Changes in the Structure, Composition, and Activity of Hospital Governing Boards, 1989–1997: Evidence from Two National Surveys

JEFFREY A. ALEXANDER, BRYAN J. WEINER, and RICHARD J. BOGUE

University of Michigan; University of North Carolina at Chapel Hill; Richard Bogue and Affiliates

HEALTH CARE POLICY IS OFTEN ASSOCIATED WITH federal and state legislation or regulation. Yet responsibility for interpreting, responding to, and implementing public policy at the local level often falls to the governing boards of hospitals and other health delivery organizations. The fiduciary role of governing boards assigns them direct accountability for accommodating the complex and often divergent demands of regulation, market forces, the community, and the organization itself. Little systematic attention, however, has been given to this important policymaking role of hospital boards and how boards adapt to fulfill this role in a changing health care environment.

The basic economic and social contracts under which hospitals and their boards have traditionally operated have been transformed in the last decade by tremendous changes in health care financing, organization, and delivery (Shortell, Gillies, Anderson, et al. 1996; Shortell, Gillies, and Devers 1995; Fennell and Alexander 1989). These systemic changes have added complexity to the thorny issues that trustees face, including responding to competitive pressures, maintaining the delicate balance between physicians and managers, responding to increased scrutiny of both clinical and operational quality, and ensuring accountability to the communities they represent (Mick and Associates 1990; Molanari,

The Milbank Quarterly, Vol. 79, No. 2, 2001

Morlock, Alexander, et al. 1993; Alexander 1991a; Fennell and Alexander 1989). Hospital boards are being asked not only to react to but to anticipate emerging issues and problems in a highly volatile and increasingly competitive health care sector (Fennell and Alexander 1989; Alexander 1990; Kovner 1990; Pointer, Alexander, and Zuckerman 1995).

Within this shifting health care landscape, questions are being asked as to how boards and trustees are responding (Alexander and Weiner 1998; Weiner and Alexander 1993). Such issues are important for at least two reasons. First, boards hold the ultimate authority for the organization's behavior by law—and, when major events occur, in practice. A board's attentiveness can launch a successful merger (Weil, Bogue, and Morton 2001); its inattentiveness can lead to bankruptcy, in one recent instance leaving over $1.4 billion in unpaid obligations (Bryant 1999). There may have been a time when hospital boards could play a rubber-stamp role, as some observers argue is the case. But, as consolidation and other multimillion-dollar transactions have become a common feature of the health care landscape, hospital boards are coming under increased scrutiny by state attorneys general, regulators, and public interest groups (Peregrine and Schwartz 1999). These stakeholders are fundamentally concerned about whether boards are capable of fulfilling their fiduciary responsibilities, particularly since access to care, accountability to communities and patient populations, and asset preservation are often affected by their decisions.

Second, hospital boards are the first, and often the last, opportunity for local community residents to influence health care decisions and policy. Traditionally, local community influence in hospital affairs was clearly established in hospital bylaws and traditionally reflected in the composition of their governing boards. However, through reorganization and consolidation into vertical and horizontal systems, hospitals are often enmeshed in multiple layers of governance and managed by those concerned with the health care operations of multiple provider organizations. Under these arrangements, power, resources, and services within the system reside not in a single organization but are distributed over the multiple organizations that comprise it, as well as the administrative authorities that manage it. This creates a situation whereby direct access to hospital leadership by community members, patients and their families, and advocates becomes far more problematic than it is for freestanding hospitals. From a policy perspective, these trends give rise to questions

about whether hospitals are providing community benefits (e.g., access to care, uncompensated care) in a manner consistent with the benefits they obtain as tax-exempt organizations. The practical issues are to identify which entity is accountable for meeting community needs while ensuring that the relevant governing body exercises its agency role as community steward, and to reassess both the mechanisms and the content of community accountability in an era of tiered governance, competition, and cost containment (Alexander and Weiner 1998).

To date, there has been little information available to address these and related questions regarding the structure, composition, roles, and activities of hospital boards in light of the significant environmental and organizational shifts experienced by hospitals since the late 1980s. The objective of this paper is to provide a description of how hospitals and hospital boards have responded to changing organizational and environmental pressures. The analyses will focus on changes in board characteristics between 1989 and 1997, the magnitude of the changes, and the direction of the changes. In addition, the paper will consider whether these changes are more or less likely to occur in certain types of hospitals. It examines changes in governance characteristics as a function of hospital membership in a health care system, rural/urban location, hospital size, and type of ownership or control status. Although it is intended to be primarily descriptive, the paper will offer some working hypotheses as to the reasons for change (or lack of change) that might provide hospital managers and trustees and policymakers with a starting point for discussion and debate regarding appropriate governance structure and practices.

Methods

Data for this analysis were obtained from two national surveys: the first conducted in 1989 by the Hospital Research and Educational Trust; and the second in 1997 by the American Hospital Association in partnership with Ernst and Young, LLP. Each of these surveys was sent to the CEOs of all acute-care community hospitals in the country. Hospital CEOs were asked to complete the survey in cooperation with key board members, such as the board's chairperson. The 1989 survey received a response rate of approximately 57 percent (3,100 hospitals). The 1997 survey received a somewhat lower response rate of 42 percent (2,100 hospitals) (table 1). It is important to note that the analytic focus of this paper is

TABLE 1
Characteristics of Responding Hospitals

	1989 (n = 3100)		1997 (n = 2100)	
	Respondent percentage	Respondent number	Respondent percentage	Respondent number
Organizational control				
Not-for-profit	63%	1,953	63%	1,323
Government, nonfederal	29%	899	27%	567
Investor-owned	9%	279	10%	210
Bed size				
Fewer than 100	42%	1,302	42%	882
100 to 299	39%	1,209	40%	840
300 or more	19%	589	18%	378
Location				
Urban	54%	1,674	62%	1,302
Rural	46%	1,426	38%	798
Region				
Northeast	15%	465	15%	315
South	35%	1,085	35%	735
North Central	32%	992	21%	441
West	18%	558	18%	378
System members				
Yes	27%	837	28%	588
No	73%	2263	72%	1512

not on changes in governance practices in individual hospitals but rather on how the population of hospitals in 1989 compares to the population of hospitals in 1997 with respect to governing board structure and practices.

