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Accountability in Health Care in Canada:

An Analysis of its Meaning

and the Development of a Conceptual Framework

for its Application

A Thesis Submitted to the

Faculty of Graduate Studies

in Partial Fulfilment of the Requirements for

the Degree of

MASTER OF SCIENCE

Department of Community Health Sciences,

University of Manitoba

Winnipeg, Manitoba

By

Charlotte Johnson B.A. (Hon.)

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Accountability in Health Care in Canada:

An Analysis of its Meaning and the Development of a Conceptual Framework

for its Application

BY

Charlotte Johnson

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University

of Manitoba in partial fulfillment of the requirements of the degree

of

Master of Science

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This thesis is dedicated to my parents, Irene and John B. Gillings.

Their commitment to social equity and its place

in Canada's system of universal, publicly administered health care

laid an early foundation for this research.

Thesis Abstract

The Problem. As we enter the beginning of the new millennium, health care systems continue to change throughout Canada and the world. Many trends can be observed, from regionalisation of health administrations to better standards for appropriate care. Such trends may change over time, but one issue remains constant and central to all others – namely: Who is accountable for health care and the many systems in place to maintain it?

The complexity of the health system and the importance of its outcomes necessitate the clearest possible understanding of accountability for decisions and for action. The Krever Commission highlighted this point, which has been more recently revisited by the Walkerton public health tragedy and the Manitoba cardiac surgery deaths inquiry.

Purpose and Methods. This thesis has two related purposes.

The first purpose is to answer the main question: What is the meaning of accountability to those in a position to influence the future of the health system as we enter the next century? To address this, the following methods have been used:

- A review of the literature with respect to the theory and practice of accountability in health care and to search for a common theory (theories) of accountability.

- The qualitative analysis of open-ended interviews with 27 key participants in Manitoba's health care system to explore conceptualizations of accountability.

The second purpose is to develop a conceptual framework for accountability for application to the Canadian health care system.

Results. The review of the Canadian literature on accountability in health care disclosed a paucity of definition and description, let alone full discussion of the meaning and applications of accountability concepts and frameworks.

Key informant interviews revealed a high degree of interest in and importance attached to this issue, and disclosed a wide range of definition, meaning and dimensions of accountability.

Based on the literature and interviews, a framework for accountability in health care was developed which included the following dimensions:

- Purpose (including definitions and values)
- Governance
- Professional
- Managerial (including economic and administrative)
- Community (including public involvement and community health)

Conclusion. Despite discussions and debate of a wide range of issues from blood

safety to federal-provincial funding and cost-sharing in Canada during the last two decades of the last century, issues of accountability in health care remain unresolved. The discourse of this thesis and the establishment of a conceptual framework with a set of defined dimensions should assist in advancing our common understanding of the issues, meaning and potential application of an accountability framework to address the issues of the day in health care and beyond.

Acknowledgements:

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Paul G. Thomas, Professor, Department of Political Science, St. John's College, University of Manitoba, Winnipeg, Manitoba.

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Thesis Advisory Committee: John O'Neil, B.A.(Hons), M.A., Ph.D.; Charlyn Black M.D., Sc.D.; Brian Postl, M.D., FRCPC. Their encouragement and patience made the completion of this work possible.

TABLE OF CONTENTS

Dedication......iii

Abstract......iv

Acknowledgements......vii

CHAPTER 1: Introduction 1
- 1.1 Organization of the thesis...... 2
- 1.2 Background 3
- 1.3 Thesis Objectives 5
- 1.4 Applications of this Thesis 7

CHAPTER 2: An Introduction to the Concept of Accountability 9
- 2.1 Introduction...... 9
- 2.2 Canadian Perspectives 11
- 2.4 American Perspectives...... 15

CHAPTER 3: Research Methods 18
- 3.1 Theoretical and Conceptual Framework...... 18
- 3.2 Research Design 21
- 3.3 Data Collection 22
- 3.4 Key Informant Interviews 24
- 3.4.1 Selection Strategy 25
- 3.4.2 Interviews 27
- 3.5 Data Analysis 29
- 3.6 Ethical Considerations 30
- 3.7. Limitations of the Research...... 31

