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**THE CASE AGAINST ELECTING DISTRICT HEALTH
BOARDS**

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The word count is exactly 13,607 words, excluding the title page, table of contents, this sentence, the appendix, and the bibliography, but including substantive footnotes.

I Introduction

In this paper, I argue that elections to District Health Boards (DHBs) should be abolished. This argument comprises the first half of the paper. My argument has two broad steps. The first focuses on the elections themselves. It shows that most voters are uninterested in and uninformed about DHB elections. The second step focuses on the powers and limitations of DHBs. It shows that DHBs' primary function is to implement health policy set by central government, not to implement the wishes of or represent their electors. The combined force of these steps provides a sufficient reason to abolish DHB elections. In short, the lack of public interest and the degree of ministerial oversight means there is no real scope for democracy. Accountability mechanisms should focus on the responsible Minister. The second half of the paper determines what the alternative should be. It canvasses a number of possibilities. I conclude that the best alternative is that DHB Boards should be entirely appointed and that their consultation function should be carried out by a committee of a local authority.

The paper itself is structured as follows. Section I introduces the paper. It explains what DHBs are, what their role is and the institutional context within which they operate. Section II presents the first stage of my argument. It draws attention to the low level of turnout to DHB elections and the potential implications for democracy. It then highlights the problem of uninformed voting. These problems show that the public has little interest in DHB governance. Section III presents the second step of my argument. In highlighting the extent of ministerial control over DHBs, it shows that the public has good reasons for its disinterest in DHB elections. Next, it explains the positive consequences that would flow from abolishing DHB elections. This step constitutes the heart of the case against DHB elections. Section IV canvasses potential counter-arguments. It refutes counterarguments based on history, competence, democracy, representation, an analogy with local councils, and the nationalistic suggestion that New Zealand 'leads the world' in having elected DHBs.

The second half of the paper has two substantive sections. Section V sets out my recommended option for reform of DHB governance. It recommends a solution I call 'outsourcing consultation'. This entails a fully appointed DHB Board but with consultation carried out by local councils. I then provide an extended defence of consultation as a mechanism for ensuring that the will of the people is heard in DHB decision-making. Section VI evaluates and compares the alternatives. Effectively, it makes the case for outsourcing consultation by comparison with those alternatives. First, it outlines five alternatives and discusses them in general terms. I then progress four of those alternatives, by assessing them against the standards of compatibility with my own argument and certain external standards, namely feasibility, affordability, and quality of healthcare and governance. Finally, I demonstrate why outsourcing consultation is superior to the remaining alternatives that satisfied those standards. By the end of the paper, the reader should be convinced that DHB elections should be abolished.

A Institutional Context

It is widely accepted in New Zealand that the state has a vital role in maintaining the health of its citizens. New Zealanders have good health by international standards.¹ Health is the second largest area of government spending, comprising around one fifth of total expenditure.² This amounts to 83 per cent of total spending on health in New Zealand. The remainder is privately funded.³ Vote Health is the primary source of government funding for the health sector; over \$16 billion was allocated to Vote Health in the 2016/2017 Budget.⁴ Twelve billion dollars, or three quarters, of this funding will be provided to the DHBs.⁵

District Health Boards are statutory organisations which have primary responsibility for providing or funding health services in their geographical areas or districts. This includes running public hospitals, as well as assessing, monitoring and planning for the health needs of residents.⁶ They also fund community and primary health providers,⁷ mainly through primary health organisations (PHOs). These PHOs focus on prevention, not just curing problems.⁸ There are twenty DHBs.⁹ Each is governed by a Board of up to eleven members.¹⁰ Seven of those members are elected at the triennial local body elections.¹¹ Up to four remaining members are appointed by the Minister of Health.¹²

II Subpar Democracy

The quality of DHB ‘democracy’ is low. The public have little interest in DHB elections, and even those who vote do so based on inadequate information. This gives us reason to be sceptical about the utility of DHB elections and thus forms one part of my main argument.

¹ Jacqueline Cumming and others “New Zealand Health System Review” (Asia Pacific Observatory on Health Systems and Policies, 2014) vol 4(2) at 197.

² “The Estimates of Appropriations 2016/17: Health Sector” (The Treasury, 2016) vol 6 at 6.

³ “Background Paper for the 2013 Statement on the Long-term Fiscal Position: Health Projections and Policy Options” (The Treasury, July 2013) at 2.

⁴ At 6.

⁵ At 6.

⁶ Ron Paterson “Regulation of Health Care” in Peter Skegg and Ron Paterson *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 3 at 5.

⁷ At 5–6.

⁸ At 8.

⁹ *District Health Board Elections 2016: Information for candidates* (Ministry of Health, June 2016) at 1.

¹⁰ Public Health and Disability Act 2000, s 29.

¹¹ Section 29(1)(a) and sch 2(9).

¹² Section 29(1)(b).

A Low Turnout

There have been six DHB elections since 2001 (the most recent were held on 8 October). Turnout has always been low.¹³ Turnout to the inaugural 2001 elections was 50 per cent, and it has never been this high again. It dropped to a low of 42 per cent in 2004, rising slightly to 43 per cent in 2007. It increased to 49 per cent in 2010, before dropping again to 41 per cent in 2013. In contrast, turnout to the 2014 general election was 77.9 per cent.¹⁴ The final results for the 2016 local elections had not yet been released at the time of writing, but by all accounts, turnout was similarly disappointing.¹⁵ There is no reason to think that this year's elections have been any more popular or well-informed than previous elections.

Since 2004, elections to DHBs have been based on the Single Transferrable Vote system (STV). This replaced First Past the Post (FPP), which had been used in 2001. Under STV, voters in multi-member electorates rank the candidates by order of preference.¹⁶ This ensures as many voters as possible are represented on the DHB. Under FPP, voters in single-member electorates simply tick the name of their most preferred candidate. In essence, FPP results in a great deal more wasted votes (votes for candidates who do not get elected).

Gauld conducted surveys of electors following the 2001, 2004 and 2007 DHB elections. The surveys asked why non-voters did not vote, how voters made their choices, what voters looked for in a candidate and whether voters found STV confusing. The surveys found that, of those who did not vote, the most common responses were that the respondent did not know why not, did not know anything about the elections, did not receive voting papers or had no interest in the elections.¹⁷

Furthermore, Laugesen and Gauld's research found that the percentage of invalid, meaning blank or informal, votes is remarkably high for DHB elections,¹⁸ much more so than for councils. On its face, this might appear to strengthen my argument, but the percentage increased significantly after the adoption of STV for DHB elections. Gauld's research found that one

¹³ Miriam J Laugesen and Robin Gauld *Democratic Governance and Health: Hospitals, Politics and Health Policy in New Zealand* (Otago University Press, Dunedin, 2012) at 145; and "2013 NZ Local Authority Election Statistics" (November 2014) Department of Internal Affairs website <www.dia.govt.nz>. See appendix.

¹⁴ John Wilson *The 2014 New Zealand General Election: Final Results and Voting Statistics* (Parliamentary Library research paper, 2015/01, February 2015) at 12.

¹⁵ See, for instance, Warwick Lampp "Wellington City Council 2016 Triennial Elections: Preliminary Result" (8 October 2016) Electionz website <www.electionz.com>; and "Preliminary election results released for Auckland region's three District Health Boards" (9 October 2016) New Zealand Herald <www.nzherald.co.nz>.

¹⁶ Voters are not required to rank every candidate; voters can rank as many or as few as they please.

¹⁷ Robin Gauld "Are elected health boards an effective mechanism for public participation in health service governance?" (2010) 13 *Health Expectations* 369 at 373. See appendix.

¹⁸ Laugesen and Gauld, above n 59, at 145. See appendix.

third of respondents said STV was confusing.¹⁹ Were one so inclined, one could respond that the answer is simply to return to FPP. However, a return to FPP would be no better than the present situation, due to its undemocratic nature. It is well known that FPP produces disproportionate outcomes. These outcomes are less representative and less likely to result in decisions that reflect the will of the people, meaning, in practice, the will of the majority. This problem would only exacerbate the one posed by the presence of ministerial appointees. The point is that whether it be a high percentage of invalid votes or disproportionality, the system would be flawed either way.²⁰ One might also consider that if people are not willing to take the time to understand what is ultimately a very simple voting system, then that is further evidence of the public's disinterest.²¹

In and of itself, the level of disinterest shown by the public is not enough to establish that DHB elections should be abolished. Electoral turnout is also low for council elections held at the same time, and turnout to parliamentary elections has been dropping as well. This is part of a general trend of declining electoral participation across the West. Yet no one could sensibly suggest that elections in general should be abolished. Even so, there must be questions, in a majoritarian democracy, about the legitimacy of a system in which a majority of voters choose not to participate. Disinterest is not determinative, but it is a relevant factor.

B Uninformed Voting

Of those who did vote, the majority used the candidate profiles that accompanied the voting papers. A significant minority, of between one quarter and one third, looked for someone they knew. A small minority simply guessed.²²

Gauld's study suggests that voters are not casting very informed votes. A vote based on guesswork is clearly uninformed. A vote based on 'someone the voter knew' is, in other words, a vote based on name recognition. It is informed only by what the voter knows about the persons whose names they recognise. Information such as the candidates' policy positions, previous record and competence are thus relevant only to the extent that the voter has a preconceived idea of candidates' qualities. The candidate profiles are helpful but not very. First, they are very short, with a maximum of 150 words.²³ Hence, they are unable to convey

¹⁹ Gauld, above n 17, at 374.

²⁰ Although, in fairness, it seems to me that the invalid vote problem could instead be ameliorated simply by counting the votes of everyone who treated it like FPP, and thus just put a mark beside one candidate, as having cast a first preference vote.

