A Response to Vaithianathan's The Failure of Corporatisation: Public Hospitals in New Zealand

By

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Rhema Vaithianathan's article The Failure of Corporatisation: Public Hospitals in New Zealand (*Agenda* 6(4) 1999 325-338) argues that corporatisation of New Zealand's public hospitals failed to yield the expected efficiency results due to the failure to recognise that the change in formal authority from an executive team comprised of medical staff to one comprised of professional managers belied the unchanged nature of real authority, which remained with medical staff, and in particular, with doctors.

However, this explanation fails to recognise that the model on which it was based has been applied successfully for many years in New Zealand's private nonprofit hospitals. These nonprofit hospitals are managed by professional managers, are staffed in most instances by the same medical personnel as the state-owned hospitals, and are constrained by essentially the same "political ownership" issues of separation of legal and beneficial ownership, and real and formal control, as the public system. Hence, the issue is not one of failure of corporatisation per se, but a fundamental failure by policy-makers to sufficiently scope and fully understand the range of stakeholders' rights impacted by the change.

While the arguments posed by Vaithianathan highlight many of the stakeholder forces operating within a public hospital environment, the discussion focuses on a set of symptoms rather than the cause of the failure to successfully implement the corporate model. This cause was a significant change in the balance of both real and formal authority at the executive level away from representatives of the interests of one of the principal stakeholders in the public hospital system: the patient clients. The resulting change created a vacuum in representation of these interests at the executive level which medical staff, as the only remaining patient-agents left close to a senior executive level, rushed to fill.

The resulting disequilibrium was exacerbated by the concurrent significant weakening of public owner representation in the decision-making process as political representation was further distanced via the replacement of elected bodies by appointed boards with no direct accountability to the public, and the conscious disassociation of politicians from both the purchasing agendas and ownership responsibilities attendant in the public health system. The inevitable result was that the public advocates closest to the ownership of hospital control – doctors - filled yet another vacuum and assumed an unofficial but incomplete and hence imperfect political agency for public 'owners', strengthening their control position and consequently their ability to subsequently utilise this control for multiple agendas, including those furthering personal interests.

Ownership of Nonprofit Organisations

Hansmann's (1996) theories on the ownership of organisations provide a basis for understanding the dynamics of the change in New Zealand's public hospitals as a result of corporatisation. Hansmann theorises that, free of constraints, the ownership rights, with respect to both the right to residual returns and the right to control the firm, will devolve onto the group of stakeholders under which the total net benefits of the *firm and its stakeholders* are maximised[1]. These net benefits are dependent on both the costs of market contracting (market power, risks, information asymmetry, bargaining costs, patron preference costs, etc.) and the

[1] Hansmann (1996) p 48. Note that Hansmann refers to stakeholders as "patrons", and defines them to include anyone with an exchange relationship with the firm. This includes suppliers and customers as well as shareholders, managers and employees.

costs of ownership (governance, monitoring, costs of poor decisionmaking, costs of risk-bearing, etc.).

In certain circumstances, the overall most efficient outcomes for all stakeholders can be obtained where there is no effective formal control by any one set of owners – that is, the classic nonprofit firm[2]. These circumstances generally arise where there is one class of stakeholder for whom the costs of contracting and ownership are high, resulting in no one class of individuals to whom ownership can be assigned without creating severe inefficiencies. The stakeholders with high costs are typically customers suffering the effects of a severe information asymmetry leaving them in a poor position to determine, with reasonable cost or effort, the quality or quantity of services they receive from a firm. Assigning ownership to anyone but them creates the opportunity for severe exploitation, but due to their diverse spread and the relatively small value of the benefits transferred, the costs of including them in the control processes of ownership are too large. To overcome the high costs of ownership, the solution is to create virtual owners where managers of the firm hold it in trust for their beneficiary customers. "In essence, the nonprofit firm abandons any benefits of full ownership in favour of stricter fiduciary constraints on managers."[3] However, the efficiency of this system relies on the ability of stakeholders to monitor and enforce the performance of these fiduciary duties.