To assess how well the 1989 and 1997 samples represented the hospital population, we compared each sample to characteristics of the hospital population in their respective years. The 1989 sample is generally representative of the population of community hospitals in that year. Except for the underrepresentation of investor-owned hospitals, no statistically significant differences were noted between the sample and the population on the basis of organizational control, bed size, location, region, and health system membership. The 1997 sample again uderrepresented investor-owned hospitals, as well as hospitals located in rural areas and

health system members. Some caution should therefore be exercised in generalizing about the findings of the analysis, particularly to these groups.

Because of the nontrivial difference in sample size (1,000 hospitals) between 1989 and 1997, we also attempted to assess potential response bias that might affect governance comparisons between the two time points. Using all general hospital attributes and governance characteristics considered in this study, we evaluated whether systematic differences obtained between hospitals that responded to both the 1989 and 1997 surveys, on the one hand, and hospitals that responded to the 1989 survey only. If substantial differences are observed between these two groups, it may indicate that comparisons are biased because of the attrition from the study group of those hospitals that possess particular governance characteristics. Of the 17 hospital and hospital governance characteristics examined, only four exhibited statistically significant differences between the two groups. Investor-owned hospitals constituted 10 percent of the 1989 sample but only 5 percent of the panel sample; 52 percent of the 1989-only sample were urban, compared to 58 percent of the panel sample; 6 percent of hospital CEOs served as board chairperson in the 1989 sample versus 3 percent in the panel; and 55 percent of the 1989-only sample conducted formal board evaluations, compared to 60 percent of the panel. In sum, the differences between the two groups were few in number, and even those that were statistically significant were rarely substantively meaningful.

Structure, Composition, and Selection

Who sits on the hospital board, how the members are selected, and how many members it has disclose much about the board's character. Likewise, the nature of the governance process is likely to be revealed in the profile of the individuals who serve on the board.

Board Size

The size of the board continues to be one of the most widely discussed characteristics. Large boards are thought to preclude effective decision making by lengthening the process and diffusing the commitment of

each member. Many health care managers and consultants complain that large boards are too unwieldy to be effective. Small boards, they argue, would reach more timely decisions, producing a comparative advantage in an environment that demands action and a clear focus on the important issues. This is true theoretically, because when fewer individuals and interests have to be taken into account in the decision-making process, the board faces a less complex task. On the other hand, small boards may be more likely to engage in risky change, as a result of being held captive by a bloc or alliance of two or three members, or by "groupthink" (Janis 1967). Moreover, health care organizations, including hospitals, increasingly align with partners to provide services that cannot be generated as effectively in-house. One way of tying these loose alliances and partnerships together is through board membership (interlocks). This often results in boards of a larger size than is ideal for decision-making purposes.

In both 1989 and 1997, the size of hospital boards averaged just over 13.5 members (table 2). In terms of control category, not-for-profit hospitals had the largest boards in 1997:16.6 members, down from 18.8 members in 1989. Investor-owned hospital boards averaged

TABLE 2
Board Size (Total Board Positions, Including Vacancies)

	1989	1997
Organizational control		
Not-for-profit	18.8	16.6
Government, nonfederal	7.8	7.9
Investor-owned	9.7	10.1
Bed size		
Fewer than 100	9.9	10.2
100 to 299	14.8	14.9
300 or more	18.8	18.5
Location		
Rural	10.3	10.0
Urban	16.3	15.8
System members		
Yes	13.8	14.1
No	13.4	13.4
All hospitals	13.5	13.6

10 members and did not display significant differences from 1989. Finally, public hospitals displayed the smallest average board size (eight members), but again displayed no difference in board size from 1989 to 1997. The size of public hospital boards is often determined by law, casting some doubt in their case on board size and changes in board size as strategic responses to decision-making efficiency or to opportunities for board interlocks.

Hospital board size tends to be proportional to hospital size. Larger hospitals have larger boards. This relationship was evident both in 1989 and in 1997. It is also notable that the size of the board appeared to have no inherent cap or plateau point. Apparently board size will increase in a manner consistent with the size of the hospital.

Hospitals that were members of health care systems in 1997 had average board sizes of 14 members, virtually unchanged since 1989. Finally, rural boards were appreciably smaller than their urban counterparts. These hospitals averaged 10 board members in 1997, versus almost 16 in urban institutions. This may be a function of size of the institutions and the disproportionate number of public hospitals in rural communities rather than their location, per se. On the whole, there has been little overall change in the size of hospital boards, although some differences across types of hospitals are evident, particularly by size of hospital, control type, and rural/urban location. A standard explanation for this pattern is that hospitals continue to find it difficult to downsize their boards over a short period of time. Board size may change primarily through a much slower process of attrition and nonreplacement of board members. More relevant to organizational policies, however, is the new trend toward partnering with outside organizations. Board interlocks help maintain the integrity of these "virtual" relationships, keeping boards large and sometimes even increasing board size, especially among larger hospitals in more competitive, nonrural areas. System hospital boards do not differ from nonsystem boards in terms of size, which indicates that having a system level and local board may not present easy opportunities for reducing the size of one or the other. This finding lends weight to the notion that system-level boards may not be able to assume some board functions that require local knowledge, such as physician credentialing, community accountability, and managed care contracting (American Hospital Association and Ernst & Young 1999).