²¹ It is difficult to conceive what precisely people find so complicated about a system where one puts a one next to one's favourite, a two next to one's second favourite, and so forth.

²² Gauld, above n 17, at 374. See appendix.

²³ Ministry of Health, above n 9, at 13.

much information. Secondly, they are provided by the candidates themselves and thus unlikely to convey unbiased information. Uninformed voting is problematic for democratic theory.²⁴

We should be wary of complaints about ‘uninformed’ voting. ‘Uninformed voting’ can quickly be conflated with ‘voting for a candidate or policy with whom one disagrees’. However, we can base our analysis on the sources of voters’ knowledge and the likelihood of such sources producing valuable information. The majority of voters in DHB elections rely on short, likely biased candidate profiles. These candidate profiles accompany the voting papers, suggesting voters only turn their minds to the question of DHB elections when they go to cast their vote. This provides little scope for an informed assessment of the link between the performance of the DHB, and the contribution of incumbent members to that performance or the potential contributions which other candidates could make.

Another problem that contributes to the lack of informed voting is the media. There is comparatively little media coverage of DHB elections, or of the performance of DHB boards during each electoral term. The coverage that does occur focuses on more tangible criteria like the number of elective surgeries performed, rather than the contribution of DHB members to those factors. David Farrar, who advocates abolishing DHB elections writes that, “The reality is that as almost no media attention is given to DHB meetings, there is no information available for people to make intelligent informed choices for DHB elections.”²⁵

Yet another problem is the lack of a strong party system for DHBs. Although political parties are much maligned, the party system is vital to the existence of representative democracy. Party representation means that the voters can choose the collective goals of the government and legislature, rather than electing parochial independents who determine the government’s priorities through horse trading, logrolling and pork barrels. It greatly improves the predictability of government and provides important signals to voters about the values and policies of the candidates. It is the “key heuristic” which helps voters inform their decisions.²⁶ Yet DHBs have not developed such a system. It might be responded that there is very little scope for party politics on DHBs, but that would only go to strengthen my argument that there is no scope for democracy.

It might even be objected, as it sometimes is, that local government is ‘no place for party politics’. If that means ‘there is no place for parties’, we have already seen why that is problematic. If it means that there is no place for politics itself, then it is also problematic.

²⁴ Jennifer L Hochschild “If Democracies Need Informed Voters, How Can They Thrive While Expanding Enfranchisement?” (2010) 9 Election Law Journal 111 at 111.

²⁵ David Farrar “Why DHB elections should be abolished” (11 October 2010) Kiwiblog <www.kiwiblog.co.nz>.

²⁶ Ian Wilson and others “Turnout, Information and Heuristics in the Scottish Health Board Elections: ‘Getting a CV with No Job Description’” (2016) 62 Political Studies 452 at 452.

Local politicians sometimes claim that they are not interested in politics or ideology but that they are about results, pragmatism and getting things done. For instance, they might say that they are elected to serve the people of, say, Wellington, not some party. They present themselves as somehow ‘above’ politics. In reality, this conceit consists of a refusal to make explicit the underlying value judgements upon which they make their decisions. Local government may well be more cooperative and collaborative than Parliament, but there is no such thing as policy without ideology and no such thing as politics without politics.

The combination of low turnout with uninformed voting casts serious doubt on the democratic nature of DHB elections. Even this cumulative case is not sufficient to prove the case against such elections. One could well argue that the solution is better education of voters. One could also suggest that even flawed democracy is better than no democracy. However, there are good reasons why people should be uninterested in DHB elections, as I demonstrate in the next section.

III Ministerial Control of DHBs

The Minister of Health has so much control over DHBs that the elected Boards are impotent by comparison. There is little point in holding elections for such powerless entities. This is particularly so considering that the Minister is an elected Member of Parliament and part of a government which enjoys the confidence of the House of Representatives. The DHBs are thus already democratically legitimate, by virtue of their accountability to the Minister. This section explains the nature and extent of ministerial power over DHBs and spells out the implications of this power for my argument.

First, four of the eleven members of the board are appointed by the Minister. This has the potential to skew the vote. A DHB could vote so that the view of the majority of elected members could be outweighed by the combined votes of the appointed members and a minority of elected members. It is true that elected members will always outnumber appointed members, and therefore that the former can always outvote the latter. However, the appointed members will tip the balance against the majority of elected members in any instance where elected members vote 5-2 and the appointed members vote 0-4, elected members vote 4-3 and appointed members vote 0-4, or elected members vote 4-3 and appointed members vote 1-3. Thus, there is no guarantee that DHB decisions will, even nominally, reflect the wishes of the majority of voters. This could well explain some of the lack of interest in DHB elections. The Minister also appoints the Chair and Deputy Chair from among the elected and appointed members, which means the Minister decides who controls the agenda.

Secondly, DHBs, including the elected members, are not primarily accountable to the people of their districts but to the Minister of Health.²⁷ Under the Crown Entities Act, individual board members owe their duties to the Minister and to the board as an entity.²⁸ The board is, according to the Public Health and Disability Act, collectively responsible to the Minister.²⁹ Indeed, despite being unique in having elected health boards, these legal accountability factors mean that New Zealand has an unusually strong “line of political accountability from DHBs to the centre”.³⁰

Thirdly, the Minister (and through the Minister, the government) has considerable power over DHBs. Boards must prepare an annual plan, which must be approved by the Minister.³¹ In any dispute between the Minister and a DHB over an annual plan, the Minister has the final say (after taking into account advice from an advisory group appointed by the Minister).³² DHBs are also required, in return for their funding, to implement health policies set by central government. Funding agreements require DHBs:³³

to adhere to a series of national strategies, national service frameworks and operational requirements, which set out national priorities for health spending and specify the minimum range and standard of services that must be provided or funded in each district.

Additionally, the Minister can direct a DHB to “provide or arrange for the provision of any service”³⁴ and can specify “the persons who are eligible to receive” publicly funded healthcare.³⁵ These directions give effect to government policy,³⁶ as determined by Cabinet. Note that such directions cannot identify specific individuals or groups.³⁷ Under 2010 amendments, the Minister can also issue directions to “all DHBs” to improve “the effectiveness and efficiency of the public health and disability sector”.³⁸ Such directions can include specifying how and by whom administrative, support and procurement services must be provided.³⁹

²⁷ Paterson, above n 6, at 7.

²⁸ *Lab Tests Auckland Ltd v Auckland District Health Board* [2008] NZCA 385, [2009] 1 NZLR 776 at [84].

²⁹ Crown Entities Act 2004, s 59; and Public Health and Disability Act, s 27.

³⁰ Pauline Barnett and others “Implementing new modes of governance in the New Zealand health system: An empirical study” (2009) 93 Health Policy 118 at 126.

³¹ Paterson, above n 6, at 6.

³² Public Health and Disability Act, s 39.

³³ Paterson, above n 6, at 6.

³⁴ Public Health and Disability Act, s 33(1).

³⁵ Section 32(2).

³⁶ *Accountability: A better way of working together (Report of the DHB Accountability Arrangements Review)* (Ministry of Health, October 2007) at 1.

³⁷ Public Health and Disability Act, ss 32(3), 33(1).

³⁸ Section 33B.

³⁹ Section 33A.

Fourthly, the Minister can intervene in DHB governance. The Minister can, if the Minister considers it desirable, appoint a Crown monitor to assist in improving DHB performance,⁴⁰ including ensuring that Government policies and wishes are “appropriately reflected in board decisions”.⁴¹ Furthermore, the Minister can dismiss the entire board and replace it with appointed commissioners if the Minister is subjectively⁴² “seriously dissatisfied” with its performance.⁴³ It should come as no surprise that DHBs rarely speak out against government policy, and that they can be penalised for doing so.⁴⁴

Ministers have shown themselves more than willing to exercise these powers. In 2015, for instance, Health Minister Jonathan Coleman dismissed the Southern District Health Board and replaced it with a commissioner.⁴⁵ He did so on the basis that “he had no confidence in the Board’s ability to suitably handle longstanding financial problems”.⁴⁶ In 2009, the incoming Health Minister, Tony Ryall, dismissed the chairman of the Otago District Health Board, Richard Thomson.⁴⁷ Ryall charged that Thomson had presided over the largest fraud in the history of New Zealand’s state services.⁴⁸ Thomson responded by accusing Ryall of political interference.⁴⁹ The year before that, the Health Minister under the previous government, David Cunliffe, dismissed the Hawke’s Bay District Health Board in favour of a commissioner, John Anderson.⁵⁰ Cunliffe’s concerns “included a projected \$7.7 million deficit and poor relations between the board and Mr Cunliffe and the board and staff, including some medical staff”.⁵¹ Cunliffe had dismissed the previous chair of the CCDHB, Judith Aitken, in favour of John Anderson as commissioner the previous December.⁵² Hardcastle suggest that “the use of intervention powers is driven by politics rather than concern for communities’ interests”.⁵³ Clearly, DHBs’ accountability to Ministers, and ministerial power over DHBs, are not merely theoretical.

⁴⁰ Section 30(1).

⁴¹ Section 30(3)(b).

⁴² Fiona Sing “The Hawke’s Bay District Health Board Dismissal: Should We Be ‘Seriously Dissatisfied’ with the Ministerial Intervention Thresholds?” (LLB(Hons) Research Paper, Victoria University of Wellington, 2008) at 16.

⁴³ Public Health and Disability Act, s 31.

⁴⁴ Gauld, above n 63, at 216–217.

⁴⁵ “Minister sacks Southern District Health Board” (17 June 2015) New Zealand Herald <www.nzherald.co.nz>.

⁴⁶ Above n 45.

⁴⁷ “Sacked Thomson hits out at Ryall” (18 February 2009) Otago Daily Times <www.odt.co.nz>.

