

Democratising health care governance? New Zealand's inaugural district health board elections, 2001

ROBIN GAULD

Robin Gauld is Senior Lecturer in Health Policy in the Department of Preventive and Social Medicine at the University of Otago, Dunedin, New Zealand.

Abstract

New Zealand's 'district health board' (DHB) system has been under implementation since the 1999 general election. A key factor motivating the change to DHBs is the democratisation of health care governance. A majority of the new DHB members are popularly elected. Previously, hospital board members were government appointees. Inaugural DHB elections were held in October 2001. This article reports on the election results and the wider operating context for DHBs. It notes organisational issues to be considered for the next DHB elections in 2004, and questions the extent to which the elections and DHB governance structure will enhance health care democratisation in New Zealand.

An overview

The 'district health board' (DHB) system is the most recent to have emerged from a succession of recastings of the New Zealand public health sector. A key factor motivating the change to DHBs is the democratisation of health care governance, particularly in terms of broadening public participation in decision making processes. In contrast with governance arrangements through the 1990s, where health board members were central government appointees and decision making was conducted behind closed doors, a majority of the new DHB members are popularly elected and DHBs are expected to engage with the public. The inaugural DHB elections were held in October 2001. This article reports the results. It draws on primary data collected by the New Zealand Ministry of Health and the New Zealand Health Sector Transition Project at the University of Otago. The article opens by backgrounding the DHB system and preceding structures. Second, it profiles the DHB elections. Third, it presents and discusses the election results. In concluding, the article notes organisational issues to be considered for the 2004 elections, and speculates on the functioning and further development of New Zealand's 'democratised' health boards.

The DHB system and its predecessors

The New Zealand public health sector has been totally restructured three times since the early 1990s. With four different structures over the space of a decade, this means New Zealand can claim the title of 'most restructured' health sector in the world (Gauld 2001). The restructuring era commenced with the formation of the area health board (AHB) system, fully operable from 1989-1991, but developed and implemented over several years from the early 1980s. The AHB system consisted of 14 regional elected governing boards responsible for planning and providing health care for their respective populations. AHBs were oriented by a series of health goals and targets agreed to in formal contract with the government, and subject to generic managerial and accountability

reforms concurrently implemented across the public sector (Beaglehole and Davis 1992). However, AHBs were developed in a context of radical public sector reform in New Zealand and their design failed to match with market models of organisation then in vogue. This explains their short life span.

In 1991, a new neo-liberal National government announced a major health sector reorganisation that would see a new internal market system implemented by mid-1993 (Upton 1991). This system involved separating the purchasing and providing roles performed by AHBs. Purchasing would be the task of four new competing regional health authorities that would contract out services delivery to 23 profit-seeking crown health enterprises (public hospitals) and competing providers in the 'marketplace'.

A new centre-right coalition government led by the National party was formed from the 1996 election, and further health sector restructuring ensued. This was largely a result of negotiations between the two parties forming the coalition government, but also due to the broad malfunction of the market system. The four regional health authorities were amalgamated into a centralised Health Funding Authority, responsible for national purchasing. The crown health enterprises were renamed hospital and health services, reflecting a new requirement to focus on public service and patients ahead of profit. Hangovers from the market model persisted through the earlier part of this period. However, by 1999, it was clear that there was greater emphasis across the health sector on notions such as collaboration and service coordination, equity of funding and service access between regions, and there was evidence of national strategic planning (Crech 1999; Davies 1999).

The 1999 election saw the formation of a new centre-left coalition government dominated by the Labour party. This spelled a further round of restructuring based on a plan laid out in Labour's pre-election manifesto (New Zealand Labour Party 1999). The current system, conceptually similar to the earlier AHB system, consists of 21 DHBs, centrally funded by the Ministry of Health. The Health Funding Authority has been abolished. Some of its functions have been taken over by the Ministry, and others have been devolved to DHBs. As with the AHBs, DHBs are responsible for planning, prioritising and purchasing health services for their regions' residents from an appropriate range of providers. They are to focus on and develop strategies to improve population health and do so in collaboration with the community and central government.

Each DHB has 11 members: seven elected by popular vote, and the remaining four appointed by the government including the crucial positions of board chair and deputy chair (although these appointees may be selected from among elected members). In recognition of the Treaty of Waitangi, the founding agreement signed in 1840 between the Crown and indigenous New Zealand Maori people, the government decided that two of the 11 members should be of Maori origin. Servicing each DHB is a permanent secretariat including a chief executive and various planners, managers and contract negotiators. DHBs have developed a series of supra-regional 'shared service' agencies to provide support in areas such as information and contract management and financial, legal and human resource services. The government's aims for the DHB system are therefore to improve population health, but also to raise public confidence in health care and the health system, recognised as depleted (Donelan et al. 1999), by devolving decision making to the local level and democratising health care governance.

