Corporate and Clinical Governance in the Public Health Sector Context: Definitions and Issues Arising

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Abstract

The health sector in many developed counties (i.e. United Kingdom, Australia, and New Zealand) continues to pursue two models of governance – corporate and clinical. At times these models are applied in an interdependent manner, often though they are applied independently of each other. This presents both possible synergies and tensions. This paper explores the concepts of both clinical and corporate governance and briefly examines their different foci. Doing so adds to a current gap in the health sector governance literature, i.e. the impact of different manifestations of governance (corporate and clinical) on advancing the overarching purpose of governance within the health sector.

Keywords: Corporate governance, theories of governance, strategic leadership, accountability.

Introduction

The health sector in many developed counties (i.e. United Kingdom, Australia, and New Zealand) continues to pursue two models of governance – corporate and clinical (Barnett, Perkins & Powell, 2001; Harrison, 1998; Hood, 2002; Travaglia, Debono, Spigelman & Braithwaite, 2011). At times these models are applied in an interdependent manner, often though they are applied independently of each other. This presents both possible synergies and tensions. This paper, as the commencement of a piece of doctoral study, will explore the concepts of both clinical and corporate governance and briefly examine their different foci. This will lead to a presentation of the potential synergies and tensions. Doing so adds to a current gap in the health sector governance literature, i.e. the impact of different manifestations of governance (corporate and clinical) on advancing the overarching purpose of governance within the health sector.

The three types of governance of relevance in this context are 'governance' as a generic term, 'corporate governance' (as has been applied or derived from the business sector) and 'clinical governance'. This last governance concept appears to have changed over recent times to reflect a morphing of clinical governance with clinical leadership tenets within Australia, the United Kingdom and Canada (Addicott, 2008; Kapur, 2009; Penny, 2000; Travaglia et al, 2011). At the same time, the emphasis of corporate governance principles within public health settings (New Zealand and other countries as above) has been used as a means to shore up public confidence within a context of greater adoption of market-based transactions believed to provide a more rational, efficient basis for organisation than other forms of governance. There is a growing body of literature to suggest that it is not appropriate to transplant the existing corporate governance concepts from the private sector directly into the public sector, and that tailoring is required (Clatworthy, Mellett & Peel, 2000).

However, there has been scant regard given to what 'governance' is about, and no attempts within the literature to explain how these might relate to the principles of clinical governance, or linking to what clinical governance aims to achieve and how it operates. If this is true, there has also been scant regard paid to the interface issues, both synergies and potentially competing demands within policy and management domains. There is the potential for conflicted imperatives. So, governance as an issue in health is playing out around how clinical leadership is reconciled within the governance agenda.

Governance and Dimensions of Governance

Governance as an overarching concept, is ultimately concerned with creating the conditions for ordered rule and collective action (Stoker,1998). The traditional use of this term was as a synonym for government. As the boundaries between public and private sectors have blurred over time, governance now can refer to the development of governing styles in which recourse to the authority and sanctions of government is no longer the modus operandi. (Kooiman & Van Vliet, 1993). Although literature continues to support a hierarchical interpretation of governance, there is an increasing belief that the focus of administrative practice is shifting from hierarchical government

toward greater reliance on horizontal, hybridized, and associational forms of governance (Hill & Lynn, 2005).

Governance has a number of dimensions. These have been referred to in various ways within the literature. The first dimension speaks to accountability and its relationship to the second dimension, the provision of strategic direction i.e. governance is the means by which management and the organisation can be held accountable for their actions, helping to provide overall strategic direction (Shortell & Kalunzy 1993; Brauer & Schmidt, 2008). The third and fourth dimensions relate to policy implementation and ensuring it is carried out, and to maintaining organisational viability (Perkins, Barnett & Powell 2000).

The fifth dimension is leadership. In the context of a changing role of government in advanced democracies and the postulated crisis of the welfare state, governing is no longer solely concerned with spending capacity, but increasingly with the ability for leadership and consensus to mobilise the public and private resources available to society. This is directed toward better meeting social needs (Mendoza & Vernis, 2008).

The sixth domain is effectiveness. This concerns the ability of the organisation to deliver against agreed goals and outcomes. The maintenance of both effectiveness and viability are further highlighted by Weiner & Alexander (1993).

