

A Strategic Review of Hospital Foundations  
Across Canada

By

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A Thesis Submitted to

The University of Prince Edward Island, Charlottetown, P.E.I.

In Partial Fulfillment of the Requirements for

The Masters in Business Administration

February 29, 2012, Charlottetown, P.E.I.

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## **Abstract**

### **A Strategic Review of Hospital Foundations in Canada**

By: Barbara Dunphy-Gotell

Hospital foundations, established to raise funds for medical equipment for their parent hospitals or health care institutions, are being challenged by changes in governance by their parent hospitals or health care institutions. The governance model for most hospitals across Canada has changed dramatically over the past fifteen years. They no longer have hospital boards but report directly to a regional, provincial board, or an authority with a broader mandate beyond one institution. This has changed the independence and authority held by the institutions and presented challenges for hospital foundations. The hospital or health care institution no longer holds the authority, or budget. This research examines the roles of hospital foundations boards across Canada and how hospital foundations are functioning in this new era of healthcare. The study's findings revealed that foundation boards and their Senior Development Officers are being forced into new roles such as advocacy and taking the place of hospital boards in filling the void left by the absence of hospital boards. The findings identified themes, including engagement, culture of philanthropy, power dimension, and board representation. The findings suggest that because of their unique relationship with their institution in this new era of healthcare, hospital foundations must look at their governance model and evaluate themselves to determine if their roles need to change.

## Acknowledgements

To pursue my MBA at this time in my life has been a very interesting journey. At no time did I consider turning back but many times I questioned my ability to continue. The support I received from my family at home was exceptional, and I thank them for it – Len, Philip, and Julie. The quiet encouragement I received from my sisters and other family members and understanding why I may have been a neglectful sister over the past two years! You helped make the journey all worthwhile. Our pets, Tigger and Mitzi, seemed to also show patience when I couldn't walk them as far as they may have liked to go or walked them farther than they may have chosen to go! A journey for everyone!

To the faculty and my advisors for seeing more in me than I thought I had. You made me reach further and strive higher. The support and encouragement went a long way in achieving this goal. Special thanks to my advisors on my signature project, beginning with Dr. Wendy Carroll who helped me flesh out the topic and find the thread to follow; Gary Evans for his keen interest and enthusiasm in my topic and positive feedback; and to Grace McCourt for always being there to answer the many questions and pointing me in the right direction.

I wish to express my appreciation to the Board of Directors (past and present) of the Queen Elizabeth Hospital Foundation for the support, encouragement and interest in my studies. To my staff, who were always interested in my progress, willing to teach me computer skills that I lacked, and worked their schedules to accommodate me. I owe you much gratitude. Thank you.

Thank you to my brother-in-law, Alex, who encouraged me to pursue my MBA. He always had more faith in me than I knew I had and was a great mentor and sounding board.

I am also grateful to have a running family who helped push me up the hills and pull me out of the valleys when the going got tough. They no longer need to hear about my woes of study!

Thanks to my dear friend Stephanie Burnett who edited my writing and killed a tree in the process! I will plant a tree in your honour!

I still can't believe I've completed this ambitious goal and it's time to move onto the next one. My accomplishment is one that I share with all of you.

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## CHAPTER 1: INTRODUCTION

### Background

Canada has one of the largest charitable sectors in the world (Imagine Canada, 2010). More than 85,500 charities are registered with Canada Revenue Agency (CRA). Charities range in size and scope, but all charities are governed by a set of bylaws and a voluntary Board of Directors. Considered the third largest sector, following private and public, the nonprofit and voluntary organizations play an important role in the Canadian economy (Hall et al., 2004; Imagine Canada, 2010).

In the fiscal year ending March 31, 2010, health care institutions received a total of \$1.204 Billion (AHP Report on Giving in Canada, 2010). This represents a 7.1 percent growth over 2009 (AHP Report on Giving in Canada, 2010),

Hospital foundations, in the early years, were established to raise funds for medical equipment for their parent hospital and to enhance the capital needs at their hospitals over and above what was provided by government. Today, medical equipment and in particular technology has driven up costs and demand. Coupled with that, is an aging population. Patients have a “fix me well and fix me fast” attitude. The protocols in medicine have changed whereby physicians and specialists are requiring more diagnostic testing prior to treatment. The diagnostic technology is costly, critically important; and a real shift from earlier years.

Government has not been able to keep up with these demands. The pressure placed on governments for a new governance model to improve and coordinate efficiency

is being tested across the county. As a result of this changing governance model, hospital foundations have had to re-consider how they do business and what impact this has on their unique relationship with their parent institution. The governance model in place is being tested and may potentially require change.

Over and above the changes in technology and aging population is the abolition of most hospital boards across Canada. Most hospitals now directly report to either a regional or provincial board, whose mandate goes beyond the health care institution. Budget allocation decisions are being made at arm's length at a regional board/authority or health department. Decisions being made by government take into consideration a more holistic approach to health care – preventative, acute, community, primary, long term care; and public health, to name a few.

Since 2006, as a result of these turning points, healthcare development professionals have shown greater concern for the relationship of their foundation with their parent hospital (Campbell, 2006). The corporate governance model is being challenged as a result of this new relationship. Has this affected or changed roles and responsibilities to these charitable organizations and the management functions of their Senior Development Officers (staff) and Board (volunteers)?

Hospital foundations are comprised of a Board of Directors consisting of volunteer leaders from the community, typically business leaders and donors. The volunteers do not receive remuneration for their time or advice, but are committed to the mission of the Foundation. Most hospital foundations, through their bylaws, allow for the senior decision maker, typically the executive director of the parent institution to hold a position on their board; some with ex officio/non-voting status. In most cases, the

position is no longer held by an individual responsible only for the institution. Many are not physically located at the institution nor do they have authority over the budget or strategic direction of the institution. Therefore, the focus of the senior decision maker of the institution has increased priorities to consider above and beyond the institution, which results in less direct authority over their singular institution as was seen in the past. This position is no longer in a decision making position, but rather reports up to an offsite director or department.

The purpose of this research is to examine the role of hospital foundation boards across Canada and the effects, if any, being experienced as a result of this new governance model of healthcare.

### Research Overview

In the early years, hospital foundations were established to enhance the capital needs at their parent hospitals over and above what was provided by government. Hospital foundations enhanced the community activity and commitment that surrounded the life of its hospital. As a result of technological advances, increased financial pressure and changes in hospital governance, the original, unique role of hospital foundations is changing.

Typically, Board of Directors of hospital foundations consist of a number of volunteer leaders with term appointments. The volunteers are truly voluntary in that they do not receive any remuneration for attending meetings and in most cases are substantive donors to the organization they serve. The volunteer is on the Board of Directors because of their commitment to the cause and their ability to either “give or get” philanthropic dollars for their institution.

This research looks more closely at a microcosm of hospital foundations across Canada to explore how new governance models are affecting how they function; and resultant strategies they are using to respond to these changes. A two-prong research approach will be used:

- primary research with select Senior Development Officers of hospital foundations across Canada; and
- secondary research from an extensive literature review..

Semi-structured interviews with the Senior Development Officers of hospital foundations across Canada were conducted. The interview questions were guided by McCracken's (1988) "The Long Interview" for both the development of the interview questions and to determine the number of interviews required to reach saturation.

Additionally, Evan's Value Added Board Model (Evans, 2010) was used as the basis of the research questions evaluating the role of existing boards. Central to this will be the role culture plays within the Boards (Evans, 2010).

### Organization of this Thesis

This Signature Project is divided into five chapters and provides results from the qualitative investigation into the changing role of select hospital foundations across Canada. The first chapter provides the foundation of the research. Chapter 2 describes the literature relevant to this study and Chapter 3 outlines the method, research design and application of the research. Chapter 4 provides the findings of the research. Finally, Chapter 5 discusses the major findings and relevant implications to hospital foundations based on the changing role of institutions as found in this research.

## CHAPTER 2: LITERATURE REVIEW

### Background

Hospital foundations were established in the early 1970's and 1980's to address an ongoing need for additional resources for their parent institution as continuing pressure on healthcare dollars from government was experienced. Hospital foundations are incorporated charitable organizations with their own bylaws, governance structure, human resources (both voluntary and staff) and a strong community interest. The mandate of hospital foundations, simply put, is to raise funds to support their parent hospital or healthcare institution. Funds are raised by special events and personal philanthropic donations. Personal philanthropy by individuals makes up 75 per cent of funds raised by foundations (Imagine Canada, 2010).

Hospital Foundations differ from other charitable organizations because of their unique relationship with their healthcare institution, a separate entity that provides/delivers health care and receives the funds raised by the Foundation. While they are independent, incorporated entities, the function for which they exist is driven by their healthcare institution. A symbiotic relationship between the hospital foundation and their parent institution is imperative in order for the hospital foundation to fulfill their mandate and create a culture of philanthropy within the institution. In the past, strong communication existed between the executive director of the hospital and the Foundation board as a result of a direct position on the Foundation's Board of Directors. This position was important to maintain communication between the two organizations and to develop a culture of philanthropy within the parent institution. Further, the executive director of the hospital was an individual with authority, reporting to a Board of Directors

of the hospital - an important role in the many solicitation approaches made by Foundation volunteers. This relationship is seen as one of three key positions in place in this unique relationship (Campbell, 2006).

Over the past twenty years as healthcare went through reformation and hospital boards were disbanded and merged into a new governance model that is more regional or provincially focused, the hospital and foundation relationship changed.

