

**Hospital Governance: An Insight from the South East of  
Ireland.**

**Submitted to the  
IAFA Annual Conference  
2006**

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## **Hospital Governance: An Insight from the South East of Ireland.**

### *Abstract.*

Recently the governance debate has moved from the private to the public sector. Growing concerns in health care systems have propelled governance to the forefront of the agenda of policy makers and managers alike. This study examines the concept of governance in a hospital setting and questions the drivers of this phenomena in both its internal and external environments. A similar approach was adopted in a Belgian study by Eeckloo et al 2002.

Using a sample of public hospitals in the South East region of Ireland the following research questions were addressed:

1. What constitutes governance in a hospital setting?
2. What are the key drivers of hospital governance in its internal environment?
3. What are the key drivers of hospital governance in its external environment?

A qualitative approach was adopted and semi structured interviews were conducted with senior managers from both the HSE and four different hospitals in the South East. Respondents stemmed from across a number of functional areas.

The results establish that a number of elements constitute hospital governance. Almost the entire hospital management group indicate that while the governance emphasis in the past primarily focused on financial dimensions, in particular value for money and resource allocation issues, this is now changing. The findings of this study are also consistent with the literature of Eeckloo et al 2002 who found that the existing governance codes on the corporate world cannot be applied in a hospital setting without adjustment. Furthermore, while there appears to have been a significant improvement in goal alignment across hospital staff there is some confusion with respect to the principal agent relationship. Clinical governance practices are now deemed very important and it is likely they will be embraced particularly as the organisational changes of the health sector become more embedded. Governance in a hospital setting is deemed a complex process but is a very important phenomena in the evolution of the Irish health service.

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## **1.0 Introduction.**

It has been a longstanding belief that governance is necessary to promote and ensure fairness, accountability and transparency within organisations. It has become an increasingly important phenomenon in recent years primarily due to the number of corporate scandals, which has resulted in a decline in shareholder value, a reduction in investor confidence and in some cases significant bankruptcies. Examples of such scandals include Allied Irish Bank (Ireland), Enron (US) Maxwell (UK) and Parmalat (Italy). Corporate governance is the best-known form of governance and to date has focused primarily on private sector entities. More recently the governance phenomena has spread to the public sector with particular attention being paid to resource allocation, expenditure programs and value for money. In turn, the governance processes of health care systems have also come under the spotlight. This research is aimed at assessing the concept of governance in a hospital context and examines the drivers of the governance process. Governance in a hospital setting has added complexity as it concerns not only economic and financial dimensions, but also incorporates societal ones. (Eeckloo et al, 2002). In addition, the challenges facing hospitals in today's environment is forcing the contemplation of the meaning of 'good governance' and how it should be implemented.

There has been much debate in Ireland in recent times over hospital expenditure, waiting lists, Accident & Emergency crises and capacity issues. However, research to date has primarily been in the form of Government Commissioned Reports with little involvement of hospital managers. This paper contributes to the debate by exploring the concept of governance in a hospital setting and questions what are the drivers of this phenomena in both its internal and external environment. Public hospitals were chosen for this study as they are the largest and most common type of hospital in Ireland and represent a unique setting that incorporates many different stakeholders but in a defined boundary setting. It aims to identify the elements that play a role in the governance of a hospital setting. It also incorporates the internal environment in which governance procedures operate, giving consideration to the accreditation process, clinical governance and Executive Management Teams (EMT's). In turn, the external environment in which hospitals

operate is also included with reference to the reorganisation within the Irish health service, concerns over patient satisfaction and the role of the Health Service Executive.

This paper seeks to address the current shortfall in available academic literature on hospital governance in Ireland. Hospitals constitute a very significant part of the overall health care sector and they provide essential services to the public. In 2003 the levels of healthcare spending in the US and Canada was relatively high, standing at \$5,635 and \$3,003 per capita respectively. In Ireland the health care sector accounted for approximately one quarter of the states budgetary expenditure in 2004. There are many different stakeholders in the setting including clinicians, patients and administrators as well as the Department of Health and health insurers. Consequently, it is an area in which the question of governance has been continually raised. It is in that context that it is hoped that this paper will be of benefit to a range of different parties including the parties outlined above, academics, practitioners, EMT's in individual hospitals, hospital managers and members of the HSE.

To provide the context for the research undertaken in this paper, the relevant prior literature is outlined in the next section. The third section outlines the research questions and method adopted. Section four follows with detailed findings and discussions. Finally, conclusions are drawn based on the research findings outlined.

## **2.0 Literature Review.**

### **2.1 Corporate Governance.**

Corporate governance is believed necessary to promote and ensure fairness, accountability and transparency within organisations. The concept initially focused on public companies, as it was in this context that problems first appeared to arise, with accountability to investors becoming a primary concern. It is not a new phenomenon and has been in existence for as long as business and commerce have been conducted, albeit in less formalised fashion. However, as both the business and commerce world have

grown in sophistication, so too has corporate governance. In 1932 Berle and Means contributed the first research into this area, which resulted in the first generally accepted meaning of corporate governance (Kakabadse and Kakabadse, 2004). Since the research of Berle and Means (1932) numerous definitions of the concept have been put forward. The progression of these definitions has been closely linked to its staged evolution and has been tweaked to include the various perspectives that have emerged. The Cadbury Report (1992) puts forth one of the most straightforward definitions where by it refers to corporate governance as ‘The system by which companies are directed and controlled’.

However, as the concept of governance evolved and as an increasing number of participants became involved in the governance process the definition was broadened to include not just shareholders, but all stakeholders of the organisation, thereby embracing the perspectives of debt holders, employees and customers to name but a few (John and Senbet 1998:372). Similarly Julien and Rieger (2003) endorse the idea of encompassing the stakeholder perspective through their suggestion that corporate governance is: ‘the system within an organisation that protects the interests of its diverse stakeholder groups. The best approaches recognise that stakeholders are more than shareholders and includes customers, employees, suppliers, retirees, communities, lenders and other creditors’.

Over the last number of years both the concept of corporate governance itself and the issues surrounding it such as accountability, managerial compensation and transparency have been highlighted to a great extent. This is principally due to the occurrence of corporate scandals that served to illustrate its associated deficiencies and weaknesses. Recent examples of such corporate scandals include Allied Irish Bank (Ireland), Enron (US), Maxwell (UK), Parmalat (Italy), Vivendi (France) and WorldCom (US). These events have served to sharpen the focus on governance practices and in turn how they may be improved. They have also forced organisations to be more rigorous with respect to their own governance procedures. In turn these scandals have also encouraged regulators to become proactive rather than reactive when it comes to preventing their reoccurrence. The diverse debate and argument stimulated by these scandals has brought corporate governance to the fore of public attention where it has remained for the last number of years.

In essence, corporate governance has increased in importance and has become one of the most topical issues in business research today. However, it is not a concept that applies to business alone. The financial scandals referred to earlier have brought home the importance of having effectual controls and procedures in place in any type of organisation. In turn it is not just a concern for large corporations and publicly listed companies alone. Instead, it is now universally recognised as a concern for all organisations regardless of the sector in which they operate. Non-governmental organisations (NGO's), police forces, educational institutions, charitable organisations and the health services are now embracing issues of governance in their establishments. These institutions have not been without criticism with concerns over accountability, transparency and controls coming to the fore in some situations. As such all now have to be seen endorsing and implementing effective governance procedures.