Age of Board Members

Hospital board members were slightly older in 1997 than they were in 1989. For example, whereas 47 percent of board members were younger than age 50 in 1989, only 40 percent were in this age bracket in 1997. Most of the shift appears to come in the middle range of the age distribution (50 to 70). The proportion of board members falling into this category in 1997 was 54 percent, compared to 48 percent in 1989. That boards are getting older may reflect our nation's general demographic trends, as well as the desire of hospitals to obtain board expertise in the form of greater experience, positions of influence, and a strong potential for leadership. In examining age by the type of hospital, both investor-owned and system hospitals had the youngest boards. Fifty-seven percent and 44 percent of these hospitals, respectively, had board members under 50 years of age. Yet, in comparing these distributions to those of 1989, the average age of board members for these hospital types also increased. Public hospitals experienced the largest percentage increase in board member age distribution from 1989 to 1997. In 1989, 47 percent of public hospital board members were under age 50, compared to only 36 percent in 1997.

Member Selection Criteria

Board member selection procedures and criteria indicate the board's expected roles and reflect efforts to broaden or deepen specific board characteristics. If new board members, for example, are selected by criteria that emphasize financial or business skills over values, there may be a tendency for boards to have a bottom-line orientation. Table 3 ranks the importance of criteria in selecting board members in 1989 and in 1997.

TABLE 3
Top Four Board Member Selection Criteria

1989	1997
1. Financial and business acumen	Community leadership
2. Community leadership	Values aligned with the hospital's
3. Values aligned with the hospital's	Time availability and willingness to commit effort
4. Political influence	Financial and business acumen

It is noteworthy that financial/business skills fell from first to fourth in this ranking from 1989 to 1997. Community leadership, values and time availability were the most important selection criteria expressed in 1997. Few differences were noted in this pattern across types of hospitals. These findings suggest that an orientation toward the community is becoming more salient among hospital boards as hospitals and health care systems forge a broader set of affiliations and services. This broadening may reflect both hospitals' need to develop new services to make up for reductions in inpatient volume and their increasing accountability for the health and well-being of populations, beyond just patient groups. The stronger emphasis on time availability for board membership suggests that a casual commitment to board work may be insufficient in an era of competition and shifting priorities.

Embeddedness of Governance Structures

Hospital governance is complicated considerably when one takes into account the increasingly complex organizational arrangements in which hospitals are embedded. The increase in complex organizational forms—such as multi-institutional systems, vertically integrated arrangements, virtual organizations, and alliances—often give rise to multiple governance entities. These multiple boards create vertical patterns of authority and control between subordinate and superordinate boards (Alexander, Morlock, and Gifford 1988). The relationship between local hospital boards and higher-authority boards or arrangements is particularly problematic. In such cases, new governance issues are superimposed upon the traditional problems of single hospital governance (Alexander 1991b). These include:

- How do organizations integrate the efforts of multiple levels of governance?
- What should be the respective roles and relationships of these various boards?
- How should key functions be allocated among various governance entities and levels?

The 1997 survey indicated that 66 percent of hospital boards were not completely independent, up from 59 percent in 1989. Accountability to a higher authority includes reporting to health care systems, state and

local governments, universities, and religious orders. Sixty-three percent of those hospitals responsible to a higher authority were accountable to a parent holding company, a common arrangement for multi-institutional health care systems. Much less common is accountability to units of local government, religious orders, investor-owned corporations, or universities or colleges. It is also noteworthy that accountability to parent holding companies increased significantly between 1989 and 1997. By contrast, accountability to other entities decreased slightly over the same period. This suggests that parent holding company arrangements are becoming the organizational structure of choice, as hospitals move to consolidate and partner in an era of competition and managed care. Investor-owned hospitals, large hospitals, those affiliated with systems, and those in urban areas are most likely to be accountable to higher authorities.

From 1989 to 1997, public and investor-owned hospital boards experienced the greatest increase in accountability to higher authorities (table 4). There was a less substantial increase among not-for-profit hospitals. Although not-for-profit hospitals tend to have a significant presence in health care systems and other vertical relationships, they also

TABLE 4
Percentage of Boards Accountable to a Higher Authority

	1989	1997
Organizational control		
Not-for-profit	60.2%	62.5%
Government, nonfederal	53.0%	66.0%
Investor-owned	74.7%	86.0%
Bed size		
Fewer than 100	51.7%	59.4%
100 to 299	62.1%	62.5%
300 or more	70.2%	77.5%
Location		
Urban	64.7%	72.1%
Rural	53.0%	55.7%
System members		
Yes	78.1%	92.1%
No	51.3%	55.5%
All hospitals	59.4%	65.8%

tend to have the greatest presence among independent, freestanding institutions. It is important to note that the boards of system hospitals experienced greater increases in accountability to a higher authority between 1989 and 1997, relative to nonsystem hospitals. While the fact of accountability to a higher authority among system hospitals may seem obvious, the greater increase points to the possibility that hospitals associated with multi-institutional systems are experiencing more centralized control by systems over their governance operations than in the past. This may be viewed as a natural evolution toward more integrated and diversified health care enterprises in competitive urban and suburban areas. It is worth noting that slightly higher rates of increase in acountability to a higher authority were noted in urban hospitals compared to rural hospitals between 1989 and 1997. Much of this may have been due to increasing consolidation and integration, driven by competition and cost-containment pressures, which are not so prominent in many rural areas, especially those served by sole-provider hospitals.

In sum, these data point to an increasing trend toward embeddedness in governance relationships, particularly in larger, system-affiliated organizations located in nonrural areas. It is reasonable to assume that governance issues become more complex in hierarchically structured board arrangements. This added complexity may lead to problems in communication and coordination, higher levels of conflict, and disagreement over governance issues (such as the division of responsibilities among boards), all resulting in systemic ineffectiveness. Indeed, many past consolidations of hospitals and between hospitals and physician groups are being reexamined. Operational experience with these hierarchically structured organizations suggest that the expected efficiencies often remained elusive, simply failed to materialize, or turned out to be major *in*efficiencies (Zinkman and Peck 1999; Fine and Marren 2000). In light of the continuing pressures to consolidate, a key to success for hospitals and systems operating in more competitive environments may emerge from the scarcely examined domain of embedded governance. Learning how to communicate, coordinate, resolve conflict, and allocate governance authorities among multiple entities better and more quickly could bring clarity to consolidation plans before they are implemented, or at least before they produce large unexpected negative outcomes.