CHAPTER 4: Accountability in Public Administration 33

CHAPTER 5: Perspectives on Accountability in the Canadian Health Sector .. 44
- 5.1 Discourse on Themes of Accountability in the Literature of the Health

Care Sector in Canada 45
5.2 Provincial Accountability Frameworks 48
5.3 The Social Union Framework Agreement 53
5.4 Additional Contemporary Discourse 56
5.5 Summary 60

CHAPTER 6: Accountability in the American Health Care Sector 62
6.1 Conceptualization and Definition of Accountability in the Health Sector 63
6.2 Accountability's Impetus - The Managed Care Environment 69
6.3 Emerging Frameworks for Accountability in Health Care 72
6.4 Summary 76

CHAPTER 7: Key Informant Findings 78
7.1.0 Establishing Purpose 79
7.1.1 Rejection of the Status Quo 82
7.1.2 Conditioning Factors for Accountability in the Health Care Sector 92
7.1.3 Values Associated with Accountability 95
7.2 Governance Dimension 104
7.3 Professional Dimension 107
7.4 Managerial Dimension 114
7.5 Community Dimension 119
7.6 Summary 122

CHAPTER 8: Perspectives of Community and Advoacy Informants 125
8.1 Meaning of Accountability 125
8.2 Governance Dimension 128
8.3 Professional Dimension 131
8.4 Managerial Dimension 133
8.5 Community Dimension 136
8.6 Summary 137

CHAPTER 9: Discussion and Conclusions 140

APPENDICES: 157

BIBLIOGRAPHY 165

CHAPTER 1

Introduction

At the beginning of the new millennium, health care systems continue to change throughout Canada and the world. Many trends can be observed, from regionalisation of health administrations to better standards for appropriate care. Throughout all of these changes, many questions remain unanswered as to what is the best way to achieve health or to deliver health care services. One of the most important questions, particularly from a systemic perspective, is this: Who is accountable for health care and the system(s) in place to maintain it? This simple question raises many more questions. What is accountability? Is it a single entity or does it have several components? How is it understood by those who shape and administer our health systems? How is it applied? Would a better and more consistent understanding of accountability assist in the further renewal and reform of health care in Canada and beyond?

Though there are many questions that can be asked about accountability in the health care sector, the main question of this thesis is: what is the meaning of accountability to those in a position to influence the future of the health system as we enter the next century? To that end, this thesis undertakes:

1. To review the literature with respect to the theory and practice of accountability in health care and to search for a common theory (theories) of accountability.

2. To conduct and analyze open-ended interviews with key participants in Manitoba's health care system to assess the adequacy of current conceptualizations of accountability.

Based on the answer to the main question stated above, the thesis has undertaken the following further objective:

3. To develop a conceptual framework for accountability which might be applied to the Canadian health care system in order to develop new processes and mechanisms for accountability.

1.1 Organization of the thesis

To achieve the above three objectives, the work and presentation of this thesis is organized as follows:

- **Chapter One:** The context of this thesis and the research objectives are described;
- **Chapter Two:** Definitions of accountability are presented and literature on accountability in health care systems is reviewed;
- **Chapter Three:** The research methods of the thesis are described as are the limitations of the research;
- **Chapter Four:** A "primer" on accountability (in general) is presented as a background to the discussion of accountability in the specific context of health care;
- **Chapter Five:** A thematic review of the discourse on accountability in the Canadian health care sector is undertaken, based on Canadian literature, the Social Union Framework agreement, and contemporary Canadian discourse;
- **Chapter Six:** A thematic review of the discourse on accountability in the American literature on accountability in health care is discussed;

- **Chapter Seven:** A qualitative analysis of the meaning of accountability in health care in Canada is presented, based on key informant interviews with health care executives and professionals;

- **Chapter Eight:** A qualitative analysis of the meaning of accountability in health care in Canada is presented, from the perspective of community advocates;

- **Chapter Nine:** Based on the literature review and the key informant research, a concluding discussion on the meaning of accountability in health care in Canada is presented, including a proposed conceptual framework;

1.2 Background

Since the beginning of the 1990's, provincial governments in Canada have reformed their health care systems in response to concerns about escalating health care costs and perceived system inefficiency. These issues, together with concerns about existing organizational structures, human resource requirements, the quality of and access to care, prompted the creation of numerous provincially-mandated commissions or task forces. (Angus,1990) As a result significant changes have occurred over the last decade in the organization and structure of health care systems. Governance is a particular area where change has occurred with new provincial and regional structures shifting authority and "accountability" for the provision and outcomes of health services. Nevertheless, as the century closed, questions continued around the quality of health care, timely access and its escalating cost. Debate has advanced to fundamental questions about what the Canadian national health care system really is, what it should be and whether or not it is sustainable in its present form.