### **2.1.2. The Theories of Corporate Governance.**

Corporate governance has three key theoretical underpinnings namely agency theory, stewardship theory and stakeholder theory. Firstly, Watson and Head (2004) define the

agency theory as ‘A theoretical relationship that exists between the owners of a company and the managers as agents they employ to run the company on their behalf’. This theory came to prominence after the industrial revolution as the size of organisations grew and resulted in separation between the ownership and control of wealth. Consequently, the relationship is characterised by a contractual basis in which one or more persons (the principal(s)) engage another person (the agent) to manage the organisation on their behalf. The principal(s) then delegates authority to the agent in order to allow them to fulfil their obligations under the contractual agreement. The primary obligation of the agent in this respect is to maximise shareholders wealth (Gay, 2002; Davis et al, 1997).

Fundamental to this theory is the assumption that both principals and agents are rational actors (Albanese et al, 1997). However, this may not always be the case and it has long been recognised that there may be a possible divergence of motivational interests between the two parties. As per human nature both parties may seek to maximise their own personal utility within the organisation and in turn their personal gain. It is from this arena that agency problems can and invariably do arise. If the interests of the principal(s) and agent correspond there is no such agency problem. However, should they diverge, the agent may take any opportunity that presents itself to further their personal gain and consequently agency costs will be incurred by the principal(s) (Davis et al, 1997). Watson and Head (2004) identify the main issues that contribute to creating an agency problem. A divergence between ownership and control where the owner’s do not manage the organisation can result in an agency problem, as there may be differing objectives. An asymmetry of information can also exist as the managers have continual access to information whereas the shareholders may only receive annual reports. It is this asymmetry that makes it difficult for shareholders to monitor the activities of managers.

In order to minimise agency problems various governance mechanisms have been advocated. Financial incentives such as salaries and bonuses can be used to reinforce desired behaviour and curb the self-interest that fuels much of organisational life (Gay, 2002). Davis et al (1997) further argue that these incentive schemes are particularly desirable if monitoring is not a viable option. This can occur in situations where the agent

may have an informational advantage over the principal(s). Furthermore, an effective governance structure can help to align the interests by undertaking performance evaluations of agents and having effective management oversight procedures.

Davis et al (1997) argue that this theory has had a notable influence on both organisational theory and business practice. They further state that it has been one of the prevailing paradigms of corporate governance to date. However, they also highlight that the agency theory has not been without criticism suggesting that there are many reasons why an agent may not deliver the results and performance desired by the principal(s). Other issues such as a lack of ability, expertise, knowledge and ineffective communication and information may come into play. They argue that the agency theorists are less concerned with these failings than with the ones concerning motivations that were set out above. Its underlying assumption has also been criticised. Jensen and Meckling (1994) as cited in Davis et al (1997) argued that the assumption that principal (s) and agents are rational actors is insufficient to describe the reality of human behaviour and all the elements that may come into play when individuals decide to take a particular course of action.

Secondly, the stewardship theory stems from the psychology and sociology arena and is derived from the Theory Y stream of McGregor's organisational behaviour research (Gay, 2002). In essence the theory purports that agents are only motivated to act in the best interests of their principal(s). Davis et al (1997) states that an agent's pro organisational interests outweigh those that are self-serving and that given a choice between the two, their behaviour will not deviate from the best interests of their organisation. They further argue that even if the interests are misaligned between the two parties the agent will still place a higher value on achieving organisational goals than personal gain.

It has been argued that due to there being no conflict of interest, the main concern of both parties should be in identifying and creating an organisational structure that permits effective coordination to be achieved (Gay, 2002). Davis et al (1997) further support this view. They argue that the performance of the steward is made effective by the structural



situation in which they operate. It is in this context that the issue of duality comes into play. Donaldson and Davis (1991) as cited in Gay (2002) noted that duality occurs when the same individual holds both the Chairman and CEO positions simultaneously. The agency theory had purported that the protection of shareholder interests could only be effectively achieved when separate individuals held the two posts. However, Davis et al (1997) among others have strongly argued that duality may not be best suited to the stewardship theory. They suggest that a control environment in such a situation would only serve to stifle the pro organisational behaviour of stewards. Consequently they state that a steward's independence should be intentionally extended in order to take full advantage of associated benefits. In turn they highlight that stewardship theorists would favour structures that empower rather than those that monitor and control.

As a result of the duality debate Gay (2002) argues that the stewardship theory may be best suited to smaller more entrepreneurial firms. In comparison it could be said that the agency theory is best suited to larger organisations with an extended ownership base. While essentially both theories address the same topic i.e. management issues, they consider very distinct realms within it. As such there is a need for both to be considered by organisations in order to get a full understanding of the impact of human behaviour on corporate governance.

Thirdly, the advent of the stakeholder theory is in line with the evolution of corporate governance whereby the concept was broadened to include not just shareholders but all stakeholders of the organisation. This theory operates on the premise that managers will treat the interests of all stakeholders as if they have intrinsic value to the firm. It is also assumed that no one set of interests will dominate over another. Donaldson and Preston (1995) as cited in Gay (2002) argue that there are three key aspects to the stakeholder theory: descriptive, instrumental and normative. The descriptive aspect aims to illustrate that the theoretical underpinnings of the theory correspond to reality. The next is the instrumental aspect, which tries to evidence a link between the stakeholder theory and organisational performance. Finally, the normative aspect is concerned with the moral groundings of the stakeholder theory.

Even though in some respects this is a relatively new theory it has become increasingly important in the world of business. Debate on it has been diverse and wide-ranging. In many ways it has also converged with the area of corporate social responsibility (CSR) with discussions on the ethical dimensions of the theory abounding. Some would believe that the two are inextricably linked while others would argue that the theory should in essence be kept to a business/corporate dimension as much as possible. Warhurst (2004) considered the roles and responsibilities of business in today's society, which is characterised by a growing range of increasingly demanding stakeholders. She ponders what the future role of the organisations will be and in doing so provides some prime examples of companies that have achieved both success and failure with respect to the stakeholder theory. She provides significant evidence on DHL as a company that has got this concept right through a proactive stance.

Conversely, less successful examples can be seen in the cases of Wal-Mart (Warhurst, 2004), Shell Oil Company who failed to react fittingly to the Brent Spar challenge and BP's evident indifference to their employees in Nigeria (Gay, 2002). It is such cases that continue to fuel the debate on the stakeholder theory, its moral underpinnings and ethical considerations. This highly publicised and hotly debated issue has encouraged many organisations to re-evaluate their mission and objectives in an effort to portray a socially responsible and inclusive corporate image from which it's believed a competitive advantage may be gained. However, some have argued that the majority of organisations are merely complying with the public perspective. Frankenthal (2001) has argued that this is merely a public relations (PR) exercise that has resulted in no real embedment of the theory in the organisation.

### **2.1.3 Corporate Governance Today.**

Corporate governance has evolved continually over the years, has grown in sophistication and become more refined. In Ireland, corporate governance has been strongly influenced by the development of governance codes and the reforms there of in the UK. Numerous

codes such as The Cadbury Report (1992), The Greenbury Report (1995) and the Higgs Report (2003) have been published. The development of these codes was initially reactive in nature and was fuelled by the unexpected failure of organisations. These failures shook investor confidence in the quality of financial reporting. Subsequently, the codes have been continuously revised and built upon in order to meet changing governance needs.

While corporate governance has evolved over time it has not been without its detractors. Many, including Frankenthal (2001) believe that the increase in rules and regulations stemming from the codes have had a different effect than the one intended. The abundance of rules is said to have resulted in a 'box ticking' exercise that has become time consuming and burdensome. In turn this is said to have incentivised people to take shortcuts rather than encourage full compliance. Many believe that this has occurred due to an increasing focus on short-term performance and the pressures associated with it. In an effort to overcome this, some have endorsed the idea of legislated corporate governance, thereby giving it the legal footing that would enforce compliance. Gay (2002) also points out that there are national differences in the corporate governance procedures and corporate laws that regulate organisational activities. In conjunction, these two issues have stimulated huge debate in the international arena. The starkest contrast in this respect can be seen in the conflict between the two basis of corporate governance procedures in the US and the UK.