DHB development and operations

As with any systemic change, the process of developing the DHB system has been complex and arduous. For example, following the 1999 election, the government's high-level plan for the system had to be operationalised. This involved extensive policy development work, from establishing new funding arrangements for DHBs through to ensuring a sound legislative framework. The initial period of the transition was particularly difficult, requiring the Health Funding Authority to both lead the change process at an operational level and plan for its own dissolution, although the Ministry of Health was arguably the overarching driver of the transition process. Hospital leaders were in a similarly complex position, being responsible for creating new local DHB structures including developing draft plans in consultation with their communities with no additional resources to do so. The process of devolving funding to DHBs required intricate work: the government needed to be clear about accountability frameworks and the range and costs of services to be locally purchased, while DHBs needed to be ready to assume initial purchasing functions by mid 2001, and for the subsequent devolution of responsibilities.

DHBs came into formal existence with the passage of enabling legislation in December 2000 following which they concentrated on recruiting staff, developing service contracts and forging relationships with local providers and communities. The existing (former hospital) governing boards were 'interim' until the inaugural DHB elections in October 2001, a key milestone in the transition. The governing board has an important role. It has ultimate responsibility for all health care planning and purchasing within the district, is accountable to central government for DHB performance, and to local providers and the public. In this sense, the DHB configuration is in keeping with the 'political model' of accountability, with emphasis on openness and community. In contrast, the former governing boards were closer to the 'economic model', with services treated as commodities, boards primarily concerned with price and quality issues and accountable only to government (Emanuel and Emanuel 1997).

DHB members (elected or appointed) have the potential to 'make a difference' in health care delivery, but also sit in a difficult position of having 'dual accountabilities' to both government and the community and having to take 'hard' decisions over resource allocation and service prioritisation (previously a central Health Funding Authority liability) in a constrained funding environment. Shortly after the elections, with the elected component of boards clear, the government appointed DHB chairs. On 10 January 2002, the government added the remaining appointees. The core elements of the DHB system have, therefore, only really been in place since then.

Lead-up to and organisation of the DHB elections

As noted above, the DHB elections were central to DHB development and the process of democratising decision making. The election date was announced in early 2000, along with a list of important deadlines timetabled for the DHB transition. In keeping with the policy of localisation underpinning DHBs, it was decided that the elections would be held in conjunction with the October 2001 local government elections. Local elections are traditionally conducted using the first-past-the-post electoral system and held every three years. The process of setting DHB constituency boundaries was a central government responsibility and would not have been straightforward. First, most DHBs cover wide and diverse geographic and demographic areas. To ensure 'representation', regions were broken into voting wards with seats allocated in broad proportion to the concentration and distribution of voters. For example, the Otago DHB covers an area including a city of 120,000 people and a large rural area containing several provincial towns. The city was roughly divided into two wards of two seats each. Each of the remaining three seats covers a rural district. In all, Otago DHB members are drawn from five separate wards with differing health care needs. Second, DHB boundaries do not relate to local authority or central government electoral boundaries. For the most part, DHB voting wards were an aggregation of city and district council boundaries. In practice, this meant a voter would be selecting perhaps two candidates from a larger 'regional' DHB ward and one city or district council candidate from the smaller geographic area in which they lived. In two instances, Ruapehu and Queenstown-Lakes, DHB wards were divided between local authority boundaries.

Responsibility for the DHB elections naturally fell with local government returning officers. New Zealand's recent local government elections have been conducted by postal vote, and this remained the case with the 2001 ballot. Therefore, local returning officers had the task of providing public education about the DHB elections, receiving nominations and facilitating polling. To assist in the process, central government also launched a public education drive to announce that candidate nominations were open and that the elections were imminent. This included television, newspaper and movie theatre advertisements, creation of an election telephone 'hotline', and household letterbox mailouts. Government information consisted of overviews of the DHB system with its aim of public involvement in health care delivery as discussed above. Particular note was made of the fact that the elections offered individuals the opportunity to participate as candidates and voters.

Nominations opened on 27 July 2001 and, initially, uptake was slow. Around a week before the closing date there had been only about 40 nominations nationally and there appeared to be little interest in the elections. This may have been due to widespread public scepticism about yet another round of health sector changes and the relative merits of setting up elected health boards, the possibility that the potentially demanding role of DHB member was not an attractive one, and the fact that there had not been a recent tradition of electing health board members. However, critics were proved wrong as an extraordinary number of candidates waited until the last days to register. By the closing date of 24 August 2001 there were 1084 candidates contesting 146 seats

nationally, making an average of 7.42 candidates for each seat. Although 147 seats were available, the seat of Queenstown-Lakes had only one nominee.