Term Limits

In an era of increased competition and volatility, there has been much discussion over term limits for hospital board members. Advocates argue that term limits prevent the board from being entrenched in a small set of strategies and allow for fresh ideas to enter the boardroom. Conversely, others suggest that stability in the boardroom is exactly what is required in an era in which so much else is in flux. In particular, opponents of term limits suggest that the core values and mission of the hospital can best be preserved through the board members' long-standing affiliation with the organization. Our survey data indicate virtually no change between 1989 and 1997 in the proportion of hospital boards with term limits. Forty-eight percent imposed limits in 1997 compared to 47 percent in 1989. Further, there were few differences in the frequency with which term limits were imposed across types of hospitals between 1989 and 1997. Generally, public hospitals were less likely to impose term limits compared to investor-owned and not-for-profit hospitals (25 versus 46 and 58 percent, respectively)—in large part, no doubt, because elections or political appointments often serve to limit public hospital board members' terms without need of a bylaw defining term limits. In addition, smaller hospitals, nonsystem hospitals, and rural hospitals were also less likely to impose term limits on board members than their larger, system-affiliated, and urban counterparts. The low frequency of term limits among small, nonsystem, and nonpublic rural hospitals may be a function of the limited pool of governance talent available in sparsely populated or restricted market areas. This may force such hospitals to continue to rely on proven board members for service on the hospital governing board. By contrast, larger hospitals, system-affiliated hospitals, and those in urban areas may have a larger pool of governance talent on which to draw, affording them the luxury of imposing term limits and cycling in new board members.

CEO–Governing Board Relations

As hospitals face increasing pressures to remain competitive and contain their costs while maintaining quality, trustees will be increasingly called upon to provide strategic direction, offer specific expertise (e.g.,

clinical affairs, managed care, competitive strategies), and challenge management to redefine the hospital's role. Such activities require effective communications and integrated working relationships with the chief executive and others on the top management team (Weiner, Alexander, and Shortell 1996). In light of the changes facing hospitals and their markets, some analysts claim that the separation of top-level management and governance is becoming less distinct in practice, and that the effectiveness of management in health care organizations is inextricably linked to the effectiveness of governing boards, the governance process, and the working relationship between boards and hospital CEOs (Bader 1997). While the traditional governance functions of monitoring CEO performance and hiring and firing the CEO will remain constant, there is considerable variation among hospitals in terms of how CEO-board relations are structured and managed.

Our results suggest that it is in this area of CEO-board relations that hospitals have displayed the greatest shifts from 1989 to 1997. Perhaps the primary mechanism for closer CEO-board integration is the CEO's involvement on the board itself. Hospital CEOs were much more likely to be the chair or the vice-chair of a hospital board in 1997 relative to 1989. In 1997, 8.5 percent of hospital CEOs were board chairs or vice-chairs, versus 4.5 percent in 1989. Although these absolute percentages are not high, this trend is clearly on the rise. Investor-owned and private, not-for-profit hospitals are more likely to have CEOs as chairs, relative to public hospitals (12 and 11 percent, respectively, versus 1 percent). In particular, the tendency of private, not-for-profit boards to have CEOs as board chairs has increased since 1989 while public and investor-owned hospitals less frequently have CEOs that serve as board chairs. Non-system-affiliated hospitals were more likely to appoint CEOs as board chairs relative to system hospitals, along with urban hospitals. Although system hospitals did not display a strong tendency to appoint CEOs as board chairs, they were more likely to increase the voting status of the CEO on the board from 1989 to 1997. Sixty-one percent of system hospital CEOs had full voting status in 1997 versus only 54 percent in 1989.

Rural hospitals were much less likely to have CEOs as full voting members of the board relative to their urban counterparts (20 percent versus 46 percent in 1997). These relative percentages did not differ significantly from those in 1989.

Employment Contracts

Written employment contracts between the hospital board and the CEO are often cited as mechanisms for specifying expectations for CEO behavior and performance as well as a stabilizing factor in CEO-board relations. Further, contracts presumably encourage more risk-taking behavior on the part of the CEO, who is protected from capricious action on the part of the board (Alexander, Fennel, and Halpern 1993). Similarly, the employment contract places less pressure on the CEO to manage the idiosyncratic behavior of individual board members. These features are particularly attractive in an era of competitive uncertainty and change.

Our data (table 5) show that CEOs were much more likely to have written employment contracts in 1997 than in 1989 (59 percent versus 43 percent). All control categories increased this practice. Overall, private, not-for-profit hospitals were most likely to have CEO employment contracts, followed by public and then investor-owned hospitals. Further, not-for-profit hospitals experienced the largest percentage-point increase between 1989 and 1997 in this practice.

A similar pattern holds for hospitals of different bed sizes. Smaller hospitals were less likely to have a CEO contract (50 percent) versus

TABLE 5
Percentage of Hospital Boards Offering a CEO Employment Contract

	1989	1997
Organizational control		
Not-for-profit	45.9%	63.8%
Government, nonfederal	41.3%	57.0%
Investor-owned	25.9%	34.5%
Bed size		
Fewer than 100	34.1%	49.6%
100 to 299	47.5%	64.0%
300 or more	52.5%	70.2%
Location		
Urban	46.6%	61.1%
Rural	38.5%	55.7%
System members		
Yes	35.6%	48.3%
No	45.8%	63.3%
All hospitals	42.9%	59.0%

medium and large hospitals (64 percent and 70 percent, respectively). All hospital size categories increased in the frequency with which CEOs were offered a written employment contract in 1997 relative to 1989. System-affiliated hospitals were less likely to have written employment contracts for the CEOs than non-system-affiliated hospitals (48 percent versus 63 percent), although, again, both categories experienced increases since 1989. In all likelihood, the system versus nonsystem disparity may be a function of the fact that CEOs of system hospitals often have contracts with the system, not with the hospital board. We were unable to ascertain the size of this effect from the survey data. There were relatively small differences between rural and urban hospitals in the frequency with which they offered the CEO an employment contract (56 percent versus 61 percent), though both increased this practice between 1989 and 1997.

