Clinical Governance in the New Zealand Health sector

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Governance in New Zealand Public Healthcare Services: what is the position of clinical governance?

Lee Mathias
RGON, BA, MBA, DHSc
Lee Mathias Limited
lee@leemathias.com

This paper has been prepared from excerpts of my doctoral thesis “The shaping of decision-making in governance in New Zealand’s public healthcare services” in which I set out to provide something useful for board members, managers and clinicians and applicable to our practice of governance in our healthcare services.

The outcome was three fold.

Firstly governance is governance – a collection of principles which underpin all governance decision-making no matter what the context. The rules for corporate and clinical governance are the same. Secondly, evidence from the literature found that two aspects to governance can be distinguished which facilitate the transferability of generic principles of governance to New Zealand healthcare services. Governance is the making of decisions in good faith (Farrar, 2005; Finn, 1977), with independence of mind (Garratt, 2005) and with the appropriate skills, diligence and care taken on behalf of others (M. King, 2002a; Tricker, 1984). Secondly, the structures of governance are audit (Power, 1997), laws (Finn, 1977; Health Practitioners' Competency Assurance Act," 2003), guidelines, codes (Cadbury, 1992) and principles (New Zealand Securities Commission, 2004) which support decision-making on behalf of others. Lastly, by contextualizing governance, that is describing governance decisions by the context in which they are made e.g. clinical governance, we obfuscate decision-making including the inculcation of a common understanding of what governance means.
Disparities in understanding have been and continue to be considerable.

Campbell (2001) refers to the origins of corporate governance in business management theory in which business is managed according to a known course or plan facilitated by defined structures. Pfeffer (1997), however, highlights that one of the dimensions of managerialism important to health professionals is the reduction of status distinctions and barriers across all corporate levels. This key characteristic of employee behaviour has been ignored in some of our large healthcare organisations in the recent past (Sage et al., 2001).

Harrison (2003) has gone so far as to suggest that the introduction of clinical governance was a way for managers to keep control over the business of healthcare organisations. My view is that the deficits in managers’ understanding of clinical practice and management of the clinical environment influence managers’ decisions, which in turn impact on clinical activity. This also raises questions about whether or not the issue is one of power rather than decision-making for clinical excellence and quality.

Gray (2003) suggests that clinical governance is an elastic concept interpreted differently depending on the people and the context they are in. It is multifaceted in terms of both constituents and perspectives, it appears as structure (Rowland, 2003), as process (Rashidan & Russell, 2003) and as behaviour (Mahmood, 2003; Moran, 2003). Clinical governance embraces providers and their representatives (Harrison & Lim, 2003) and patients and their representatives (Quennell, 2003). It employs the carrot-and-stick metaphor to coerce health professionals into participation (Rowland, 2003); and it is informed in both study and practice by the history of the management of UK NHS health care services. Clinical governance is also used as a traditional command model to reinforce a rule-based system of care (Rashidan & Russell, 2003). We have similar experiences in New Zealand where there are strict guidelines and measuring tools to establish who should receive care and who should not in some services, e.g. cardiothoracic surgery guidelines (New Zealand Guidelines Group, 2003).

The conclusion is that there are a variety of interpretations and understandings of governance in clinical activity, predominantly with a focus on quality assurance. The interpretation of governance in clinical activity as quality assurance masks the operationalising of the other aspects
of governance identified in the literature; those are transparency, accountability and fiduciary duty. The potential for confusion in interpretation is high and has the potential to impact on governance decision-making in clinical activity.

In the New Zealand environment the focus on audit has been all-consuming for some organizations, over-shadowing the purpose of organisations as described by Kenny (2002) and Power (1997). For example the Waikato DHB has withdrawn from the formal accreditation process because the value gained was considered insufficient to warrant the expenditure in light of the certification requirements under the Health and Disability Services (Safety) Act (2001).

At ADHB there is a formal and rigorous credentialing programme which ignores the credentialing role of the regulatory authorities under the HPCA Act. We are prone to reinventing, double acting and other unnecessary activity in the name of safety.

