this activity requires a substantial

amount of reporting to be done to Ministry and DHB entities). Whilst this activity includes consultation with communities and providers, it occurs in the context of using the information gathered to assist in the design and development of the contracts under which subsidised care will be co-ordinated and supplied.

It is of extreme concern, therefore, that it is a condition of the funding agreement between the government and PHOs that providers must be represented in the decision-making arrangements of PHOs. The very type of conflicts that, as a consequence of electoral (mis)fortune, arose when an interested party found himself on both ends of a contract to provide his services to the DHB, are actually mandated as the expected state of day-to-day decision-making in the governance design of PHOs. Every one of the more than 80 PHOs in New Zealand must have foxes in the henhouse if the hens are to get any of the farmer's corn. At the very least, it would be expected that the foxes would be very tightly constrained.

Yet there are no explicit government requirements about how PHO decisions will be made and how the conflicts are to be managed. As long as the henhouse management committee is made up of both hens and foxes, the farmer leaves them to get on with the decisions about allocating the corn themselves. Conflicts are not just potential – they are as real as the one examined by Justice Asher. Many PHOs have entered into management contracts with companies owned by the self-same GPs who sit on the board of the PHO. In turn, these management companies have the constitutional power to appoint the board members who made the decisions to let the contracts in the first place[3]. And this does not even take into account the contracts for provision of services.

Analysis reveals that service providers (predominantly general practitioners and nurses) make up between a third and a half of the board members of most PHOs. These members are conflicted in every service design and contracting decision made by the PHO – that is, in every meaningful activity that the PHO takes. By lesson 1, it has to be questioned why they are there in the first place, given that their fiduciary duties are to protect the interests of the beneficiaries (i.e. subsidised citizens). By lesson 2, in order to provide credible assurance to beneficiaries that standards of conflict management undertaken are of the level denoted as acceptable by Justice Asher in the Auckland laboratory case, service provider board members would have to exempt themselves from every service design and contract-letting decision (i.e. every meaningful activity) undertaken by the PHO. The shackle must be so tight that it prevents the foxes from undertaking any corn management activity in the henhouse. The simplicity of the analogy reveals why it is in fact inappropriate in well-designed governance structures to have the fox there in the first place. The costs of restraint are so great (i.e. the risks are so great, and the costs of providing credible assurances so substantial) that the most satisfactory means of managing the problem is by not invoking it in the first place.

So why would the PHO governance requirements have been established by the government in at all? Justice Asher's rulings on consultation requirements provide some insights. The PHO governance arrangements appear to have emerged because service providers, as stakeholders in the primary health care market, have information about the services they provide and the means of co-ordinating services, that will assist PHOs in carrying out their duties. Stakeholder governance models suggest that boards comprised of representatives of all stakeholder groups are a good source of information upon which to base decisions. If all stakeholders are represented, by this reasoning a 'balanced' decision, taking into account the views of all stakeholders, can be made.

The difficulty with 'representative' decision-making bodies is, however, that 'representation' can get confused with 'consultation'. If boards rely upon conflicted decision-makers to provide information, it invokes the risk that the conflicted individuals may distort both the information provided and the decisions made in their individual favour. In order to overcome this problem, sound governance processes would require consultation to be undertaken to verify the truthfulness of the information provided. If consultation must be undertaken anyway, then what additional value do the conflicted members bring to the table? If consultation must be undertaken anyway, they add no special skills or knowledge to the decision-making process that consultation could not surface. Yet they also bring with them the added risk that their mere presence creates a level of suspicion that is costly to manage, and would be avoided altogether if they were not there. It is simpler, less risky and more cost-effective not to have them there in the first place, and rely upon consultation processes to surface the necessary information. The conflict is avoided. The potentially conflicted party's involvement with the organisation is confined to a contractual one where the roles are both sides are clear, transparent and unconflicted[4].

