Trustee Insights

VIEWPOINT

Time for a New Model of Governance

The traditional governance model is showing symptoms of failure

BY JAMIE ORLIKOFF

The quality of governance that was sufficient to get health care organizations where they are today will be insufficient to get them where they will need to be tomorrow. Certain reasons for this are well known: a rapidly changing and evermore challenging health care environment; the growing burden of regulatory requirements placed on health care boards; and the growing complexity of governance structure and function itself, especially in increasingly large health care systems. Other, less obvious systemic reasons are likely even more impactful on governance.

These issues, both obvious and obscure, drive the increasingly common paradoxical lament from health care board members who say: "Governance is taking too much of my time, and our board still doesn't spend

enough time on key strategic and generative issues." These issues are behind the reports of health care executives and board leaders noting the growing difficulty in recruiting qualified board members, and the increasing burnout among experienced board members.

The only effective way of addressing these and other governance fissures has been for a board to aggressively adopt and implement the principles and techniques of "best governance practices." These efforts can indeed be very effective in improving governance … to a point. But, all these efforts have been conceptualized, implemented and evaluated within the context of the current model of governance – a model that has been in existence for more than 250 years in this country.

Signs of Stress

The traditional governance model has several implicit components, which include: community-based governance; voluntary (uncompensated) trustees; minimal-to-manageable time commitments; lack of standardized or mandatory training; diffuse and variable accountability of both boards and their members; long-tenured board members and leaders; and a tolerance for conflicts of interest on the board in service of community relationships, among others.

This model is showing both its age and the early signs and symptoms of failure. From the time Ben Franklin founded the nation's first hospital until today, trustees volunteered their time and expertise on the hospital board to strengthen their community and, in the aggregate, their country. Often, they served on the hospital board while running a business, or while in full-time employment. Frequently, trustees served on several different not-for-profit boards in the community at the same time, all of which had the same basic governance model. But the turning of generations, the changing culture, and a radically different economy have fundamentally changed the societal dynamics that gave birth to and sustained the traditional governance model.

The drivers of the possible failure of the governance model include broad societal, economic and demographic challenges in addition to those daunting and disruptive pressures of the health care environment. These profound systemic forces will likely stress the governance model more than even the tornadic forces within health care. Together they foretell the probable demise of the traditional governance model.

Limits of the Traditional Model

Even the best governance practices within the current model may be inadequate in the face of a health care market where the pace of change continually accelerates as its complexity grows. Similarly, as the size, scale and scope of health care systems grow, so does the complexity of effective system governance, bringing increasing time and performance demands on health care boards and their members. This trend challenges the deeply imbedded and long-standing tradition of the volunteer board member of the nonprofit hospital or health system.

We now live in a 24/7 world where demands on professional and business time grow relentlessly, where two incomes are required for a married couple to maintain a middle-class lifestyle, and where the "gig" economy requires 100 percent effort and very flexible schedules. Further, the economy is compressing the number of Americans who are comfortably in the middle class, the traditional pool of potential community board members.

In the past, many corporations encouraged their executives to serve on local community boards, including those of hospitals, as a demonstration of corporate commitment to the community. Now, however, many corporations discourage or prohibit their executives from serving on community boards because they want all of their time devoted to the business; and they are concerned about the reputational risk attendant to

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nonprofit board membership and do not want to take the risk of blowback to the corporation if one of its executives is on the board of a nonprofit organization that is involved in a scandal.

Also, due to corporate consolidation, many midsize communities no longer host the same number of independent corporations or businesses as they used to. Hence, there is a smaller pool of "executives" as potential board recruits to draw from. Rather than hosting corporate headquarters or independent businesses, more midsize and larger communities now have local branches or ancillary sites. The individuals who run them are more likely to have the skills and focus of middle managers rather than big-picture, financial, strategic, human-resource and other business acumen typically desired as skill sets for members of hospital and health system boards.

Anecdotal but very common reports from hospital and health system executives and board and Governance Committee chairs around the country speak to the difficulty of recruiting members of both the millennial generation and Generation X to health care boards. As boards seek age diversity, they attempt to recruit younger people who are taken aback when they learn of the traditional and growing time demands of serving on a health care board.

Meanwhile, those boards with a modicum of age diversity find themselves struggling to reconcile the striking cultural differences between the generations. These generational differences present radically different approaches to volunteerism, use of technology between and during board meetings, participation in group dynamics, and tolerance for ambiguity and the diffuse decision-making processes that result from it.

Can society continue to expect Gen X or millennial professionals – or business executives dealing with family pressures in today's hectic and disruptive environment – to volunteer significant, if not excessive, amounts of their time to governing hospitals and health systems?

Can society continue to expect Gen X or millennial professionals – or business executives dealing with family pressures in today's hectic and disruptive environment – to volunteer significant, if not excessive, amounts of their time to governing hospitals and health systems? If, as seems likely, the pool of qualified and willing potential system and hospital board members diminishes in the near future, we will be looking at a future where the only individuals who can afford the time to serve as effective volunteer members of health care boards are either retired or independently wealthy; or who have the luxury of working for generous employers or owning businesses that essentially run themselves; or who are individuals who are employed by the health care system itself. Meantime, the baby-boom generation is aging and cannot be the primary source of health care board members for too much longer.

Further, many current board members are becoming concerned that the complexity, regulation, quality and safety challenges of governing a health system expose them to inordinate and unacceptable amounts of liability and reputational risk. A growing number of them say: "I can volunteer to serve on the boards of other organizations that require less of my time and effort, and that have much less liability and reputational risk exposure. Why should I serve on the board of a hospital or health care system?"

The crisis brewing in the traditional governance model will threaten the very health care system it is tasked with leading. To prevent this, we must ask the foundational and uncomfortable questions that lead to the conscious construction of other, new models of governance that are relevant to new times.

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