Quality assurance programmes as a risk management tools are only one area in which governance is operationalised. Other aspects of governance are given much less attention by the authorities or left to the traditional forms of management; for example the moral and ethical principles in decision-making are often left to the debate of the professions. The separation of aspects of governance in clinical activity further impacts on clinical decision-making because of incompleteness of application of the generic principles.

O’Neill (2002) suggests that the focus on audit and compliance tells people that they are not trusted to undertake their professional roles and this has led to a crisis of trust. The conclusion is that audit has overwhelmed other attributes of governance and suggests the probity functions, including audit, of governance need to be embedded in the clinical decision-making. An important question to explore is how audit impacts on the shape of decision-making, specifically in clinical governance.

O’Neill (2002) also identifies trust as valuable social capital, and therefore power and she links the mutual trust around the board table with

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1 Waikato DHB press release 29 March 2007, “WDHB withdraws from Accreditation”
stewardship, an integral attribute of the board. However, O’Neill suggests that we have a culture of suspicion brought about by a relentless need for people, especially professionals, to demonstrate accountability which, in her view, damages trust rather than supports it. The Minister has to trust DHBs to make decisions which ensure the provision of healthcare services and assure the public of the quality of those services. In DHB governance Crombie proposes that board members and executives need to have trust in health professionals to use resources appropriately and efficiently. Perkins (2004b) extends the context to those making governance decisions needing to demonstrate trust through the creation of an environment conducive to best, as well as innovative, practice. Boards, who have the stewardship of public healthcare services, need to have trust of and in clinicians because, as O’Neill (2002) states, processes cannot be put in place to guarantee everything.

The trust in directors, managers and employees to undertake their role as stewards of the public healthcare services resources is paradoxically opposed to the “sacred duty of trust” (Halligan, 2006), the fiduciary duty in which health professionals accept to always make decisions in their patients’ best interest. The literature, however, does not provide a link between trust around the board table and trust at the bedside and my research demonstrated that such a link improves decision-making in governance in all settings.

So what is governance?

*Governance is the decision made on behalf of others within a given and accepted relationship of trust. Decision-making in governance in healthcare services is firstly characterised by professional maturity which enables accountability, quality and safety which assures probity, power and tension which supports transparency and balancing the duty of utility and the duty of care which compliment fiduciary duty. Secondly, governance decisions are supported by the structures of law and policy and within the context of time.*

Governance in healthcare services is multifaceted. It is underpinned by the generic principles on accountability, probity, transparency and fiduciary duty which are operationalised through the four key concepts of professional

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2 Crombie, D. 2003 in a lecture to Doctor of Health Science entrants, Auckland University of Technology
maturity, quality and safety, power and tension and balancing the duty of care with the duty of utility.

**Professional maturity**

Professional maturity is a prerequisite for the ability to be accountable for one’s decision-making in governance. Professional maturity is a dimension of decision-making in governance based on life experience, professional experience, education and technical skills. Those who are professionally mature demonstrate leadership in that their credibility is recognised by others. While this concept may be compared with Senge’s (1990) “personal mastery” people who are professionally mature have reached a turning point with self-recognition of confidence in their own competence to make decisions in their *practice* and recognise the views of others which is expressed as *metaliteracy* by Webb *et al.* (2002). The increase in the *cultural power* of those who are professionally mature is recognised by others through the consistency observed in decision-making. Professional maturity is confirmed by understanding when not to proceed but also when to *practice* outside of the established processes using knowledge based on qualification and experience.

The characteristics of professional maturity are:
- Education and credibility
- Experience and credibility
- Leadership
- Skills
- Metaliteracy – being able to recognise the value in the views of others

However, professional accountability within clinical governance is regarded as a separate concept from the accountabilities of the healthcare service organizations, and this is supported by Deighan (2006). Professional accountability relates to the decisions made by autonomous health professionals, especially in their role as practicing clinicians and involves accountability to patients.

**Quality and Safety**

Healthcare consumers, the public of New Zealand, have an expectation that the publicly funded healthcare services being offered will be of the best quality and available when they are required at the price funded.
research showed that those services are underpinned by the professional morality of the healthcare service providers as organisations and individuals.