The evolution of hospital ownership in New Zealand recognises the strong informational asymmetries present in the health care market. Medical staff, and doctors in particular, as identified by Vaithianathan, hold a strong informational advantage over both patients and hospital owners regarding the form, quality and quantity of care or treatment required. By Hansmann's arguments, in order to overcome this advantage for the overall benefit of all stakeholders, there is a strong incentive for hospitals to be owned by patients. The solution to the practical difficulties of each individual patient having a separate ownership share is to adopt the nonprofit form. In New Zealand two distinct nonprofit hospital forms have evolved. By far the largest (95 percent of hospital services) is state ownership on behalf of patients, utilising the processes of political accountability to represent patient and public owner interests. Of the remaining 5 percent of hospital services, most are under the control of private nonprofit enterprises, where a group of trustees manage the hospital within a strictly defined set of fiduciary duties designed to minimise individual exploitation and preserve the rights of patients.

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[2] "Yet frequently – and especially in large-scale enterprise where the relevant classes of patron are sizeable – the efficient assignment of ownership is not so obvious. One reason is that, when the costs of market contracting are high for a given class of patrons, the cost of ownership are also high too, and for much the same reason: because it is costly for the patrons in question to become informed about how well the firm is serving them." ….
Such patrons are often efficient owners, despite their high costs of ownership. Even if they cannot monitor the firm's management effectively, and thus cannot exercise much control over the firm beyond that available simply through market transactions with the firm, it does not follow that there is no substantial gain from having those patrons own the firm. To use Albert Hirschman's felicitous terminology, it can be efficient to assign ownership to a given class of patrons even if, for those patrons, voice adds little to (the role of) exit in controlling the firm. An important reason for this is that, by virtue of their ownership, the patrons are assured that there is no other group of owners to whom management is responsive. It is one thing to transact with a firm whose managers are nominally your agents but are not much subject to your control; it is another to transact with a firm whose managers are actively serving owners who have an interest clearly adverse to yours.
In short, the costs of contracting for a class of patrons may be substantially reduced by making those patrons owners even if they will be very passive owners. …
In the extreme , where both the costs of market contracting and the costs of ownership are exceptionally high for a given class of patrons, the efficient solution is to assign ownership to none of the firm's patrons but instead to an unowned, or nonprofit firm." Hansmann (1996) p 48.

[3] Hansmann (1996) p 228

Nonprofit trustees are generally accountable to their beneficiaries via publicly published statements, a public election process, and where a membership status exists, to an additional set of fiduciaries with public accountability – the members[4].

However, in adopting the nonprofit form it is important to recognise that the fiduciary duties of managers must address both of the principal rights of their owner principals: the right to the proceeds (or benefits) of the organisation, and the right to control of the organisation. To balance the power of a strong stakeholder, in a nonprofit organisation both of these rights must remain in the control of the beneficiary-owners or their representatives. However, it is common to find two separate representative processes operating – one to account for the right to benefits (beneficial representation) and one to account for the right to control the organisation (legal representation). In the publicly-owned hospital, this separation applies with respect to the rights to benefits of hospital services when a patient enters the hospital for treatment, and the right of the general public to ensure their interests as technical owners of the hospital's assets are preserved in the operation of the business.

Beneficial and Legal Ownership and the New Zealand Hospital Reforms

Prior to the reforms and "corporatisation" of New Zealand's public hospital system in the late 1980s, there was a transparent attempt to balance these rights at the executive level. On one level, the clinical executive management team was directly accountable in its members' professional capacities to their patient principals for the elements of care relating to patient benefits, while simultaneously on another level it was accountable to the public owners in the capacity as agent of the legal owners, the elected Area Health Boards. By placing both agency relationships directly in the same management team, the public hospital management process replicated the dual agency present in the trustee managers of private nonprofit hospitals, who held responsibility for both clinical care of patient beneficiaries and the effective operation and maintenance of the hospital assets legally held in trust by the organisation.

While it is acknowledged that the public hospital beneficial and legal owner accountability processes were far from perfect, being subject to the effects of political leverage and the significant operational inefficiencies present in the middle and lower levels of the public hospital management hierarchy, this 'mutual agency relationship'[5] ensured that the public ownership issues, both beneficial and legal, were addressed simultaneously at the same table. These managers were subject to the dual disciplines of their professional accountability to patients and their employee accountabilities to political principals, requiring each decision to be made with both stakeholdings in mind. That is, they executed the two distinct fiduciary duties to the public owner simultaneously via two separate accountability mechanisms.