A literature review will follow to provide evidence of governance models for nonprofit organizations. Additional attention will be paid to articles that apply directly to hospital foundations and demonstrate the strong governance model followed by hospital foundations.

#### *Governance of Charitable Organizations*

Transparency and compliance of charitable organizations are key in good corporate governance (Cornforth & Edwards, 1999). The legal responsibilities of charitable organizations require that the Board of Directors comply with Canada Revenue Agency regulations and are guided by bylaws to safeguard assets, account for expenditures and act on their organizational mission (CRA). Transparency to their constituency, including donors, patients, staff and clients, is a main focus to ensure a good relationship and accurate flow of information (Cornforth & Edwards, 1999). As a result of good corporate governance, the stakeholders will trust the organization, resulting in financial support. Hospital foundations take a strong position in ensuring compliance and transparency.

Judge and Zeithaml (1992) state that nonprofit boards generally play a relatively more active and instrumental role in guidance and control than what is more commonly

found in for-profit organizations. Nonprofit boards help signal compliance with stakeholder interests, communicate with the public, and establish trust-based relationships that can generate additional resources (Klausner & Small, 2005).

Charitable organizations have a real interest in letting their community know who sits on their board. In addition to value created through their governance roles, boards also represent valuable links to resources and relationships that support the nonprofit activities. Representation on the Board and promotion of their Board of Directors tends to attract others to support their cause and become more aware of the need, thus adding credibility.

The nonprofit boards face diverse pressures as they not only must interpret, promote, defend, and maintain the integrity of the organization's social mission, but also remain responsible to numerous stakeholders such as: donors, clients, employees, volunteers, regulators and the community (Oster & O'Regan, 2005). In the nonprofit sector, governance responsibilities are magnified, with strong pressures for boards to be morally responsible in their efforts to protect public interests (Fama & Jensen, 1983).

#### *Function of a Nonprofit Board*

Cornforth and Edwards (1999) research outlines the various models for boards and how boards operate depending on how they interpret their role. The four models identified include: compliance, partnership, political and supporters' club.

**Table 1: Summary of Characteristics of Models of Nonprofit as Identified by Cornforth and Edwards, 1999**

*Table 1. A summary of the main characteristics of each of the models*

	Compliance model	Partnership model	Political model	Supporters club model
Interests	Mandators' / share-holders' interests differ from managers	Mandators' / share-holders' and managers' interests overlap	Stakeholders have different interests	Supporters and staff have similar interests
Role of Board	Compliance: safeguard assets; select and monitor top management, check processes	Strategic: add value; improve top decisions; develop strategy	Representatives: further stakeholder interests; reconcile conflicts; make policy; control executive	Supporters: support the organisation and its management; secure resources
Board members	'Trustees'; may be selected, elected or externally appointed	Experts; careful nomination or selection	'Lay' members; elected or appointed by stakeholder groups	'Elite', careful nomination or selection

**Source: Cornforth, C. & Edwards, C. (1999), What Makes Boards Effective? An Examination of the Relationships Between Inputs, Structures, Processes and Effectiveness in Nonprofit Organizations**

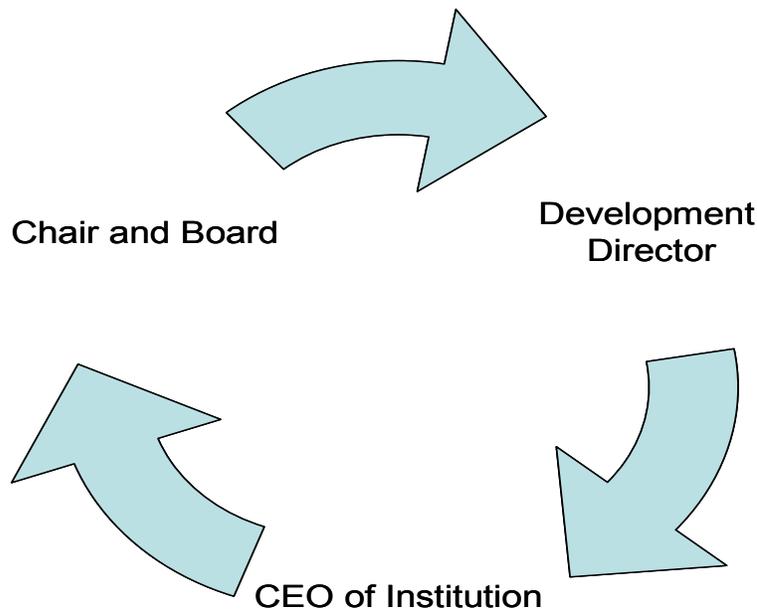
Hospital foundations would appear to fall within the supporters' club model, wherein the board's main function is to ensure the flow of resources into and from the organization and to help the organization respond to external change. Supporters and staff have the same interests. The role of the board is one of supporting the organization and its management; hence, securing resources. There is an "elite" perspective to careful nomination and selection of Board Directors.

#### *Function of a Hospital Foundation*

Hospital and healthcare organizations must work even more effectively together as they have a unique relationship compared to other nonprofits. In order for each to

fulfill on their philanthropic mission they must live up to each other's respective obligation to deliver a shared leadership model (Campbell, 2006). A shared leadership model is described as equal participation between Senior Development Officer of the Foundation, Foundation Chair and Board of Directors; and Hospital Chief Executive Officer (CEO) (Maude, 1997).

**Figure 1: Shared Leadership Model**



**Source: Campbell, M. (2006), In Search of a Best Practice Model for the Hospital-Foundation Relationship, AHP Journal**

By working together in their shared model they effectively work together with outcomes such as: community involvement, enhanced philanthropic activity; and better healthcare outcomes for the community. Campbell (2006) suggests it starts with the hospital CEO in; creating an environment for philanthropy within the institution, providing organizational vision and mission and participation in philanthropic activities. The Board Chair and through the Chair's leadership, the Board, has obligations that

include governance, committee work, advocacy, charitable giving and gift solicitation (Campbell, 2006).

*“The Senior Development Officer is described as the ‘servant leader’, a concept that demonstrates the facilitation or ‘behind the scenes’ role of the professional. In this way, Senior Development Officers not only ‘lead from behind’ but also support the leadership of others in the model.”* (Campbell, 2006)

The role of CEO in a best practice model includes providing the organizational vision and direction, creating an environment for fund development and participating actively in fund development activity (Campbell, 2006). The presence of the CEO at the Boardroom table presents opportunity to understand the timeliness of identifying hospital needs and providing the culture of philanthropy within the institution. The hospital’s CEO also assists to ensure fundraising is recognized in the strategic management function of the organization by giving it a higher profile within the management environment.

### *The Role of the Board*

The role of the Board of Directors for nonprofit organizations is one of involvement and directive. Board Directors are expected to play an active role in Board meetings and provide advice to advance the mission of the organization.

Practitioners and researchers suggest Boards spend more time on strategy and policy issues and less time on operational issues and sustain the vision of the organization (Carver & Carver, 1997). Effective nonprofit boards are more likely to engage in self-evaluations (Herman & Renz, 2000). Little time is spent reflecting on Boards’ own evaluation and this might be because it is difficult to be critical of a director’s performance when their time and talents are voluntary.

In Cornforth's (2001) analysis, board effectiveness was defined by five functions:

- Setting the organization's mission and values;
- Helping raise funds or other resources for the organization;
- Overseeing financial management;
- Reviewing and deciding strategic direction; and
- Reviewing board performance

This supports Bradshaw et al's (1992) that the most important determinant of board effectiveness is board involvement in strategic planning.

A board and its effectiveness can further be defined by the integrity and character of individual Board Directors. Dalton and Dalton (2005) state that "the challenge at the board level is to fully integrate each director into board processes such that the whole truly does constitute more than the sum of its parts."

Cornforth (2001) found Board effectiveness was related to Board Directors having sufficient time and training, clearly defined roles, a common vision between board and management on how to achieve set goals and self-evaluation. Training and education of Board Directors provide good board practices (Cornforth & Edwards, 1999).

Oster and O'Regan (1999) state that for profit board's central function is to monitor senior staff on behalf of their shareholders. In comparison, the nonprofit board has three functions: monitoring, contributing financially; and volunteering (work, wealth and wisdom). They go on to suggest that the questions surrounding board effectiveness in the nonprofit sector have more dimensions than are apparent in for profit boards.

A hospital foundation, whose mandate is solely based on raising funds, typically gets measured on funds raised and cost per dollar raised. These measures do not examine the effectiveness of the Board, but rather the effectiveness of the Foundation's operations.