Some wards had very large numbers of candidates by any standards. For instance, voters in the Waitakere ward, one of three composing the Waitemata DHB, had a choice of 50 candidates contending three seats. In the Christchurch ward, 75 candidates contested five seats. Whether voters were able to make informed choices with such large candidate fields to choose from remains an important question, which is taken up below. The 1084 candidates were 55.17 percent male and 44.83 female. 54 candidates (4.98 percent) were DHB employees, 73 (6.73 percent) were incumbent board members, and 127 (11.72 percent) were of indigenous New Zealand Maori ethnicity. Perhaps predictably, given the different objectives and potential for greater politicisation inherent within the DHB system, many incumbents did not present themselves for election.

Campaigning was permitted up to and including the election day, 13 October 2001. In most cases, campaigning was a low-key affair limited by a number of factors. Campaign spending limits were in accordance with local government election regulations. For many candidates, reaching the allowable expenditure level would have been out of the question. For example, in a metropolitan ward of 60,000 residents, candidates could spend up to \$NZ40,000. Candidates were also vying for public attention alongside local and regional government candidates. Thus, billboard areas and newspaper public notice pages were filled with advertisements from candidates for at least three different elections. Following tradition, in virtually all electorates, meetings were held at which local government candidates presented themselves to the public. In contrast, there were no such forums for DHB candidates, perhaps again a reflection of the incipient nature of the DHB system and lack of a representative tradition in contemporary health care governance. In at least one case, DHB candidates were actively discouraged from presenting at a public meeting for fear that, with five minutes each, the 20 or so candidates would take too much time (Personal Communication, local government candidate). There was an almost complete absence of political party representation among DHB candidates, meaning that votes could not simply be cast along party lines. In submitting their nominations, candidates were given the opportunity to provide a photograph and 150-word biography. This information was compiled into a booklet that was mailed out with voting papers and, as noted below, became a key line of communication between candidates and voters.

The election results

Figures show that only around 42.85 percent of registered electors exercised their right to vote. In some wards, turnout was as low as 35 percent while in others, the turnout was closer to 70 percent. The low polling is in keeping with a recent history of low participation in New Zealand local government elections, with a national average of only 48.5 percent voting in the 2001 poll. Almost six percent of those who voted in the local government elections failed to return voting papers for the DHB elections. North American election research suggests that postal voting increases turnout, especially in local government elections (Karp and Banducci 2000). If so, it may be considered fortunate that postal voting was the method for the DHB elections. The low turnouts have, nonetheless, elicited charges from politicians that measures to raise participation in New Zealand's local government and DHB elections may need to be introduced.

Elected to DHBs were 81 males (55.47 percent) and 65 females (44.52 percent). Of these, only four (2.72 percent) identified as Maori, meaning that in most DHBs two of the four government appointees had to be of Maori ethnicity to satisfy the government's legislative requirements. Twenty-six (35.62 percent) incumbents were re-elected. Those elected hail from a wide range of professions and experiences and will likely bring differing knowledge and perspectives to their respective DHBs. For instance, 55 (37.41 percent) members have backgrounds in the 'health professions' including medicine, nursing, midwifery and pharmacy, 45 (30.61 percent) have worked in business or law or have company director/analysis experience, and at least 16 (10.88 percent) have backgrounds in community work and advocacy. However, voters did not deliver an even spread of skills: four DHBs have only one elected member with health service experience or knowledge, 12 have three or more 'health' members, and one DHB has no elected health members. Similarly, in four DHBs, voters failed to elect anyone with a background in business, management or corporate governance. Five DHBs had only two elected members with such skills.

The high candidate volume in many wards meant that most DHB members were elected with a very small percentage of total votes and backed by a minority of voters. For example, in the Tauranga ward (33 candidates; three seats) 87,485 votes were received from 45 percent of eligible voters. The three successful candidates received between them 23,160 votes (26.47 percent of the total). The levels of support for a number of unsuccessful candidates were close to those of successful candidates.