Moreover, if stakeholder governance models are to be truly credible, they also carry with them the requirements that all representative board members be directly accountable to all members of their constituent communities. That is, all beneficiary representatives must be elected via transparent processes that enable all beneficiaries to have a say in who represent them, and to exert sanctions (e.g. via voting processes) in cases of breach. Likewise, all provider representatives must be transparently accountable to all current and likely future service providers. In practice, the constitutions of the vast majority of PHOs that I have studied provide no such representational assurances. Service provider board members are most often appointed by strong stakeholder groups such as Independent Practitioner Associations, thereby shutting out representation of service providers not already in these 'clubs' or from different service provision paradigms (e.g. alternative health care providers). Community representatives are often nominated by special interest groups (e.g. who have no direct accountability to

the vast majority of the relevant citizens served, or taxpayers in general). Few are appointed by transparent election processes in the manner that community representatives are appointed to DHBs as part of the triennial local body elections.

In summary, then, the PHO governance arrangements are neither good models of stakeholder governance nor good models of interest conflict management. It begs the question of who will identify the risks and consequences of conflicted actions and who can sanction the decision-makers, even if a conflict is identified. The answer does not appear to inspire confidence in the ability of either of these outcomes arising. Unlike the DHBs, the PHOs are not statutory bodies subject to judicial review. Indeed, they are not even subject to the requirements of the Official Information Act. If all conflicted service providers are already involved in the governance web via their professional bodies, who will contest a conflicted service delivery decision? Whilst community representatives may be able to draw attention to the conflict, what effect would it have? Such disclosure cannot affect an election outcome. At best, it might create a media furore, leading to patients changing PHOs. But as most PHOs are local geographical monopolies, there are no competing PHOs for consumers to switch to. At worst, it might lead to intervention by the DHBs or the Ministry. Yet this is all academic, as no such concerns have been raised by the community representatives of boards letting conflicted contracts. And no actions have been taken. Because the governance arrangements set in place have ensured that, unlike the DHB case, information will not be easily revealed and satisfactory sanctions are not readily available to disaffected stakeholders.

The health care governance systems and processes covering over 20% of government expenditure appear to defy most rational principles of sound governance design. Ultimately, responsibility for this shortcoming lies at the feet of the politicians who have established these systems, and the ministerial officials who advise them and carry out the disbursement processes. Questions need to be asked about

what will be done to redress the problem. Justice Asher has dealt with one of the symptoms, but the underlying cause lies elsewhere. The 'wolf in sheep's clothing' who let the foxes loose in the henhouse without adequate restraints bears much of the responsibility. How will that wolf be called to account?

Footnotes

[1] Treasury's (2005) Key Facts for Taxpayers <http://www.teasury.govt.nz/budget2006/taxpayers/default.asp> and New Zealand Treasury 2005 Briefing to the Incoming Government 2005:Sustaining Growth.

[2] Self-interest must be viewed in light of all activities of the firm. Of especial concern is the ability to affect contacting processes – that is, the search for contract partners (including influencing the terms of reference), negotiating the contact, defining its terms, monitoring its performance and enforcing performance in the event of breach. Other important issues concern the access a board member has to sensitive information that may be used for personal gain. This includes, but is not limited to, insider trading and the use of information to provide undue advantage to the conflicted board member in any activity other than that associated with the entity being governed.

[3] See, for example, Howell, Bronwyn (2005). Restructuring Primary Healthcare Markets in New Zealand. Wellington, New Zealand : New Zealand Institute for the Study of Competition and Regulation. <http://www.iscr.org.nz/navigation/research.html>

[4] Jensen, Michael C. 2001. Value maximisation, stakeholder theory and the corporate objective function. *European Financial Management* 7(3): 297-317

Bronwyn Howell is Programme Director, Post-Experience Programmes at Victoria Management School, Victoria University of Wellington, and a research associate at ISCR. She has held management positions and undertaken research

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