As a part of this development there has been a call for accountability in the provision of health care services. With new governance bodies pressured to use limited resources to best advantage, those responsible both for funding health care and delivering health care services have identified that there is a general need for accountability to ensure that services are developed and provided in a way that governors at all levels of the national system can be seen to pass the tests of public scrutiny.

This call for accountability is evident in the current Canadian health care environment in several ways. First there is an unprecedented public interest in government-managed health care systems brought about by many years of reform and fiscal restraint. In addition the fact that many Canadian governments are now in a position to reinvest in health care creates some pressure to "get it right", to not replicate the management or spending patterns of the past and to ensure that new investments have the desired effect on the health of Canadians. Several provinces have developed "frameworks for accountability" either as a government-wide mechanism that includes health care activity or in a few cases, frameworks specific to the health sector. These augment traditional accountability mechanisms that have been embedded in departmental legislation or in the legislation that created decentralized health authorities.

Another piece of evidence for the current preoccupation with the idea of accountability is the plethora of published and unpublished reports that are being generated to provide information about health care to the public - reports that satisfy a myriad of purposes from overall health status to procedural outcomes, waiting times, financial management

of government expenditures, institutions, provider wages. All of these interests are backed up by processes, study groups or, indeed, institutions, that make it their business to continue the production of reports.

At the national level of leadership of Canada's health care system there are two recent and important developments. The first is the emphasis that the federal Minister of Health, the Honourable Alan Rock has put on accountability. Notably his September 1998 address to the Canadian Medical Association refers to "openness and transparency" that will characterize the behaviour of health partners as they become more accountable for resources, management and results of the health care system. (Rock, 1998) He developed this theme further in a subsequent annual address to the same association indicating that "governments must be more accountable to Canadians for the use that we make of taxpayers' money". (Rock, 1999) Secondly, and of great significance to all aspects of government in Canada is the agreement of federal and provincial governments (except Quebec) to strengthen Canada's social union by "enhancing each government's transparency and accountability to its constituents"

1.3 Thesis Objectives

Notwithstanding this general interest in accountability there is little discussion about what it actually means. A common definition of accountability has not been promulgated. Neither has a conceptual framework for accountability in health care been developed that adequately describes and expands upon the full range of ideas about what accountability

is, where it needs to exist and what means can be exercised to implement it. "Performance measurement" has emerged as the main mechanism for achieving this end. In fact, a widespread expectation has developed amongst governors, health care providers and the public that report cards, at the level of a health care unit, activity or disease, will be the mechanism through which accountability in health care will be achieved. It might be asked, however, whether this approach will achieve a genuine model for accountability or whether it will simply create an illusion of accountability that serves short term ends.

Many questions can be addressed to develop our understanding of accountability as it applies to the health sector in Canada. What does the word mean when it is applied to the health care sector? To whom? What is its typical scope and is that scope sufficiently broad? Are there particular areas of health care for which accountability is more important than others? Can its elements or the values that underpin it be described, explained, or prioritized? Can one target specific accountability objectives and still satisfy a need for accountability generally? Can sub-sectoral accountabilities be added up to achieve system accountability? Are sufficient mechanisms being devised to satisfy the need in the health sector? Do they hit or miss the mark? What is the mark?

These questions are many and varied. It is not the purpose of this thesis to answer all of them here. Indeed, one may ask how important it is to answer them at all? In other words, what consensus already exists on the importance of these questions or their actual answers? As discussed briefly at the beginning of the *Introduction*, the main original

research of this thesis is the inquiry of the definition and meaning of accountability, as perceived by major participants of the health care sector. The jobs which they carry out as senior advisors, decision-makers and community advocates are typically based on the assumption of a predefined accountability and include the responsibility to define the idea for others and for the health care system. Therefore, a common conceptualization of accountability (and its practical implications in the Canadian health care system) may be identified by a careful survey and analysis of significant contributors.