How voters made their choices is an important question, given the number of candidates in many wards, and the fact that numerous candidates lacked any track record in DHB governance. Voters clearly selected 'high profile' candidates, and also those with histories of community and health service. Two of the highest polling candidates nationally (from two of the largest DHBs – Auckland and Canterbury) were prominent sports personalities with strong public profiles. Dame Susan Devoy, a former world squash champion, was the highest polling candidate in Auckland with 22,425 votes, double the tally of the next elected member. Canterbury's highest polling candidate was Erin Baker, a former world champion triathlete. At 40,995 votes, Baker was more than 10,000 votes ahead of the next highest polling candidate. A fixed-response telephone survey of 500 voters was commissioned by the New Zealand Health Sector Transition Project, University of Otago, in the two weeks following the DHB elections to ask voters how they made their choices. 100 respondents were sampled from each of five wards. Three of these were urban: Auckland Northeast (28 candidates; two seats), Christchurch (75 candidates; five seats), and North Shore (50 candidates; three seats); one an urban/rural mix: Dunedin North (16 candidates; two seats); and one rural: South Waikato (21 candidates; two seats). Telephone numbers were randomly selected from telephone directories. 65.4 percent of the respondents had voted, suggesting that the sample was not entirely representative of the general voting population. Those who had voted were asked a range of questions. Those who had not voted were asked why. Of this group, around 15 percent did not know about the elections, while 20 percent did not know why they did not vote. Almost 27 percent did not vote because they did not know any of the candidates. 11.5 percent failed to receive voting papers. 60.5 percent of respondents stated that they used the candidate profiles provided with their voting papers to inform their choices, whereas around 25.7 percent simply 'looked for someone they knew' on the candidate list. Respondents were also asked to state the 'main quality' they looked for in candidates. 57.4 percent sought 'experience in health service', while 20 percent looked for 'experience in community representation/community work'. Only 4.6 percent voted for 'experience in management', and 2.2 percent for 'experience in financial matters'.

Around a month after the elections, the government announced its list of DHB chairpersons. As noted above, other appointees were announced in January 2002. Appointees were selected in accordance with a number of criteria, including prior experience in health sector governance. Of the 84 appointees, 53 had been pre-election incumbents and 46 were Maori. A number of appointees stood as candidates but had failed to win seats. In all, 79 (53.7 percent) of the 147 DHB members had served as board members prior to the elections. This implies that there will be some continuity in the continued transition from one health care governance system to another.

Discussion

The inaugural DHB elections raise a number of important issues for the democratisation of health care governance and its future in New Zealand. Whether the elections succeeded in democratising health care governance, or were merely a step toward this, is open to debate. Non-voters outnumbered voters, and the low level of voter interest, of course, weakens the legitimacy of the democratic process and the new governing health boards. The (in)action of non-voters can be viewed in different ways by the government and DHB members. For instance, boards could plausibly see themselves representing those who voted, and overlook the views and needs of non-voters. Similarly, boards could succumb to the advances of sectional interests. The government's directions, however, are quite clear and enshrined in the New Zealand Public Health and Disability Act 2000: boards must be responsible for the health care needs of the entire community. The strategic planning process that boards must engage in, which includes a needs assessment exercise, requires open community consultation. This said, there have been criticisms that DHB consultation processes have been superficial. This may be due to a tight central government determined planning cycle and the fact that many DHB decisions are simply confirmations of existing arrangements, but also the difficult position in the health care system that DHBs are in. As discussed above, they have prioritisation and resource allocation functions previously performed at a

national level, and there is limited scope for reconfiguring existing services or reducing their budgets in favour of new services identified through needs assessment exercises. Thus, board members are government envoys carrying a thorny message: they are constricted to seeking community assistance with making difficult choices between different service and patient demands.

It might be assumed that elected representatives will 'speak out' where they perceive action is needed, for instance, over issues of underfunding or impracticable government policy. As noted above, elected DHB members have 'dual accountabilities' to both government and electors. However, the legislation enacting DHBs makes it clear that boards are principally accountable to the government, and that sanctions can be drawn against boards seen as performing poorly. These operating constraints were clearly spelled out in a government-run induction programme for elected board members. It is possible that 'poor performance' could arise as a consequence of being excessively responsive to voters. To allay such fears, the Minister of Health has advised that boards can themselves decide whether members can speak out against the government as private individuals. The implication is that government criticism is not the role of collective boards.

It may be some time before the incipient boards are ready to assume their tasks, and it is possible that elected members and democratic processes could delay what might once have been the taking of routine decisions. With DHB meetings now public affairs, health care governance decision-making processes can be scrutinised. There has been at least one case of an elected board member, new to health care governance, requesting that a financial decision be deferred because he did not have the experience and knowledge to effectively participate. We do not know whether such cases arose in the closed-door environment of the prior appointed hospital boards, or whether (at least in their initial period of service) elected members potentially bring to DHBs less experience or ability in governance matters. There is also the possibility of tensions between the more than half of DHB members, perhaps more accustomed to 'economic' accountability, who served under the former governance arrangements, and those committed to 'political' accountability intrinsic to the DHB system. This said, those serving prior to the DHB elections had been involved in the DHB transition process. A number had been appointed earlier in 2001 for a short pre-election term.