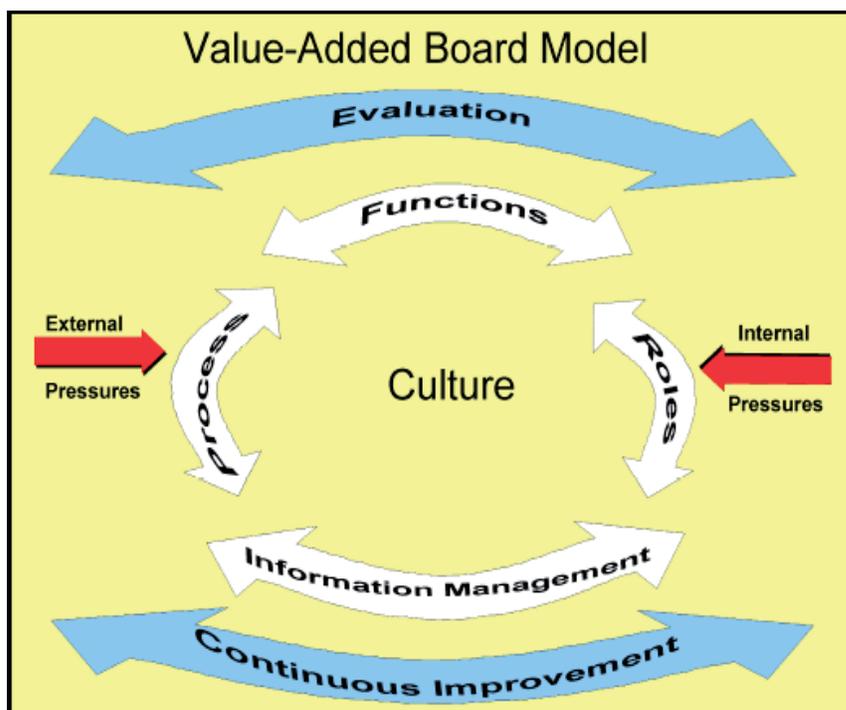
### *Board Recruitment*

Dalton and Dalton (2005) advocate that board recruitment practices should involve as much rigor as a high-level executive search. They suggest that rather than identifying one director for each opening, a slate of candidates should be provided and a wide net cast to ensure the best replacement possible is chosen. Use of a director skills matrix is essential to ensure the overall board profile is enhanced by nomination and leads to a more diverse board with broad representation from the community.

### *Culture as Value Added*

Little attention has been given to the culture of Boards and the role it plays in effective governance. Morten Huse (2005) is the original architect of culture on the board; he suggested that it is a key element in any boardroom. The culture of philanthropy is central to hospital foundations in their role of fundraising. Evan's Value added Model (2010) places culture in the middle of an organization. Evans explored the role of culture on the Board by discussing various aspects of the board such as: function, process, roles and information management (Evans, 2010).

**Figure 2: Evans (2010) Value-Added Board Model**



**Source: Evans, G. (2010), Corporate Governance Culture – An Interview-based Ethnography of Two Boards of Directors Using Grounded Theory**

Boards interviewed by Evans had many common similarities, but obvious differences in culture. Board practices were similar when interviewed but processes differed, in some cases, as a result of the maturity and culture of the Board (Evans, 2010). Good corporate governance suggests that a strong board will have an open learning culture with participation by all Board Directors. While culture is very difficult to evaluate, it is becoming more evident that it is a main pillar in creating effective organizations.

Cameron and Quinn (2006) developed a diagnostic tool, “Competing Values Framework” (CVF) that assist to define culture. Cameron and Quinn’s CVF provides four distinct culture types, namely, hierarchy, market, adhocracy; and clan. Hierarchy (control) emphasizes security, predictability and highly structured culture. Market

(compete) emphasizes that culture is results driven, goal oriented with emphasis on growing the market. Adhocracy (create) culture emphasizes leadership, individual initiative, creativity and freedom. Clan (collaborate) culture emphasizes teamwork, participation and consensus.

In applying Cameron and Quinn's (2006) CVF method to ascertain culture in hospital foundation boards, it becomes evident that they fit into the market culture (Cameron and Quinn, 2006). To expand further on the definition of the market culture, it is defined as:

*"A results-driven organization focused on job completion. People are competitive and goal-oriented. Leaders are demanding, hard-driving, and productive. The emphasis on winning unifies the organization. Reputation and success are common concerns. Long-term focus is on competitive action and achievement of measurable goals and targets. Success means market share and penetration. Competitive pricing and market leadership are important" (Haworth2009).*

### **Board Size**

Oster and O'Regan (2005) suggest that the size of the Board does matter and should be relative to the size of the organization. Nonprofit organizations tend to push toward larger boards, which may reduce internal monitoring, but may also increase personal giving capacity. From a good governance perspective, Oster and O'Regan's (2005) results suggest that a large board size is a "mixed blessing": – there is increased philanthropy but possibly at the risk of a reduction in oversight that may well improve Board productivity.

The Globe and Mail Survey of “Board Games in 2002” by Janet McFarland gives extra points for a smaller board implying that smaller boards lead to good corporate governance. This was not supported by empirical evidence. In effect, if a board is measured by the funds it raises, it would stand to reason that a larger board with actively contributing members would raise more money and hence be more effective. Research conducted by Fama and Jensen (1983) suggest that agency theory can exist with governance as the size of the board increases, but personal giving is protected.

### *Board Agenda*

Dalton and Dalton (2005) suggest appropriate processes for Board meetings including executive summaries for Board Directors ahead of time to ensure that meeting time is used for constructive dialogue. Accompanying this approach is the need for Board meetings to encourage debate and time for discussion. Dalton and Dalton (2005) identify three impediments that stifle dialogue at Board meetings:

- The first is learned passivity on the part of directors. To initiate discussion where the boardroom culture has been one of listening to management make presentations may be viewed as obstructionist and disruptive. This supports the need for Board representation to be diverse with differing point of views and varying backgrounds.
- The second impediment is the assumption that the Board operates as a natural team. With Board Directors meeting infrequently (ranging from five to twelve meetings a year), directors are not naturally used to working with each other as a team. To remedy this, Dalton and Dalton (2005) suggest periodic board retreats with the sole agenda of team building. This is especially important when there is

board turnover and new directors are added. Teamwork takes time but enhances Board performance and leads to a more cohesive, yet effective, board. Brown (2005) states that “time spent building an effective board as a team is not wasted.”

- The third impediment is preparation and an honest desire of the directors to be responsive and effective. Dalton and Dalton (2005) state that no amount of board independence and structure can compensate for the lack of individual accountability and responsibility on the part of directors. Board engagement and independent evaluation of Board Directors allows for self-reflection and evaluation.

Cornforth and Edwards (1999) further stress that Boards need to periodically review their roles with regards to governance, composition and performance with management. Also, the Chair and Senior Development Officer need to take the governance process and board development seriously. The agenda for Board meetings needs to be managed by the Chair in concert with the Senior Development Officer.

### *Board Term*

Term limits on for profit Boards are unusually long and many serve until retirement. Nonprofit boards typically practice term limits for board service. Oster and O’Regan’s (2005) research suggests that Board Directors with longer tenure also make larger donations and attend a larger share of meetings, but this will decline at some point with increased tenure: the positive benefits of tenure outweigh the negative. Their research suggests total amount of giving is maximized at 13.6 years while attendance drops off faster. Attendance is maximized at 10.5 years. Total time and money given to

a board is higher for Board Directors who serve on multiple boards (Oster & O'Regan, 2005).

Statistics Canada (2007) recently reported that the average amount donated increases with the number of pro-social behaviour (volunteer, work, and philanthropy) that people perform. The top quarter of donors (who gave \$364 or more) and who also volunteered at least one hour during 2007 accounted for only 14% of the Canadian population, but contributed 59% of total donations and 40% of total volunteer hours (Statistics Canada, 2007). The top 25% of donors who volunteered are sometimes referred to as core supporters (Statistics Canada, 2007).

The nonprofit board's true value remains its ability to perceive the need for change and innovation, to move strategic direction forward, to govern implementation toward such change; and to continue creating resource bundles that maintain competitive advantages (Coombs et al., 2011). This can only be achieved with both a strong Senior Development Officer and a strong board.

### *Independence/Interdependence Model*

In Steven R. Covey's Book "The Seven Habits of Highly Effective People" Covey addresses the selected seven habits through the following stages:

1. Dependence: the paradigm under which we are born, relying upon others to take care of us.
2. Independence: the paradigm under which we can make our own decisions and take care of ourselves.
3. Interdependence: the paradigm under which we cooperate to achieve something that cannot be achieved independently.

Covey goes on to stress that while most of the literature encourages us to be independent, the reality is that we are interdependent. The independent model is not optimal in an interdependent environment where leaders and team players are required. Covey's first three habits include:

- be proactive,
- begin with the end in mind, and
- put first things, first

by focusing on an individual's staging from dependent to independent. Covey's next three habits are:

- think win/win,
- seek first to understand, and
- then to be understood, synergize

by focusing on moving to interdependence.

Covey's seventh habit is one of renewal and finding proper balance. Hospital foundations need to find that proper balance between independence and interdependence with their institution through strong leadership and team work.

### *Role of Leadership*

Oster and O'Regan (2005) suggest that Board independence in nonprofit boards is more difficult to measure as most empirical work relies on shareholders as outsiders. They do suggest that one way to look at nonprofit board independence is to look at the role of the Senior Development Officer in Board matters.

Does the Senior Development Officer have influence on Board composition?

Does the Senior Development Officer have a vote on the Board?

Further, much of the literature suggests that a portion of Board meetings should be held in camera without the Senior Development Officer. In order for this practice to be effective, Oster and O'Regan (2005) suggest the Board must have a strong Chair.

Oster and O'Regan (2005) further suggest that as in for profit boards, Senior Development Officers likely favour less controlling, less independent boards. They suggest further that a common complaint in nonprofit sector is meddling Board Directors. Oster and O'Regan (2005) further state that Senior Development Officers are more likely to have high-giving individuals, rather than directors that are active in other ways. Oster and O'Regan (2005) state that their research supports directors of high-giving tend to do less monitoring, but concentrate on higher fundraising efforts. Fama and Jensen (1983) suggest the major donors on boards are motivated to ensure their financial support is used as directed; therefore, enhanced monitoring activities. Many nonprofit organizations feel they are judged only on their fundraising abilities. Oster and O'Regan (2005) further state that a strong Senior Development Officer will likely spend more time on fundraising than other governance activities.