Participants in my study suggested that clinical governance in current practice, that is, with the focus on quality and audit, has obscured the other dimensions of governance and their application to governance decision-making in clinical activity. Issues of duty, power and tension and professional maturity in clinical activity are not recognised as issues requiring governance decision-making.

In healthcare services, probity is operationalised through the structure of the quality and safety programmes in all functional areas, including the professional requirements for currency in practice ("Health Practitioners' Competency Assurance Act," 2003), the maintenance of professional autonomy and institutional memory. It is of some concern that credentialing has not been left with the professional councils and has been confused with good employee practices.

Quality and safety is based on:
Guidelines
Rules
Audit
Professional thesis and morality of the clinician
Institutional memory

**Power and tension**

Maintaining healthy tensions between stakeholders through robust debate, recognition of competence in others and confidence in their opinions ensures transparency in organisations. Tensions which are the result of an imbalance in the *symbolic power* between individuals and/or groups in the particular healthcare service are unhealthy. As expressed in the data, negative tension costs time and money and is a distraction from the governance of healthcare organisations.

Power and tension is characterised by the balanced tensions in:

Symbolic Power
Trust
Collective responsibility
Democratisation of healthcare
Duty of care balanced with the duty of utility

The primary purpose of governance in healthcare services is to balance the tension between the duty of utility, the efficient and effective use of resources, with the duty of care demanded by both professional *practice* and the legislation in relation to DHBs ("Crown Entities Act," 2004) which are required to take due care.

For the purposes of my research the duty of care as enshrined in common law and codified in the Companies Act (2003) does not remove, override or pre-empt the concept of duty of care of heath professionals who are bound by oath or pledge. The health professionals’ duty of care is now formalised in the Code of Patient Rights of the Health and Disabilities Commissioner Act (1996). Any case arising under that code would be dealt with on merit of the particular case.

The duty of care is the same in both the corporate and patient care contexts demonstrating the same characteristics of trust and accepted authority to care on behalf of others. They are enacted differently because of different contexts but the underlying principles are the same. The point is important as my research showed that decision-making in governance is the same no matter within which context they are applied, that is corporate, management or clinical. It is recognised however that all decision-making in public healthcare services is complex as it is limited by economic rationality.

The balance is attained through:

- Economic rationality
- Ideologies and philosophies
- Cultural power
- Professionhood
- Conflicts of interest

Fiduciary duty to the entity, the trust authorised by others and accepted by directors, takes precedence over all other duties and responsibilities including that duty to the shareholder (Hinnant, 1988). In contrast, the legislation relevant to DHBs (Crown Entities Act, 2004; NZPHD Act, 2000) specifically ensures that primary accountability of board members is to the Minister of Health prior to any accountability to the organisation. DHBs cannot make independent decisions in the best interests of the organisation, with the confidence that those decisions will not be overturned by the

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Minister. The Minister is vulnerable to decision-making in response to political pressure and the government’s broader situation and not primarily in the interests of the DHB as shareholder. Others describe this problematic situation as a dual accountability (Mays et al., 2007) i.e. duty to the Minister and the organisation. It becomes problematic when the Minister’s decision impacts on the strategic and operational decision-making of the DHB. Secondly, attaining the balance between duty to the organisation and duty of care to the patient or community recognises that there will be conflicts of interest which require management. However, self-interest is very difficult to manage and in some cases cannot be managed. DHB members should be appointed without ongoing conflicts of interest. While board members are drawn from the local communities, maintaining the original intent of the legislation, the wider public voice could be provided for through participation in a health tribunal using the model of Smith (1999).

Governance is supported by structure within the context of time.

Structure
Organisational structure of healthcare services influences both the way decisions are made and where they are made. Organisational structure must incorporate disciplines which ensure adherence to the primary principles of governance. A traditional example is the separation of the audit function from management and representation independent of the board on the audit committee. Governance disciplines should also include personal accountability for and transparency in practice in all parts of the healthcare services.