1.4 Applications of this Thesis

It is intended that the results of this thesis will serve as a starting point in the endeavour to establish a common frame-of-reference for accountability in the health care system.

In a practical context, the results of the study will be useful to governors, government officials and providers who have the responsibility to communicate with the public about health care systems and who frequently do so in the context of "being accountable". The results will be useful as well to those who have the responsibility to design mechanisms through which various publics (patients, consumers, citizens, providers) can judge whether or not the system is achieving what it is charged to achieve. The study results will provide information about the idea of accountability as it applies to health care in Canada as well as information about how accountability is conceived by individuals who have leadership roles in the health care system and influence on the way that accountabilities are defined, prioritized and pursued. The research will provide a

backdrop to discussions about accountability that are inevitable in the current health care environment and may serve to provide a common understanding of the conceptual underpinnings of accountability in the real world that should be considered before accountability's scope, dimension and tools are set in stone.

On a more practical level the framework could be used as a diagnostic tool to assist in reviewing complex situations in the context of risk management for accountability. The examinations of problems against this framework could assist to identify issues of accountability's conceptualization, management and execution.

CHAPTER TWO

An Introduction to the Concept of Accountability

The principle purpose of this thesis is to explore the meaning, dimensions and importance of accountability as it applies to the health care system in Canada. The purpose of establishing the definitions of accountability is to begin that process. The literature reviewed in this chapter addresses only those sources that specifically speak to the definition and meaning of accountability and establish, largely by its absence, the need to examine this issue more fully through research.

2.1 Introduction

The Canadian Oxford Dictionary offers eight meanings for the root word "account". Four meanings are offered for "accounting for". "Accountable" is defined as "1. responsible; required to account for one's conduct. 2. explicable, understandable"(Barber, ed.,1998).

Both of these meanings of "accountability" are relevant to this work and have been applied, for the most part, in our popular understanding, to systems of government and public administration in general. The theory of accountability, that has been examined most thoroughly within the political studies discipline, is a developing theory that has important relevance in Canada where health care has been (in recent history) in the public domain. Traditional meanings and mechanisms of accountability have been applied to the health sector. The appropriateness of this application and the results which have achieved

from it are a matter for consideration.

A review of academic literature, popular titles and government documents pertaining to accountability was undertaken with emphasis on work that describes the definitions, meanings and conceptual underpinnings of accountability. A specific objective was to identify existing frameworks for understanding and applying accountability in the Canadian health care system. Literature which only addressed the practical applications or methods for establishing accountability were not included.

The formal search for related literature included the identification of key words including **accountability**, (its meaning and definition), **policy, health, health care, governance, stewardship, ethics** singly and in combination. Databases for MEDLINE, (1995-99; 11 articles) CINAHL(1982- 09/1999; 35 articles), HealthSTAR(1994-10/1999; 83 articles), and International Political Science Abstracts(1989-10/1999; 21 articles) were reviewed. Initial references to "accountability" produced in excess of 3000 references. "Accountability" in combination with "policy" and " health" produced a similar volume of references. Key words such as "meaning" and "definition" produced no references. In order to determine where definition or meaning was discussed it was necessary to review the above-noted articles and texts and to search for unreferenced discussion about meaning and definition and to exclude references when the discussion was disease or problem specific.

An immediate observation in carrying out the search was the lack of definition and

specificity applied to the use of the word "accountability" and the paucity of literature that attempted comprehensive consideration of accountability, its definition, scope and meaning. Literature that used the idea of accountability to generate a rationale for the development and implementation of other systems was more common, but this was eliminated for the most part, because of its failure to address the concept of accountability as a foundation piece.

2.2 Canadian Perspectives

There is little Canadian literature about accountability and its overall meaning or application in the health sector. Accountability is mentioned frequently, but usually in a such a way as to imply that its place, meaning and importance are obvious to the audience and requires no contextual or purposeful explanation.

Jonathon Lomas, for example, refers to accountability associated with devolving authority for health care in the provinces (1997, 819). He limits notions of accountability to the political sub-dimension - to the electorates who will ultimately decide the course of events by choosing or rejecting a government at the provincial level. He does not examine the nature of the accountability but rather assumes the traditional definition of accountability as one of the givens of governance. Robert Evans, too, skirts the issue of what accountability consists of in the Canadian health care system. Despite a promising title, his published address to a North American forum "Systems of Accountability: The Canadian Approach" refers mainly to the physician's critical role in controlling cost and

quality of care (1995).