⁴⁸ Above n 47.

⁴⁹ Above n 47.

⁵⁰ “Health Minister fires Hawke’s Bay DHB” (27 February 2008) Stuff <www.stuff.co.nz>.

⁵¹ Above n 50.

⁵² Above n 50.

⁵³ Laura Hardcastle “For the People, by the Minister: Ministerial Interventions in Subnational Elected Bodies and a Principled Approach to their Future Use” (2015) 13 NZJPI 297 at 315.

Gauld concludes that DHBs are:⁵⁴

in a complex and unusual position of having elected and yet highly constrained members whose role is restricted to responding to, explaining and implementing government policy.

This degree of ministerial control speaks against having elected DHB members. There are two reasons for this. First, DHBs have little scope to govern according to their own understanding of the best interests of their electorate or to the will of the electorate. In other words, there is little scope for democracy; “no man can serve two masters”.⁵⁵ That is particularly so given the democratic input – voting – is so unpopular and uninformed. As *The Dominion Post* once editorialised, DHB elections are a “charade”.⁵⁶ They provide the illusion of popular control but not the reality. Abolishing them would be no great loss for democracy. Put positively, the time and money spent on DHB elections could be better spent on other priorities (healthcare, for instance). Abolishing DHB elections would also reduce the complexity of local elections from the voters’ perspective. This could lead to more interest in elections to councils. In other words, it could improve local democracy.

Secondly, it is the Minister who should hold DHBs to account; the fear of removing elected members could well impede the Minister’s ability to do this. The other side of this coin is that the Minister, and the government as a whole, should be held accountable for the performance of DHBs. In a democracy, it is essential that those who exercise public power are accountable to the people. Thus, one could argue that since DHBs exercise significant public power, they should be directly elected by the people to whom they are accountable. However, this would be far too simplistic. A vast array of bodies exercises public power despite not being directly elected. In the health sector alone, there is ACC, Pharmac, and the Ministry of Health. Yet these bodies are nonetheless democratically legitimate, for, quite apart from the fact that they are established by legislation, they are linked to a democratic chain of accountability. Each of these bodies is accountable, by way of its Chief Executive, to the responsible Minister. In turn, it is a matter of elementary constitutional theory that the Minister is accountable to the House of Representatives, which in turn is elected by the people. This is how our system of representative democracy works.

It follows that, under my proposal, DHBs would still be democratically accountable. As Greer and others put it:⁵⁷

⁵⁴ Gauld, above n 63, at 216–217.

⁵⁵ Matthew 6:24, KJV.

⁵⁶ “Health boards fatally flawed” (5 March 2008) *The Dominion Post* <www.stuff.co.nz>.

⁵⁷ Greer and others, above n 116, at 227.

For some, the philosophical case for direct election of local decision-makers negates any scope for cost-benefit analysis of electoral outcomes. In the case of adding an additional layer of representation to organizations already ‘vertically’ accountable to the public through central government, however, we argue that it is reasonable to look for demonstrable change in return for the financial costs and upheaval of the intervention.

Furthermore, DHBs already are – or should already be – so accountable, given that their primary legal accountability is to the Minister of Health. The presence of elected members is a convenient way for the Minister of Health to avoid responsibility for the actions of DHBs. At present, then, the elected nature of DHBs blurs the Minister’s democratic accountability for the health sector. Abolishing elections would clarify the lines of accountability.

IV Arguments in Favour of Electing DHBs

There is a compelling case for removing DHB elections. Naturally, there will be counterarguments. As I have shown, it is not enough simply to say that because DHBs are significant public bodies they should be elected. Rather, to show that DHBs should be elected, there would have to be some special reason why elections are appropriate. This section will canvass and refute four possible reasons that might be advanced, namely reasons based on history, competence, democracy and representation. It then dispatches two other possible counterarguments, namely an analogy with local councils and the suggestion that New Zealand leads the world in having elected health boards.

A Historical

One possible reason is the historical argument. To understand this counter-argument, one must first understand the history of DHBs. Indeed, Laugesen and Gauld suggest that it is necessary to understand the debate over elected health boards in the first place.⁵⁸

District Health Boards were established in 2001, but they are only the latest incarnation of a long history of state-funded healthcare in New Zealand. Laugesen and Gauld, in the first systematic analysis of New Zealand’s elected health boards, write that, “The New Zealand health care system has remained stubbornly resistant to government attempts to remove elections from local hospital or health boards”.⁵⁹ In every attempt at reform from the 1920s until the 1990s, the government “struggled in vain” to accomplish its goals of reforming hospital board representation and closing small, local hospitals.⁶⁰ It finally succeeded in 1991, when the Fourth National Government used the Budget and urgency to abolish elections

⁵⁸ At 26.

⁵⁹ Laugesen and Gauld, above n 13, at 13.

⁶⁰ At 13.

literally overnight.⁶¹ However, they were reinstated a decade later by the Fifth Labour Government.⁶²

Britain acquired sovereignty over New Zealand in 1840. From the beginning, the colonial government sought to minimise its role in providing for the welfare of its citizens.⁶³ It did so under the influence of the laissez-faire ideals which held sway in the imperial metropole.⁶⁴ However, the realities of colonial New Zealand necessitated a different policy response. Hence, Gauld writes that:⁶⁵

From 1841, the government began to post state-funded doctors to remote regions in recognition of an expanding settler population who had little or no access to health care. State involvement increased in 1846 with the governor, George Grey, commissioning four district hospitals in the hope of offering to the indigenous Māori population access to modern Western medicine. These were not ‘public’ hospitals; aside from Māori, indigents were the only patients to be given access free of charge.

The dialectic between laissez-faire and colonial circumstances drove the ad hoc development of a public health system. The government encouraged the provision of healthcare by private and voluntary organisations.⁶⁶ However, it continued to establish public hospitals, and, in the early 1850s, it made them responsible for providing charity and relief to the poor.⁶⁷ It also, in 1872, created a separate system of local health boards to implement preventative (as opposed to curative) public health measures.⁶⁸ Thus, healthcare became increasingly public.

This resulted in unsystematic and poorly funded provision of healthcare.⁶⁹ The government responded by having passed the Hospital and Charitable Institutions Act 1885.⁷⁰ By this point, the government had, despite itself, become the dominant provider of healthcare.⁷¹ Hence, the Act sought not only to standardise health funding and provision but to shift responsibility to local communities. New Zealand was divided into a series of hospital districts.⁷² Elected hospital boards were to obtain funding by levying rates on their districts, to which central

⁶¹ At 13.

⁶² At 13, 15.

⁶³ Robin Gauld *Revolving Doors: New Zealand's Health Reforms – The Continuing Saga* (2nd ed, Health Services Research Centre and Institute of Policy Studies, Wellington, 2009) at 8.

⁶⁴ At 8.

⁶⁵ At 8.

⁶⁶ At 8.

⁶⁷ At 8.

⁶⁸ At 9.

⁶⁹ At 9.

⁷⁰ At 9–10.

⁷¹ At 9.

⁷² At 10.

government contributed a subsidy.⁷³ Thus, the Act “created the network of local hospital boards that would persist for the next hundred years”.⁷⁴ Preventative public health remained a separate system, but it was centralised under the Department of Health in 1900.⁷⁵

In 1935, the First Labour Government came to power and created the welfare state. Included in its vision was a system of universal public healthcare, free to users.⁷⁶ However, the medical profession opposed this, and as a result, the reality fell short of the vision.⁷⁷ Thus, the ‘dual system’ of partly private and partly public healthcare continued to develop.⁷⁸ The Social Security Act 1938 did shift responsibility for funding public healthcare from the health boards to central government.⁷⁹ However, Labour found it had to retain the existing local hospital boards.⁸⁰ While the Government exacted some additional ministerial control in return for this funding, the boards largely retained their autonomy.⁸¹ Over the next several decades, health expenditure continued to grow, to the increasing concern of the government.⁸² The government attempted to reform health governance in the 1950s and again in the 1970s, but health boards successfully rallied public support and preserved their basic structure.⁸³

Beginning in the early 1980s, New Zealand’s health sector underwent two tumultuous decades of reform. In 1983, the National Government passed the Area Health Boards Act 1983.⁸⁴ The vision behind this Act was the creation of 14 elected Area Health Boards (AHBs), which would replace the old hospital boards and combine their functions with the Department of Health’s preventative public health functions.⁸⁵ However, progress was slow, because, in light of previous failed reform efforts, the new system was voluntary.⁸⁶ This voluntariness came to an abrupt end in 1989, when the Fourth Labour Government forcibly abolished the remaining hospital boards in favour of AHBs.⁸⁷

⁷³ At 10.

⁷⁴ At 10.

⁷⁵ At 11–12.

⁷⁶ Peter Quin *New Zealand Health System Reforms* (Parliamentary Library, Research Paper 2009/03, April 2009) at 2.

⁷⁷ At 2.

⁷⁸ At 2.

⁷⁹ Laugesen and Gauld, above n 59, at 18–19, 54.

⁸⁰ At 18–19.

⁸¹ At 19.

⁸² Quin, above n 76, at 2.

⁸³ Laugesen and Gauld, above n 59, at 61, 80.

⁸⁴ At 79.

⁸⁵ Quin, above n 76, at 5–6.

⁸⁶ At 6.

⁸⁷ At 6.

In 1993, the National Government again reformed the health system, this time on a market basis. The AHBs were abolished and replaced by a two-tier system based on separating purchasing from provision of services.⁸⁸ Four Regional Health Authorities were established, which would purchase services from a competitive healthcare market, including 23 Crown Health Enterprises (the former AHBs).⁸⁹ The Crown Health Enterprises were to be managed commercially by boards appointed by the government.⁹⁰ In short, elections to health boards were abolished. This state of affairs was not to last for long.