Following the financial fallout from corporate scandals such as Enron and WorldCom the US has embarked upon the road of legislated corporate governance. 2002 saw the introduction of the Sarbanes-Oxley Corporate Fraud and Accounting Act. It was enacted with the intention of improving the practices of public companies (Yakhou and Dorweiler, 2004). This Act has placed the primary duty of care upon the CEO and Chief Financial Officer (CFO) of the organisation. They now have to ensure and certify that there are no omissions from the financial statements and that they do not contain any untrue declarations (Sutton, 2002). In essence, the Act holds these two parties personally liable should the financials prove to be wrong or misleading.

However, those responsible for governance procedures in the UK have argued that the principle approach allows for more flexibility than the legislative basis. They believe the principle approach acknowledges that all companies are not the same (there are differences in size and structure), an issue which many believe needs to be taken into consideration in governance procedures. Nevertheless, Gay (2002) would argue that there might be a growing consensus recognising the need to change.

In turn, Brennan (2004) would argue that Ireland is taking the safe direction and is moving in the same direction as the US – toward legislated corporate governance albeit on a more gradual approach. He would also suggest that recent scandals and their aftershocks have made legislators quick to understand the alleged long-term benefits of a strong regulatory framework of corporate governance. Consequently, Ireland's efforts in this regard come under the pretext of the Companies (Auditing and Accounting) Act 2003, which is forcing executive and non-executive directors to keep a tighter reign on corporate governance. However, whether this move from a principle to a statutory basis will result in success is as of yet to be determined.

## **2.2 Governance in the Public Sector.**

The public sectors of countries in the developed world are large both in terms of their size and the financial resources needed to maintain them as they encompass many areas including education, policing, transportation and the health and social services. In turn the public sector today is a large employer accounting for as much as 5.7 million employees in the UK and approximately 525,000 in Ireland in 2005 (CSO, 2005). Associated with this are large budgetary resources, the allocation of which has become increasingly scrutinised. As such governance today has become synonymous with the public sector but that has not always been the case. Historically, corporate governance referred to the private sector and within that, the focus has rested mainly on large publicly quoted companies. However, the current business and economic environment is one of increased scrutiny on organisations be they in the public or private sector. The repercussions of the corporate events of recent years have not been contained within their own sector. It has

reached outside its own realm to effect aspects of the public sector and beyond. As shareholders demand greater accountability of the companies in which they invest, taxpayers are now demanding the same of the public service. To bear the burden of the governance spotlight, more and more public sector organisations worldwide are moving toward accepting the governance philosophies of the private sector such as accountability and transparency.

However there are differences in governance between the public and private sectors. Apart from the obvious for profit, non-profit difference between the two, the most fundamental comes down to the philosophical elements that underpin any public service. Ezzamel and Willmott (1993) assert that a key element of the public sector is that services are provided for the public good, suggesting that the public sector would have a higher sense of purpose in what they do than the private sector. Another difference lies in the fact that people who use public services may not be ‘willing customers’ as may be the case with health care. In addition, consideration should also be given to the fact that the public sector is not concerned with economics alone. A strong societal aspect comes into play and as such many argue that governance frameworks need to be tailored accordingly to take into account the complexities of this sector (Eeckloo et al, 2002).

Over the years some countries have embarked upon privatisation programs in an effort to reduce the levels of expenditure on the various elements of the public sector (such as education and the police force) and improve its efficiency. Despite this attempt at ‘downsizing’ the public sector of a country is still perceived as hugely important and questions as to its associated costs and efficiency levels still come to the fore. There have been moves made to reform the governance practices and procedures of the public sector in many countries. Following this shift in focus there were calls for consideration of existing practices and in turn reform abounded in a number of health care settings in the US, UK, Canada and Ireland (Tuohy, 1999).

### **2.3 Governance in Health Care and Hospitals.**

With respect to the health care dimensions of the public service, the capacity of a government to provide a good standard of health care is deemed one of the most important elements contributing to a country's standard of living. Universal access to health care, irrespective of one's ability to pay, is regarded as a basic human right in the developed world. Healthcare in developed countries is now big business and this is true also in Ireland where in 2004 the budget of the Department of Finance for public spending was €41.1 billion of which it was estimated that €10.05 billion would be spent on the health service alone. The OECD (2005) detail the latest figures available on the health care spending patterns of its member countries. The US is by far the biggest spender on health care comprising some 15% of GDP in 2003 with Canada following closely behind with 9.9% of GDP. In 2002 Ireland spent 7.3% of GDP on health care and had an annual growth figure of 11.4%. In the UK, the public sector is the primary source of funding for the health service comprising some 83%, which stands in stark contrast to the US figure of 44% where private insurance is the dominant source of finance. Ireland follows closely behind with 75% of funding for the health service coming from public sources. With such large sums of money involved it is not surprising that the governance spotlight has now focused on the public sector and its health care dimensions.

It is in the context of Section 2.2 above that the issue of governance in hospitals arises. In recent years there has been much emphasis on the Irish health service. Hospitals are huge economic entities that consume significant expenditure and resources. In 2001 the total health care expenditure in Ireland amounted to 6.5% of Gross Domestic Product (GDP), approximately €9.2 billion with 76% coming from public sources, predominately through taxation (Purcell, 2003). This in conjunction with increasing concerns over value for money and the way that money is spent has resulted in the area of hospital governance receiving considerable attention and debate.

Governance in a hospital setting concerns not only economic and financial dimensions, as there is a huge societal aspect associated with the provision of health care. In turn it could be argued that hospital governance takes a more institutional approach. As the concept of hospital governance has been broadened to include both financial and non-financial

elements, Eeckloo et al (2002) argue that its purpose is to enable a more integrated approach of supporting and supervising all hospital activities including clinical performance. While the previous governance focus in this setting may have been primarily concerned with managing organisational structures, infrastructure, departments and the resourcing of facilities, the hospitals of today are focusing more on managing processes and supporting care activities.

Indeed, the concept of hospital governance is relatively new. It has stemmed from studies and initiatives in countries such as Canada and the US. It has in turn become a consideration in many European countries. However, defining governance in a hospital setting may not be as straightforward as it would appear. Many elements may come into play. Some may consider governance in purely financial terms while others believe that clinical governance should be the primary governance concern. Many have indeed considered the issue of defining governance in a health care setting. Bader (1993) argued that governance in a hospital is not a function of board activity only, it is very much driven by top-level individuals in an American setting as is illustrated by the following quote ‘Governance is a shared process of top level organisational leadership, policy making and decision making [of] the board, CEO, senior management and clinical leaders...it’s an interdependent partnership of leaders’. Bader’s definition highlights the necessity of having all perspectives in the hospital involved in order to make governance in a hospital setting work. Alternatively, Eeckloo et al (2002) when considering the concept in a Belgian context defined hospital governance in terms of its processes where by it referred to it as ‘the process of steering the overall functioning and effective performance of a hospital by defining [its] mission, setting objectives and...[having them realised] at the operational level’. This definition is also in line with the arguments of Taylor (2000) who considered the concept in Canada. He argues that one of the key elements needed in order to achieve excellence in hospital governance is having a clear mission and an achievement-orientated culture in which to realise it.