For the determinants of decision-making in governance to influence decision-making in healthcare services a political structure is required which does not impede the decision-making within those services. The Crown Entities Act (2004) was created in order to establish definition of the roles of Crown Entities (State Services Commission, 1999, 2000a, 2000b, 2000c). A consequence has been easy access by Ministers to interfere with the decision-making of DHBs. This means that the best interests of the healthcare service organisations are not the primary interest of the Minister or board members. Economic logic can be thwarted too easily. DHBs should be defined as Autonomous Crown Entities (ACE) which are not subject to the impulse of Ministers or the vagaries of political tensions. Structure should enhance good governance not impede it.

Time
Recognising *time* in context and managing tempo are part of the role of those making decisions in governance and they impact on the present, future and how we make *time*. Managing *time* and timeliness of decision-making is a function of leadership of efficient healthcare services. Similarly the context of *time* in history or the present influenced governance decisions through institutional memory, the changes in the *cultures* of healthcare service professions and currency in *practice*.

So, I have introduced a framework which can be used in any area of governance in healthcare services and can be applied to any context where professional governance abuts the corporate governance of the organisation.

From my research I propose some changes.

The purpose of healthcare services is to provide education, treatment and care to individuals and their communities and to achieve positive health outcomes. The purpose of decision-making in governance in healthcare services is to enable clinical *practice* which incorporates inclusion of the patient or community in decision-making. Ideally, all healthcare services governance should be directed at supporting clinical *practice* and providing the resources and environments in which *practice* can be carried out.

The implications of the framework include:

- Making **transparent** the characteristics of personal and group experience which influence the shaping of decision-making in governance.

- The framework is suitable as the basis for a **code of healthcare services governance** which would demonstrate, for all stakeholders, a set of common values to be used in governance decision-making in New Zealand public healthcare services. Those values would emanate from the dimensions of governance which shape decision-making of professional maturity, quality and safety, power and tension and fiduciary duty.
• The inculcation of a common **definition of governance** and its operationalisation in New Zealand healthcare services, recognising the patient and the community role in decision-making as centre of the governance process in healthcare services.

Considering the impact in law
• DHBs, so that they may act within government policy but independent of shareholder involvement in decision-making, would be re-classified as **Autonomous Crown Entities** as defined in the Crown Entities Act (2004). While still having regard for government policy, autonomy would support decisions related to economic rationality in the provision of services, and ease the tensions caused by perceived multiple accountabilities.

• DHB members would be appointed, by the Minister as shareholder, based on their experience, qualification and skill in healthcare services governance in a similar manner that health professionals are appointed to positions based on qualification, skill and experience. The **balanced board** would include qualified members from the community and health professionals who do not benefit or are not at risk of benefiting personally from the decisions of the board.

Considering the impact on process
• **DHB clinician engagement** would be established through the board committee and advisory process including the clinical advice function. Each board would have at least one clinician without personal interests as a member.
• Service specifications will require inclusion of modules which support interdisciplinary practice. For example, in maternity services an antenatal service module which allows the lead maternity carer and general practitioner to coordinate care, and similarly between them and the well child provider during the post natal period, would encourage **clinical networks**. Both modules have been be added to the existing section 88 notice (NZPHD Act, 2000) which covers the provision of care and payment. A subsequent project under negotiation will allow for virtual integration via a referral and post natal reporting process which will include obstetricians.

• Community engagement and the function of community consultation are combined with the function of the National Health Committee in the **New Zealand Health Tribunal**. The Tribunal, based on the ideas of Smith (1999) would be open to any member or group of the public. It would hear the views of the people in locations throughout the country ongoing and throughout the years. The DHB statutory committees would cease as their contribution has varied across DHBs (Mays *et al.*, 2007), but public providers would attend the Tribunal when held in their district and hear the views of the public directly. In practice the Health Committee has been strengthened but the consultative aspect has not yet been included.

• **Intersectoral engagement**, that is, between health and other social agencies, would be formalised at Ministry and District levels with governance recognising a similar model for decision-making in social services governance. The navigator project which is part of Whau Ora has been announced this week.
Thank you

lee@leemathias.com