The 1996 National-New Zealand First coalition government initiated the next round of reforms. The four RHAs were to be combined into one Health Funding Authority, which would purchase services from CHEs, now renamed Hospital Health Services.⁹¹ Although the health sector was now to be run on a ‘business-like’ yet not-for-profit basis, the use of appointed boards was maintained.⁹²

This new arrangement apparently began to improve healthcare.⁹³ However, the next Labour Government followed through on an election promise to restructure the health system (once again).⁹⁴ It created the system of 21 elected DHBs⁹⁵ (now twenty, following the merger of the Southland and Otago DHBs).⁹⁶ This is the system which has endured to this day and which I propose to reform (yet again).

Despite a brief interregnum during the period following the neoliberal revolution, New Zealand has a long history of electing the historical equivalent of DHBs. In itself, this is not enough to sustain a counter-argument. The fact that things have always *been* so does not mean that they should always *remain* so. ‘Is’ does not lead to ‘ought’, as the philosophers tell us.⁹⁷ One could say that because of this long history, New Zealanders have come to value having elected health boards, and they should be retained for this reason. In reply, one could say that New Zealanders are simply mistaken about the value of elected DHBs. If there are good reasons to abolish DHB elections, then a reasonable public will accept the argument. It may, furthermore, be that this

⁸⁸ At 9.

⁸⁹ At 9.

⁹⁰ At 9.

⁹¹ At 14.

⁹² At 14.

⁹³ Laugesen and Gauld, above n 59, at 135–136.

⁹⁴ Quin, above n 76, at 18.

⁹⁵ At 18.

⁹⁶ Eileen Goodwin “Southland discontent over merger” (29 September 2010) Otago Daily Times website <www.odt.co.nz>.

⁹⁷ David Hume *A Treatise of Human Nature: Being an Attempt to introduce the experimental Method of Reasoning into Moral Subjects* (eBook ed, eBooks@Adelaide, 2015) at 424.

valuation is misplaced. Perhaps what New Zealanders really value is a) hospitals and/or b) local health governance. Neither of these would change were elections abolished.

B Competence

One might then try to argue that electing DHBs will lead to elected members doing a better job. Electors will vote out incompetent members, and the fear of losing the vote will encourage members to do better. Yet competence can be assured by other means. Performance-based contracts, options for renewal, and performance reviews may well be a better means of ensuring competency than a triennial vote by the minority of a largely disinterested public which primarily casts its vote based on 150-word profiles and name recognition. Certainly, there is no evidence that elected DHBs are any more competent than the alternative. The performance of DHBs has been “mediocre”.⁹⁸

C Democratic

One could advance a democratic argument. I have already proven that democratic accountability can be secured through ministerial responsibility. Let us nonetheless take the potential democratic argument at face value. Democracy is a good thing, either instrumentally or intrinsically, and it should therefore be encouraged wherever reasonably possible. The instrumental argument stands or falls on the evidence. As we have seen, the evidence is that DHB performance is mediocre and that there is little real democracy. Consequently, DHBs are incapable of producing the instrumental (or indeed intrinsic) goods of democracy. The instrumental argument fails.

The second democratic argument is purely normative, based on the premise that democracy is an intrinsic good. On its own, the normative argument is not enough to show DHBs are *uniquely* suited for elected governance. However, a stronger argument emerges when one considers the very fact that DHBs already have such governance. One could say that it is not feasible to elect the governing boards of all public sector organisations, so we have good reason not to do so; the infeasibility outweighs the intrinsic good of democracy. Yet DHBs are an exception: it clearly *is* reasonably possible to elect DHBs, because we already do so. All we have to do to make it feasible is leave things as they are. It would be great if we could have even more elected public bodies, but since that is not realistic, we should at least maintain what we do already have.

However, elections are not all there is to democracy. The intrinsic goods of democracy, namely that it grants respect to persons and ensures that their rights and interests are taken into account, can be achieved through other forms of participation. I am not suggesting that there should be

⁹⁸ Laugesen and Gauld, above n 59, at 169.

no public participation in health governance. Public participation could be provided for by requiring appointed DHBs to consult with the community. At present, the Act already provides that one of the objectives of DHBs is “to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services”.⁹⁹ To that end, DHBs have the specific function of ensuring that there is informed participation by Maori in matters affecting Maori health.¹⁰⁰ They also have discretion to establish processes to ensure other demographics participate in matters affecting group health.¹⁰¹ Indeed, Gauld has argued that the statutory requirements for transparency and consultation may have contributed more to the democratisation of health policy than DHB elections.¹⁰² “DHBs routinely seek to engage with the public and affected groups when developing new policy initiatives”, which has led to “significant policy adjustments”.¹⁰³

Finally, any suggestion that abolishing DHB elections would be anti-democratic must also be seen in the international context. Every other country in the democratic world gets along without elected health boards. We could, too.

Another problem with the democratic argument relates not to the ‘rule’ element of democracy, but to the ‘people’ element. One might well question why the people of a hospital catchment should be seen as constituting a political community. Take the Capital and Coast DHB. The people of Wellington and the Kapiti Coast only exist as a political entity for the purpose of the DHB. They have separate territorial councils, and they form part of a larger whole for the purpose of the regional council. Why the capital and coast constitute a political entity which must be ruled democratically is not clear. Not every organisation or group of people is a proper subject of democratic government. Families, churches, companies, NGOs, and private hospitals, for instance, are not ‘peoples’ which we demand be governed democratically. Of course, those are all private entities. Yet we do not, say, demand that the people subject to the jurisdiction of each District or High Court have democratic government. The same goes for Work and Income and its branch offices, and, as we have seen, for any number of other government entities.

D Representative

One might argue that elected health boards are more likely to be demographically representative of their communities and thus more attuned to the diverse needs of those communities. This, however, has proved to be false. Elected members have tended to be

⁹⁹ Public Health and Disability Act, s 22(1)(h).

¹⁰⁰ Section 23(1)(d)–(f).

¹⁰¹ Section 23(6).

¹⁰² Gauld, above n 63, at 216.

¹⁰³ At 216.

predominantly white and predominantly men.¹⁰⁴ This is not in itself an argument against elections, for such demographic unrepresentativeness is not limited to DHBs. Rather, this is a widespread phenomenon in New Zealand and the rest of the world. However, it suffices as a counterargument to the demographic representation argument *for* electing DHBs. It would be simple to mandate that the Minister have regard to the need for demographic representativeness when making appointments. We could also potentially impose quotas. Indeed, ministerial appointees have proved to be a better method of ensuring Maori representation on DHBs than elections. The legislation requires that at least two DHB members be Maori,¹⁰⁵ but elections rarely produce this quota. Thus, the Minister has had to appoint Maori members to meet the requirements of the statute.¹⁰⁶

E The Local Government Analogy

It does not follow from this argument that elections should be abolished for other forms of local government. There are a number of differences between DHBs and councils. Most importantly, councils do not contain ministerial appointees, and they are accountable primarily to the electorate. They do not serve two masters.

Historically, the government had no power to dismiss local councils and replace them with commissioners, as they do with DHBs. However, in 2010, Parliament passed ad hoc legislation doing just that to the Canterbury Regional Council, known as Environment Canterbury.¹⁰⁷ Subsequently, it amended the Local Government Act to allow the Minister to do this.¹⁰⁸ However, a) the historical context is still an indication that there is a difference between DHBs and local government, and b) there is a different,¹⁰⁹ presumably more objective, threshold before Ministers can dismiss Councils.

Councils also possess a far wider range of functions than DHBs.¹¹⁰ This means there is a lot more scope for democracy. Councils have coercive powers, such as the power to make and enforce bylaws.¹¹¹ They derive their funding from their statutory authority to levy rates on the people of their districts.¹¹² The fact that councils can coerce citizens provides a strong justification for their being politically accountable through local elections. Liberty requires that

¹⁰⁴ Laugesen and Gauld, above n 59, at 146–147.

¹⁰⁵ Public Health and Disability Act, s 29(4)(b).

¹⁰⁶ Gauld, above n 63, at 216.

¹⁰⁷ Philip Joseph “Environment Canterbury legislation” [2010] NZLJ 193.

¹⁰⁸ Local Government Act 2002, s 258F.

¹⁰⁹ Section 258F.

¹¹⁰ Dennis Shum “Role of District Health Board and Local Government” (LLM Research Paper, Victoria University of Wellington, 2010) at 18–19, 33.

¹¹¹ At 32.

¹¹² At 33.

citizens have a say in decisions that affect them, in the laws to which they will be subject and in decisions that involve spending their money. Of course, DHBs have significant influence over the health of individuals. Yet they have no coercive powers,¹¹³ and private healthcare is an alternative. Furthermore, they receive their funding from general taxation, by way of central government. Therefore, the rest of the country has a stronger interest in how DHBs spend money than councils. Consequently, councils have stronger reasons to have an accountability mechanism that is limited to their geographical districts.

F The World-leading Counterargument

The New Zealand model of standalone elected health boards is unique,¹¹⁴ with the exception of failed pilots in Canada in the 1990s¹¹⁵ and more recent pilots in Scotland.¹¹⁶ Other countries use either appointed health boards or include healthcare as one of the functions of local government.¹¹⁷ New Zealand is thus seen as an example for other countries considering such a system. Some might be tempted to claim this as yet another world-first for a plucky little nation. The fact that the world looks to us might suggest that we are on the right track. However, it could also be that there are good reasons why other countries have not followed, and should not follow, in our footsteps. This is the argument I have made. The argument presented here thus has international implications.

Furthermore, as we shall see, other countries' elected health boards have fared no better than our own. To assess the international evidence would be, to some extent, to work backwards. However, it buttresses my primary argument and provides a compelling rejoinder to this counter-argument.