In considering governance in health care settings, one must first try to identify the parties of the principal agent relationship referred to in Section 2.1.2. In an Irish context it could

be argued that this relationship (at its most simplistic) is one where the government is the principal and the Health Service Executive (HSE) is the agent. This involves the government delegating authority to the HSE to manage the health service. This in turn represents the separation between ownership and control that is deemed to be important for effective corporate governance (Gay 2002). The agency relationship in a hospital setting differs from that in the corporate world, as there are so many differing stakeholders to be taken into consideration. However, problems can and invariably do arise whereby the agent may not always act in the best interests of the principal. Consequently, financial accountability plays a large role in the functioning of not only the HSE but also the individual hospitals under its remit. However, governance in this setting is broader and incorporates many different stakeholders including patients, General Practitioners, community care groups etc. As such it is not straightforward. It is a rather complex issue due to the intricacies of the agency relationship, the demands of taxpayers and the inherent bureaucracy that some associate with the public sector. Another factor contributing to this complexity is the fact that governance in hospitals is not concerned with economics and finance alone as a huge element of the provision of health care is societal. In addition hospitals are not uniform, they vary in size, culture, remit and budgetary support all of which will have an effect on the governance system in place. Furthermore, culture may play a role. Prior to the reorganisation of the health service, local politicians played a role as they were represented on the Health Boards. Now however there are no longer people involved whom the local population has mandated.

### **2.3.1 International Evidence.**

While research on hospital governance in Ireland to date has been relatively scant, much consideration and discussion has abounded on the topic in Belgium, Canada, the US and the UK.

Eeckloo et al (2002) completed an empirical investigation on governance in Belgian hospitals over a three-year period. Using a sample of 82 hospitals they investigated the extent to which governance codes developed for the corporate world can be used in a



hospital setting. Their research involved an analysis of the governance structures of the different hospitals, the form of governance entities, the separation of competencies and the relationship between management and medical staff. They identified several key drivers of reform in Belgium and highlighted several differences between public and private hospitals, the most pertinent of which being in relation to the professional backgrounds represented on the Executive Management Team (EMT), time demands on team members and the separation of competencies. They found that the principals of the governance codes developed for the corporate world cannot be applied to a hospital setting without adjustment. They also found that while on one hand the EMT held their traditional supervisory role they were also becoming increasingly involved at the operational level. They recommended that there be a clearer demarcation of the governance structures in a hospital setting. However, there are some limitations associated with the study. It is very much focused at the board level of the hospital with no consideration given to functional managers or the issue of clinical governance. In addition, given the sensitivity of the area and its associated confidentiality concerns perhaps the use of personal interviews would have revealed additional pertinent information.

The 1990's was a decade of significant change for the Canadian health service. It was significantly restructured and while it did encounter its problems, it has been heralded as successful. It is in this context that Taylor (2000) produced a theoretical paper by summarising the pertinent literature on the era of restructuring and from that identified nine principals and five benchmarks of 'good' governance in hospital settings. He argued it is advisable to adhere to the key principals of governance in the development and implementation of governance models in hospitals. These principles include (i) a knowledge of what governance is, (ii) achievement of goals, (iii) EMT relationships, (iv) unity in direction, (v) unity of command, (vi) accountability, (vii) ownership needs, (viii) self-improvement and (ix) understanding governance costs. The benchmarks of excellence in governance put forward by Taylor (2000), as seen in Figure 1, provide a framework, which can be used to determine the degree of excellence achieved in our hospital organisations. As they are generic they can be adopted for use in any country.

However, the main limitation of this study is that no empirical research was undertaken and as such it was limited to a theoretical discussion on existing practices.

INSERT FIGURE (1) HERE.

Middleton (2005) focused his appraisal on what he believes to be the pressing issues facing hospital EMT's in the United States from his 20-year experience as a hospital Chairman. He considered the main functions of EMT governance and provides some recommendations for their implementation. Some of the key elements of EMT governance discussed include qualifications and structure, costs, services provided by the hospital, executive compensation and evaluation, audit, compliance and physician participation. He further argued that while the traditional ideal in the US of viewing hospital EMT's as a cross representation of community perspectives is noble; it is a recipe for poor governance in today's complex health care delivery arena. One of the most important points to emerge is in respect to physician participation. He argued that while in the past physician participation was viewed as a token gesture, today, extensive physician participation is vital to any health care organisation, as a rounded perspective is needed to ensure success. However, one of the main limitations associated with this is that it is purely focused on a US setting.

Orlikoff (2005) focused his attention on the implications that the new environment in the United States, which has become increasingly complex, poses for hospital EMT's. He did so in his capacity as a senior consultant to the Centre for Healthcare Governance in the US. He argued that the Sarbanes-Oxley Act (2002) and other forces have augmented the awareness of the importance of good governance and what is considered to be best practice. This in turn is the context in which he stated that it would result in the onset of increased accountability, scrutiny and reform. He considered the fact that governance in a healthcare setting in the US is now at a cross roads and in turn detailed the main risks to governance in the new environment and some key strategies that can be used to implement successful governance. One of the key risks Orlikoff (2005) identified is the inability to both attract and retain experienced and knowledgeable team members. He highlighted the fact that increasing time demands and heightened accountability

requirements on them may result in a higher turnover rate of team members. This in turn prompted him to question whether the traditional approach of having members serve on a voluntary basis is now defunct. In answering this question he put forward compensation as a possible solution. While he acknowledged that this might invoke negative feelings, he contended that any approach, including compensation should be considered as a possible solution to attracting and retaining suitable EMT members. In turn, he argued that compensation may very well emerge as an element of successful governance in the coming years. However, a limitation associated with this study is that again it is very much focused on the US context. In addition, it is a discussion-based paper with no empirical research undertaken.

Ezzamel and Willmott (1993) produced a paper in the United Kingdom (UK) on the public sector reform with respect governance and accountability. While the research is broad in the context of this study, it does provide specifics with respect to healthcare and the National Health Service (NHS). In the study they used the markets and hierarchies framework as a means of interpreting the reforms in the governance of public sector organisations over the decade up to 1993. This research argued that the introduction of market disciplines into the UK public sector has shifted the focus from ‘Clan Control’ of the hospital professionals to financial accountability. They also put forward that the key to improving governance practices lies in the development of communication and accountability between those who fund, obtain and supply public services. They concluded that several reports published in the UK in the early to mid 1980’s were influential in motivating reform. However, a limitation here would be that it may have limited application in this study given the differences between the Irish and UK health services.

### **2.3.2. Clinical Governance.**

When examining governance in a hospital setting, there are more elements to consider than merely the financial. Due to the nature of the setting and the service provided within it, the concept of clinical governance, which is inward focused, has emerged. The World

Health Organisation (WHO) first used this term in 1983 as a means to summarise the main elements of the provision of quality health care. The concept evolved slowly and was only introduced on a formalised basis by some countries in the latter years of the 1990's. Clinical governance is regarded as a framework used to improve the quality of the health care service provided (Vanu Som, 2004). Freedman (2002) highlighted that its introduction on a formalised basis means that hospitals now have to report on issues of quality whereas previously there had only been financial accountability.

The concept of clinical governance tries to improve the quality of healthcare provided through integrating the financial, performance and clinical quality aspects of a hospital. It has also recognised the essential role of clinicians in delivering quality in this setting. It has been argued that the main aim of clinical governance is to accomplish continuous quality improvement in a health care setting and is designed to consolidate fragmented approaches to quality improvement (Vanu Som, 2004).

Many definitions of clinical governance have been put forward since its inception, each illustrating differing perceptions and perspectives on the topic. Freedman (2002) highlights the formal definition of the concept in a UK context as 'A framework through which organisations are accountable for continuing to improve the quality of service ...by creating an environment in which excellence in clinical care would flourish'. However, Vanu Som (2004) argued that none of the many definitions put forward captures the core of clinical governance with respect to the organisational wide implications that its implementation presents. As such, she set out to undertake a fresh examination of its definition. Consequently she defined the concept as 'A governance system for health care organisations that promotes an integrated approach towards management of inputs, structures and processes to improve...clinical quality'.