The seventh dimension concerns authority and management. It is imperative that organisations are able to articulate rules and processes around how organisations and its stakeholders will interact. This governance domain provides a means to observe and order thinking across a wide range of situations, stakeholders, relationships and concepts that may otherwise appear disconnected (Rhodes, 2007).

The eighth dimension relates to ethical orientation. A governance structure should include articulate the stance the organisation takes in relation to its values base, and how it understands and communicates its corporate responsibilities (Zimmerli, Richter & Holzinger 2007). Problem solving

is the ninth dimension. In this sense, the governance role is to solve problems and create opportunities (Kooiman, 1999).

Corporate Governance

We turn now to consider the concepts and definitions specifically relating to corporate governance. Corporate governance refers to the way big organisations are directed and controlled (Kooiman, 1999). Corporate governance is the effective management of corporations, discharging fiscal responsibilities, creating acceptable returns on investment, the direction and control of boards and executives, and the structures and decision-making processes to achieve corporate goals. Corporate governance should be centrally concerned with fairness, transparency and ethical business practices (Braithwaite & Travaglia, 2008).

Where there has been an expectation of a literal translation of corporate governance tenets to the public health setting, this has produced interesting outcomes. There is significant debate around whether there is sufficient congruity between the public and private sectors to allow the application of private sector models within the public sector (Perkins et al (2000), Clatworthy et al, 2000, Mendoza et al, 2008). The conclusion is that there are overwhelming differences between these sectors, with the public sector agencies having to satisfy a complex range of political, economic and social objectives, than do private businesses. In addition they are subject to expectations and forms of accountability to their various stakeholders who are more diverse and lively to be more contradictory in their demands that those of private companies. This leads to the conclusion that tailor-made governance frameworks are required.

Clinical Governance

Clinical governance is the other concept under consideration. The ever-increasing public concern over patient safety and quality in healthcare was the key driver of the development of clinical governance (Speccia, La Torre, Siliquini, Valerio, Nardella P., Camparo, & Riccia, 2010). The term originated in the United Kingdom, and in 1997 the Department of Health published a White Paper

'The New NHS: Modern, Dependable' which introduced the concept as a method of accounting for clinical quality in health care. It was further promulgated by Scally and Donaldson (1998) who put forward clinical governance as the key driver towards quality improvement in the National Health Service (NHS). They define clinical governance as 'a system through which health care organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment win which excellence in health care will flourish'. The main themes cover responsibility and accountability, comprehensive quality improvement, risk management and the identification and remedy of poor performance. Further descriptions of aspects of clinical governance are summarised as: changing the culture, lifelong learning, audit, evidence-based practice and clinical guidelines, and evaluation (Houghton & Wall, 2000).

However, it became clear that the translation of these broad concepts into action required interpretation and some degree of tailoring, in order that the ideas can be made to work in real settings. There is a proliferation of writings around the scope and inclusions within the clinical governance agenda. In promoting good clinical governance during the last decade, policymakers, managers and clinicians have started to tease out what actually has to be done to promote good clinical governance. This is said to include accountability, vigilant governing boards and bodies, a focus on ethics, regulating qualified privilege and a vast number of other processes (Braithwaite et al 2008). While Clinical governance is also utilised to strengthen links between the health services clinical and corporate governance arenas (Travaglia et al, 2011), there is currently little that describes the desired outcomes of this engagement.

In more recent times, a trend to more actively involve doctors in leadership and governance activities has emerged (Clark & Armit, 2008; NZ Ministerial Task Group on Clinical Leadership, 2009). In the New Zealand context Health Minister Ryall (2009) noted that globally, clinical leadership is recognised as a fundamental driver of a better health service. He has instructed District Health

Boards (DHBs) to foster effective clinical leadership and has committed to working with the Boards to make this happen.

The table (Table 1) summarises the points raised and their application within a health sector context. It also introduces the possible tensions and synergies, each of which is discussed further.

Insert Table 1 about here

Discussion: Governance Domains and Tensions/Synergies Arising

In answer to the question as to how governance in health is playing out around the reconciliation of clinical leadership within the governance agenda, the following points can be noted. The context for this discussion assumes that the corporate governance agenda flows through the health sector accountability systems (from the Minister to Ministry to Board then Chief Executive and so on), and that the clinical governance agenda manifests through the many forms of clinical leadership. The governance domains translate differently within these corporate and clinical governance contexts, and it is the potential synergies or tensions between each that are of interest.