In 2007, Hardy points out that many charities are looking for leaders with skills that resemble those of a proactive transformational leader that so many for profit businesses seek:

- vision and strategic planning;
- a desire to innovate;
- a willingness to take considered risk;
- the ability to create and sustain growth;

- the ability to delegate and collaborate;
- excellent communication skills; and
- risk management and crisis intervention skills.

Fine (2011) experienced a transformation in their Foundation's approach to philanthropy by looking at the role leadership plays at the CEO levels of the institution and the Foundation. Their strengthened culture of philanthropy was a result of defining who needed to be involved in the process. All signs pointed to the organization's leadership. Leadership set the tone for their newly transformed culture of philanthropy both in their organization and their community.

#### Gaps and Future Research

Much of the academic research available is focused on nonprofit organizations and governance. There is no obvious academic research relating specifically to the unique relationship between parent hospitals and their foundations, but literature exists through philanthropic articles anecdotally sharing their practice and experiences. A great deal of academic research is available on health care governance and healthcare fundraising. Access to Board Directors and senior officials willing to speak confidentially might be a problem in advancing academic research, but was not evident in the subsequent primary research.

#### Summary

This research is one of the first academic research studies conducted that focuses on the unique relationship between hospital and hospital foundations and whether the

governance shift or reformation of healthcare is affecting healthcare foundations in fulfilling their mandate to raise funds for their institution.

Future research is needed to understand how foundations can address their need to change, modify or to adapt their governance model in this new healthcare environment. Future research is also needed to understand whether foundations need to play a larger role in advocacy in the future and how they might balance this role with one of philanthropy.

## CHAPTER 3: METHODOLOGY

The focus of this research is to better understand the role of Foundation Boards and whether Board effectiveness, as a result of the change in the governance model of healthcare in Canada, requires Foundation Boards to reconsider their governance model. The dynamics of Foundation Boards change as directors retire, new directors join, the Executive or Development Director changes. What remains constant is the culture of the board and the ongoing interactions required between Board Directors and the Development Director with the community.

This study also looked at Board recruitment, training and succession planning. The role of the Development Director was discussed from an operational perspective addressing both internal and external pressures. The external role of the Development Director was defined as the relationship with the public and the face of the public. The relationship with the Board Directors and keeping Board Directors up to date was defined as the internal role of the Development Director. This framework focuses on exploring the need for leadership by the Development Director as well as the Chair's role.

This chapter provides a theoretical framework used to guide this study and the development of the interview questions. The findings were subsequently analyzed to identify themes resulting from similarities in individual responses.

### Theoretical Framework

To address and better understand the role of Foundation Boards, it became evident that the culture of the board plays a key role in board operations and performance. The framework used was Evan's (2010) value added model which placed

culture in the centre of all Board activities. Evan's (2010) model looked at the composition of the Board, the roles of: the Development Director, Chair and the individual Board Directors.

This framework looked at overriding factors of evaluation and continuous improvement required by the Board, while from an operational perspective evaluated functions, process, roles and information management.

## Research Framework

### *Research Context*

To become theoretically sensitive, a literature review on nonprofit boards was conducted. Experience with nonprofit boards requires caution so as to not develop preconceived ideas of where the data will lead. Understanding the terminology and culture of the Board works best with grounded theory as it enables the interviewees to provide information without a hypotheses, while allowing the interviewer to have an understanding of the terminology used. Grounded theory facilitates relating new findings to existing theories within the field of study (Laws and McLeod, 2004). It is important that an objective view is developed and no biases based on personal experience appear.

In order to conduct this research, access to Development Directors of hospital foundation boards was essential. Confidentiality is important in order for participants to fully disclose key information. The role of the interviewer is to listen, take notes, and better understand the information being disseminated from the interviewee before performing analyses. It begins with no preconceived theory, but is an opportunity to discover potential similarities and differences in response.

## Research Approach

Qualitative research was conducted based on research and interview questions framed from Evans' Value Added Model (2010). All participants gave permission, ahead of time, to have the interviews taped and were reminded that the interviews were confidential. All interviews were voluntary and permission slips were signed by all participants and received prior to the interviews.

Participants were Development Directors (positions that were the most senior at the hospital foundation that had a direct reporting relationship with the Board) of hospital foundations across Canada. Individual interviews took between 45 to 70 minutes per participant, depending on the length of their answers. The interviews were taped and notes were taken during the interview.

These semi-structured interviews used open ended prompts (McCracken, 1988). Listening to the responses and watching the mannerisms of the interviewee is imperative for this type of effective research. With grounded theory, there is no preconceived hypothesis but through listening and constant comparison analysis, the main concern of the participant is identified (Glaser 2004).

Semi-structured interview questions were used as a guide and unplanned questions were asked to further probe unexpected responses by interviewees.

Upon completion of eight interviews, saturation was reached. No additional themes or information was being provided, so interviewing ceased. Riley (1996) states that most studies achieve saturation with between 8 and 24 interviews depending on the topic focus. While it is dangerous to provide specific numbers in the development of a saturation point it is a guideline in a methodology that has often developed over-rigid

rules for judging the credibility of grounded theory products (Skodol-Wilson and Ambler-Hutchinson 1996).

The interviews were transcribed after they were conducted so analysis could take place (McCracken, 1988).

A compilation of information was analyzed and a search was completed outlining themes identified by the participants – these were subsequently coded.

The literature review was revisited in more detail once core categories were identified through constant comparison and analysis of the research. Glaser 2004 states that the grounded theory method focuses on the generation and emergence of concepts, problems and theoretical codes. The goal of grounded theory is to generate a conceptual theory that accounts for a pattern of behaviour which is relevant and problematic for those involved. As a result, theory will emerge. Grounded theory requires following its rigorous procedures to generate a theory that fits, works, is relevant and readily modifiable (Glaser 2004).

Selective coding was based on the core variables that were relevant to the emerging conceptual framework. As a result the research became more focused only on the theories identified.

### Research Summary

The interviews identified consistency with regard to compliance and best practice among the Boards. Four themes became evident from all interviewed and provided rich data on the varying practices and challenges among the eight hospital foundations. It is important to highlight that regardless of where the boards were in the corporate governance journey, the culture of philanthropy was prominent. While this

research is qualitative, it became apparent from the research and primary data provided by these foundations that all foundations are being challenged to strictly comply with their mission given the current economic pressures on healthcare funding and reform.

## CHAPTER 4: FINDINGS

### Method

This section provides the methods used in this study to conduct the research including: selection of participants, data collection and completed analysis. It also includes the study findings gathered from the interviewees. It identifies the themes uncovered and the findings leading to these themes.

#### *Selection of Participants:*

Eight Senior Development Officers (senior executive position reporting to the Board of Directors of healthcare foundations) were interviewed. The titles of those interviewed varied from Chief Executive Officer, Executive Director, President and Manager. For the purposes of the study, the position will be identified as Senior Development Officer. The interviews were conducted across Canada: three from Western Canada, two from Central Canada and three from Atlantic Canada. Participation was voluntary and interviewees could withdraw at any time from the study. The hospital or healthcare institutions for which they raised funds ranged in size from 66 beds to over 900 beds. The hospital foundations had annual disbursements from \$250,000 to \$9 Million. In all cases, the healthcare foundations raised funds for at least one hospital, but some foundations raised funds for multi-sites or other facilities such as long-term care facilities. Two Foundations interviewed were teaching hospitals or affiliated with research or universities. For the purposes of this study, parent institutions will refer to those facilities for which the foundation raises funds.

In all cases the Senior Development Officers had worked for the institution for at least five years in their current position.

The study refers to Chief Executive Officers, which are the most senior position at their respective hospitals or parent institution. Again, these titles may vary but in each case they refer to the senior leadership position at the parent institution. These positions differ from the Senior Development Officer, as the Senior Development Officer reports to and works for the hospital foundation board. The Chief Executive Officer reports to the director of the region or authority responsible for the parent institution.

*Data Collection:*

All interviews were assigned a code based on birth date and all audio, electronic and paper files were coded this way. Interviews were conducted to examine the relationship the Senior Development Officer had with the foundation board and the foundation board with their parent institution. The interviews also reviewed: the role of the Board, the focus of the Board, board selection criteria, terms of service, policy and procedures, decision making processes, self- evaluations and changes implemented to deal with potentially new governing bodies. This research will provide insight into the relationship between foundation boards and their parent institution.

*Analysis:*

Following the completion of the interviews, a compilation of information was analyzed and a search was completed outlining themes identified by the participants which were subsequently coded. Upon completion of theme identification, a manual identification was conducted to identify like themes to categorize responses by

participants and their responses. Four themes consistently emerged from all interviews: culture of philanthropy, power, board representation and engagement.

## Findings

### *Function of Hospital Foundation*

The interviewed Senior Development Officers agreed that the mandate of their hospital foundation is playing a vital, supporting role to their parent institutions, who deliver healthcare to their community. The means for fulfilling this mandate is solely focused on raising funds.

Foundation boards function by committees reporting up to the Board of Directors.