The election of Maori members is a critical issue. As noted above, around half of the appointees were selected on the basis of being Maori, although many of these individuals had been incumbent board members and share between them extensive experience in health care governance and service delivery. Clearly, if these people were elected, it would raise their legitimacy in the public eye as board members and perhaps bring a closer connection between Maori people and their representatives. New Zealand's parliament historically contains members elected from Maori seats to ensure Maori representation. Eligible voters can opt to be on the Maori electoral roll. It may be prudent to establish similar arrangements for DHB elections, allowing Maori to vote in the two Maori board members for their DHB region.

Over time, it might be expected that the processes of health care democratisation in New Zealand will mature, as voters learn more about the existence and role of DHBs and board members. It may be that voter participation will increase at the 2004 DHB elections. The government had proposed the use of a single transferable voting system for the 2001 DHB elections, but considered that, if first-past-the-post was being used for concurrent local government elections, this could create voter confusion. Single transferable voting will be the method for the 2004 DHB elections. However, without a strong electoral system education campaign, more complex voting arrangements could be an additional deterrent to the many non-voters in the 2001 election. It will be interesting to see whether there is a similarly high number of candidates in the 2004 polls. Some may be discouraged by the fact that they would be competing against incumbent elected members with an established DHB service profile. It may be that there will be larger numbers of early nominations. Anecdote indicates that many of the 2001 candidates registered in the belief that there would be few competitors, only to become one of a vast pool.

Conclusion

This article reviewed the development of New Zealand's DHB system, the latest in a succession of health sector restructurings implemented through the 1990s. The central focus of the article was the inaugural DHB elections, a core component of the government's programme designed to democratise health care governance.

The article discussed a variety of aspects of the elections, and the operating parameters of the new health boards. It questioned whether the inaugural elections have accomplished the government's aims, or are simply part of a developing process. Doubt was also cast on the extent to which the operating framework for DHBs tempers democratic processes. Boards are accountable firstly to government, yet also answerable to providers and communities. This could lead to difficulties.

The article noted areas that could be improved to make the next DHB elections more effective, particularly arrangements for Maori candidates and voters. It would also be useful to somehow raise voter participation levels but, short of making voting compulsory, it is not clear what the prospects might be. The single transferable voting system could further deter voters. It may be that as DHBs continue to develop and embed themselves, community knowledge will concurrently increase and improved participation could be a natural corollary. Of course, if, in New Zealand's constrained and contentious environment of health care organisation and financing, there are altercations between the government and board members and the members seem to come off second best, this could reduce the perceived efficacy of voters. If this occurred, then the impact on the state of health care governance, fragile through constant recasting, would undoubtedly be negative.

Acknowledgements

The author is grateful to: the New Zealand Ministry of Health for providing DHB election data; the Dunedin School of Medicine, University of Otago, for funding the DHB voter survey; Jo McKenzie for statistical support and, for comments on a previous draft, Dr Chris Rudd, Department of Political Studies, University of Otago, and Dr Chris Hunt.

References

- Beaglehole R & Davis P 1992, 'Setting national health goals and targets in the context of a fiscal crisis: the politics of social choice in New Zealand', *International Journal of Health Services*, 22(3): 417-28.
- Creech W 1999, *The Government's Medium-term Strategy for Health and Disability Support Services 1999*, Ministry of Health, Wellington.
- Davies P 1999, 'Making sense of integrated care in New Zealand', *Australian Health Review*, 22(4): 25-44.
- Donelan K, Blendon RJ, Schoen C, Davis K & Binns K 1999, 'The cost of health system change: public discontent in five nations', *Health Affairs*, 18(3): 206-16.
- Emanuel EJ & Emanuel LL 1997, 'Preserving community in health care', *Journal of Health Politics, Policy and Law*, 22(1): 147-84.
- Gauld R 2001, *Revolving Doors: New Zealand's Health Reforms*, Institute of Policy Studies and Health Services Research Centre, Wellington.
- Karp J & Banducci S 2000, 'Going postal: how all-mail elections influence turnout', *Political Behavior*, 22(3): 223-39.
- New Zealand Labour Party 1999, *Labour on Health: Policy – September 1999*, New Zealand Labour Party, Wellington.
- Upton S 1991, *Your Health and the Public Health: A Statement of Government Health Policy*, Government Printer, Wellington.