When professional managers were inserted at the executive level, any direct representative input from and direct fiduciary duty to patient beneficiaries in executive decision-making was lost. The principal accountability of these managers was solely to the legal ownership represented by the public owner in the form of the shareholding minister and his appointed board. All performance measures were solely aligned to discharging this ownership duty

[4] The legally defined members of a nonprofit organisation play an important role in both disciplining the board of trustees, and providing an additional avenue of representation for non-member beneficiaries in the decision-making process (e.g. Mason (1984), Howell (1999)).

[5] This term is used to reflect the ability of a dual agency in one body to work synergistically for the benefits of both agency relationships by reducing both the conflict and coordination costs of ownership identified by Hansmann.

(financial returns on assets) with patient-beneficiary advocacy relegated to second-tier clinical staff. As expected, the measurable and the incentivised activities were performed at the expense of the hard to measure and unrewarded[6]. Simultaneously, any capacity for either patient-beneficiaries or individual public owners to voice their ownership rights or call their fiduciaries to account in any individual hospital via a direct political process was eliminated when the locally-elected Area Health Boards were replaced by ministerially-appointed boards, whose fiduciary responsibilities were also clearly limited to the issues of legal ownership. Direct accountability to beneficiary ownership was thus restricted to the national parliamentary political process, which itself was intent on separating its accountabilities for purchasing (patient benefits) from providing (legal ownership). Each successive level of division further restricted the ability to balance both of the public ownership rights at the same table, and further disenfranchised the beneficial owner.

The end result had three significant impacts. The first was the local optimisation of each of the ownership processes, without consideration of the impacts of one on the other. The second was a significant increase in the cost of ownership in the health system, predictable from Hansmann's theories and evidenced by Ashton (1998), as the coordination of all the diverse interests which were previously combined in the single management structure had to be procured at financial expense, both in terms of explicit purchase of coordination, and the hidden costs of inefficient decisions made as a result of local optimisation in the interests of only one of the stakeholder ownership interests rather than balancing of both. This is illustrated by Vaithianathan's examples of holdup by doctors in the contract negotiation process, where optimisation of ownership interests represented by management clashed with optimisation of beneficial ownership interests represented by doctors, with the consequence that the combined beneficial and legal owner lost out on both counts, and had no ability to call the fiduciaries to account outside of a very remote generic political response via parliamentary representation and a triennial election process.

The third impact, the symptom recognised by Vaithianathan, was the move by doctors to fill the void of patient-beneficiary representation at hospital management level. While clinicians had been removed from key decision-making processes in executive management, as patient-advocates they were left closest to the hospital executive decision-making process of any of the patient-agents as a result of the restructuring. As restoration of the natural equilibrium required the patient beneficiary representation void to be filled, the patient-agents best equipped to fulfil this role – doctors - sought to gain some control of the executive process. However, without formal control, the only way that the equilibrium could be restored was by strengthening their effective control. Legitimate beneficial agency representation on behalf of their own patients was possible, but this limited stakeholder power base was too small to counter the strength of the legitimate ownership control exercised by management. Thus, by seeking, and gaining, wider public support for their representative activities, they assumed an informal proxy representation status for the otherwise disenfranchised wider public ownership.

The result, as Vaithianathan shows, was the increased political advocacy roles of umbrella groups such as the Medical Council and the Specialist Association. The effective power of these groups was increased by public support. However, as the representation was informal, it lacked the discipline of a specific accountability process with respect to the public's legal ownership stake. Consequently, there was little ability for the public to constrain the umbrella groups' use of their newly reinforced power to advance their own personal agendas as well as

[6] Holstrom and Milgrom (1991)

those of their public quasi-principals. While Vaithianathan's findings indicate that the real but unrecognised power of doctors was overlooked in the application of the corporate model, my analysis shows that this application of the corporate model actually *created an opportunity for doctors* to add an informal string to their agency bow *which actually increased their effective power* as it was unchecked by any formal accountability process. Opportunistic exploitation of this unbridled power was inevitable, with consequent efficiency losses which exceeded those incurred in the former imperfect, but more equitable, representative process.