It might be useful to note that in the history of reform of the health care system in Canada the idea of accountability has received little attention until very recently. In the aforementioned review in the early 1980's of Health Care Commissions and Task Forces in Canada, only a brief reference was made to accountability. Angus's summary identifies a theme of accountability "for achieving predetermined results from allocated resources" (1990: 3) but elaborates no further.

L.C. Carrothers et al in Regionalization and Health Care Policy in Canada:A National Survey and Manitoba Case Study observe that the literature about regionalization has failed to note "how policy change has altered or threatens to alter the allocation of accountability and responsibility"(1991, 6). Unlike other scholars the authors identify clearly the importance of the idea of accountability. They further observe that common research questions in other policy fields characterized by decentralization include "Who is accountable? To whom? For what? By what mechanisms? And with what consequences?"(1991, 6) issues that remain unexplored in the health sector.

In Quality of Care: Issues and Challenges in the 90' s, Marylou Harrigan makes general reference to a new era of assessment and accountability emerging in health care. She notes that the public trust has been replaced by a demand for public accountability (1994, 6). This is a perceptive observation about health care and accountability that is not developed further in the course of her work.

The authors of a report on health care reform commissioned by the Canadian College of Health Services Executives, External Environmental Analysis and Health Reform Update: Special Report, scarcely mention accountability in what is otherwise a fairly broad external environmental analysis. The only reference to accountability predicts that it will be "greater....politically and financially" for (institutional) board members (1994: 5).

In 1995 the Ontario Premier's Council published a report, "Challenging Assumptions: Restructuring Health Systems Across Canada" that addressed representation and accountability in the context of appointed and/or elected boards. The reports raised questions about the degree of accountability that boards in their various forms exercise in comparison to governments, and observed that "There is a question whether we'll create an effective interaction or a system of structured civil war."(1995:17)

In more recently published assessments of Canada's health care system in the 1990s, the focus has been on its particular strengths and weaknesses, but the meaning and scope of accountability continues to be taken for granted. In Canada's Health Care System, Crichton et al draw attention to the potential of regionalization to improve rationalization of services by increasing accountability (1994), but neither defines the concept, nor addresses it as an issue unto itself. The review's analysis of future trends and issues does not refer to accountability as a general issue.

Similarly, authors Michael Rachlis and Carol Kushner in Strong Medicine: How to Save Canada's Health Care System (1994) do not identify accountability as a central issue. The authors hold Canadian governments responsible for the successes and failures of Medicare and the nation's health system in general. In this way accountability is implicitly suggested; its nature not explicitly defined. Accountability here is loosely linked to citizen participation and identified as an important aspect of financial management for provincial Ministers of Health.

A deliberate attempt to address accountability is contained in Lisa Priest's Operating in the Dark: The Accountability Crisis in Canada's Health Care System (1998). The author does not employ either definition or dimensions of accountability in the health care system as an aid to her critique. She asserts that there is little accountability and supports this, using anecdotal evidence. The idea of accountability, itself, remains unaddressed. Some aspects of patient care, notably physician competence and hospital performance, are the main subjects of anecdotal evidence that seek to demonstrate that accountability is limited. In support of her thesis she calls upon the Honourable Monique Begin, former federal Minister of Health and Welfare, who claims "I think that we have very little accountability. So little that, right now, the only channel of accountability would be a major, major health care crisis." (1998: 20)

A notable exception in the literature is the work of Carolyn Tuohy, who has addressed accountability specifically. She has pointed out that, despite the tumult of the 1990's, "no major policy change occurred" (1999: 114). She discusses this absence of decision-

making in the context of two dimensions: first, balance of influences and second, mechanisms of social control. These are then linked to accountability and information requirements. This analysis considers the driving forces and incentives historically associated with accountability in Canada and contributes a framework of players and powers that are relevant to a discussion about accountability. Still no definition of accountability is offered and no discussion of its meaning attempted.

