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A Seat at the Table: An Examination of Hospital Governing Board Diversity, 2011–2021

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SUMMARY

Goal: Board diversity is increasingly important for hospitals and healthcare systems, with national attention focused on eliminating health disparities and improving health equity. Yet, it remains a challenge despite concerted efforts by leading professional associations (e.g., American College of Healthcare Executives) to galvanize their constituents around the importance of the issue.

Methods: This study used survey data from The Governance Institute to explore the ethnoracial and gender diversity of hospital boards spanning 2011 through 2021.

Principal Findings: The results showed modest gains in the mean number of female board members, although a small proportion of hospital boards still have no female representation. There was little change in the number of boards with ethnic minority representation until an uptick in 2021, likely in direct response to high-profile racial incidents and protests.

Practical Applications: Intentional and sustained efforts are necessary to increase diversity and create a culture of inclusion that fosters meaningful engagement of diverse board members.

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INTRODUCTION

Scholarly research and trade publications have repeatedly documented the need for diversity in the composition of the boards of directors of both for-profit and nonprofit organizations. Internal and external stakeholders advocate for greater diversity in governing boards for numerous reasons such as improved decision-making, increased stakeholder engagement, and a better understanding of market opportunities (Brown, 2005; Fredette & Bernstein, 2019; Jaskyte, 2012). Not only do boards need to be diverse, but they also need to be inclusive (Bernstein et al., 2020).

Organizations must initiate practices that will drive engagement and participation to move beyond the potential traps of tokenism and assimilation into the dominant culture and reap the benefits of diverse boards. Boards can do this via shared power, the equitable treatment of all members, and inclusive communication practices (Barak et al., 2016; Bernstein et al., 2020; Nishi, 2013).

Board diversity is increasingly important for hospitals and healthcare systems, with national attention focused on eliminating health disparities and improving healthcare quality (Dolan, 2013; Totten, n.d.). However, attaining and sustaining board diversity has been challenging and this is not unique to the healthcare field. A survey of board members and leaders of public companies even indicated some fatigue with the topic (Rappleye, 2019). More recently, this same group of leaders expressed a renewed commitment to board diversity, responding to regulatory and other pressures and recognizing that it takes a concerted effort and deliberate actions to bring about changes (PwC, 2021). According to a 2019 survey of nonprofit organization leaders, nonprofit boards are slightly more ethnoracially diverse than reported just 2 years earlier, but still far from representative of the communities they serve (BoardSource, 2021). However, the survey results showed that nonprofit organizations have successfully increased gender diversity, as women hold a majority of the chief executive, board chair, and board member positions. Two other notable findings from the survey were that board recruitment practices and organizational goals for diversity, equity, and inclusion (DEI) are often misaligned, and racially diverse boards are more likely to engage in DEI practices than boards that do not include people of color.

In healthcare, the challenge of diversifying boards has been longstanding. Leading professional organizations, including the American College of Healthcare Executives (ACHE) and the American Hospital Association (AHA, 2019), have advocated for hospitals to increase the diversity of both organizational leaders and governing boards for many years. In 2011, the *AHA Health Care Governance Survey* found that board membership was predominantly White and male, with approximately 28% female membership and 10% ethnic minority membership (AHA Center for Healthcare Governance, 2014). Over the past decade, the ACHE, the AHA, and other leading organizations have made concerted and targeted efforts to galvanize their constituents around the importance of leadership diversity and provide education and training for potential board members. Yet, the 2019 *AHA Health Care Governance Survey* shows little progress in either gender or

ethnic minority board diversification, with a reported 30% female membership and 13% ethnic minority membership. Beyond improving representation at the individual board member level, we believe it is also important to understand how board-level diversity is evolving.

The purpose of this study was to conduct a fine-grained examination of hospital governing board diversity and within-board trends from 2011 through 2021. Recent survey data from The Governance Institute (TGI) were used to explore the present state of ethnoracial and gender diversity on hospital boards, as well as conduct a trend analysis of board diversity spanning from 2011 through 2021. TGI is a membership organization that serves not-for-profit hospital and health system boards of directors, executives, and physician leaders by providing information, resources, tools, and solutions to support board members' efforts to lead and govern their organizations. Each analysis was performed to explore the degree to which hospital board diversification efforts have translated into more diverse boards. In this article, we also discuss the results and their implications, as well as governing board diversification strategies that hospitals and health systems can use in this endeavor.