When WHO first gave consideration to the topic of clinical governance it highlighted four main dimensions of it including professional performance, resource allocation, risk management and patient satisfaction. However, subsequently many other elements have been incorporated as the concept has been rolled out into hospitals. Other elements include:

- a. Patient involvement in service delivery.
- b. Staffing and staff management.
- c. Continuous professional development.
- d. Clinical effectiveness.
- e. Education and training.
- f. Using available information.
- g. Clear lines of accountability and responsibility for clinical care.

Even though extensive consideration has been given to the issue, no one recognised model of clinical governance is held up to be ideal. As a result, many hospitals may still face a situation of trial and error in their efforts to find a suitable clinical governance framework. It can be regarded as an issue still undergoing significant development (Lewis et al, 2002). On the whole, clinical governance can be viewed as a mechanism to facilitate multi disciplinary teams all working toward the same goal – the continuous improvement of the quality of care. It is hoped that these cooperative working practices will have a positive influence on both the behaviour of medical professionals and in turn the delivery of care (Vanu Som, 2004). While consideration is given to the issue of clinical governance in this research, its main focus will remain on the corporate aspects of governance in a hospital setting.

### **2.3.3 The Irish Context.**

While there has been little or no research conducted on governance in Irish hospitals the publication of several reports in recent years have exerted a motivational influence over the Irish governance reform program with respect to health care settings. These reports included The Brennan Commission (2003), The Prospectus Report (2003) and The Hanly Report (2003). These reports were commissioned by the government to investigate specific aspects of the Irish health service.

Several key drivers of the governance reform program in Ireland include the desire for value for money and reassurances about the way that resources are utilised. The performance of the Irish health service has been criticised over the last number of years as

despite an increase in spending of 125% from 1997-2002, the quality and quantity of the services provided is perceived not to have improved (Purcell, 2003). Indeed, Barrett (2003) takes this argument further, arguing that the Irish health service is plagued by several serious problems with efficiency, accountability and anti competitive practice that all serve to fuel ineffective governance practices. This issue of value for money was given consideration by Deloitte & Touche in conjunction with The York Health Economics Consortium (2001).

A lack of patient satisfaction has also served to drive the reform program forward. Incidents such as unresolved waiting lists, the closure of hospital wards, the apparent lack of nursing staff, lengthy waiting lists and Accident and Emergency crises due in no small part to a shortfall of hospital beds, have all become familiar headlines in the press. These incidents have served to exacerbate the perceived low levels of patient satisfaction among Ireland's population. In addition to the those outlined above, other generic issues such as the changing demographic profile of the country, an increasingly educated population and the expected higher standards that have come with the country's affluence have also contributed to the strengthening voice calling for reform.

The first of the government commissioned reports was The Brennan Commission (2003). This was established to investigate the financial management systems and control procedures within the Department of Health and Children. The Commission found that there was no means to manage the system on a unified national basis and therefore recommended the establishment of a single authority to do so. This authority would also serve to streamline the 11 health boards and 53 agencies that were in existence. It also recommended the reform of existing governance practices in order to support the HSE as the present system failed to provide incentives to manage costs in an effective manner. The report also highlighted that the main elements of financial accountability would be the clinical consultants and general practitioners (Barrett, 2003). Barrett (2003) also highlighted some of the key examples of "totally inadequate planning and costing" that were found by The Brennan Commission (2003), such as unapproved capital expenditures and audit failures.

Secondly, The Prospectus Report (2003) was established to conduct an audit of the structures and functions of the health system. Similar to The Brennan Commission it recommended that simpler governance and greater accountability should accompany the reorganisation of the system. It further advised that one body should take over the day-to-day running of the health service. It recommended that under the new system there should be a National Hospitals Office, which would assume responsibility for the running of all publicly funded hospitals. Furthermore it advised that the Department of Health should also be restructured to allow it to focus more on policy than the day to day running of the health service (Barrett, 2003).

Thirdly, The Hanly Report (2003) recommended the introduction of the European Working Time Directive to overcome the large levels of 'institutionalised' overtime associated with the Irish health service. To do so it proposed increasing the number of consultants and decreasing the number of non-consultant hospital doctors (Barrett, 2003).

Fourthly, PriceWaterhouseCoopers (PWC) (2004) conducted a survey on corporate governance and financial reporting in Irish hospitals. The sample was comprised of a representative number of Irish hospitals with the majority having a budget of less than €20 million and employing in excess of 500 people. The focus of this study was on the functioning of the boards in place in the hospitals in the sample. The main areas considered in the report included accountability and risk assessment, board of directors, financial reporting, and internal control practices. The key findings included the following: only 42% of the sample of hospital boards undertook an annual assessment of the effectiveness of their internal control systems, 46% of hospital boards did not have an audit committee, 74% did not have an internal audit function, the members of hospital boards were not given an induction program or relevant training when first appointed and nearly a third of the sample did not have specific arrangements in place for management reporting on risk and control matters. Despite these insights, it could be argued that the reports fail to capture the views of hospital managers on hospital governance. They also failed to explore the levels of awareness of what governance is, what influences it in a hospital setting and what is likely to emerge in the future.

### **3. Research Questions.**

The overall objective of this research was to assess the concept of governance in a hospital setting and what influences the processes and procedures of this phenomena. In particular, this study set out to answer the following questions in order to address the research objective outlined above.

#### *1. What constitutes governance in a hospital setting?*

This question aimed to identify the elements that play a role in the governance of a hospital setting.

#### *2. What are the key drivers of hospital governance in its internal environment?*

This question aimed to identify what has been driving hospital governance forward. In doing so this question was concerned with the internal environment of the hospitals. As such, consideration was given to the accreditation process, clinical governance and the Executive Management Teams (EMT).

#### *3. What are the key drivers of hospital governance in its external environment?*

This question also aimed to identify what has been driving hospital governance forward. However, in doing so this question was concerned with the external environment in which the hospitals operate. As such, consideration was given to the reorganisation of the Irish health service, patient satisfaction, and the HSE itself.

In answering these questions it was decided to adopt qualitative approach using semi-structured interviews. The interviews were conducted with ten senior managers from the HSE and 4 different hospitals in the South East of Ireland. The hospitals represented in the sample are large public hospitals catering for the population of the South East, which currently stands at over 400,000. Public hospitals were chosen as they represent the largest and most common type of hospital in Ireland and represent a unique setting that incorporates many different stakeholders but unlike areas such as primary care, it has defined boundaries. The functional areas represented in the findings include the HSE



(both regional and national), Hospital Managers, Members of the Executive Management Team (EMT) in individual hospitals, Hospital Finance Managers, Directors of Nursing and HR Managers. Despite efforts to secure clinician participation none was available. The interview questions came primarily from the consideration of studies such as Eeckloo et al (2002), Freedman (2002) and Middleton (2005). This resulted in a large list of questions being compiled. As a result, it was decided that the interview questions would be tailored to suit different perspectives and functional areas of the respondents. In all, the interview questions were tailored into six different groupings. All interviews took place in July/August 2005 with each lasting between forty-five minutes and an hour.

#### **4. Findings & Discussions.**

Following the analysis of data collected from the ten interviews, it became apparent that a number of themes emerged. These themes were identified as the governance concept, what constitutes governance in a hospital setting, pertinent issues in the governance debate, EMT's in individual hospitals, the role of clinical governance, integration and HSE considerations. These themes interconnected with the research questions outlined and as such merged to form the basis of the discussions below. This approach is also in line with those adopted by previous studies such as Eeckloo et al (2002). While many functional areas were represented reference is primarily made to the three largest respondent groups of – the HSE, nursing and hospital management groups.

##### **4.1 What Constitutes Governance in a Hospital Setting?**

In considering what constitutes governance in a hospital setting, two of the themes referred to above came to the fore – the governance concept and what constitutes governance in a hospital setting.