From the literature it can be seen that many if not most of the ten domains presented here have very different interpretations within the two contexts. The expression of accountability within a corporate governance setting, for example, is clearly articulated through accountability structures referencing central government as a proxy for both the taxpayer and the patient. Clinical accountabilities align to professional bodies and to patients, with limited if any tethering to organisational vehicles such as hospitals or other grouped local delivery mechanisms. Alignment between these perspectives can result in the formal sanctioning of clinical leadership and provide improved patient outcomes. However, non-alignment can result in organisational resource being directed to non-clinical priorities. This can lead to clinician frustration, and potential recruitment difficulties where clinicians opt to work in organisations where they see greater congruency with their priorities. In

extreme cases, possible escalation of issues to professional bodies and government can ensue, where polarised views can result in high profile public debate.

The domains of strategic direction, policy implementation and effectiveness have similar issues. Where there is non-alignment between corporate and clinical models of governance, there is the potential for Boards to make arbitrary decisions about clinical services/targeted activities resulting in a lack of clinical support at service level. There is also the potential for service-level conflict over which clinical activities would be supported eg audit, review etc. At a strategic level, an increased focus on the achievement of inter-organisational goals without a clear framework can lead to exposure of clinical services to a responsibility for unmet social need. However, in a positive vein, synergies across organisational boundaries may also result in better and more effective clinical outcomes.

The domain of leadership raises slightly different issues. Within the corporate sphere, increasingly leaders within health are being required to demonstrate their ability to work across public and private sectors to better meet health need. Clinicians on the other hand show leadership directed toward meeting clinical need. In a constrained funding environment this raises the potential for debate where Boards may seek to direct resources toward meeting population health and/or meeting social need rather than health need.

Organisational viability is of increasingly sharp focus for a range of reasons, including both the exponentially increasing ways that the health dollar can be spent and the current constrained funding environments. Where the corporate governance model aligns with clinical governance and leadership, better decisions about targeting scarce resource can be made, and alternatively, lack of congruency in this domain is particularly problematic. While clinical governance discussion focuses on excellence in health care and a range of processes to assure that these are occurring, it remains silent on aspects such as financial considerations and rationing. Patterns of clinical delivery drive financial commitment, so without attention to the financial aspects, sustainable delivery of healthcare services can be jeopardised.

Authority and management issues are similar to accountability issues as above, however the ethical orientation is of particular interest. Should Boards with a corporate focus not fully align with explicit clinical outcomes, there is likely to be significant conflict at all levels of the organisation. In the processes of agreeing priorities however, there may be robust debate as to how organisations best achieve clinical outcomes.

In addition, some domains within each governance type are well developed, while others can be completely absent. While problem-solving is listed as a domain, there is little in the literature that describes how this relates to the corporate governance function. It is however a highlighted activity with the clinical governance arena, with a focus on clinical risk management processes and guidelines. Failure of Boards to grasp the importance of this process is likely to lead to significant organisational risk around clinical process.

The tenth and final domain is quality improvement. It has not been highlighted within generic governance literature or corporate governance literature. It is, though, a strong feature within the clinical governance arena. In order to be effective, a focus on quality improvement should be supported by all levels within organisations, so it is interesting that governance discussion does not currently encompass this.

These results indicate a range of practical implications. It would seem reasonable to suggest that organisations might benefit from explicit discussions around the models of governance employed, if only to make clear that a range of potential tensions can be expected at the intersection of these two models. From a positive perspective, it can also be signalled that the range of potential synergies are great where the strengths of both governance perspectives can be harnessed.

As a general statement, examination of the interactions between these two governance domains appears to add to the discussions in the literature. Ideas around the potential conflicts and areas of dispute are not apparent, neither are the ways in which synergistic governance models might progress health sector outcomes. Current authors appear to interrogate one or other of the two governance

models, most often in the context of changing political imperatives around the introduction of new public management changes. However, explicit dissection of intersections between corporate and clinical governance models does not appear to be subject to current debate.

Future Research

These are fertile fields for further exploration. The issues raised also lead to a myriad of further questions. For example, in the event that there is significant non-alignment around a range of domains within a certain organisation, what processes and/or behaviours might be employed to reach a positive outcome. Is it possible that one governance perspective has greater efficacy or results in better health outcomes in a specific set of circumstances, and what might these be. Or maybe one governance perspective or a specific mix of governance perspectives could routinely produce better health outcomes in all circumstances. Are there training implications inherent in these situations, and if so, how might they best be enacted.