There is regrettably little evidence available from those jurisdictions which have implemented similar models of health governance, namely Canada, England, and Scotland. Even so, the evidence that does exist does not convincingly favour elected DHB elections. Greer and others have concluded that in all three of these jurisdictions "elections to health bodies have failed to deliver the transformational changes promised in policy rhetoric".¹¹⁸

¹¹³ At 33.

¹¹⁴ Laugesen and Gauld, above n 59, at 9.

¹¹⁵ At 38–39.

¹¹⁶ Scott L Greer and others "Victory for volunteerism? Scottish health board elections and participation in the welfare state" (2014) 106 *Social Science & Medicine* 221 at 223; and Wilson and others, above n 26, at 453.

¹¹⁷ Helen Dickinson and Chris Ham *The Governance of Health Services in Small Countries: what are the lessons for Wales?* (Welsh National Leadership and Innovation Agency for Healthcare, January 2008) at 6–7.

¹¹⁸ Greer and others, above n 116, at 227.

1 Canada

Five Canadian provinces have experimented with elected health boards.¹¹⁹ All failed. Alberta, Quebec, and Prince Edward Island all abandoned elections to health boards, although no primary evidence exists on why.¹²⁰ Elections in New Brunswick were abandoned apparently because they were not producing members with the right skills to govern the boards.¹²¹

New Brunswick later reinstated elections to its Regional Health Authorities. Turnout to the 2012 elections was approximately one quarter.¹²² Detailed statistics for the 2016 New Brunswick Regional Health Authority elections do not appear to be available yet. However, since overall turnout to New Brunswick municipal elections was 34.5 per cent compared with 35.5 per cent in 2012,¹²³ there is little reason to suppose that there has been any significant improvement.

More evidence is available regarding Saskatchewan. Saskatchewan had held three elections, to which turnout was extremely low.¹²⁴ Turnout to the 1995 elections was one third; turnout to the 1997 elections dropped to one quarter; and turnout to the final elections in 1999 dropped to one tenth.¹²⁵ Furthermore, 30 per cent of candidates in 1995 were elected unopposed; approximately two thirds of candidates at the 1997 and 1999 elections were similarly ‘elected’.¹²⁶ I should note that where elections are unopposed, people cannot vote.¹²⁷ Therefore, turnout might have been higher had there been more elections and fewer ‘acclamations’. Nonetheless, these two factors paint a dismal picture overall. Hence, Saskatchewan abandoned elected boards in 2001, on the basis that:¹²⁸

¹¹⁹ Ellen A Stewart and others *Health Board Elections and Alternative Pilots: Literature Review* (Scottish Government Social Research, 2012) at [4.3]

¹²⁰ At [4.3].

¹²¹ At [4.3].

¹²² Michael P Quinn *Regional Health Authority Elections: Report of the Municipal Electoral Officer* (Elections New Brunswick, 14 May 2012) at A-3.

¹²³ Daniel McHardie “Voter turnout dips to 34.5% in municipal elections” (10 May 2016) CBC News <www.cbc.ca>.

¹²⁴ Stewart and others, above n 119, at [4.4].

¹²⁵ At [4.4].

¹²⁶ At [4.4].

¹²⁷ See above n 123. While this article was written in the context of the 2016 New Brunswick municipal elections, none of the New Brunswick Regional Health Authority seats appear to have been acclaimed this year: see Daniel McHardie “Municipal election: Key numbers behind the 2016 campaign” (8 May 2016) CBC News <www.cbc.ca>.

¹²⁸ Stewart and others, above n 119, at [4.7].

This system has been costly and not very popular. With few candidates coming forward for elected positions, and poor voter turnout, board elections have not proven to be an effective way to involve the public.

The Canadian experience is not encouraging.

2 *England*

Most English hospitals are run by Foundation Trusts.¹²⁹ These trusts allow patients, staff, and any member of the local community to join them.¹³⁰ The trusts then elect a Council of Governors which holds the hospital boards and chief executives to account on behalf of members of the trust.¹³¹ Rather than electing hospital boards, the model thus places a layer of elected members between the board and the community. Additionally, although anyone can join the trust, only members vote, rather than the community in general. One would think would restrict those voting to those who took an active enough interest in healthcare governance to join such boards.

The results there are not encouraging either. The Trusts were created in 2004. Average turnout at the 2004 elections was less than half (48 per cent).¹³² By 2011, this had dropped to one quarter.¹³³ Over the same period, the number of uncontested elections rose from 24 per cent to 47 per cent.¹³⁴ These numbers relate to turnout of members of the trusts, meaning overall community turnout is much lower. Hence, Berry concludes that “participation in these democratic processes is so low that we have to consider this aspect of Foundation Trusts to be a failure”.¹³⁵

3 *Scotland*

Scotland has also tried and failed successfully to implement DHB elections. It ran pilot elections in the Fife, and Dumfries and Galloway DHBs in 2010,¹³⁶ after assessing the evidence from Canada, England and New Zealand.¹³⁷ The Scottish Government abandoned the scheme in 2013, citing low turnout out of under 20 per cent in Dumfries and Galloway and 10 per cent

¹²⁹ “The NHS in England: NHS authorities and trusts” NHS website <www.nhs.uk>.

¹³⁰ Richard Berry “NHS Foundation Trusts – a democratic failure?” (16 April 2014) openDemocracy <www.opendemocracy.net>.

¹³¹ Above n 130.

¹³² Stewart and others, above n 119, at [4.9].

¹³³ At [4.9].

¹³⁴ At [4.9].

¹³⁵ Berry, above n 130.

¹³⁶ “Scottish health board elections abandoned” (7 November 2013) BBC News <www.bbc.com>.

¹³⁷ See Stewart and others, above n 119.

in Fife.¹³⁸ It also cited the cost of the scheme.¹³⁹ It is also worth noting that Scottish health boards are similarly accountable to and constrained by central government (meaning the devolved Scottish government) as are New Zealand's DHBs.¹⁴⁰

4 Analysis

Elected health boards have been a failure in cognate jurisdictions overseas. They have been abolished in Scotland and in five Canadian provinces, although they were later reinstated in New Brunswick. As in New Zealand, voters in England, Scotland, and Canada are largely uninterested in health board elections. Indeed, out of all the jurisdictions that have implemented elected health boards, turnout is the highest in New Zealand. The publics of these liberal Western democracies simply do not concern themselves enough with the running of district health boards (or whatever they are called) to cast votes, let alone informed votes.

Beyond that, the international comparison does not tell us much. Rather, after all, it is to New Zealand that other jurisdictions look when considering whether to adopt elected health boards. However, the limited evidence that is available ultimately goes to reinforce my argument. DHB elections do not work overseas, so there is no reason why we should expect them to work here either.

V Recommendations for Reform

Everyone agrees that democracy and accountability are good things. There, the agreement ends. How governmental accountability is best achieved in a democratic society will likely never be settled. This essay certainly does not provide the answer. However, the arguments presented in this paper demonstrate that, in the context of DHBs, elections are not the best way of pursuing these lofty ideals. Having argued that elections to DHB Boards should be abolished, it is incumbent on me to suggest what the best option for reform is. The remainder of this paper therefore outlines and compares a number of possible alternatives to the status quo. Section V outlines and defends my recommendation for reform. Part A argues that the best possible alternative to the status quo is to have fully appointed DHB Boards which outsource their consultation functions to local authorities.¹⁴¹ Part B engages in an extended defence of consultation as an adequate mechanism to ensure community voice and representation in the decision-making process. Section VI evaluates a number of other possible alternatives and

¹³⁸ Above n 136.

¹³⁹ Above n 136.

¹⁴⁰ Greer and others, above n 116, at 224, 226.

¹⁴¹ This is an idea originally proposed by Dean Knight: Dean Knight "Local elections: Trifecta STV and modifying DHB representation" (15 October 2013) LAWS179 Elephants and the Law <www.laws179.co.nz>

compares them with my recommendation. In so doing, it shows that outsourcing consultation is indeed the best solution.

A My Preferred Option for Reform: Outsourcing Consultation to Councils

The outsourcing consultation solution has two components. First, DHB Boards should be retained, but they should be fully appointed. Secondly, the representation and community voice functions which elections are supposed to ensure should be transferred to local councils:¹⁴²

A public health committee of the local authority could provide the interface with the local community and local views could be channeled through that into DHB decision-making. In addition, it would strengthen the environmental health-public health nexus – and perhaps may also open the door to different types of folk wishing to be involved in local government.

This would, apparently, mean that while councils would carry out consultation, DHBs would remain the ultimate decision-makers (within the limited scope of the discretion the Minister allows them). This proposal would have several advantages. First, it would remove the pretense of democracy from DHBs. Secondly, in so doing, it would reinforce ministerial responsibility for the health sector by refocusing public and opposition attention on the Minister. Thirdly, it would harness the institutional capacity and experience local authorities have in consulting with the public.

One potential problem with the proposal is that council and DHB boundaries do not perfectly coincide. Thus, there is a pressing issue as to which councils would carry out consultation for which DHBs. On the one hand, where a DHB's boundary exceeds that of a council, a council would run the risk of exceeding its geographical jurisdiction were it to consult within the jurisdiction of another council. On the other hand, if councils consulted only within their jurisdictions, a DHB could end up with multiple reports, each purporting to represent the views of the DHB's catchment.