While all respondents replied that they were relatively familiar with the term corporate governance, differences emerged in the extent to which they were familiar with it. In addition, of those with exposure to the concept, the source from which it stemmed varied.

Yet while half of the respondents claimed to be fully aware of the governance codes developed for the corporate world, the remainder appeared to have limited awareness. A further issue considered was the extent to which the codes developed for the corporate world can be used in a hospital setting. The findings of this study are consistent with the literature with the overwhelming majority of respondents feeling that only the principles of the codes are relevant. Eeckloo et al (2002) argued that the corporate codes cannot be in a hospital setting without adjustment. In turn it was argued by the three groups that the codes could act as a frame of reference that in turn can be '*tailored*' to suit a hospital setting. Accordingly it can be argued that care should be taken to consider all pertinent aspects of hospital governance and their implications when devising the '*tailored*' governance codes. Eeckloo et al (2002) further argued that the past focus of hospital governance was primarily on managing organisational structure, the infrastructure, divisions and the resourcing of facilities. However, they further stated that its essence should now be in managing processes and supporting care activities. This perspective is also evidenced in the findings. Here the HSE respondents and hospital management in contrast to their nursing counterparts argued that the historical focus of hospital governance was very much on the financial. Nevertheless all three groups cited that hospital governance is now much broader and constitutes a combination of both financial and non-financial elements.

The interpretation of the study's findings would appear to suggest that at present it is the agency theory rather than the stewardship theory of governance that is prominent in a hospital setting. In a hospital setting it would appear that power is institutional and the management philosophy is control orientated particularly with respect to resources. In addition, as evidenced by the findings one of the primary objectives has been cost control. However, the findings also evidence that the system is becoming more involvement orientated with an increased focus on performance enhancement, as such in time the stewardship theory may come to the fore.

One of the main findings to emerge concerns the principal agent relationship as there appears to be confusion as to what parties are envisaged in each role. The government

and the HSE were overwhelmingly cast as fulfilling the role of the principal by nursing and HSE respondents yet in contrast hospital management viewed the patients and public in the role. Conversely nursing respondents viewed the patients and public in the role of the agent while the HSE and hospital management groups viewed managers in the role. In essence, the literature argues that the principal agent relationship is one where the principal engages the agent to manage the organisation on their behalf (Gay, 2002; Davis et al, 1997). Consequently, in the light of the governance framework it could be argued that in the context of the Irish health service this relationship (at its most simplistic) is one where the government is the principal and the HSE is the agent. However, it appears from the findings that the relationship is not well understood and could be perceived to be relatively complex. One of the key assumptions of the principal agent relationship is that all parties are rational actors. It could be argued that in a hospital setting where societal aspects, personal involvement and emotions come into play this may not necessarily be the case. This supports the view of Jensen and Meckling (1994) who have criticised this underlying assumption arguing that it is insufficient to describe the reality of human behaviour. Furthermore, if this relationship is not clearly defined, as could be argued from the differing perceptions of the respondents, then fulfilling the accountability relationships stemming from it may be difficult and it is in this context that problems may arise. Consequently, it may be difficult to ensure that the interests of both parties are aligned if there is confusion as to who fulfils the roles.

INSERT FIGURE (2) HERE

This was evidenced in the findings with respect to the accountability relationships. All three groups (with the exception of two respondents) described the relationship as *'problematic'*. They referred to it as *'confusing'*, *'unclear'* and not *'fully embedded'* which is made even more complex by issues such as the public private split in hospitals and the differences between statutory and non-statutory hospitals. Indeed, a perception was also put forth that while the HSE has set down guidelines there has been *'very little communication'* as to what the accountability process is going to be and as such believes it needs to be developed further.

The overriding consensus was that the problems stem from the reorganisation of the health service and the fact that it is still a system in transit. In addition, by and large no problems were perceived to arise due to the lack of a clearly defined ownership structure that can be associated with public hospitals. However, nursing respondents in particular were critical of the old health board structure, which they perceived to be too bureaucratic and suffered from political interference. In light of this it appears their hope is that the problem will be reduced under the new system. In turn the HSE and hospital management groups highlighted that the main cause of concern now is dealing with the private dimensions within public hospitals and managing the internal politics in hospitals whereby parties '*vie for power*'.

A further element of the process of structural change was whether or not it impacted on hospital performance. The HSE group perceive that while it made little very little difference to clinicians, there may have been a '*fall*' on the financial side and the process of managing a budget has slipped as there is no longer '*the feeling of being under the microscope*'. Furthermore, the HSE group did perceive a significant impact on the performance of hospitals as it has now placed greater demands on management. This group also voiced a strong concern that there may be a danger that the changes were rolled out too fast and that there is '*a danger that we are going to take our eye off the ball locally*'.

There was an overwhelming consensus that the goals of management, health care professionals and the hospital executive management teams are now well aligned. It was argued that previously they were not as well aligned as they are currently. The respondents contribute this change to initiatives such as the Clinical Directorate Model and improved communication. However, some respondents believed that '*the alignment will often be fractuous and they will never be totally aligned*' and that relations are '*often constrained by the resources available*'.

Eeckloo et al (2002) argue that governance is based on the two pillars of accountability and transparency. The findings would appear to concur with the accountability aspect.

However, it diverged from the literature with respect to transparency, to which very little reference was made. A possible explanation for this is that the new system is still very much in its infancy and as such the focus may be on trying to embed the organisational changes undertaken. As such there may not be a direct focus on transparency as of yet.

#### **4.2 What are the key drivers of hospital governance in its internal environment?**

In considering what constitutes governance in a hospital setting, three of the themes referred to above came to the fore – Executive Management Teams (EMT's) in individual hospitals, the role of clinical governance and integration.

Eeckloo et al (2002) argue that as the provision of health care is a 'social good' each group of stakeholders merit recognition of its interests. The findings of this study concur with the literature to some extent. The respondents highlighted that extensive work has been completed in this area. While the majority acknowledged multi stakeholders to be involved, the groups referred to by over 60% of the respondents were primarily patients and community interest groups. Little reference was given to other stakeholders; indeed one respondent who argued that no efforts were being made to involve the taxpayers who fund the system. This position could be further exacerbated by perceptions of one HSE respondent who was adamant that the HSE has '*fallen down*' on its accountability to the taxpayer.

Practically all respondents argue that the goals of hospital managers, the Executive Management Teams (EMT) and healthcare professionals are now more aligned. The emphasis now appears to be on working toward a common goal. The respondents cited that improved communications, an improved health system and the Clinical Directorate Model have all contributed to the process. This supports the arguments of Eeckloo et al (2002), Middleton (2005) and Scholten et al (2002) that there is a growing need for the alignment of the goals and actions of hospital managers and healthcare professionals.

Indeed they further state that the effective participation of medical staff in hospital management will become indispensable. However, in this study a number of respondents from both the HSE and hospital management groups identified internal and medical politics as potential problems in maintaining this alignment.

