

Not for Profit But for Whom?

Past ownership patterns dominate both the formation and allocation of controlling interests in PHOs – the non-profit ‘primary health organisations’ that the government funds to deliver its primary healthcare services. But the origins of these controlling interests isn’t just a matter of historical interest. Recognising their different forms helps identify the risks of healthcare funding being directed away from the government’s objectives; it also helps identify measures for mitigating such risks. Carolyn Cordery and Bronwyn Howell report.¹

It’s often claimed that, because they have no shareholders receiving dividends, non-profit firms have no reason to charge excessive prices or skimp on the quality of the products and services that they deliver. This so-called ‘nondistribution constraint’ underpins the belief that stakeholders can ‘trust’ non-profit firms to a greater extent than their for-profit counterparts. Consequently, non-profit firms are often favoured for delivering some types of services – notably those paid for by third parties, such as healthcare funded by charity, government or insurance. For example, under the New Zealand Primary Health Care Strategy (NZPHCS), the government requires that PHOs be non-profit entities ‘to guard against public funds being diverted from health gain and health services to shareholder dividends’.²

However, the ‘nondistribution constraint’ does not mean that ‘trust’ can be blindly applied. Even though they may not have shareholders receiving dividends,³ non-profit firms can still charge higher prices and use the proceeds to underwrite private purposes – for example they can prioritise ‘pet’ projects or pay higher salaries to staff who, if they owned the firm, would have appropriated the same as dividends. Such expropriation is more likely to occur where the firm faces limited competition and its stakeholders (suppliers, customers or beneficiaries) are ‘locked in’ with few options to trade elsewhere. In these circumstances, ‘trust’ relies upon further explicit measures which limit the likelihood of vested interests within the firm diverting firm resources for personal benefit. For example, the governance arrangements of many non-profit firms preclude staff members and suppliers of the firm’s goods and services from sitting on the board and thereby exerting undue influence on key decisions (such as project prioritisation, salary-setting and the letting of key contracts) from which they might benefit personally.

Trust me, I’m a

Internal governance arrangements that target firm-specific risks of expropriation thus support ‘trust’ in non-profits. To identify the risks and develop appropriate countervailing measures, the interests that hold the balance of decision-making control must be identified.

¹ B Howell & C Cordery (2011) ‘From Providers to PHOs: an institutional analysis of non-profit primary health care governance in New Zealand’ (available at www.iscr.org.nz/f650,18412/18412_Health_non-profit_governance_in_NZ_May_24.pdf).

² Minister of Health (2001) *The Primary Health Care Strategy* p14.

³ A firm may have defined owners (shareholders) and a non-profit objective, or have no defined owners (be non-owned) and a non-profit objective. A co-operative exemplifies the first; a charitable trust the second.

Competition for the control of non-profit firms occurs as surely as competition for ownership and control of shareholder-owned ones. And even though the NZPHCS requires PHOs to have decision-making bodies with representation from both service provider and community (patient) stakeholding groups, it is highly unlikely that control will be evenly spread across those interests. In any given PHO, one or the other is likely to hold the balance.

Henry Hansmann's theories of the ownership of enterprise⁴ provide a useful framework to help understand which interests will likely prevail, given the nature of the economic environment in which healthcare-delivery firms operate.

Hansmann theorises that firms will ultimately be owned (or, in the case of non-profits, controlled) by the stakeholder group whose ownership (control) leads to the lowest joint costs of 'ownership' and market contracting. Stakeholders are the firm's suppliers⁵ or its customers. The costs of 'ownership' include those of communicating with shareholders, making decisions, influencing, lobbying, ensuring that management runs the firm efficiently, using incentives, and avoiding losses from imperfect agency relationships. The costs of market contracting include transaction costs as well as those from market power imbalances (including information asymmetries), contractual incompleteness, bounded rationality and contractual hold-ups.