This outcome, however, begs the question of how the private nonprofit hospital sector utilises this corporate structure without the same efficiency losses, given that in most instances, professional managers rather than medical personnel have traditionally filled the executive roles, and the same clinical staff employed in the public sector also work in the private hospitals. The key to this lies in a full stakeholder analysis. Generally, private nonprofit hospitals have two additional stakeholder classes which are absent in the public model – paying customers and donors. These two stakeholder classes exert an additional discipline on the management which is clearly lacking in the public model. Even though they make a part-payment, nonprofit hospital customers are nonetheless beneficiaries, as they receive a fee reduction as a result of cross-subsidisation from other fundraising. However, if the managers make a decision which breaches their beneficiary rights, such as the excessive personal opportunism evidenced above which increases the part payment required, the beneficiary group can discipline that management by voluntarily withdrawing their custom and patronising another nonprofit hospital[7]. Similarly, if donors perceive that their donations are not being applied in the manner intended, they will also withdraw their support. In either case, the private nonprofit hospital runs the risk of failure. These disciplines bind the behaviour of not only the managers, but also the trustees in the execution of their legal owner duties, to further the interests of beneficiaries.

The application of the public "corporatisation" model, as well as overlooking the interests of beneficiary owners, also overlooked the role of direct customer discipline of both hospital management and the management of purchasing authorities, by combining the purchaser and donor role into a single authority with no direct accountability to the beneficiary recipient outside of the political process. While the purchasing body could discipline hospital management by applying patronage constraints, beneficiaries could not discipline the purchasing agency management in any direct manner for hospital purchasing activities which impacted on their beneficial status. Again, this opened the market for patient representation to the professional umbrella groups. As they were already engaged in advocacy with hospital management, there were economies of scope available to these groups to extend that advocacy role to matters of beneficiary disenfranchisement at the purchasing level as well. Thus, public hospital management became hostage to holdup not only as a result of its own internal activities, but also as a result of the activities of the purchasing body. Vaithianathan's example of staff at one hospital refusing to carry out operations purchased on behalf of a second hospital is evidence of this. Again, while the patient-beneficiary may have gained some representation, the owner-beneficiary paid the cost, both of the advocacy and the efficiency losses due to any concurrent opportunistic advancement of agents' personal agendas.

[7] It is noted that medical insurance companies as customer-agents can also exert a purchasing discipline on nonprofit hospital managers and trustees, notwithstanding any beneficiary status.

Implications for Future Policy-Making

The failure of this particular corporatisation attempt should not, however, be interpreted as either a structural failure of the model applied, or as advocacy for replicating the ways of the past. The private nonprofit application of this structure shows that, with balanced stakeholding representation and accountability in the management and governance levels, there is a role for the corporate model in achieving greater operational efficiencies in a nonprofit, and hence state-owned, hospital environment. The Area Health Board structure, while offering some level of direct public input in hospital management processes, provided far from ideal representation due to biases and opportunism related to its own political accountabilities, agendas and purchasing power, and hence appears to offer little in the way of new approaches to the representation dilemma, especially given the reforms which have subsequently occurred in the rest of the health sector.

The real challenge for policy-makers is to examine the stakeholding dynamics of public hospitals and determine alternative ways of not just reintroducing direct public owner accountability, but also of introducing additional monitoring and disciplining mechanisms which measure and enforce the performance of the managers' fiduciary duties to *all* of their stakeholding principals. Furthermore, this must be done within the context of the wider publicly-funded health system, to ensure that reforms in the hospital sector do not create unexpected flow-on effects elsewhere.

The salutary lesson for policy-makers from the hospitals' experiment with 'corporatisation' of a state operation is that any changes that don't take into account the *full* stakeholding profiles of the organisation will fail. As state-owned organisations are nonprofit organisations, there must be a careful analysis in particular of the separate and distinct rights of the public as both beneficial owners and as ultimate legal owners of the organisation and its activities, and the rights and responsibilities of the public as customers. For in the final analysis, the primary stakeholders in any organisation are its owners and its customers – managers and employees are merely brokers who facilitate an exchange of value which, if well-designed, will enhance the position of both of these primary stakeholders. Hence, any change must look at the needs of owners and customers first. It was failure to give due priority to, in particular, the needs of the beneficial owner which precipitated the failure of the hospital reforms. The behaviour of doctors was a direct consequence of this, but not, as Vaithianathan argues, the cause of the failure.

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