The EMT could be classed as the driving force of individual hospitals. In considering its composition, the findings illustrated that the role of the individual in the hospital will determine whether they will be eligible for EMT selection. In essence no set criteria for appointment to EMT's are established. This is in stark contrast to the prescriptions of the governance codes developed for the corporate world. It was also established that the tradition of voluntary membership is still in place. Furthermore, the nursing group did indicate that consultants who also serve as Clinical Directors are given further remuneration for fulfilling this additional role. In addition, despite the acknowledged importance of independence by all three groups, there is no independent representation on any of the EMT's in 4 hospitals. This diverges from the arguments of Eeckloo et al (2002) who perceive the EMT to be the 'supreme internal supervisory body' of a hospital and as such should have independent representation. However, it could be argued that tentative moves are being made toward it. Both the hospital management and HSE group indicated a recognised need for it in the future with consideration being given to it under the accreditation process. However, while the HSE group argued that a move to include independent representation in individual hospitals may serve to reinforce accountability and transparency it will necessitate a cultural change. In addition, PWC (2004) highlights that best practice suggests 1-3 years with a possibility of reappointment as an optimal term of office for EMT members. However, this was not evidenced in the findings of this study. In all the 4 hospitals in the sample, once appointed to the EMT members remained on it for as long as they fulfilled their role within the hospital. Furthermore the evidence provided by the HSE and nursing groups suggests that members are assumed to have an understanding of the requirements and objectives of the EMT based on their experience of the system. As such it was found that no hospital gives an induction to newly appointed members of the team, which also supports the findings of PWC (2004). In addition, the frequency of the meetings of the Executive Management Teams varied

across the hospitals as in places they were conducted on a weekly basis while in others it is conducted monthly. Finally, it was established that there are a substantial amount of sub committees stemming from the executive management team, all of which vary in nature. While these committees are acknowledged as a necessity, they are viewed as time consuming and in some cases burdensome.

Internal audit functions were found to be in place as part of the finance departments of most hospitals in the sample. This is done in an effort to complement the internal audit element of the National Hospitals Office. A systematic approach to risk management was also adopted by all hospitals in the sample. While an in house risk management program is in place in the majority of hospitals problems associated with it were highlighted. The hospital management group in particular argued that an all-encompassing program is needed as the concept incorporates so many differing areas such as financial risk, clinical risk, infection control, health and safety, maintenance and HAACP systems.

Resources are one of the most pressing issues in hospitals. In order to make the most of resources it is commonly acknowledged that there is a need to have an understanding of associated costs. In consideration of this the perceptions of the respondents appeared to diverge. While finance respondents generally believed that the EMT, hospital management and associated committees understand hospital costs the hospital management group in particular argued that these parties do not understand the costs, particularly non-pay costs. It was argued that as the financials are presented every month the issue is *'drummed in'* and so an understanding is developed. However, Middleton (2005) argues that the EMT must insist that all parties understand hospital costs. As such the EMT should not take for granted that costs are understood.

Furthermore, the overwhelming view of all three groups is that the accreditation process is proving to enhance governance in participating hospitals. The HSE group in particular believe that it is *'hugely effective through a system of peer review'* and that it has been accreditation that has put hospital governance on the agenda [of both hospitals and the HSE].

A noteworthy finding to emerge from the research is that despite its perceived importance by the three groups, effective guidelines have yet to be rolled out by the HSE on the issue of clinical governance. Vanu Som (2004) argues that concept of clinical governance tries to improve the quality of healthcare provided through integrating the financial, performance and clinical quality aspects of a hospital. However, it was illustrated by the findings that the structures in place on the clinical side are '*not as formal*' as their corporate counterparts. It currently appears to be driven by the professions and as such there is very little structured clinical audit systems in place. Indeed respondents from two of the hospitals highlighted that while some clinical audit is undertaken in their hospitals, the information gleaned from it is kept within the speciality areas and not shared. Furthermore, clinical governance assumes a strong level of clinical participation in governance processes. However, this may not be the case in all hospitals. Indeed in one hospital in the sample clinicians are not involved in hospital management at the moment. Furthermore, in no hospital in the sample was there a sub committee established to consider the issues and implementation of clinical governance. Finally, the HSE group believed that it is necessary to establish a body like the National Institute of Clinical Excellence in the UK, which would allow standards to be set across a range of clinical issues.

Eeckloo et al (2002) argued that hospital professionals have significant autonomy that is enhanced by separate reimbursement negotiations among the hospitals and professionals with health insurers. They further argued this has a negative influence and that a more integrated organisational structure would be better. The evidence in this study would appear to suggest that while the respondents agree with Eeckloo et al's statements, the nursing group believe that its achievement in the Irish setting is a long way off. Evidence would also suggest that the issue of integrating professionals into the management of the hospital has been significantly advanced particularly through the Clinical Directorate Model. This is perceived as having a positive effect on hospital governance by the hospital management group in particular. These findings reinforce the position of Scholten et al (2002) who argue that such integration is necessary to improve hospital



governance and in doing so the hospitals may gain the commitment of the professionals in promoting greater efficiency. However, it does not appear to be working perfectly in all hospitals in the sample with respondents from two hospitals indicating they were experiencing problems. Yet, a number of respondents perceive that further advancements on the issue may be affected by the ongoing negotiations of the new consultants contract where tensions have arisen as many have called for an increase in the accountability of consultants.

#### **4.3 What are the key drivers of hospital governance in its external environment?**

In considering what constitutes governance in a hospital setting, two of the themes referred to above came to the fore – pertinent issues in the governance debate and HSE considerations.

Hospital governance can be very much influenced by what goes on external to the hospital setting. The three main groups of nursing, hospital management and the HSE believe that issues such as value for money, the reorganisation of the health service and patient satisfaction has served to drive the governance process forward. These, in association with the accreditation process would appear to have put governance on the agenda of the health service and hospitals in particular. Perceived differences in interests and priorities among internal and external parties have also served to drive governance, primarily through the media attention associated with it. Evidence in the findings would support this view with nursing respondents in particular perceiving the situation to be one where the interests of internal and external parties are *'not aligned'* and as a result everyone is *'not focused on the same agenda'*. The significance of this lies in the arguments of Eeckloo et al (2002), which the findings support. They argue that differing interests may clash with the interests of the EMT and as such the EMT does not operate in full independence. This is also evidenced in the findings, as respondents from the HSE and nursing groups (in contrast to their hospital management counterparts) perceive that such differences may impact on the performance of the EMT.

As has been referred to earlier, the structural changes of the health service over the last number of years have played a significant role. The three groups of hospital management, nursing and the HSE perceive that the changes have put significant demands on hospital management. As such, the HSE respondents in particular believe that this has the potential to adversely effect hospital performance. It is their perception that the changes may have been rolled out too fast resulting in a knowledge deficit and a dip on the financial side where it is perceived that the *'process of managing a budget has slipped'*. While approximately 60% agree that the structural changes have been matched by appropriate governance changes, the remainder including respondents from both the hospital management and HSE groups perceive it to be an evolving process. In addition, it is broadly believed by the three groups that the governance issue was the last to be rolled out. Furthermore, the HSE and hospital management groups broadly believe that the organisational changes will affect governance at the local level. These respondents believe, as there are no longer people involved whom the local population has mandated, local accountability is now diminished and has been reduced to a *'token gesture with little discretion'*. This is in stark contrast to the criticism voiced by the nursing group in who criticised the political involvement associated with the old health board structure.

Evidence would also suggest a belief that the capacity of the HSE to govern the Irish health service is *'diminished'* and *'struggling'* due to its size, range of services and complexity, particularly on the part of the HSE respondents. A concern was voiced that the HSE *'lacks the capacity to make everything better for the patient at the moment'*. Indeed two of the respondents in this group raised the question as to how the system can overcome political pressures overriding what may be in the patients (and systems) best interests. Contrasting views also presented themselves among the group as to whether the governance process is two-way between the HSE and individual hospitals. Respondents seemed split on their views with many perceiving that hospital governance at present is a top down process with a limited role for patients and clinicians.

A number of the HSE group also put forward their perception that the HSE has *'fallen down on its accountability to the taxpayer'*. While these respondents acknowledge that

there are structures in place to fulfil their accountability to taxpayers, they are not believed to be *'fully embedded yet'*. In turn it is this respondents perception that the performance of the HSE is very much reflected by the performance of the Minister for Health.