Incentive Compensation

Consistent with this theme of increased emphasis on accountability and oversight, the survey also asked whether the board offered hospital CEOs an incentive compensation plan. Such plans are, in principle, designed to align the incentives and balance the interests of hospital management with the goals and priorities of the board.

Although the health care industry has traditionally lagged behind most other American industries in their use of incentive compensation systems for top management, such systems may have a place in hospitals that are competing more vigorously. Indeed, our survey data (table 6) indicate that the frequency of incentive compensation increased from 33 percent in 1989 to almost 48 percent in 1997. Investor-owned hospitals were most likely to have such a plan, but other control categories experienced more dramatic increases since 1989. Larger hospitals were more likely to use incentives and also showed the greatest increase since 1989. System hospitals also displayed a greater tendency to have incentive compensation plans, and showed a greater percentage increase in this practice, relative to their non-system-affiliated counterparts. Indeed, the high frequency of incentive compensation found in system hospitals suggests that this form of control may be a substitute for the formal employment contract, which is found less frequently in system hospitals. Consistent with the bed-size finding, hospitals in urban areas were more likely to have incentive compensation plans for their CEOs

TABLE 6
Percentage of Hospital Boards Offering CEO Incentive Compensation

	1989	1997
Organizational control		
Not-for-profit	37.2%	52.2%
Government, nonfederal	12.3%	24.6%
Investor-owned	76.4%	82.0%
Bed size		
Fewer than 100	21.5%	32.4%
100 to 299	39.9%	55.7%
300 or more	45.8%	65.7%
Location		
Urban	43.3%	59.3%
Rural	21.7%	28.9%
System members		
Yes	47.7%	71.8%
No	27.3%	38.2%
All hospitals	33.4%	47.7%

than their rural counterparts (60 percent versus 29 percent), although both categories increased the practice since 1989.

CEO Performance Evaluation

Perhaps the most direct board mechanism for ensuring CEO accountability is a formal performance evaluation by the board using pre-established standards or criteria. As table 7 indicates, 79 percent of all hospital boards conducted such an evaluation of their CEOs in 1997, compared to only 63 percent in 1989. Among hospital control categories, investor-owned and private, not-for-profit hospitals were most likely to conduct CEO performance evaluations (84 percent), while public hospitals were less likely to do so (67 percent). All control categories increased this practice since 1989. Our data indicate that as hospitals grow larger, they are increasingly likely to engage in formal performance evaluations of their CEOs. Perhaps this is because with larger size comes increasing complexity and greater difficulty for the board to monitor management activity and performance more informally. Larger size may also require a greater need to formally specify goals and criteria for hospital management in light of the multiple objectives and strategies perceived by larger

TABLE 7
Percentage of Hospital Boards Evaluating CEO Performance against Pre-established, Written Criteria

	1989	1997
Organizational control		
Not-for-profit	66.8%	83.8%
Government, nonfederal	52.2%	66.9%
Investor-owned	69.6%	84.0%
Bed size		
Fewer than 100	55.5%	73.3%
100 to 299	66.6%	82.5%
300 or more	71.0%	86.0%
Location		
Urban	68.0%	83.6%
Rural	56.7%	72.2%
System members		
Yes	73.0%	88.3%
No	58.5%	75.7%
All hospitals	62.8%	79.3%

organizations. System-affiliated hospitals were more likely to practice formal CEO performance evaluations than their nonsystem counterparts, although both system and nonsystem hospitals increased this practice since 1989. As might be expected given the findings on hospital size, urban hospitals were more likely to engage in a formal evaluation of the CEO than their rural counterparts. This relationship held in 1989 as well as 1997.

Although our data indicated a significant increase in the frequency with which boards formally evaluated their CEOs, there was relatively little change in the criteria employed to conduct such evaluations. In both 1989 and 1997, financial performance and physician-relations/integration were the top two criteria for CEO evaluation. The only change in the ordering of the evaluation criteria occurred between fulfillment of strategic plans, which assumed greater importance in 1997, and quality-of-care/outcomes management, which was more important in 1989. Some differences in the ranking of evaluation criteria are noted by hospital type. Financial performance remained paramount for all hospitals except government hospitals in 1997. However, investor-owned hospitals placed relatively more emphasis on legal and regulatory

compliance and the fulfillment of a strategic plan in 1997 than these hospitals did in 1989. Similarly, relatively less emphasis was placed on physician relations and integration among investor-owned hospitals in 1997, relative to 1989 when it ranked second.

In all other categories of hospitals (system versus nonsystem, urban versus rural) financial performance was the first-ranked criterion by which the board evaluated the hospital CEO. Except for the differences previously noted by control type, physician-relations/integration invariably was listed second, with little difference between 1989 and 1997. Some increased emphasis on the fulfillment of a strategic plan as an evaluation criterion was noted between 1989 and 1997, particularly among nonsystem hospitals and among both very small and very large hospitals. Quality-of-care/outcomes management received a lower priority ranking among criteria used to evaluate the hospital CEO between 1989 and 1997, giving way to financial and strategic concerns as competition and cost-containment efforts have increased.