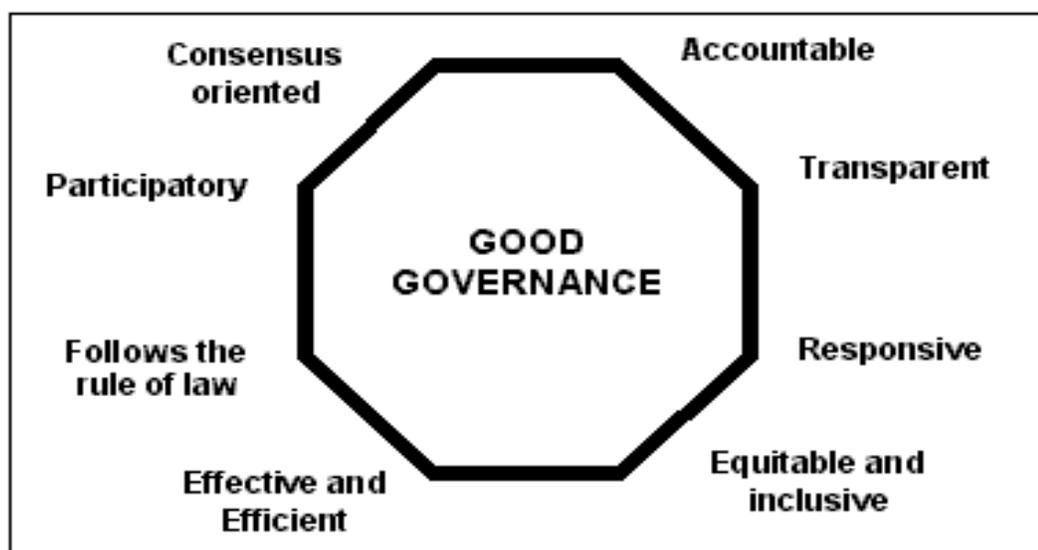
All foundations had some form of:

- Executive Committee,
- Finance and Audit Committee,
- Investment Committee,
- Governance or Board Development Committee,
- Recruitment/Nominating Committee, and
- Committees that focused on specific fundraising projects (Annual, Special Events, Major, Planned Giving Committees).

In some cases the responsibilities were blended or carried out by just the Executive or were accomplished by the Board as a whole.

All eight interviewees showed strong governance practices, but were at different stages of development. Some hospital foundations were focused on bylaw review, nominating practices, strategic planning cycles, policies, benchmarking, best practice,

etc. Transparency and accountability were evident with all Boards and community engagement was important to their success in fundraising. All Foundation Senior Development Officers shared their passion for their job and a great deal of support and respect for the Board of Directors. The Boards and staff worked very cohesively and were very focused on their mandate to raise funds for their parent institution through a team approach.



**Figure 3: United Nations ESCAP Governance Model**

Hospital foundations are separate and independent from their parent institution, while the parent institution is governed by an independent regional authority. Currently, there are four types of relationships between the foundation and its parent institution:

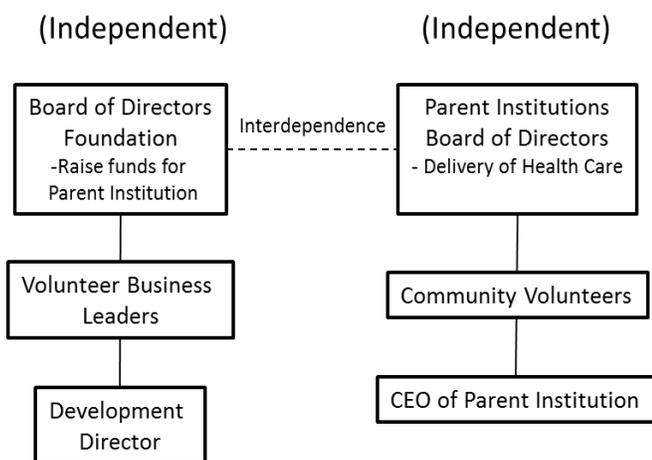
1. The historical model: the parent institution sits on the foundation's board and has authority and responsibility.
2. The foundation board meets independent of the parent institution it serves and the governing regional authority.

3. The seat originally held by the parent institution on the foundation’s board, is now held by the regional /health authority, with delegation to the executive director of the parent institution,

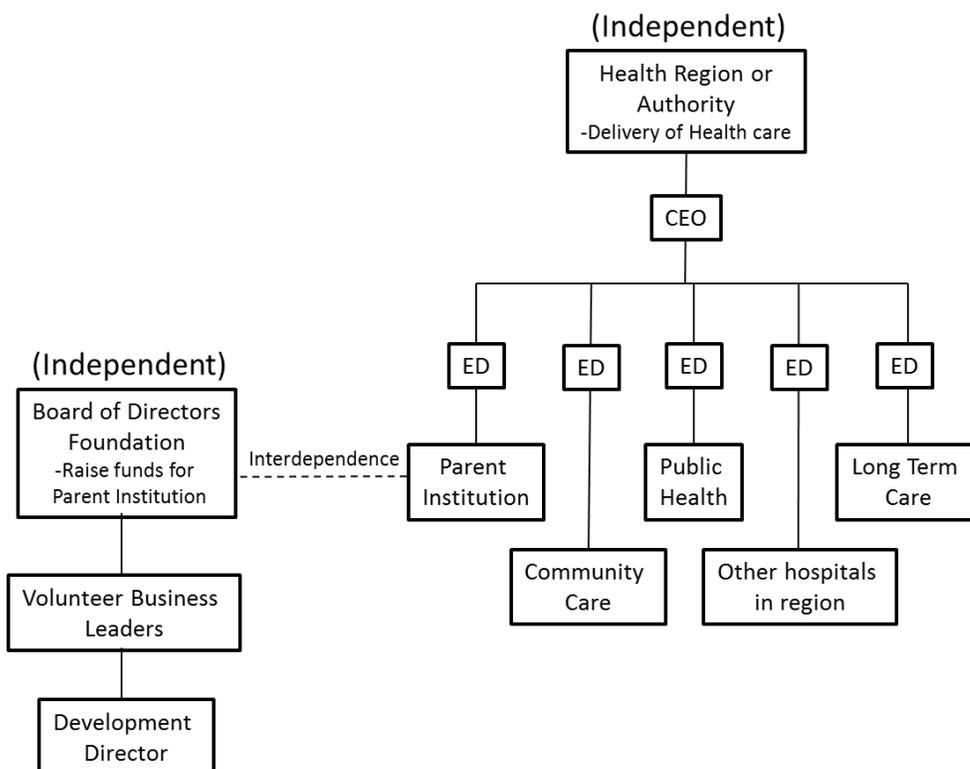
4. The seat is held by the parent institution on the foundation’s board but this position has little authority or budget discretion.

**Table 2: Relationships Models**

**Historical Model**



**Present Model**



The foundation board without parent representation experiences the same effects as the foundations boards that have the CEO or health authority representative. The further away the regional/health authority is from the foundation, the worse the communication.

### *Role of the Board*

All eight foundations interviewed practiced strategic planning with direct participation by the Board of Directors. This could be in the form of a Board Retreat or Annual Planning Session. Strategic Planning sessions were conducted in a three-year cycle and most Senior Development Officers felt this was long-term in their planning cycle. Many felt that a five year strategic planning cycle was too lengthy and required many changes to fit with future (and sometime unanticipated) realities.

Foundations were consistent in doing Board evaluations. These were conducted in many forums, including:

- face to face interviews,
- surveys,
- annual review,
- feedback during orientation or Board retreats,
- board attendance at special events and foundation activities, and
- financial support.

Most foundations keep attendance at Board meetings and included this in evaluating Board Directors for re-occurring terms or identifying possible lack of engagement.

Very few Foundations have their directors do self-evaluation. Some are presently conducting a confidential survey. Most felt that if the directors were engaged in the

activities – attended meetings, special events, or participated on committee work; this in itself signified a high level of satisfaction. Most also felt that evaluation and engagement were directly related to financial giving, but no real evidence was presented. Those that provided large gifts were considered to have a high level of engagement.

Evaluations by Board of Senior Development Officers were inconsistent among the foundations interviewed. In all cases, the practice of evaluation was left up to the Senior Development Officer to lead and/or implement. Volunteers may feel that evaluating a salaried position is beyond the scope of their philanthropic mandate. For those Boards that do evaluate their Senior Development Officer, the process seems to be formalized with a small committee holding an in camera Board discussion, followed by a meeting with the Senior Development Officer. Goals and objectives are established and discussions are held with regard to achievement. One Foundation indicated that evaluation is ongoing with their Executive members and expressed satisfaction with their level of constant feedback.