METHODS

Data for board composition were obtained from the TGI biennial survey of hospitals and healthcare systems for 2011 through 2021. The TGI survey, which covers structures and practices, is distributed to the governing boards of all hospitals and healthcare systems every 2 years. Survey participation is voluntary and TGI receives no financial support from the government or other third-party payers for the survey (Peisert, 2015). The results of the survey are shared only among TGI member organizations, which can use them for benchmarking purposes. The sample used in this study consists of responses to two questions: (1) "How many voting board members are female?" (female) and (2) "How many voting board members are from an ethnic minority?" (minority).

Sample

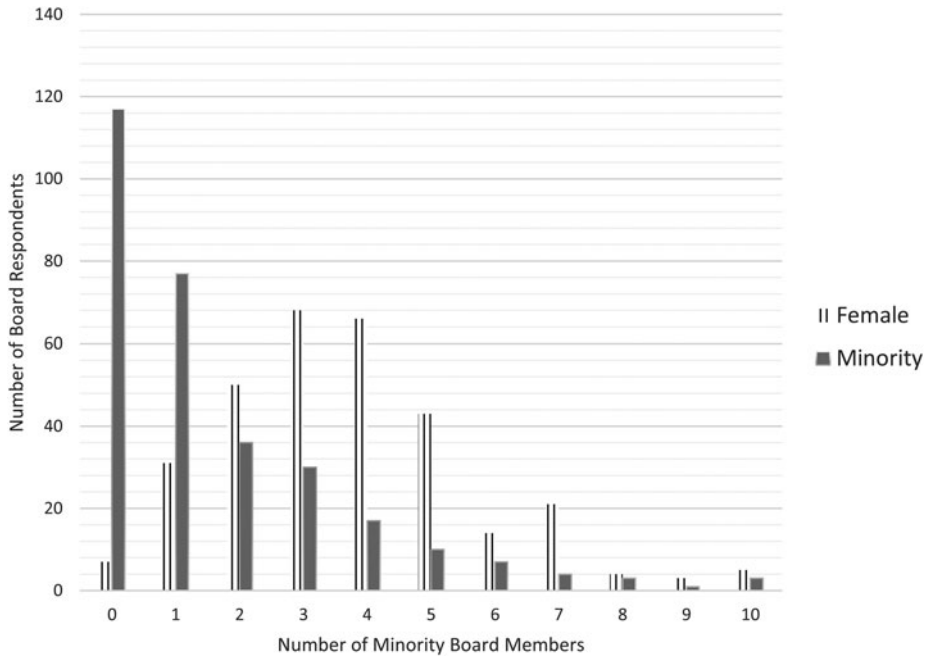
In the 2021 TGI survey, the response rate to the question about female board members was 81%; the response rate to the question about ethnic minority members was 79%. Across the study period, the number of hospitals responding to the survey ranged from 238 to 622. This range over the decade reflects a reduction in the number of hospital boards as a result of consolidation in the U.S. hospital market, with more hospitals responding earlier in the decade than toward the end of the decade.

Analysis

Responses to the 2021 TGI survey questions are presented in Figure 1. As depicted, the number of board members who identify as female or ethnic minority ranged from 0 to 10. Next, a trend analysis of the decade was performed to determine the changes in demographic composition of hospital governing boards over time. To examine overall patterns of diversity, we first organized data into categories based on the number of female and/or ethnic minority board members (0 to $\geq$6) for each year. Because the largest category of respondents consisted of hospital boards with no ethnic minority members

FIGURE 1

How Many Female or Ethnic Minority Board Members Do You Have (2021)?



(minority = 0), the analysis focused on changes in the percentage of governing boards without either female or ethnic minority members. All data were analyzed using an electronic spreadsheet (Microsoft Excel, Version 16).