Board Evaluation and Compensation

In 1983, the Joint Commission on Accreditation of Healthcare Organizations mandated the formal evaluation of hospital boards' performance. By 1989, 56 percent of all hospitals reported that they engaged in board self-evaluation, using predetermined criteria. This number rose slightly to 62 percent in 1997 (table 8). Considerable differences were noted by category of hospital. Among the three control categories, investor-owned hospitals displayed the greatest tendency to engage in board self-evaluation on the basis of predetermined objectives. Seventy-eight percent of responding investor-owned hospitals in 1997 formally evaluated their boards. This contrasts with only 61 percent who engaged in such an evaluation in 1989. Whereas both public and not-for-profit hospitals also displayed an increase in this practice, the increase was much smaller, as was the percentage actually engaging in this practice. Only 45 percent of public hospitals and 67 percent of private nonprofit hospital boards routinely evaluated their performance on the basis of predetermined objectives by 1997. Larger hospitals were more likely to have boards that conducted an evaluation of board performance than smaller hospitals. Seventy-one percent of hospitals with more than 300 beds engaged in this practice in 1997, versus only 51 percent of hospitals with fewer than

TABLE 8
Percentage of Hospital Boards Conducting Formal Self-evaluations

	1989	1997
Organizational control		
Not-for-profit	63.4%	67.2%
Government, nonfederal	41.5%	44.6%
Investor-owned	60.8%	77.5%
Bed size		
Fewer than 100	45.6%	51.3%
100 to 299	64.7%	69.3%
300 or more	65.3%	71.1%
Location		
Urban	65.1%	70.0%
Rural	47.2%	49.2%
System members		
Yes	68.9%	75.4%
No	51.6%	56.8%
All hospitals	56.9%	62.0%

100 beds. System hospitals were more likely to engage in self-evaluation of the governing boards than nonsystem hospitals (75 percent versus 57 percent). Finally, urban hospitals were more likely to self-evaluate board performance than their rural counterparts (70 percent versus 49 percent). All categories of hospitals appeared to increase this practice between 1989 and 1997.

Financial Compensation

As the challenges of governing hospitals increased, there was considerable discussion about providing financial compensation to board members, to make it easier to hold them accountable for governance responsibilities, and to raise expectations about their performance. Much of the impetus for paying hospital board members comes from practices in the corporate sector, where directors are typically paid for their services to the corporate board. Because payment rarely compensates board members fully for their time in the not-for-profit and governmental sectors, in health care it is often seen as a symbolic mechanism for tying board members more closely to the organization and to the activities of the board. Despite its widespread use in other sectors, there is considerable controversy among

hospitals over its use. Generally, the dilemma is seen as balancing the traditional values associated with voluntary hospital trusteeship with the pressing need to ensure an active and committed board. However, some experts have pointed out that the frequent and large transfers of assets and funds that take place may make the idea of board compensation in not-for-profit hospitals less viable today, though it never has been popular (Smith and Bogue 2000). Indeed, the Volunteer Protection Act of 1997 affords a higher level of protection from liability for not-for-profit board members who are not compensated, and the Standards in Philanthropy of the National Charities Information Bureau strongly discourage compensation for board members of nonprofit organizations.

Reflecting the greater caution that perhaps should come with more frequent and larger transactions among not-for-profits, the survey results indicate that the practice of financially compensating board members for their service on the board actually declined slightly since 1989 (table 9). In 1989, 14 percent of responding hospitals provided some form of compensation to their board members whereas only 11 percent did so in 1997. Investor-owned hospitals were not the most prominent in this practice. Only 20 percent of responding investor-owned hospitals provided financial compensation to board members, as compared to

TABLE 9
Percentage of Hospitals Providing Financial Compensation to Board Members

	1989	1997
Organizational control		
Not-for-profit	6.6%	3.7%
Government, nonfederal	24.1%	24.1%
Investor-owned	31.2%	19.9%
Bed size		
Fewer than 100	17.0%	13.7%
100 to 299	13.0%	10.4%
300 or more	9.0%	5.4%
Location		
Urban	12.4%	12.2%
Rural	15.2%	7.5%
System members		
Yes	13.7%	13.6%
No	13.8%	9.2%
All hospitals	13.7%	10.9%

24 percent of public hospitals (where political appointments and elections often tie board members to specifically legislated job titles and salaries) and only 4 percent of nonprofit hospitals. Further, investor-owned hospitals declined in the frequency with which board members were compensated since 1989 (31 percent to 20 percent). The larger the hospital, the less likely it was to compensate its board members. This reflects, in part, the fact that public and investor-owned hospitals are found disproportionately among the smallest bed-size category (fewer than 100 beds) and not-for-profit hospitals are found disproportionately among the largest bed-size category. But it may also reflect the need for higher levels of protection from legal liabilities in larger organizations, which tend to be involved more often in larger business transactions. System affiliation appears to make some difference in the tendency to compensate board members financially. Fourteen percent of system-affiliated hospitals provided such compensation, compared to only 9 percent of nonaffiliated hospitals. This difference was not statistically significant in 1989. Urban hospitals were somewhat more likely to provide compensation to board members than their rural counterparts (12 percent versus 8 percent). The frequency with which rural hospitals provided compensation declined by nearly 50 percent since 1989, whereas the proportion of urban hospitals providing compensation remained stable over the two periods.

Summary

Taken as a whole, our findings suggest that hospital boards act more as a source of continuity than as the leading edge of change. Despite the tremendous shifts that have occurred in health care financing, organization, and delivery over the past decade, change in hospital governance has been modest. In general, change in governance structure and function between 1989 and 1997 can best be characterized as selective. Not all hospitals have changed their governance arrangements, and those that have did so in incremental rather than wholesale fashion. This may mean that hospitals operating under particular competitive or resource constraints may be compelled to change certain features of their boards in response to these pressures. At the same time, however, these same hospitals are attempting to maintain a core governance structure that remains stable and provides continuity in the face of rapid change. Over the

long term, it may be that boards will change in more fundamental and profound ways. However, processes of change in highly institutionalized entities, such as governing bodies, are usually more slow and gradual than sudden and dramatic (Starkweather 1988). It remains to be seen whether those changes we did observe are the "tip of the iceberg" or simply adjustments to the traditional board structure in response to local organizational or market changes.