In all cases, Board Directors were expected to demonstrate their commitment by way of making charitable gifts as well as volunteering time. Board engagement is key and most felt engagement is reached by committee participation. Some Foundation Boards use tours, mentorship or a buddy system, evaluations and interviews to determine a Director's interests and satisfaction with his/her experience on the Board. *“They may not know how to raise money but we look at who they are and their sphere of influence, personality and fit.”*

### *Board Recruitment*

Boards spent a great deal of time focused on recruitment and orientation to the Board recognizing the need to build a culture of philanthropy on the Board, while simultaneously looking for good distribution and reach out into the community served. One Foundation cited its Nominating Committee as its “*most important committee that works year round.*”

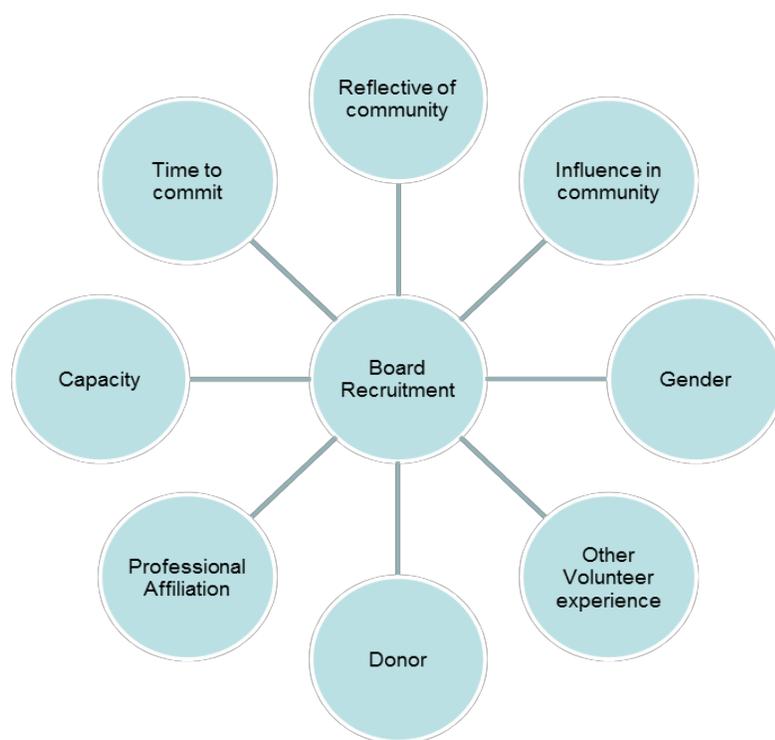
Varied representation on the board allows for access, influence and capacity. The culture of philanthropy is evident and central to the capacity for foundation fundraising.

Having a diverse board means different thoughts and ideas percolating around the Board table that may well lead to expansion of the community/donor base. If a board is not diverse, then it has more “likeminded members” with very few original thoughts or fresh ideas.

With a philanthropic board it is essential that the net be spread as far and wide as possible. Varied representation on the Board enables this to happen. As one Senior Development Officer said “*diverse representation on the Board allows for a refreshed different board with new ideas and contacts cycling through at all times*”. The primary dimensions of diversity – gender, race, religion and age were not often alluded to in the research. Of more importance to the Foundation Board was influence and affluence. Foundations Boards strived to be reflective of the economic generating industries in their community. Most importantly, the foundation boards, because of their single mandate, require Board Directors that can “give or get” donations. This differs from most nonprofit boards that have policy and program delivery that are not singly focused on fundraising.

Foundations are moving away from a more closed recruitment model to one of evaluating the skills and professions missing around their boardroom table and recruiting based on need. As a result, foundations are experiencing a much more open and welcoming process.

Recruitment grids are used to ensure the Board is representative of the community.



**Figure 4: Recruitment Matrix**

One Foundation identified their recruitment as either “*born and bred or “relocates” balance (relocates – sway, retired, business, fundraising, business) – clout (make calls), commitment (entrenched in the organization) and capability (make a gift). (We) Try to get two out of the three in each board member.*

As stated previously, the culture of philanthropy is addressed through quality Board Directors who understand the need to “give and get” for their institution. Philanthropy is central and therefore the key to quality Board Directors. One Foundation spoke about the importance of “*power and influence; and with this, you get a level of financial sway.*”

Engagement includes both involvement and commitment to the cause. Hospital foundations include stakeholders such as: physicians/institutional staff, government/politicians, the community served, donors and social movers and shakers, as well as the Board Directors themselves.

Representation from the medical community (physicians) appears to be important to hospital foundations – perhaps this is based in part with the trusted and vaulted position physicians experience in their role as key players in health care provision. Additionally, physicians from the parent institution may also be considered more in-tune with both patient needs and the tools required to fulfill health care, while also embracing the culture of philanthropy.

Staff of the institution is important to the foundation board in providing priorities, but also acknowledging the importance of the work conducted by the foundation within the community. The staff of the institution needs leadership to create a culture of philanthropy within the institution and to embrace philanthropy in strategic matters. Engagement by the staff requires leadership by the Chief Executive Officer of the institution.

Interviewees that had representation from the regional authority express concern with this representation with regard to weaker attendance, lack of priority setting by

senior personnel and diluted engagement in the position. Some interviewees cited that regional authority personnel are: “*too busy to attend meetings*,” “*too far away to attend meetings*” or “*have too many other issues*” to be attentive to the foundation board.

There appears to be too many demands on this position for them to play an active, key leadership role around the Foundation Board table. Their vision is unlike those of the volunteers on the Board.

The agenda or motive of a regional senior personnel sitting on the foundation board was decidedly different from that of the individually-recruited volunteers as it was part of their job and seemingly a very small part at that. While the Senior Development Officer identified the problem, they felt, in many cases, it was not a result of disinterest or disengagement, but simply a question of priorities placed on the senior regional personnel which the foundation board was largely unable to resolve. Further, the role of this position has evolved with the dissolution of hospital boards when the CEO of the hospital was an employee of the hospital board and held authority over the institution.

It was evident from the interviews that recruited Foundation Directors understood their mission while those placed on the board by position (CEO) did not demonstrate the same culture of philanthropy.

Engagement by the community served is also vital in keeping the cause top of mind in the community and focused on becoming their charity of choice. Foundation Boards depend on their community to conduct third party fundraising events as well as private donations. A major portion of their funds are a result of private donations, philanthropic dollars sourced from their community.

### *Board Size*

The Board size widely ranged from nine to twenty-six directors. The largest board, with 26 directors, defended their size by stating:

*“Our Board is a large board by design to look at best practices in the country for governance review.”*

This Board did not focus on regional representation, but rather community and corporate leaders that can open doors and bring in gifts. Further, this board has no representation from the parent institution or authority.

Another Foundation with a mid-size board of fifteen, suggests they need this size to have access, influence as well as the capacity to give.

*“(On) The present board, we have some very strong leaders from local business, financial, lawyers, presidents and CEOs, retired persons. The numbers on the board are not as important as their capacity to help raise funds and open doors.”*

The smallest foundation interviewed (nine directors) believe that size is not as key as the individuals sitting on the board.

*“My strategy was to build a very strong and capable board with a good distribution and reach out into the community. Currently the Board is not quite a 50/50 mix of male/ female capability, which is not the overriding factor. It is more about capability and availability.”*

It became evident that the size of the board did not appear to matter as long as they had fundraising capacity and were fully engaged in the culture of philanthropy.

### *Board Agenda*

The Board agendas varied greatly from foundation to foundation. The differences ranged from a consent agenda to a standing agenda for the year which tied back into their strategic plan. The Board agendas were developed between the Senior Development Officer and the Board Chair or as an offshoot of the Executive Committee. In defining their Board agenda, comments made were as follows:

*“You have to structure board meetings (so) that there is an opportunity for Board Directors to talk and share information.”*

*“...at the same time we went to a consent agenda, so really freeing up time to focus on things that need discussion the most.”*

*“...it’s a Macro Agenda for the year. So that we don’t lose sight of the items over the year. For example if we said we’re going to have four Board education sessions so we schedule those in, we said we would do a quarterly review of the strategic plan so we schedule that in. It’s a standing agenda but tweaked a little bit.”*

All interviewees agreed that their role was one of listening to the Board Directors, allowing for participation in discussion and encouraging an advisory role. It was not evident that Board meetings held any part in camera, with the possible exception of when Senior Development Officer evaluation took place.

### *Board Term*

In most cases, bylaws allow for succession of Board Directors to cycle through the Board with a fixed term. Only one Foundation is presently transitioning from no term for Board Directors to fixed terms. The Senior Development Officers felt this was

opportune in refreshing the Board and having a more diverse and changing Board with new ideas, new opportunities for philanthropic gifts and diverse backgrounds.

Terms varied from two-year terms renewable to two three-year terms. The term on the Executive Committee in many cases was outside the Board term simply to allow for succession into the Executive positions. When asked about their satisfaction level with board terms, Senior Development Officers supported the terms, citing the following:

*“I haven’t seen a situation where someone is hanging out and is disengaged.*

*They really operate in a good manner. Very productive while they’re there and go off when they need to go off.”*

*“...Always new blood coming onto the board which, personally, I agree with.*

*Sadly we see some Board Directors go, some we are sad to see go, others we are happy to see go. We are blessed with very good Board Directors, very fortunate that way.”*

*“In 2005, our bylaws were revisited and we took on different terms for the Board.*

*Prior to this the Board didn’t have terms, they were there for life!”*

*“They are eligible to sit for two three-year terms. The only exception is the Chair who can stay on an extra year (backing out clause). After two three-year terms, they are invited to be a Honorary Trustee, if they are in good standing.”*

*“I think there is a pretty strong reason for Board Directors to have a fixed term. If Board Directors stay on too long, we don’t have that renewal and engagement that you have with fixed terms. Then they know how long they have.”*

### *Role of Leadership*

#### Independence/Interdependence

As previously discussed, historically there was a unique relationship between foundations and their parent institutions; while they conduct their business independently, they were dependent on one another in communicating their needs and fulfilling their individual mandates.

All Foundations followed a similar process in how priorities were identified. The priorities were established by the parent institution, with the Foundation's input around: the capacity to raise funds, financial goals attainable and perceived appeal by their community to embrace the fundraising priority.

The frequent dissolving of the parent institutions' seat on foundation boards and the possible inclusion of government health authorities has upset the balance previously enjoyed by both the hospital and its foundation.