This problem is not insuperable. It would hardly be unreasonable to ask (or require, if need be) councils to cooperate on such consultation. After all, when faced with the prospect of amalgamation, councils swear up and down that they are perfectly capable of working together. Of course, a resident of one council might well be confused by receiving an invitation to participate in a consultation being run by another council, for the purposes of the DHB. Yet it would be a simple matter to make clear, in whatever form that invitation was transmitted, that the consultation was being carried out by the three in cooperation. For instance, a prominent triangular placement of the logos of the three organisations would demonstrate at a glance that

¹⁴² Knight, above n 141.

the consultation was a collaboration. In short, it does not stretch the imagination to see a way past this difficulty. Council officials already conduct elections for DHBs.¹⁴³

Councils might well object that healthcare decisions are not their speciality. However, they are not being asked to make decisions. They are merely being asked to run a consultation exercise, something of which any competent council should be capable.

This option is my ultimate recommendation. I shall now set out a number of conditions which any recommendation of mine would have to satisfy and show how outsourcing consultation meets those criteria. First, the recommended reform option would have to be consistent with my own argument. A number of criteria would have to be met for it to be so consistent. The alternative arrangement must not purport to be more democratic than it actually is. It must, however, provide for some representation of community views in the decision-making process (notwithstanding the limited scope DHBs have to implement those views). There must also be some means of holding decision-makers to account. Secondly, the alternative would have to satisfy a number of conditions external to my argument. Naturally, it must not compromise the quality of governance or healthcare. It must also be affordable and otherwise feasible.

Outsourcing consultation is consistent with my argument. First, it would not purport to be more democratic than it really is. The absence of elections to DHBs would create no illusions. One could say that if councils carried out consultation, there would be a mistaken expectation on the part of consultees that the results would be binding. However, this is the case with consultation in general. Secondly, it would naturally allow for representation of community views, for it is predicated on the notion that councils would consult the public to determine its views and then provide the results to DHBs. Thirdly, it would enable decision-makers to be held to account. The Minister would hold the Board members to account through their employment contracts, and the public and the opposition would hold the Minister to account through Question Time and the ballot box. Judicial review would also be an option, and we might expect a closer standard of review owing to the removal of the electoral mechanism. Councils would be accountable to their publics for the quality of the consultation exercise.

Outsourcing consultation also satisfies the conditions external to my primary argument. It would not compromise the quality of governance or healthcare. Removing elected members in favour of appointed members should not degrade the quality of governance, for reasons which I discuss later. Furthermore, the fact that the consultation would be carried out by councils rather than DHBs should really make no difference to how the resulting information is applied. It is the quality of the consultation that matters, not its provenance. Indeed, having councils, which are more experienced with consultation, perform this function may well increase the

¹⁴³ Laugesen and Gauld at 143–144.

quality. Finally, it is affordable and feasible. It would shift the costs of consultation from DHBs to councils. There would likely be some disagreement about whether councils or DHBs should share or bear the costs of consultation, but the cost to the state overall would be the same either way.

Outsourcing consultation satisfies all the conditions both internal and external to my argument. Therefore, I recommend that elections to DHB Boards be abolished in favour of this alternative.

B In Defence of Consultation

I shall take the opportunity provided by the previous part to engage in a more extended defence of consultation vis-à-vis elected DHBs. The goals which DHB elections purport to serve are important. Individuals and communities have a right to have a say in decisions that affect them. However, consultation on specific issues would send a much clearer and more nuanced message about what individuals and communities think about those issues than the blunt instrument of a triennial vote. It might be objected that consultation, by its nature, is not binding and that an appointed DHB Board would thus have no obligation to implement the views of the community. That is true, as far as it goes. However, the current part-elected, part-appointed Boards have no such (legal) obligation either.

To this, it might be responded that the virtue of elections is that they create (political) incentives for elected members to act in accordance with the public's views and desires. Again, however, I return to my primary argument. Owing to the low participation and uninformed voting, there is little reason to think that there is any meaningful connection between the degree to which elected members act in accordance with the views expressed in public consultations and the election results. Then it might be said that as long as elected members think there is such a connection, there will nonetheless be an incentive. However, if there is no strong reason for us to think such a connection exists, there is no strong reason why elected members should think that either. Besides which, there will always be an incentive to act in accordance with public views, if for no other reason than to avoid bad publicity for the DHB. Thus, the political incentive which elections might theoretically create is only a difference in degree, not kind. A truly persistent defender of DHB elections might respond that there is still a difference. Frankly, however, it would be a very slim difference on which to hang a rejection of my entire argument.

Consultation is not supposed to be binding. It is supposed a) to give people the chance to express themselves and b) to provide decision-makers with information with which to make more informed decisions. Requirements to take account of the results of consultations could be written into the legislation and/or into the appointed members' employment contracts. The

dogged defender of DHB elections could then turn to a *reductio ad absurdum* argument: such a person could argue that if the benefits of elections can be achieved through appointed members with legal constraints, one might as well abolish parliamentary elections as well. Again, however, the answer to this claim is to be found in my primary argument. DHBs have only a limited scope of functions and, owing to the extent of ministerial control, an even more limited scope to implement the wishes of the community. Parliament, in contrast, is the supreme legislative body of this country; there is no question that it must be subject to electoral accountability. If it were considered that DHBs had to obey community wishes, then we could always institute local referenda for that purpose.

However, it is far from generally accepted that the purpose of government is simply to implement the wishes of the people to whom it is accountable. The trusteeship theory of democracy holds that the role of elected officials is to govern according to their own beliefs about what the best interests of the people are; this is often expressed by the phrase, “governments are elected to govern”. Community views are to be taken into account, but not to determine results. There is no reason why this could not be encouraged by statutory or contractual requirements to that effect. Again, whatever difference in incentive remained apropos electoral incentives is too slim to reject my whole argument.

One might then attempt to defend DHB elections from the perspective of the trusteeship model. This essentially involves voters trusting their representatives to govern in the voters’ best interests. However, if this be how voters conceive of DHB elections, then one has to say that they trust rather easily. If they are going to trust representatives based on the limited information they use to make their decisions, voters might as well trust the Minister to appoint competent members.

Another argument against consultation could be founded on the fact that consultation is demographically unrepresentative. Those who engage with public consultation exercises tend to be those who have the time and inclination to do so, who tend to be elderly white males. Election turnout may be low, one could argue, but it is sure to be much higher than the number of people who participate in consultation. Comparatively few notice when public consultations are being held, as this requires one to go actively looking for consultations or at least to notice notices to the effect that consultation is taking place on some issue. In contrast, (practically) everyone receives voting papers in the post. Therefore, while elections are far from perfectly demographically representative, they are likely to be more so than consultation.

This, too, may be true, as far as it goes. On the other hand, those who have the time and inclination to take part in consultation are probably going to be better informed as well. They can also provide reasons for their decisions. Overall, then, their contributions may well outweigh whatever disparities exist between the demographic representativeness of elections

and consultations. Additionally, innovations in consultation may be able to overcome this problem. Greer and others write that, “Other mechanisms, including designed (not self-selecting) mini-publics, might be more practical ways [than elections] to seek the opinions of those segments of a community that do not have a volunteerist orientation.”¹⁴⁴ Consultation is a versatile method of measuring public opinion.

VI Alternatives

There are a range of other alternatives which we could adopt to replace the present mainly elected DHB Boards. This section will canvass five alternatives which are suggested by the literature and by logic. Those are 1) replacing elected members with a fully appointed board with no other changes, 2) decentralising DHB functions to local councils, 3) reducing the number of elected positions without abolishing them entirely, 4) creating a new elected body to advise appointed Boards, and 5) centralising public healthcare. Part A will outline each of the alternatives and discuss their strengths and weaknesses in general terms. Part B will apply the criteria outlined earlier to demonstrate why these alternatives are inferior to the proposal to outsource consultation.

1 Option One: Minimal Change

The default option would be simply to replace the elected members with additional ministerial appointees and to make no other changes. It would be rather more difficult for the Minister to blame problems for which the Minister bears responsibility on such a Board. The rejoinder would immediately arise, “by whom were they appointed?” Of course, it may be that they were appointed by a previous Minister, perhaps even under a previous government. On the other hand, it may not. Besides which, the scope available to the Minister to shift blame would still decrease. While it is difficult to find explicit examples where the Minister has a) blamed the elected nature of DHBs b) for something for which the Minister should have accounted, that scope is always there. It may well be part of the Minister’s thought processes: certainly, the courts have explicitly cited the elected nature of DHBs (as well as ministerial accountability) as a reason for holding DHBs to account through a less rigorous standard of judicial review.

A variation on this option would be to require each DHB to establish a committee to carry out consultation. Statute could require more visible, frequent, and otherwise fulsome consultation than takes place at present, to make up for the removal of elections. Such a committee would perform essentially the same role as the council committee were consultation to be outsourced, without involving councils in the exercise. Councils could, perhaps, be called upon to provide support in building capacity for DHB Consultation Committees.

¹⁴⁴ Greer and others, above n 116, at 227.

2 *Option Two: Decentralisation*

DHB functions could be transferred to local councils.¹⁴⁵ Shum argues that there is doubt whether DHBs can provide healthcare efficiently and cost-effectively, but that local (or regional) authorities are capable of taking on this function.¹⁴⁶ This would involve a shift in responsibility for public health from central to local government and, presumably, a shift from taxes to rates as a funding method. Thus, it would remove healthcare from the control of the Minister of Health to a superiorly democratic form of local government. However, any such shift would require the support of both central and local government. It may seriously be doubted whether central government would be willing to relinquish its control over health policy. Furthermore, as I shall now demonstrate, such support is unlikely to be forthcoming from the latter.

The events of earlier this year provide an interesting case study into the differences between councils and DHBs. In April, the government proposed to transfer responsibility for fluoridating water supplies from local councils to DHBs.¹⁴⁷ The government itself favours fluoridation. The proposal may therefore be seen as a negative reflection on the institutional competency of local authorities to deal with public health matters. Councils themselves seem to agree with this assessment. Councils say the issue is not within their area of expertise and should not be their responsibility.¹⁴⁸ Many councils have been embroiled in legal challenges to fluoridation which have made them reluctant to deal with the issue.¹⁴⁹ There is thus likely to be little enthusiasm for transferring DHB functions wholesale to councils.