What implications can be drawn for health care policy? With respect to corporate policymaking, incremental change in governance promotes stability and continuity. This may be highly desirable given the rapid pace of change in the health care sector. Board stability may help ensure that a hospital stays the course in terms of its mission, vision, and values. Board stability may also provide continuity of leadership in a time when top management turnover continues to affect hospitals. On the other hand, board stability may produce stagnation and inertia. Board knowledge and skills may not keep pace with new challenges, and traditional structures and routines may inhibit the ability of hospital management to initiate much-needed change. Previous research would suggest that effective boards are those that strike a balance between the need for continuity and the need for change in governance, composition, and structure. From a national policy perspective, the incremental changes observed in governing board structure and practice mirror the changes in the broader health care sector. Market and competitive forces now operate within a seemingly anomalous context of regulation and government funding. Providers, states, and communities are attempting to strike a balance between the new technical demands for efficiency and market performance, on one hand, and traditional institutional accountabilities to community, the disenfranchised, and philanthropic service, on the other. As a microcosm of these broader changes, hospital boards have not abandoned their traditional form for more corporate-like structures, but instead have opted to combine elements of both.

Although composition and structure remain relatively stable, hospital boards appear to value more general skills such as community leadership, values, and time availability in contrast to the more focused business or financial skills that were emphasized in 1989. One might argue, therefore, that boards are increasingly called upon to represent the interests of the community and the conscience of the hospital in the face of turbulent and unpredictable change. Radical transformation in structure or composition may ultimately have less practical impact than changes in

the basic orientations to the job of governance, as reflected in the criteria for membership on the board.

The survey findings suggest strongly that there are tighter linkages between hospital management and hospital governance. Survey findings point to closer involvement of the hospital CEO on the board and to greater CEO power in board activities. Greater management involvement in the board may reflect a need to shorten the lines of communication in order to respond quickly to strategic opportunities. Other research has indicated, for example, that forms of governance in which the principal (management) and agent (board) are integrated provide greater incentive for entrepreneurship and innovation.

Although hospital management has assumed a greater presence on the hospital board, there is also a corresponding shift toward accountability for management performance. More boards are formally evaluating the performance of the hospital CEO and providing either formal employment contracts or incentive compensation plans to align the interests of the CEO to the hospital. It is no longer enough that management simply carry out its functions free of scrutiny by the board or external agencies. In an era of competition and managed care, boards must ensure that management is performing up to standards and that incentives are aligned appropriately. On balance then, there appears to be a simultaneous move toward greater integration of management and governance, on the one hand, with increased board scrutiny and assessment of management performance, on the other.

The survey results also indicate that more complex organizational and governance arrangements in hospitals are becoming the norm. Increasingly, hospital boards are accountable to a higher authority. These vertically integrated governance arrangements have profound implications for the allocation of key governance functions such as quality, administrative oversight, and community service. Together, these findings suggest a tension between the need to become more businesslike and the need to maintain more traditional responsibilities and accountabilities. We observe more hospital embeddedness in corporate structures—a change likely prompted by the increasing complexity, competitiveness, and resource constraints of the health care environment. Even hospitals that are part of health systems more often report accountability to a higher authority, suggesting more centralization of decision making. While this may promote emphasis on systemwide priorities and greater rationalization of health srvices delivery, it may also

weaken local accountability, market intelligence, and the ability to be responsive to local conditions. In contrast to these trends, however, our data indicate that board size remains unchanged, giving hospitals the opportunity to incorporate diverse stakeholders. Further, board service is increasingly uncompensated, suggesting that voluntary board service remains intact and perhaps that legal risk management is a more important issue for today's more active boards. Finally, we note greater emphasis on community responsiveness and accountability in selection of new board members.

A number of these results converge to point to two general governing styles. Larger, system-affiliated hospitals in more competitive, nonrural areas tend more often to have larger boards, embedded governing structures, more actively engaged CEOs, CEO incentive compensation schemes, and formal CEO and board performance evaluations than smaller, nonsystem, rural hospitals. Moreover, many of these differences appear to be increasing. Policymakers should give special attention to the apparent difference in governance styles between what Seavey, Berry, and Bogue (1992) summarized as "competition-driven" hospitals and "public utility" hospitals. Boards are ultimately responsible for organizational behavior, and set the framework of performance expectations directly for the chief executive and indirectly for the physicians and other staff. As policy and regulation seek to modify or shape organizational behavior, taking the styles of "competition-driven" and "public utility" governance into account may help policymakers design policy and regulation with greater precision, and a greater likelihood of successful implementation. In turn, those who would offer advice to health care organizations concerning their corporate policies are likely to offer more precise and effective guidance if they understand these two general styles of governance. Policies that encourage boards to allocate responsibilities clearly at appropriate levels of the corporation for gathering community input on services and quality and for reporting to the community on performance would fit better with the "competition-driven" style of governance, as would using formal performance measurement and evaluation methods. Alternatively, policies that establish criteria and facilitate search processes for attracting more and different kinds of talent to the board to improve community input, community reporting, and board self-evaluation might better fit the needs of the "public utility" style of governance.