Senior Development Officers cited that:

*“They (Board of the Directors of the foundation) were not the experts and not in a position to determine what was a priority for their institution.”*

*“Government's lack of partnering on campaigns is a huge concern.”*

*“The increasing demands and expectations placed on foundations is concerning.”*

*“We are extremely concerned about the lack of understanding by healthcare or government officials on the Foundation's role. Hospital foundations were not part of the planning process and were not involved or considered in the planning cycle.”*

Lack of communication appeared evident by foundations describing health regions' activities as "*working horizontal*." The region's role is the community as a whole thereby leading to difficulty in focusing on the parent institution only. This highlights the shift in responsibilities away from the parent institution, upward to a regional or health authority.

As a result of increased demands from an aging population and the accelerated pace of innovation in technology, there are increasing pressures placed on the healthcare budget with no end in sight.

Participants spoke about their foundations being asked to stretch their mandate to cover costs for budget line items such as: staff education, replacement medical equipment, healthcare promotion and staff travel. Further, Foundations are being asked to play an advocacy role as it relates to negotiating capital contracts, lobbying for special services for the institution or pushing projects along that appeared to be stalled at the government level. Foundations are being approached by physicians for funding not available through normal funding sources.

*"Foundations and volunteers are feeling inadequate to address pressing, ongoing, expanding needs requested with no real level of government involvement or communication to resolve these matters."*

The mandate of the Foundations is being stretched and challenged as a result of these additional pressures with Board Directors trying to continue to make sound decisions for their community as it relates to quality health care.

Most are concerned about the additional demands being imposed upon the volunteer board to leverage dollars and the lack of planning beyond one year by their

institution. This posed difficulties for the Foundation and had a band-aid effect. Some expressed the lack of understanding by hospital/authority personnel to understand not only the Foundation's role, but fundraising in general.

*“Did they think the money just fell out of the sky?”*

Participants spoke about their relationship with their parent institution and government. A lack of communication and understanding for their role in the healthcare cycle became apparent. It is evident that there is a disconnect among the hospital foundation, the parent institution and government. Hospital foundation boards are dealing with this lack of communication in different ways;

- Some Foundations Boards have chosen to take on an advocacy role that is lacking in their healthcare region.
- Others have chosen to ignore the institutional management and develop communication with their government.
- Others are extremely frustrated with the short-sightedness of their institution and lack of engagement by their senior leadership at the hospital.
- Planning at the institution appears lacking, short-term or reactive.
- Foundation Boards feel frustrated with their need to plan over a longer term when their institution is incapable of planning for the present fiscal year.
- Others felt the senior leadership of the region needed to place more emphasis on philanthropy in their leadership team to allow for two-way communication and education and real value added to healthcare planning.

Their relationship with their healthcare authority was described as “*a vacuum*” “*non-existent*,” “*apples and oranges*,” “*terrible disconnect*,” “*them and us, no we*” “*clarity of roles is critical*,” “*push/pull scenario*,” and “*lack of leadership and understanding*.”

Board Directors have a significant role to play and in some cases, the Foundation Boards have more political influence than the health authorities.

In other instances, even when the Board representation includes the highest level of leadership from the healthcare institution, there appears to be no authority for the health care institution to make decisions at the appropriate level. The authority has been removed from hospitals, planning done elsewhere, if at all, and the planning is often surrounding the entire healthcare system. This conflicts with the mandate of the Foundation Board and causes problems for the board to fulfill its single mandate. The reformation of healthcare appears to be moving forward in one direction and there appears to no longer be a focused approach of healthcare institutions which further complicates the Foundation’s role in fundraising.

At the same time, fundraising for healthcare is essential going forward and the community has embraced giving to their healthcare institution. Charitable donations to hospitals increased by 35 % from 2004 to 2007 (Statistics Canada, 2007). Government has not openly recognized their dependency on their Foundation for this level of support.

### *Board Engagement*

Board engagement is of the utmost importance to the Senior Development Officer. Board engagement occurs in various ways.

*“It might be a mentorship/buddy system that is established in order that new Board Directors are mentored by a more senior Board member. This provides deeper engagement by the more senior Board member and ensures the incoming member has the opportunity to feel welcomed, ask questions and feel comfortable in year one”.*

*“Engagement by all Board Directors is essential to filling their mandate and ensuring they are engaged in their first term”.*

*“Board engagement also is an excellent recruitment model.”*

*“Board engagement was also evident from hospital tours offered to new Board Directors and senior members invited, of which they all come.”*

In comparison, Senior Development Officer leadership was also key to progress. Senior Development Officers did conduct evaluations and provide feedback to their staff on performance. Some Senior Development Officers require their staff conduct a 360 degree review which provides the Senior Development Officer with anonymous feedback from staff on their own performance in order to become more effective in mentoring their staff in training or leadership.

One Foundation recognized that not all Board Directors can be leaders in soliciting for gifts. For those that cannot give or get, there remains the important role of ambassadorship. Thanking donors for gifts is also a key function of philanthropy and there is room on their board for members who do just thank you calls and build relationships.

Power and influence are important for a fundraising board. One foundation board suggested that *“the very ones who are giving the money give the best strategic*

*advice. You want advice, ask for money...you want money, ask for advice.*” This was evident through statements such as: *“Volunteer leadership is the tool to success.”*

In order for the institution to have a culture of philanthropy, leadership within the institution is required. This leadership appears absent from the institutions. When referring to leadership within the institution, participants shared comments such as: *“the individual had no authority,” “the authority was removed from the hospital,” “planning done elsewhere if at all,” “senior position at the hospital are clinical with no real authority over priorities for the hospital.”*

### Conclusion to Findings

Four consistent themes became evident with respect to hospital foundations’ changing roles: culture of philanthropy, power dimension, board representation and engagement. The table below includes the themes, sub-themes and descriptions.

**Table 3: Summary of Themes**

Concept/Theme	Sub-Themes	Descriptions
<b>Culture of Philanthropy</b>		Board Directors are donors, which lends itself to the quality of the Board
		Capacity to give money and raise money (affluence, influence)
<b>Power Dimension</b>	<b>Interdependence</b>	Dependent on hospital/HCF to provide needs for facility
		Misunderstanding or empathy by public servants for role of Foundation
		Need to elevate conversation to government
		Act in role of advocate for parent institution
		Becoming more removed and less dialogue

	<b>Independence</b>	Board very engaged and work as a team with staff and community
		Independent Board with mandate to raise funds
		Independent board with decision making power for themselves
		Basically financially independent
<b>Board Representation</b>		Appropriate representation that expands community/donor base
		Enhances capability to raise more funds
		Representative of the community
		Allows for refreshed board with new ideas and contacts
<b>Engagement</b>	<b>Community</b>	Board engage community, politicians, physicians, community
		Social engagement
		Excellent recruitment model if community engaged
	<b>Board</b>	Diversity leads to more money by community
		By Board Directors - the more engaged the more they give...engagement low, satisfaction low

## CHAPTER 5: DISCUSSION AND CONCLUSION

The purpose of this study was to examine the role between hospitals and foundations given the changes that have taken place in healthcare over the past fifteen years. The research indicates that the Senior Development Officers interviewed place strong emphasis on governance and compliance, but the foundation boards are currently struggling with communicating with their parent institution, which has an obvious impact on their relationship. The best practice model worked in the old healthcare governance model, but it is evident from this research it is not well working in the newly reformed governance model.

### Summary of Study Findings

The research points out that foundation boards do have a unique role as a charitable organization because of their relationship with their parent institution or healthcare facility. As a result of this relationship, communication with and leadership by the parent institution or senior personnel responsible for the institution is critical.

#### *Independence/Interdependence*

The research points out the struggle between hospital foundation boards and their parent institutions when there is lack of leadership by the parent institution. The literature suggests that an interdependent relationship must be present which is built on teamwork and strong leadership. Hospital foundations that have that strong presence at the boardroom table work very effectively at building the culture of philanthropy within the institution. Those hospital foundations without representation or with weak representation struggle with communication and decisions by their parent institution

resulting in difficulty moving their mission forward. Campbell (2006) showed the best practice in this unique relationship is to have a shared leadership model between hospital CEO, Foundation Chair and Senior Development Officer. Foundation boards may need to review their mandate or determine how they are best positioned and who can provide the best link of authority to their institution.

### *The Board and Culture*

This research pointed out board functions and operations of hospital foundation boards and the lengths they go to comply with their mandate and CRA regulations.

Hospital foundations place special emphasis on its recruitment of Board Directors in order to fulfill its single mandate of philanthropy. With the absence of policy or program deliverables, the emphasis is placed on those with wealth and wisdom – the ability to “give or get”, with additional consideration given to gender, profession; and social status.

The research did not clearly support that the size of the Board had any notable impact on size of gifts or engagement. Leaders with influence and affluence on the board and who are fully engaged have greater impact than numbers. As the literature suggested, board terms cycling through new members provide for new ideas, new sources of revenue; and new money. Effective Board Directors may move up the hierarchy with placement on advisory boards or trustees.

As found in Evans (2010) model on a value-added board, culture is central to hospital foundation board.

### *Engagement*

Hospital foundation boards are perceived to have strong credibility and leadership by the community. Relationships are integral to their organizations and in all cases the Senior Development Officer is seen as key to building and fostering these relationships as well as playing a leadership role in philanthropy.

In all but one instance, Foundations are experiencing relationship blocks with their institution – while this sometimes has to do with personality, more worrisome is when it is a result of lack of authority. Relationships are necessary to building a culture of philanthropy for their institution whereby their mutual community is the benefactor.