3 *Option Three: Fewer Elected Members*

Laugesen and Gauld suggest that, rather than abolishing elections entirely, we should reduce the number of elected members.¹⁵⁰ The continued presence of elected members would ensure there was always someone to “fight for” patients.¹⁵¹ With fewer positions available, elections would be more competitive and it would be easier for voters to identify elected members as their representatives. Laugesen and Gauld would couple this reform by limiting the role of these elected members to facilitating public consultation. The task of actually running the

¹⁴⁵ Shum, above n 110, at 56–58.

¹⁴⁶ At 57.

¹⁴⁷ Peter Dunne “Fluoridation decision to move to DHBs” (12 April 2016) The Beehive <www.beehive.govt.nz>.

¹⁴⁸ Rachel Clayton “Why has the Government proposed DHBs decide on water fluoridation? And what is fluoride anyway?” (13 April 2016) Stuff <www.stuff.co.nz>.

¹⁴⁹ Clayton, above n 148.

¹⁵⁰ Laugesen and Gauld, above n 13, at 172.

¹⁵¹ At 172.

Health Board would seemingly be left to the appointed members. It can be seen that, under this proposal, elected members would not have quite the same role as they currently do. Therefore, it does not necessarily matter as much that they would have little power.

4 *Option Four: A New Elected Advisory Body*

A fourth alternative would entail smaller DHB Boards, comprised of both ministerial appointees and rotating members from a new elected Community Advisory Board (CAB). An independent review commissioned by the Ministry of Health proposed this alternative last year. It recommended that DHB Boards be reduced from eleven to nine members.¹⁵² Six of those members would be appointed by the Minister.¹⁵³ The remaining three would be rotated onto the Board in staggered six-month terms from the CAB.¹⁵⁴ The CAB itself would consist of twelve members elected triennially.¹⁵⁵ The stated rationale for the proposal was to:¹⁵⁶

Provide for more effective governance leadership of DHB Boards by enhancing the DHB Boards through greater community input and a better focus on competence in decision-making.

The review argued that:¹⁵⁷

The DHB Board structure presumes competence in governance and leadership, including from elected members, which appears to be lacking in practical day-to-day execution.

Furthermore, the review asserted, without evidence, that the current size of Boards and the ratio of elected to appointed members:¹⁵⁸

is not respectful of the leadership requirements needed to competently operate large, complex organisations. This can lead to a disproportionate influence of executive management on Board decisions and compromise the separation of leadership and operations.

This was the extent of the Review's reasoning. Interestingly, the suggestion in the final quoted sentence seems to suggest that the current structure results in unelected officials having too much influence over Board decisions. One wonders whether it would be reading too much into

¹⁵² Sue Suckling, Andrew Connolly, Jens Mueller and David Russell *The New Zealand Health System Independent Capability and Capacity Review* (Ministry of Health, June 2015) at 25.

¹⁵³ At 25.

¹⁵⁴ At 25.

¹⁵⁵ At 25.

¹⁵⁶ At 24.

¹⁵⁷ At 24.

¹⁵⁸ At 24.

the report to suggest that the implication is that reducing the number of elected members would increase their power.

Predictably, the opposition objected to the proposal on the grounds that it would “take away” local democracy,¹⁵⁹ and the government quickly moved to distance itself from the proposal.¹⁶⁰ As I have already demonstrated however, there is little reason to think that there is any meaningful local democracy to take away in the first place.

That being said, the review’s proposal is poorly conceived. It is also sparsely reasoned, so the following critique is based on assumptions about how the model would work in practice. These assumptions seem to be implied by the information we do have on the proposal. The CAB would, it seems, be elected to consult with the community about its health needs and desires. In and of itself, the CAB would be powerless. The very term ‘advisory’ implies an absence of binding decision-making power. The DHBs would continue to make the decisions, within the limited scope of discretion available to them. Community voice would be channelled through the Advisory Board’s representation on the DHBs, but there would be no requirement to follow it and the appointed members could outvote the co-opted ‘elected’ members. One has to question the wisdom of creating a new elected body which is essentially powerless. Its existence would nonetheless create the illusion of local democracy, which would be harmful in itself. Not to mention that the model seems needlessly complicated. Consulting with the community is, of course, an important function. However, there are other, simpler, ways to go about doing that.

5 Option Five: Centralisation

One final possibility would be simply to centralise healthcare in New Zealand. If DHBs were folded into the Ministry of Health, this would make it abundantly clear that the power, and thus the proper focus of accountability mechanisms, lay with the Minister. One could say that if the Minister already has so much power, this would just make it official. However, this would be a considerably more radical change to the status quo than my argument could bear. It would raise significant issues of substantive health governance policy which I do not address, namely issues related to the importance of having localised health governance at all.

One might object that this would, in fact, appear to be a natural consequence of my argument. If there is little scope for democratic decision-making, then it might be said that there is little scope for DHBs to respond to differing community needs at all. The possibility of option two

¹⁵⁹ Kate Gudsell “DHB heads to meet about governance overhaul” (27 July 2015) Radio New Zealand <www.radionz.co.nz>.

¹⁶⁰ Kate Gudsell; and “John Key pours cold water on proposed DHB governance overhaul” (27 July 2015) Stuff <www.stuff.co.nz>.

thus becomes a challenge to my very argument, inasmuch as it may suggest that I have proven too much.

Any such counterargument would, however, miss a few crucial points. First, much of the geographical variation in the delivery of healthcare will be at the operational level, not the policy level. Secondly, the Minister does not simply issue directions to DHBs generally nor require ministerial directions to be implemented without regard to the individual needs of different DHBs. While the Minister does, as a result of relatively recent legislative changes, have the power to issue directions generally, this does not substantially undermine the point I just made. If one were to conceive of each individual DHB as having a certain scope of policymaking discretion, subject to directions from both the Minister and the electorate, then directions from the Minister would take up most of the room DHBs have to manoeuvre. However, that scope to respond to local differences would still exist. There will always be a need for someone who is more closely connected to the situation on the ground to have a role in transforming policy into operations.

Since this option goes beyond the scope of my argument, I shall not discuss it further. I mention it here for the sake of completeness. This leaves us with four potential alternatives to my recommended option.

A Evaluation and Comparison

I now proceed to evaluate the four remaining alternatives against the criteria I explained under section four of this essay. I set out three conditions internal to my argument. It should not promise more democracy than it delivers. It must allow for community voice in decision-making. It must hold decision-makers accountable. There are also two conditions external to my argument. It must not degrade governance or healthcare. It must be affordable and generally feasible. An acceptable alternative to the status quo must satisfy all five conditions.

The first condition internal to my argument was that the alternative must not purport to be more democratic than it really is. Option one satisfies this condition, because it simply reflects the true extent of ministerial control and the consequent lack of democracy. Option two would be essentially neutral in this regard; in other words, it would satisfy the condition. The Minister of Local Government has less control over local authorities than the Minister of Health does over DHBs. Thus, folding DHBs into councils would decrease vertical accountability through the Minister to the people. In return, however, delivery of healthcare would thus become the responsibility of a form of local government which has a superior claim to being democratic than DHBs. As for option three, any option that retained elected representatives would, at first sight, violate this condition. Indeed, it would appear to do so *a fortiori*, since elected members would be in a minority. However, Laugesen and Gauld might respond that while the elected

members could not outvote appointed members, this is not the point in retaining them. The point, rather, is for there to be someone to ‘fight for’ individuals (in a David and Goliath sense), to facilitate consultation, and to focus and sharpen public attention at elections and thus public interest. As long as their role was clearly delineated, I am inclined to think that this would satisfy the condition. Option four goes too far, however. Creating an entire elected board, particularly one whose members served on the DHB from time to time, would seem more than likely to create unrealistic expectations. Therefore, option four fails this condition.

The second internal condition was that any alternative must allow for community views to be represented in decision-making. Option one would satisfy this condition, as the DHBs would be required to consult in certain situations as currently required by legislation and the common law. Similarly, under option two, local authorities would be required to consult as the law currently requires; although more so than option one, for statute imposes broader obligations on councils than DHBs. Options three and four satisfy the condition, because they retain elected members for the express purpose of seeking and representing community views.

Finally, to be consistent with my argument, the alternative must provide a means of holding decision-makers to account. Option one would have ministerial responsibility as the primary accountability mechanism. The Minister would hold the Board members to account through their employment contracts, and the public and the opposition would hold the Minister to account through Question Time and the ballot box. Judicial review would also be an option, and we might expect a closer standard of review owing to the removal of the electoral mechanism. Option two would shift the focus of accountability from the Minister to the relevant local authorities, who are accountable primarily to the electorate through the ballot box. As we have seen, they are also accountable through various statutory mechanisms to the Minister for Local Government, although to a lesser degree than DHBs. Judicial review would also remain a possibility, as it would for all options. Options three and four would retain a focus on electoral accountability, as well as ministerial accountability.

Aside from being consistent with my argument, the alternative must not compromise the quality of governance or actual healthcare. My argument thus far has not been focused on the substantive goals of the health system, but the way in which that system is structured is ultimately a means to those ends. That includes the way in which democracy and accountability are given form in that system. It would be artificial to insist on too bright a line between my argument and the quality of healthcare.

Some, particularly those of a neoliberal persuasion, would argue that removing elected members would likely *increase* the quality of governance (and thus eventually healthcare). It might be said that appointments based on merit are more likely to guarantee quality than popularity. While this would support my argument, it is not strongly supported by the evidence.