RESULTS

The results of the data compilation for female membership on hospital governing boards are presented in Table 1. Over the decade between 2011 and 2021, the mean number of women serving on hospital boards increased slightly from 3.5 to 3.7. Table 2 shows the results for ethnic minority board members. Over the decade, the mean number of ethnic minority members of hospital boards also increased slightly from 1.2 to 1.6. Of note, 49.5% of hospital boards reported having no members from an ethnic minority group in 2011, and that percentage was largely consistent across the decade until the most recent survey in 2021 when the percentage decreased to 38.4%.

To appreciate the changes in female and ethnic minority hospital board membership in concert, Figure 2 represents the percentage of hospital governing boards with no diverse membership with respect to female and ethnic minority members from 2011 to 2021. Figure 2 shows that, in 2011, most hospital and health system boards reported having at least one female board member; only 2% to 3% of boards had no female board membership over the study period. Regarding ethnic minority board membership, about half of

TABLE 1

Hospital Boards With Female Members (2011–2021)

	2011	2013	2015	2017	2019	2021
Hospitals with no female directors	3	3	4	2	3	2
Hospitals with one female director	13	12	13	14	8	10
Hospitals with two female directors	24	22	21	21	27	16
Hospitals with three female directors	18	21	22	21	24	22
Hospitals with four female directors	17	17	13	16	14	21
Hospitals with five female directors	10	11	12	12	11	14
Hospitals with six or more female directors	15	14	16	14	13	15
M	4	4	4	3	3	4
Range	0–29	0–70	0–21	0–13	0–10	0–10
Sample size	620	522	351	407	238	312

the boards (45%–51%) reported having no ethnic minority board members across the study period, until 2021 when 38% reported that they had no ethnic minority board members.

A χ^2 test of independence was performed to examine the proportion of boards with no ethnic minority membership in 2011 and in 2021 and separately with no female membership in 2011 and in 2021. Each χ^2 test was run to see whether there was a significant difference within 1 degree of freedom and a sample size of 88 governing boards (1, $N = 88$).

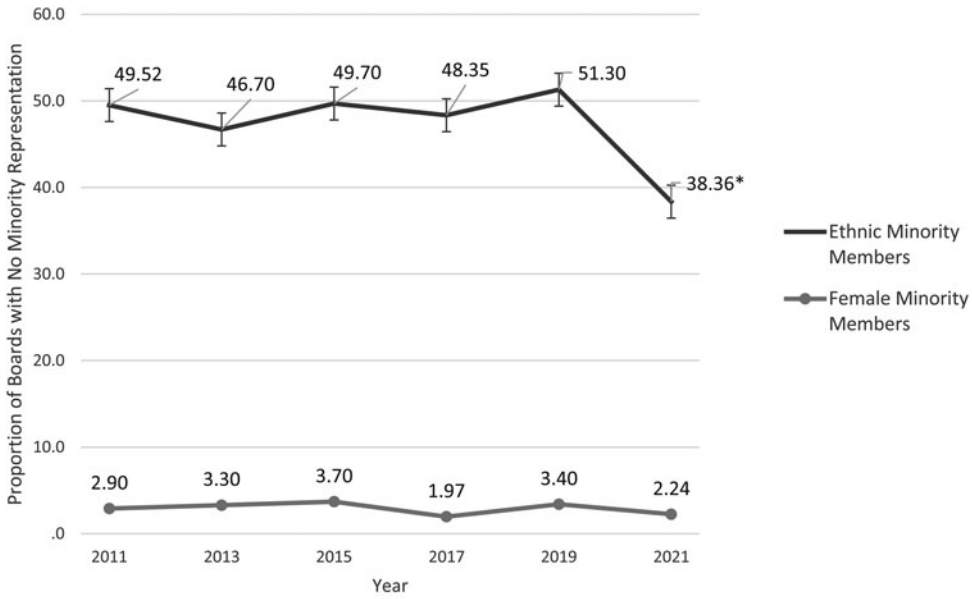
TABLE 2

Hospital Boards With Ethnic Minority Members (2011–2021)

	2011	2013	2015	2017	2019	2021
Hospitals with no ethnic minority directors	50	47	50	48	51	38
Hospitals with one ethnic minority director	23	23	19	22	21	25
Hospitals with two ethnic minority directors	11	14	15	13	13	12
Hospitals with three ethnic minority directors	8	6	7	6	5	10
Hospitals with four ethnic minority directors	4	4	4	4	3	6
Hospitals with five ethnic minority directors	2	3	2	3	5	3
Hospitals with six or more ethnic minority directors	2	3	3	3	3	6
M	1	1	1	1	1	2
Range	0–16	0–13	0–13	0–15	0–10	0–10
Sample size	622	512	344	393	240	305

FIGURE 2

Proportion of Hospital Boards Without Diverse Membership (2011–2021)



*$p \leq .05$.