## **5. Summary & Conclusions.**

The overall objective of this research was to assess the concept of governance in a hospital setting and what influences its processes and procedures. Having given consideration to both the research objectives and questions, examined the existing literature and the primary research findings, some overall conclusions can be drawn.

It can be concluded that there has been a shift in the focus of governance from a traditional focus on the private sector (in particular on large public companies). Greater consideration is now given to governance in the public sector. The health services, is one such example. While the concept of hospital governance is relatively well established in Belgium, Canada and the US it is not yet on the same footing in an Irish context, despite increased concerns with respect to issues such as resource allocation.

In considering hospital governance, it was found that while the principles of the governance codes of the corporate world may apply, they cannot be translated into hospital settings without adjustment. In addition, it was established that while the historic focus of hospital governance appeared to be very much on the financial it is now much broader and constitutes both financial and non-financial elements. There also appears to be confusion over the principal agent relationship in a hospital setting with the accountability relationships stemming from it referred to as confusing and problematic.

Many including Middleton (2005) argue that there is a growing need for goal alignment between hospital managers and medical professionals. This study suggests that this need is being addressed with the goals of hospital managers, Executive Management Teams and medical professionals becoming more aligned. With respect to Executive

Management Teams it was established that no set criteria are in place with respect to the selection of members. The tradition of voluntary membership is also still very much in place. In addition this study would also appear to indicate that effective guidelines with respect to clinical governance have yet to be rolled out by the HSE.

Finally, the structural changes of the health service over the last number of years has had a significant impact on the processes and procedures of the hospital governance phenomenon in Ireland. While approximately 60% of respondents believe that the structural changes have been match by appropriate governance changes, the remainder perceive it to be an evolving process. This study highlighted a belief that the structural changes impacted on hospital performance and that governance at the local level is affected as a result. In addition, not only did this process of change entail a lot of additional work and pressure for the parties involved, it also necessitated a change in organisational culture to some extent. As such it may take time for the changes undertaken to become fully embedded across the health system. Going forward, ongoing issues within both the health service and the HSE itself will continue to impact on the concept of hospital governance. Ongoing problems such as unresolved waiting lists, A&E crises and the negotiation of the new consultants contract will all have an impact on the health service arena.

### **5.1. Limitations & Suggestions for Future Research.**

There are some limitations associated with this research. Firstly, the sample was limited to one region and was comprised of statutory public owned hospitals only. As such no consideration was given to either private hospitals or non-statutory (voluntary) hospitals. In addition, the sample size is relatively small and therefore limits generalisability. While a number of functional areas were represented, the findings were driven by 3 of the larger respondent groups, namely the HSE, hospital management and nursing groups. Furthermore, the hospitals in the sample are at different levels of the accreditation process and as such one could argue that they are on differing platforms. Finally, there was no

patient participation in this study and despite efforts to secure clinician participation none were available to take part.

There is wide scope for follow up research to be conducted. Given that both governance and health care delivery systems are in a state of constant evolution there is huge potential to consider any number of perspectives in a research project. Examples of such follow up research include a longitudinal case study or consideration of topics such as accreditation, contractual issues and the HSE. It may also be useful to conduct a comparative study over time with either another Irish region or another country.

The tentative conclusion of this paper is that while the past focus of hospital governance was very much on the financial it has now been broadened to include both financial and non-financial elements. With that comes the task of trying to refine the necessary practices and procedures in an effort to incorporate all that constitutes governance in a hospital setting. Whilst hospital governance is a complex issue there is widespread belief that it is a very important phenomena. As such much work has been completed on the issue to date but the Irish health service remains a system very much in transition.

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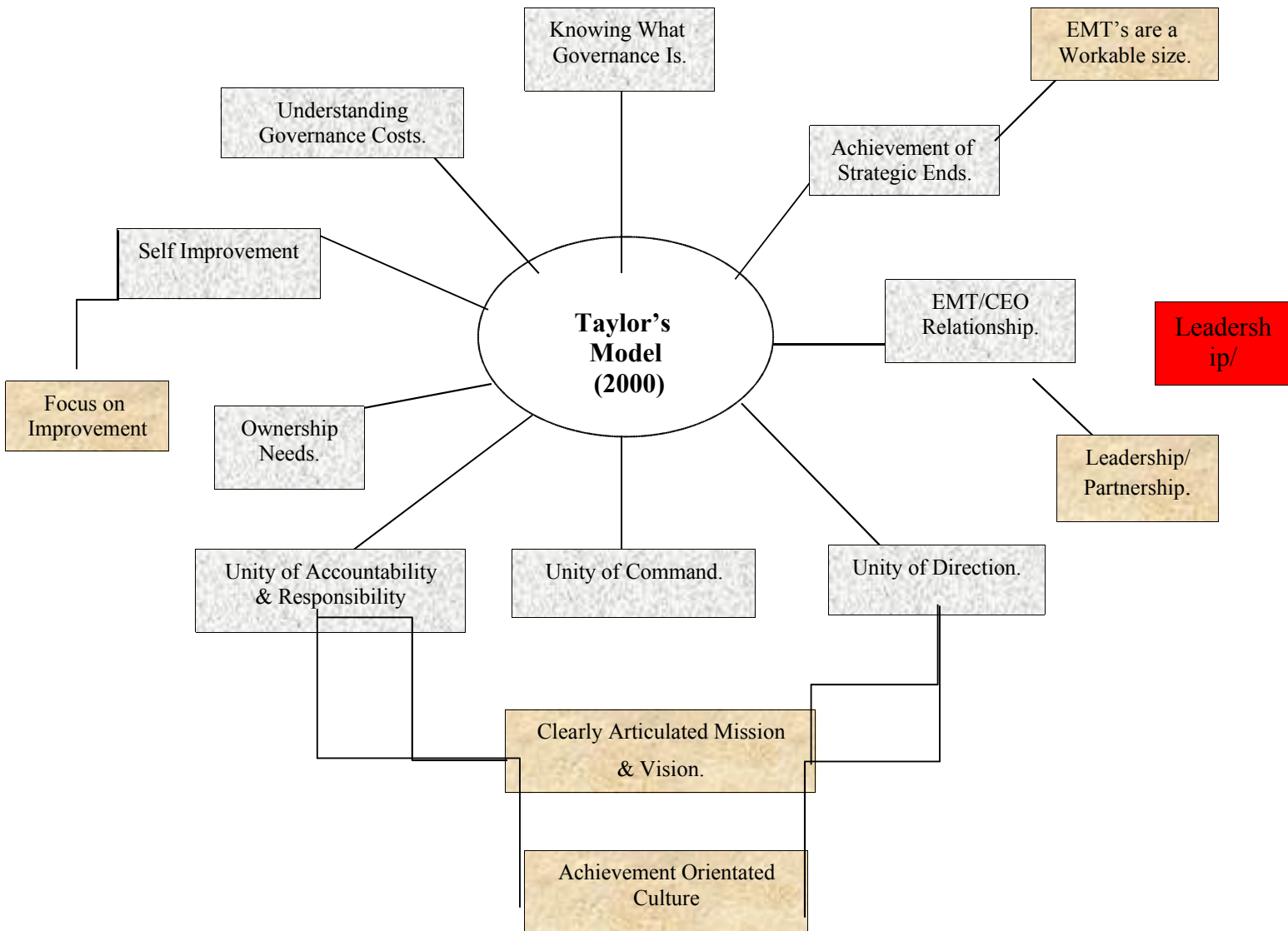
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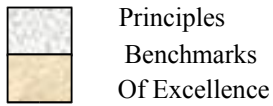
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**TABLES & FIGURES:**

**Figure 1: Taylor's Model (2000).**





(Adapted from Taylor, 2000)

**Figure 2: Agency Relationships in Hospitals.**