Concerns have indeed been expressed as to the capabilities and skillsets of elected members. However, the evidence is considerably equivocal about whether this has translated into a poorer quality of decision-making. Indications seem to be that elected members have been able to overcome those concerns. It must also be remembered that public participation and responsiveness to the community are important elements of good governance.

Additionally, while concerns have been expressed about the health system generally, the capability of elected members is just one component of this system and thus of the concerns expressed. It can be difficult to disaggregate concerns about the health system into claims about the relative competencies of elected and appointed members.

I turn now to assess each of the remaining options. Option one, the minimal change option, would, one would expect, have little impact on governance or healthcare. One could argue that elections are the best way of guaranteeing competent members, since the people know best. One could therefore argue that abolishing elections would decrease the quality of governance, particularly since consultation and responsiveness are, indeed, important elements of governance. However, just as there is little evidence to suggest that elected members lack competency, there is no evidence to suggest that they are more competent than appointed members. The wisdom of the crowds cannot be said to manifest itself in DHB elections, because, to repeat my primary argument, turnout is low and voting is uninformed. Furthermore, it would be unduly cynical to think that appointed members would not take into account community voice. Certainly, elected officials would have more of an incentive than appointed officials to be responsive. Yet there is no reason to suppose that appointed members do not value community voice, a) on principle, b) as an element of good governance, and c) because successful implementation requires community consultation and support. They would be particularly so inclined if their employment contracts and the legislation required them to take these things into account. In short, abolishing DHB elections would not compromise the quality of governance.

I turn to option two, decentralisation. While Shum is optimistic about the ability of local government to make health policy decisions, we have already seen that councils themselves are less confident about this. Of course, as Knight suggests,¹⁶¹ transferring these functions to councils would likely encourage those with the relevant skills and capabilities to run for local government. There is already some overlap between DHB and council membership. In the absence of any evidence, we cannot conclude that decentralisation would necessarily degrade the quality of health governance.

¹⁶¹ In the context of his own proposal.

The effect of options three and four would be to vary the ratio of elected to appointed members. Having established that there is, on the evidence, no significant difference in competency between elected and appointed members, it would seem to follow that varying the ratio would not make a difference. Option seven would also slightly reduce the size of the Board. This would, in theory, make it less unwieldy. At worst, it probably would not reduce the quality of governance. Both of these options would have elected officials whose offices exist specifically to consult with the public. If this effected any change vis-à-vis the status quo, it would seem likely to result in some beneficial specialisation.

In summary, none of the options I have canvassed would be likely to compromise the quality of governance or healthcare.

The final condition which any viable alternative must satisfy is that it needs to be affordable and in all other respects feasible. First, I must acknowledge that any change will inevitably cause transaction costs, to a greater or lesser degree. Whether the change is worth those costs depends on the strength of my primary argument. I suggest that the benefits of the change are worth the cost. Abolishing elections would save some administration costs; of course, the *reductio ad absurdum* counterargument to this point would be “why not just abolish democracy entirely, if it be so expensive?” However, I have already shown that we have good independent reasons to abolish DHB elections; I raise the cost of elections merely in response to the fact that there would be transaction costs. The next paragraph deals with costs other than transaction costs, although it does not purport to be anything like a systematic economic analysis.

Option one would not impose any significant monetary costs, as far as I can imagine. If one were truly desperate, one could probably contrive of some instance where the change might cost more, but it would not be significant. Under the variation which requires greater consultation, there would be a slightly greater cost. However, it would not be a significant burden in the grand scheme of things. Option two would involve a significant transfer of the cost of running the health system from central to local government. To afford this, either central government would have to provide the funds it currently spends on health to councils, or councils would have to raise rates (with the money central government saved being returned in the form of tax cuts). Overall, however, it would likely be fiscally neutral, since the same functions would be performed. This is surely an oversimplification, but a full analysis of all the possible and likely effects of such a change is not possible here. Option three would be, one would think, somewhat more expensive than the status quo or minimal change. That is because, while it would retain some elections, it would place a greater importance on consultation. Option four would cost even more. It would also combine elections with a greater emphasis on consultation. Additionally, it would require the creation of an entirely new Community Advisory Board. While the DHB Board would have fewer members, there would be an overall

increase in the combined number of employees. Again, however, in the context of the billions of dollars spent on DHBs, none of these costs would be prohibitive in and of themselves.

As for being ‘otherwise’ feasible, this essentially refers to political feasibility. It is difficult to imagine that any of these proposals could be technically unfeasible. As for political feasibility, this is, in a sense, an irrelevant consideration. My argument is that we *should* make certain changes. The fact that politicians may be *unwilling* to do so does not strictly affect that argument. The fact that female suffrage (or universal male suffrage, for that matter) was once politically unfeasible does not change the fact that women (and non-property owning men) always *should* have had the vote. Still, it would be remiss of me not at least to consider it; an ivory tower policy proposal which took no account of the real world would be of little use to anyone. Of all the options, decentralisation would be the biggest change to the status quo. As I have already said, local government is likely to resist it, and central government is unlikely to be willing to relinquish that power or the responsibility that comes with it. Therefore, it would seem not to be politically feasible, and I reject it for that reason. None of the other proposals would seem to be beyond the boundaries of feasibility.

B Recommendation

Three options fail to satisfy the necessary external conditions and the conditions internal to my argument which an alternative must meet if I am to recommend it. Option two (as well as option five) was too radical a change for my argument to bear. Option four would replicate some of the very faults of the current system which justify its reform. This means that two potential alternatives to my recommendation satisfy the necessary conditions. The question thus becomes which would satisfy them the best. This section of the essay will compare my recommended solution with the remaining two alternatives. It will demonstrate that outsourcing consultation is superior to those alternatives.

First, I rule out Laugesen and Gauld’s suggestion. Laugesen and Gauld attempt to reorient the justification for having (a reduced number of) elected members from a more general democratic argument to a suggestion that elected officials would consult with and represent the community on the Boards. They would not have the majority necessary to ensure that those views carried the day, but they would still be able to make the case for them and to ‘fight for’ individuals who had been poorly treated. Laugesen and Gauld also seem hopeful that having fewer positions would make elections more competitive and thus more important to the public. There is a certain attraction to this reasoning. On the other hand, one might query whether, given the general disinterest people show both here and internationally in such elections, it would make that much difference. One might also question whether the public would understand the distinction which Laugesen and Gauld try to draw. Finally, there is no reason why a committee

of appointed members cannot carry out consultation; plenty of consultation by ministries is run by public servants.

This leaves us with only one alternative, namely option one. The only difference between this option and my recommendation is who carries out the consultation, the DHB or local authorities. DHBs would be the intuitive choice. On the other hand, councils, or at least territorial councils, are more closely connected to their communities. They are more visible and they have more experience carrying out consulting exercises. As we saw, the fact that council boundaries do not coincide with DHB boundaries is not an insurmountable problem. Therefore, I recommend that New Zealand institutes fully appointed DHBs that outsource consultation to local councils.

VII Conclusion

“[T]here are no new policy debates in health care,” Lomas writes, “just a constant revisiting of the same debate about who should govern and manage the system”.¹⁶² That is surely an overstatement. Consider, however, the never-ending debate, across time and space, about how best to manage New Zealand’s public health system. This essay is only the most recent instalment in this debate. In that light, one cannot help but think that there is a kernel of truth to the claim.

The alternative to having elected District Health Boards that I have promoted in this essay would amount only to a modest change. Elected members would be replaced by additional appointed members. Consultation with the community on how to implement DHB policy would be carried out by local authorities, in cooperation with each other and the DHBs. The feedback which the councils received would then be submitted to the DHBs, which would take it into account in assessing priorities in healthcare decision-making.

As I have demonstrated, DHB elections serve no useful purpose. In theory, they do. In practice, they do not. Few people cast votes in DHB elections, let alone informed votes. Besides which, there is little scope for elected members to serve the wishes or interests of their electorate, because members are primarily accountable to the Minister. A principled commitment to democracy does not require us to retain elected DHBs. Appointed DHBs would still be democratically accountable and legitimate. That is because they would remain vertically accountable to the responsible Minister and thus, by way of the government and Parliament, to the people. Elected DHBs are fraudulent and unnecessary. They should be abolished.

¹⁶² Jonathan Lomas “Devolving authority for health care in Canada’s provinces: emerging issues and prospects” (1997) 156 CMAJ 817 at 818.

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IX Appendix

This appendix depicts Laugesen and Gauld’s research into voting habits in tabular form.

Reference footnote 12.

	2001	2004	2007	2010	2013
Turnout (%)	50	42	43	49	44.7

Miriam J Laugesen and Robin Gauld *Democratic Governance and Health: Hospitals, Politics and Health Policy in New Zealand* (Otago University Press, Dunedin, 2012) at 145; and “2013 NZ Local Authority Election Statistics” (November 2014) Department of Internal Affairs website <www.dia.govt.nz>.

Reference footnote 14.

	2001 (sample size = 173)	2004 (sample size = 183)	2007 (sample size = 237)
Did not know why not (%)	20	28	35
Did not know about elections (%)	15	16	19
Did not receive voting papers (%)	12	18	12
Had no interest in elections (%)	27	30	17

Robin Gauld “Are elected health boards an effective mechanism for public participation in health service governance?” (2010) 13 *Health Expectations* 369 at 373.

Reference footnote 15.

	2001	2004	2007	2010
Blank or invalid votes (%)	6	15	17	16

Laugesen and Gauld at 145.

Reference footnote 19.

	2001 (sample size = 327)	2004 (sample size = 345)	2007 (sample size = 263)
Used candidate profiles (%)	61	53	64
Looked for someone the voter knew (%)	26	35	27
Used guesswork (%)	4	3	3

Gauld at 374.