### Research Implications

Hospital foundations across Canada are all experiencing a shifting role in their community. This shift is outside their control as governments across Canada are reforming healthcare and attempting to slow down the spending and high administrative costs for their institution. At the same time, they are depending more than ever on the philanthropic support provided by the foundations. As a result, hospital foundations are being pulled into the shift without consultation or consideration at the planning stages. If hospital foundations are at the table when decisions are being made, a stronger partnership would be formed, communication blocks would be removed; and a culture of philanthropy would evolve across the institution. This would enable government to become a strong leader in the important role played by Foundations for their healthcare institution. The respect the hospital foundations have in their community could be even further enhanced, resulting in even greater financial support from the community.

It was evident that the hospital foundation is the bridge between the community and the hospital. Building the bridge to the community is through the foundation, its donors and Board of Directors. Most of the positive public relations occur through the hospital foundations.

### Limitations and Future Research

The research conducted involved eight hospital foundations of moderate size across Canada. The hospital foundations interviewed are in relatively small very close knit communities. This was not by design but rather was impacted by timing. As requests were put forward to Senior Development Officers for interviews, participation was based on geographic representation across Canada and a mutually convenient time to interview. Further research could be considered involving larger hospital foundations across Canada. Access to the larger hospital foundations may affect future study conclusions.

Future research could also look at board terms and determine what maximum level of giving is based on years on the Board.

While the findings were very consistent among the foundations, the interviews were conducted with Senior Development Officers only. Future research might be considered whereby the Chair of the Foundation Board and the CEO of the institution could also be interviewed to determine whether the same themes would be identified.

Future research could be conducted on the suggestion that the agency theory exists with larger boards. There was no evidence of agency theory on the boards interviewed.

## Conclusions

This study continues the discussions that have begun with regard to the current role of hospital foundations and their need to adapt to the changing governance of healthcare delivery in Canada. With healthcare continuing to cost more (CBC recently reported 17 percent of the GDP is spent on healthcare) and the ever shrinking healthcare dollars available for staff education and training, research and medical equipment, the pressures continue to be placed on hospital foundations with much consideration from the decision makers of how the charitable organization can react to these pressures without burning out their volunteers and further contributing to donor fatigue.

There is evidence that there is a role of leadership for government to play but the model is yet to be defined. Since the role of government personnel on the foundation board does not seem to be effective, the model needs to be adjusted. A provincial advisory board for government and foundations might assist in overcoming the communication block between the two organizations. This model may lend itself to better communication and information sharing. The role of the Senior Development Officer could also be explored as a possible link between health care institutions and government.

The ongoing need for financial support by hospitals will not change in the foreseeable future and is critically important. Forging a workable relationship between the foundation and government is critical in moving forward their collective goal of excellent healthcare for their community.

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## Appendix A - Interview Questions

1. Participant Code : \_\_\_\_\_
2. Tell me about your Hospital Foundation.
  - Priorities
  - Mandate, Mission, vision
  - Board of Directors
  - Composition of the Board
3. Describe the roles played by the governance committees within your organization
  - Executive
  - Board
  - Chair
  - CEO
  - Individual Board members
  - Parent hospital
  - Government
  - Decision of medical equipment
4. Tell me about the process of Board recruitment and orientation.
  - Nominating Committee
  - Governance Committee
  - Governance Policy
  - Characteristics of Board members
  - Grid for demographics
  - Orientation of new Directors
  - Orientation conducted by whom
  - Follow up and Feedback
5. Tell me how your Executive gets formed and its function
  - Committee responsible
  - Process for identifying members
  - Terms
  - Evaluation
  - Meeting frequency
6. Tell me about process for policy and decision making?
  - information evaluated by committee
  - tabled at board meeting
  - frequency of policy review
  - Planning
7. Tell me about evaluation and assessment.
  - Board members self-evaluate

- Board members evaluated by committee
- Board members evaluate board
- Process for Executive Director evaluation

## Appendix B – Sample Letter to Interview

Date

Dear Participant,

Thank you for agreeing to be part of the research I am conducting for my Masters of Business Administration Signature Project. Please know that I appreciate your time will respect your confidentiality in this process.

As a means of referral, I will ask that the following convention be used to identify you for record keeping purposes: Middle Initial – First Initial – Birth Month Number – Birth Day Number

I will be contacting you soon to arrange a time to meet and interview you for my research.

Thank you again for your consideration.

Sincerely,

Barbara Dunphy-Gotell

## Appendix C – Sample Consent Form

Study Title – A Strategic Review of Hospital Foundation Boards

Researcher – Barbara Dunphy-Gotell, Master of Business Administration Candidate,  
University of PEI

(902)368-2133 bdunphygotell@eastlink.ca

Supervisors – Dr. Wendy Carroll, PhD (902)566-0573 wcarroll@upei.ca

You are invited to participate in A Strategic Review of Hospital Foundation Boards. Barb Dunphy-Gotell will conduct the research, supervised by Dr. Wendy Carroll. This research is being conducted to fulfill the requirements for Business 801, Signature Project.

If you choose to take part, your participation will take approximately 1 hour, no harm will come to you and you may withdraw at any time, without consequences. All information collected in this research will be kept confidential and anonymous and will ensure that you will not be identified by any of your responses. Any reference to you will be made by pseudonym in the final transcript. No compensation is being offered for your participation.

Only the supervisors and the researcher will have access to the research data. This information will be retained for five years after the project's completion and will then be destroyed. Please direct any questions or concerns about this research project to Dr. Wendy Carroll (566-0573 wcarroll@upei.ca). Results of the research study are available to any participant upon request by contacting Barb Dunphy-Gotell or Dr. Wendy Carroll. The UPEI Research Ethics Board has approved this research project. If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, or the ethical conduct of this study, please contact the UPEI Research Ethics Board for assistance 620-5104 lmacphee@upei.ca.

Hospital boards over the past fifteen years have been removed and hospitals are governed by either regional or provincial boards. The purpose of this study is to more clearly define the role of the Board as well as determine if the Boards have taken on greater importance as it relates to advocacy for the respective parent institution.

Participants will be invited to participate in a voluntary qualitative research study, agreeing to take part in semi-structured interviews. Interviews will be scheduled with individual participants until theoretical saturation is reached. It is expected that this will require a minimum of 8 to an approximate maximum of 16 participants. Participants will be asked interview questions in a private one on one setting and all responses will be kept confidential. No written assessment or pre-work is required. Interviews will take place at a convenient location for the interviewee.

The confidentiality and anonymity of all participants and their responses will be respected at all times. No information that discloses the identity of a participant will be disclosed unless required by law. The data collected will be for the sole use of the researcher and her advisors and will be stored in a locked, fireproof cabinet maintained by the researcher. Keys to this locked cabinet will be held by the researcher and her advisors only.

Participants will be referenced on interview forms by an alpha numeric code comprised of their first, middle and last initials, followed by their numeric birth month and birth date. Should quotes be required participants will be identified by pseudonyms with any specific identifying data removed.

The sole benefit of this study is for my educational research purposes. As Executive Director of the Queen Elizabeth Hospital Foundation, this research will be beneficial in providing strategic direction and new insight into the roles of hospital foundation across Canada.

If you have any questions about this study, please contact: Barbara Dunphy-Gotell(902)368-2133 or bdunphygotell@eastlink.ca. Please note - any new information affecting your decision to participate or continue participation in this study will be provided to you.

### **SIGNATURE PAGE**

Title of Study – A Strategic Review of Hospital Foundation Boards

I, \_\_\_\_\_, have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time. I understand that the information will be kept confidential within the limits of the law. I understand that I can keep a copy of the signed and dated consent form. I give my permission to be audio-taped.

Research Participant

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Researcher

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Would you like to receive a copy of the research findings? Yes No (please circle one)

If yes, please provide the following contact information:

Email address: \_\_\_\_\_

Phone: \_\_\_\_\_

I consent to my interview responses being quoted in a research report corresponding to this study, where my anonymity is protected by a pseudonym. Yes No (please circle one)

Problems or Concerns

If you have concerns about the ethical conduct of this study, you may contact the UPEI Research Ethics Board, for assistance at (902) 620-5104, [lmacphee@upei.ca](mailto:lmacphee@upei.ca)

## Appendix D – REB Approval



550 University Avenue  
Charlottetown  
Prince Edward Island  
Canada C1A 4P3

May 5, 2011

Barb Dunphy-Gotell  
School of Business

Dear Ms. Dunphy-Gotell,

Re: REB Ref # 6004216

### “A strategic review of hospital foundation boards.”

The above mentioned research proposal has now been reviewed under the expedited review track by the UPEI Research Ethics Board. I am pleased to inform you that the proposal has received ethics approval. Please be advised that the Research Ethics Board currently operates according to the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and applicable laws and regulations.

The approval for the study as presented is valid for one year. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the ORD prior to the renewal date. The information provided in this form must be current to the time of submission and submitted to ORD not less than 30 days of the anniversary of your approval date. The Ethics Renewal form can be downloaded from the ORD website  
[http://www.upei.ca/research/reb\\_forms](http://www.upei.ca/research/reb_forms)

Any proposed changes to the study must also be submitted on the same form to the UPEI Research Ethics Board for approval.

The Research Ethics Board advises that **IF YOU DO NOT** return the completed Ethics Renewal form prior to the date of renewal:

- Your ethics approval will lapse
- You will be required to stop research activity immediately
- You will not be permitted to restart the study until you reapply for and receive approval to undertake the study again.

*Lapse in ethics approval may result in interruption or termination of funding.*

Notwithstanding the approval of the REB, the primary responsibility for the ethical conduct of the investigation remains with you.

Sincerely,

Lori Weeks, Ph.D.  
Chair, UPEI Research Ethics Board

cc Dr. Wendy Carroll, School of Business