As agents of public or community constituencies, hospital governing boards are charged with setting organizational policy, monitoring management performance, and ensuring fulfillment of the organization's mission. These critical responsibilities suggest that significant changes in governance structures and practices are likely to affect the hospital in multiple and fundamental ways, from its operational practices to its strategic direction. Future research might examine whether hospitals that embrace change in governance practices exhibit greater emphasis on efficiency, greater responsiveness to changing environmental conditions, or greater accountability to community needs. Indeed, one early study linked emphasis on community and quality issues in not-for-profit hospital board deliberations to a higher likelihood that the hospital provides a broad set of typically unprofitable, non-inpatient, community health promotion services, except when no excess revenue exists (Friedman, Hattis, and Bogue 1991). Such behaviors might be evaluated relative to boards that remain stable in composition and structure, or those that adopt hybrid governance configurations. In a similar vein, future research must also attend to the potential negative consequences of governance change, including the loss of community support when philanthropic values are abandoned and the change in quality of care and other patient-based performance standards when larger corporate policies supersede those of local policymaking bodies.

References

Alexander, J.A. 1990. Governance for Whom? Dilemmas of Change and Effectiveness in Hospital Boards. *Frontiers of Health Services Management* 6(3):38–41.

Alexander, J.A. 1991a. Hospital Governance: Problems and Prospects for Health Services Research. *Journal of Health Administration Education* 9(4):395–424.

Alexander, J.A. 1991b. Adaptive Change in Corporate Control Practices. *Academy of Management Journal* 34(1):162–93.

Alexander, J.A., M.L. Fennel, and M.T. Halpern. 1993. Leadership Instability in Hospitals: The Influence of Board-CEO Relations and Organizational Growth and Decline. *Administrative Science Quarterly* 38(3):74–99.

Alexander, J.A., L. Morlock, and B. Gifford. 1988. The Effects of Corporate Restructuring on Hospital Policymaking. *Health Services Research* 23(2):311–27.

Alexander, J.A., and B.J. Weiner. 1998. The Adoption of the Corporate Governance Model by Nonprofit Organization. *Non-Profit Management and Leadership* 8(3):223–42.

American Hospital Association and Ernst & Young, LLP. 1999. *Shining Light on Your Board's Passage to the Future*. Chicago: American Hospital Association.

Bader, B.S. 1997. *Board/CEO Relationship Builders*. Chicago: American Hospital Association.

Bryant, L.E. 1999. *What Boards Can Learn from the Allegheny Bankruptcy*. La Jolla, Calif.: Governance Institute.

Fennell, M.L., and J.A. Alexander. 1989. Governing Boards and Profound Organizational Change in Hospitals. *Medical Care Review* 46(2):157–87.

Fine, A., and J.P. Marren. 2000. Health Care Systems: The Emperor Has No Clothes. *Trustee* (July/August):20–4.

Friedman, B.S., P.A. Hattis, and R.J. Bogue. 1991. Tax Exemption and Community Benefits of Not-for-Profit Hospitals. *Advances in Health Economics and Health Services Research* 11:131–58.

Janis, I.L. 1967. *Victims of Groupthink: A Psychological Study of Foreign-Policy Decisions and Fiascos*. Boston: Houghton-Mifflin.

Kovner, A. 1990. Improving Hospital Board Effectiveness: An Update. *Frontiers of Health Services Research* 3(6):3–27.

Mick, S., and Associates. 1990. *Innovations in Health Care Delivery: Insights for Organization Theory*. Ann Arbor, Mich.: Health Administration Press.

Molinari, C., L. Morlock, J.A. Alexander, and C.A. Lyles. 1993. Hospital Board Effectiveness: Relationships between Governing Board Composition and Hospital Financial Viability. *Health Services Research* 28(3):357–77.

Peregrine, M.W., and J.R. Schwartz. 1999. Top Ten Health Care Corporate Developments in the Last Year. *BNA's Health Law Reporter* 8(28):1164–70.

Pointer, D.D., J.A. Alexander, H.S. Zuckerman. 1995. Loosening the Gordian Knot of Governance in Integrated Health Care Delivery Systems. *Frontiers of Health Services Management* 11(3):3–37.

Seavey, J.W., D.W. Berry, and R.J. Bogue. 1992. *Strategies and Environments of America's Small and Rural Hospitals*. Chicago: Hospital Research and Educational Trust.

Shortell, S.M., R.R. Gillies, D.A. Anderson, K. Morgan-Erickson, and J.B. Mitchell. 1996. *Remaking Health Care in America: Building Organized Delivery Systems*. San Francisco: Jossey-Bass.

Shortell, S., R.R. Gillies, and K. Devers. 1995. Reinventing the American Hospital. *Milbank Quarterly* 73(2):131–60.

Smith, R.W., and R.J. Bogue. 2000. Let's Not Take the Trust Out of "Trustee." *Trustee* (January):30–2.

Starkweather, D. 1988. Hospital Board Power. *Health Services Management Research* 1(2):74–86.

Weil, P., R.J. Bogue, and R.M. Morton. 2001. *Motivating Community Health, Cambridge Health Alliance Case*. Ann Arbor, Mich.: Health Administration Press. (In press.)

Weiner, B.J., and J.A. Alexander. 1993. Corporate and Philanthropic Models of Hospital Governance: A Taxonomic Evaluation. *Health Services Research* 28(3):325–55.

Weiner, B.J., J.A. Alexander, and S. Shortell. 1996. Leadership for Quality Improvement on Health Care: Empirical Evidence on Hospital Boards, Managers, and Physicians. *Medical Care Research and Review* 53(4):397–416.

Zinkman, R., and C.A. Peck. 1999. To Be or Not to Be? How Hospitals and Doctors Should Decide Whether to Reinvest in or Divest of Their Group Practices. *Trustee* (October):14–7.

Acknowledgments: This research was funded, in part, by the American Hospital Association and Ernst and Young. We thank these organizations for access to the data used here. The analysis presented is the authors' and does not necessarily reflect the opinions or position of either the AHA or Ernst and Young.

Address correspondence to: Jeffrey A. Alexander, Ph.D., Department of Health Services Management and Policy, University of Michigan, 1420 Washington Heights, Ann Arbor, MI 48109 (e-mail: jalexand@umich.edu).