Hansmann further suggests that non-owned (non-profit) firms will emerge endogenously when the costs of maintaining defined ownership stakes outweigh the benefits. In these circumstances, the costs are least when the controls and disciplines typically applied by shareholder-owners (either suppliers or customers) on the directors and managers of the firm are replaced by a set of fiduciary obligations. These fiduciary requirements will specify in whose interests the assets of the firm will be applied and how its revenues will be used. If the firm would otherwise have been owned by suppliers (such as doctors or nurses), the fiduciary duties could be expected to reflect interests beneficial to those suppliers. Alternatively, if the ownership interests would otherwise have been vested in customers, then the fiduciary duties could be expected to reflect interests beneficial to those customers.

You can't escape your past

So how does Hansmann's reasoning help us to understand the dynamics in the markets for control of PHOs? Principally, it enables us to examine how economic factors influencing the costs of ownership and market contracting shape the ownership and control of primary healthcare firms. We can examine these prior to the NZPHCS, and then see how the NZPHCS requirement for firms to align with non-profit PHOs would influence the balance of governance control in those new PHOs.

Prior to the NZPHCS, as Hansmann's framework predicts, most primary healthcare firms were owned by providers – usually medically qualified general practitioners

⁴ H Hansmann (2006) *The Ownership of Enterprise*. The Belknap Press of the Harvard University Press. Cambridge, Massachusetts.

⁵ These are suppliers of raw materials, labour and finance (this last includes both equity and debt).

(GPs), operating typically as for-profit sole practices.⁶ However, ‘independent’ GPs frequently collaborated together as independent practitioner associations (IPAs), which had started out as local co-operatives set up to provide education, locum provision and advocacy services to their GP owner-members and which gradually expanded into the co-ordination and delivery of a range of additional government-contracted primary care services. Although IPAs exhibited a range of institutional forms, almost all had a non-profit objective as well as fiduciary duties clearly focused upon furthering the interests of their for-profit GP members.

A very much smaller number of primary-healthcare firms operated as consumer-controlled entities. These tended to hire providers as salaried employees – but they had two very different origins.

The first were effectively consumer-controlled co-operatives, set up to serve the interests of a clearly defined and relatively homogeneous consumer community that was already linked together for a variety of other reasons. They included clinics and collectives providing care to specific communities of interest such as marae, trade unions and student associations. The costs of ‘owning’ and governing these bodies were low – most likely because they could be shared across many other services provided to the same consumer groups and because the homogeneous interests of the consumers meant fewer disputes about the types of care provided or the allocation of benefits.

The second were non-profit entities formed in (usually rural) communities where independent GPs were unwilling to assume the high costs and risks of practice ownership, given the alternative returns available elsewhere. As the costs of service provision in these areas were necessarily higher (for example, a GP or nurse might have to be employed on a ‘full-time’ basis for a part-time workload), revenue had to be carefully husbanded using methods such as the charitable donations and tax-exempt status available exclusively to non-profit entities.

It’s a worry

It is unsurprising to find that primary-healthcare firms used their existing collaborative relationships to form new non-profit entities which would meet the NZPHS’s requirements. Of the 77 PHOs in existence in 2004 (covering 95% of the population), 30 had their origins in community-led organisations and 47 emerged from practitioner-led IPA initiatives. The PHOs with community origins delivered services to 8.3% of the registered population. The PHOs emerging from IPA initiatives covered the remaining 91.7%.

We contend the primary healthcare sector is dominated by supplier-controlled PHOs which favour service-provider interests. There are risks that these PHOs may divert funds either towards rewarding supplier interests financially or towards ‘pet’ projects not necessarily aligned with government purchasing purposes.

A minority of PHOs are dominated by community interests. Those whose community control arises from failures in the market for GP ownership are likely to have higher costs associated with control and market contracting, which may lead to compromises in

⁶ Some ‘group’ clinics existed: these were usually GPs sharing common overheads such as premises and administration but maintaining individual professional autonomy. Low capital requirements meant GPs had little need to form equity-sharing partnerships.

service quality. Other community-control PHOs serve ‘niche’ consumer interests – and so their services will reflect those interests, which may diverge from the government’s.

The government should not rely solely on trust in these PHOs’ non-profit status to protect the public interest. Its contracts with these entities must reflect the different risks their control differences invoke.

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