The relationship for no ethnic minority membership was statistically significant with a $\chi^2 = 4.65$, $p = .031$. Boards were more likely to have ethnic minority board members in 2021 than in 2011. The relationship was not significant: $\chi^2 = 0.10$, $p = .76$, however, for female board membership. Boards were not more likely to have female board members in 2021 than in 2011.

DISCUSSION

At the beginning of the study period, more than 75% of hospital respondents had at least one female member on the governing board, and that percentage has been consistent over the decade. Additionally, the increase in the mean number of female board members from three to four has driven an increase in the proportion of boards with three or more women serving on them. While the increase in the mean number of female board members might appear to be insignificant, it is worth celebrating for at least two reasons. First, this happened during a period in which hospital boards were reducing their size, and the number of hospital boards was also decreasing (Mazurenko et al., 2019). Second, the increase from three to four female board members, on average, indicates a reduced likelihood that female board members will be viewed as tokens. However, this is not the case for ethnic minority board members; if a hospital board had any ethnic minority board members,

they were likely serving alone and, thus, at risk of experiencing tokenism.

How boards diversify is also important. It may be that a hospital's environmental context influences its board's ability to recruit and retain female and ethnic minority board members. In some rural hospitals, for example, members of the board are publicly elected, which results in unique challenges that other boards may not have to consider. In most contexts, however, challenges remain as board members are typically invited by existing board members and are sourced primarily through networks based on previous service together on other boards or from board members within the organization.

The challenge in the traditional board recruitment process is that if the networks of existing board members are not in and of themselves diverse with respect to female and ethnic minority representation, then their recommendations for new board members will also not be diverse. In effect, the traditional election processes that have created hospital boards to date—ones with less than representative diversity—will not serve well in the pursuit of diversified boards. Thus, successfully recruiting female and ethnic minority board members may require new approaches, not because there are no board-ready female and ethnic minority individuals, but because qualified individuals have been historically excluded from the networks that have served as pipelines to board membership (Totten, n.d.; White & Griffith, 2019). At the beginning of the study in 2011, for example, nearly half of the responding boards had no ethnic minority board members, a pattern that continued throughout most of the decade.

While the data show instances in which hospital boards have had many ethnic minority members (a maximum of 10 in the 2021 sample), by and large, these individuals are serving on boards as the sole member of an ethnic minority. Furthermore, the mean number of ethnic minority board members remains at fewer than two, which has likely led to tokenism. Tokenism in corporate settings has been an issue since at least the 1970s when Kanter (1977) introduced the concept. Because members of minority groups are easily marginalized when their presence in a larger group is modest, they can be viewed as a symbol or token (Kanter, 1977). For these individuals, stereotyping by the dominant culture can create barriers to their ability to influence group decision-making. Further, tokenism can lead to many poor outcomes such as negative perceptions, derision, doubt, distrust (Maass & Clark, 1984), discomfort, isolation (Nemeth & Wachtler, 1983), and self-doubt (Kanter, 1977); ultimately, and perhaps unsurprisingly, being perceived as a token can interfere with one's performance (Powell, 1993).

Tokenism is difficult for the individual subjected to it as well as for the board, as it fails to create an environment in which members from ethnic minority groups can contribute to their fullest capabilities. Another important consideration is that the diversification process requires some degree of tokenism, as most boards will start with one member of an ethnic minority group based on board turnover cycles. Although this individual may be the first board member from an ethnic minority group, it is made clear that they are the

first of many and that the board intends to continue to diversify its membership.