Summary

In summary, the expression of governance in both corporate and clinical governance forms are evident within the public health sectors of many Western countries. The table (Table 1) shows aspects of both and the potential tensions and synergies where the differences between governance models intersect. In aggregate form, a lack of alignment is likely to result in conflict of one form or other, and a failure of organisations to deliver the best health outcomes possible. However, it is believed that further work to explore the differing imperatives inherent within the different governance models as they exist within health settings currently may shed further light on these issues. A proposed course of doctoral study is being developed to pursue these ideas further, with a view to later additions around how tensions might be managed. It is also believed that explicit dialogue between the stakeholders within organisations will ultimately lead to the best decisions possible being made about the application of scarce resource to produce the best health outcomes.

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Table 1: Domains of Governance, Corporate Governance and Clinical Governance: Tensions and Synergies

Domain	Governance tenets	Corporate Governance in public health sector	Clinical Governance	Possible Tensions &/or Synergies
1 Accountability	Accountabilities & structural conditions **defined** o 'Government' processes conferring accountability & sanction o Systems of 'rule', structural conditions o Defining relationships between structures /organisations	Accountabilities to government. **Conferred** through legislation and overarching policy documents.	Accountabilities to professional bodies, patients, and to Boards. **Adopted** by professional & health sector bodies, sanctioned by board and enacted through accountability mechanisms	Alignment can result in sanctioning of clinical leadership and provide improved patient outcomes. Non-alignment can result in clinician frustration, recruitment difficulties. In extreme cases, escalation of issues to professional bodies/ government.
2 Strategic direction	Strategic directions determined & linked to policy implementation.	Focus on achievement of multiple goals as agreed by central government, linked to local population imperatives and increasingly to inter-organisational goals.	Focus on patient safety, safeguarding high standards of care & quality improvement. Can be driven by individual clinicians with particular interests.	Potential for: - arbitrary Board decisions about clinical services/targeted activities, resultant lack of clinical buy-in. - service-level conflict over which activities can be achieved eg audit, review etc. - exposure of clinical services to a responsibility for unmet social need. However, synergies across organisational boundaries may also result in better clinical outcomes.
3 Policy Implementation	Role to ensure policy implementation.	Imperative, directed by Central government and their agent (Ministry).	May not be mandatory, except in specified areas.	Can result in clinicians being directed to achieve government targets, where these may not be perceived as valid.

4 Effectiveness		Goal focus.	Patient safety paramount, identification & remedy of poor performance. Can be a powerful tool to improve clinical performance.	Alignment can result in improved performance. Where goals do not align, clinical governance activities may not receive funding/other resource and support.
5 Leadership	Leadership and consensus to mobilise resources available.	Leadership increasingly to work across public and private sectors to better meet health need.	Clinical leadership to meet identified clinical health need.	Debate about organisational goals where strategic alliances and resources may be directed toward population health and/or meeting social need rather than health need.
6 Organisational viability	The maintenance of organisational viability.	Focus on financial viability & acceptable return on investment.	X	Pursuing clinical governance without concern for cost could result in non-adherance to budgets. Pursuing non-clinical financial imperatives may compromise clinical outcomes.
7 Authority & management	Linked to accountability. Explicit rules governing interactions between stakeholders.	Effective management, direction & control of boards & executives.	X	Where hierarchy does not explicitly support clinician leadership, potential service-level conflict about clinical priorities and resource application, devaluation of clinical work.
8 Ethical orientation	'Good governance'.	Focus on ethics & ethical business practice.	Focus on safeguarding high standards of care & excellence.	'Good' business practice should focus on clinical outcomes ie alignment should be assumed, however, increasing costs and potential spend on healthcare may lead to un-resolvable/ unacceptable rationing debates and tensions for clinicians in senior roles.
9 Problem solving	In relation to solving problems and creating opportunities.	X	Clinical problem solving & formulation of clinical guidelines.	Potential lack of organisational understanding of clinical risk and risk management.
10 Quality improvement	X	X	Comprehensive quality improvement focus,	Should there be no support for clinical

			evidence-based practice, & audit.	improvement, or factoring in of associated costs, may result in downgrading of clinical effectiveness over time.