The changes in hospital board demography over the study period are noteworthy for both female and ethnic minority membership. With regard to female membership, a small proportion (2.9%) of boards did not have any female members in 2011. Over the past decade, the proportion did not change appreciably, as 2.2% of responding hospital boards did not have a single female member in 2021. Although the results of the study show that changes in female board membership are not significant, the fact remains that some hospital boards are still excluding female perspectives from their decision-making and board activities. However, women make up almost 51% of the U.S. population (U.S. Census Bureau, 2022) and 76% of the healthcare workforce (Day & Christnacht, 2019); moreover, they make 80% of all healthcare purchasing decisions (Matoff-Stepp et al., 2014). In light of these realities, hospitals would be wise to ensure that female perspectives are well-represented within their governing boards.

The lack of significant increases in female board members over the past decade is certainly a cause for concern. However, it pales in comparison to the underrepresentation of board members from ethnic minority groups. At the onset of the study period in 2011, roughly 50% of hospital boards reported that they had no ethnic minority representation, and almost no progress occurred during the past decade. The lone exception was in 2021 when the number of boards without any ethnic minority representation declined to 38%. This dramatic shift in ethnic minority membership on hospital boards may have been in direct response to the murder of George Floyd and the subsequent summer of racial reckoning in 2020 (Dreyer et al., 2020; Weine et al., 2020). Sad as that reality may be, the increase provides some hope, as a nearly 13% improvement in the proportion of hospital boards with ethnic minority representation over a 2-year period (2020–2021) provides evidence that changes in board demographics can happen quickly.

Study Limitations

This study has several important limitations that we need to acknowledge. First, the data were from a convenience sample of respondents to TGI's surveys. While the overall number of boards in the sample offered ample statistical power, it represents a relatively small proportion of hospital and health system boards overall. Therefore, our results may differ from those for the broader population of hospital governing boards in ways that we cannot determine based on the data available to us. For example, organizations that responded to the survey may be more likely to be actively working on improving their governance practices than those that did not.

A second limitation relates to intersectionality. We were only able to identify summary demographic statistics from the data set; there was no way to identify board members who represented more than one minority category (e.g., Black women). As such, ethnic minority women would be identified in this analysis as both female and a member of an ethnic minority, but aspects of the intersectional background could not be addressed. These

limitations notwithstanding, we believe our findings offer several important conclusions. Perhaps most importantly, despite the many efforts to diversify hospital governing boards over the past decade (2011–2021), there appears to have been little progress regarding the inclusion of women and members of ethnic minorities on hospital boards overall. We also found that the trends for women appear to be very different from those for ethnic minorities, with somewhat more favorable progress for women. Our findings also show, however, that changes in hospital board demographics can happen quickly.

CONCLUSION

The findings of this study show that, despite marginal changes over the past decade, hospital board demographics can shift rapidly. This is a welcome realization as much of the drive to diversify hospital boards is based on the call for them to reflect the demographics of the communities they serve; at the same time, the demographics of many communities across the country are also rapidly changing. Changes in hospital board diversity, however, do not occur by happenstance. Thus, hospital boards should be intentional in their efforts to diversify, and the process may be challenging and wrought with missteps. To that end, the literature offers suggestions for board diversification strategies germane to the study's findings (e.g., BoardSource, 2021; PwC, 2021).

Most notably, the risks related to board member tokenism are especially fraught. For hospital governing boards interested in diversifying, it may be particularly important to recognize these risks and pursue goals of reaching a "critical mass" of ethnic minority board representation (Torchia et al., 2011) so that tokenization risks can be minimized. To identify a diverse pool of potential board members, hospital boards must broaden their recruitment strategies, expanding beyond their personal and professional networks. Boards should be intentional about member recruitment, including setting board composition goals, developing and implementing a recruitment strategy, and monitoring progress toward their recruitment goals.

Next, organizations must commit to building an inclusive and welcoming board culture (BoardSource, 2021). It is one thing to offer individuals from ethnic minority groups a seat at the table, and yet another to offer them a voice. Diversity efforts must be accompanied by a culture of inclusion in which all board members feel that they have equal access to information and resources, involvement in work groups, and the ability to influence the decision-making process (Bernstein et al., 2020; Mor-Barak & Cherin, 1998). New members should be welcomed to committees, task forces, board meetings, and social gatherings. These steps should be accompanied by a commitment of the board to continuously learn and grow in understanding the importance of racial and gender equity in meeting the organization's mission, vision, and values and in meeting the needs of the communities the organizations serve.

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