2.3 American Perspectives

Despite the general reluctance of Canadians to be influenced by their American models of health care, there exists considerable American research on accountability in the health care sector. While some of these data may seem to have little direct applicability to Canada, America's geographical and cultural proximity is sufficient to warrant a review of American conceptualizations of accountability.

Mark Peterson, in his article "Managed Care: Ethics, Trust and Accountability," proposes that preoccupation with accountability is a response to the fact that "managed care has become the organizational framework of the new U.S. health care system" and has prompted "concerted action by policy makers at all levels of government to seeking to mitigate the resulting fears of patients qua consumers qua citizens." (1998: 611) The federal *Health Insurance Portability and Accountability Act* (1996), adopted specifically to assert federal authority to regulate health insurance in the United States associates accountability specifically with the idea of competition and in this respect supports

Peterson's view.

Not only does the word "accountability" seem to have been easily incorporated into discussion in the American health care sector, it garners a considerable amount of entrepreneurial enthusiasm. Gary Horsfall, in his article "Accountability: The Force behind Empowerment," considers it the "force behind empowerment...the underlying buck-stopping, driving force behind any and all successful programs, initiatives and companies." (1996:1)

In the American health care literature the issue of accountability has frequently been applied to isolated dimensions. These include provider accountability, especially physician accountability (Greenspan, 1980; Hanchak, 1996; Emanuel, 1996); leadership and organization (Porter-O'Grady and Wilson, 1995); procedures and tools (MacNeil, 1993); communication with the public (Ribnick, 1997); quality care (Hanchak, 1996) and assessment (McGlynn, 1997); and medical ethics (Emanuel, 1996). These serve only as examples of the work undertaken on each of what might be considered a single dimension of accountability in a larger health care system framework. That each one and others could be expanded into a framework of its own, indicates the breadth of the issues and points to the need for defining the fundamental concept of accountability, illuminating its dimensions and establishing their relative importance.

More general frameworks have been proposed in the American health system sector and while they tend to focus on a single dimensions as well, several of these may be broad

enough to have relevance to the Canadian health care "system."

The Canadian healthcare community has yet to ascribe meanings to the idea of accountability. The Canadian academic literature reflects this gap and popular discourse has failed to address this vital area of meaning as well. The American literature, does better, but still the focus has been largely on addressing the sub-sectoral challenges of accountability to serve the interests of particular groups and disciplines.

CHAPTER 3

Research Methods

3.1 Theoretical and Conceptual Framework

In the absence of meaning attributed to the idea of accountability in Canadian literature, this research builds on three assumptions about the development of the meaning and dimensions of accountability in the Canadian health care sector. These are discussed below.

The first assumption is that the generation of meaning and the definition of the dimensions of accountability in Canada is a uniquely Canadian phenomenon, inextricable from the Canadian values-system and reflective of Canada's health care history. The understanding of what accountability means in this context not only reflects the history of the Canadian health care experience, but also influences its future. Work undertaken by Canada's National Health Forum, for example, reflects this assumption. (Graves, 1998)

Secondly, the current idea and application of accountability is at least in part a function of its definition and meaning to date for Canadian governments, experts, and interest groups. This reality may be observed in the views of health care leaders, government reports, proceedings of conferences on this subject. It is also evident in the efforts of governments and agencies which have sought to meet public demand for accountability

before that need is carefully defined or understood.

The third assumption is that the discussion about dimensions of accountability for the health care sector are led largely by participants and leaders of the health care sector. This is similar to the way in which the public leaves management and decision-making to the leaders in the health care sector or the way the patient has traditionally left judgements pertaining to medical intervention to health professionals (Lomas, 1994, 820) and the way in which the views of public servants affect the conceptualization of accountabilities in the public sector. (Thomas, 1997:349)

The examined literature has suggested that environmental context and societal values are expressed whenever the issue of accountability is discussed and debated. In Canada this environmental context characterized by publicly administered health care, is unique and the values applied to the popular idea of Canada's health care system well known. The views of the study's participants about accountability might be seen to reflect a range of interests, including those associated with market/managerial goals to the basic social good associated with Canada's favourite social program. (Graves, 1998: 352) This research explores that continuum and determines its importance in defining the dimensions of accountability in the health care sector.

Figure 1 illustrates the assumptions that form the conceptual model for this research.

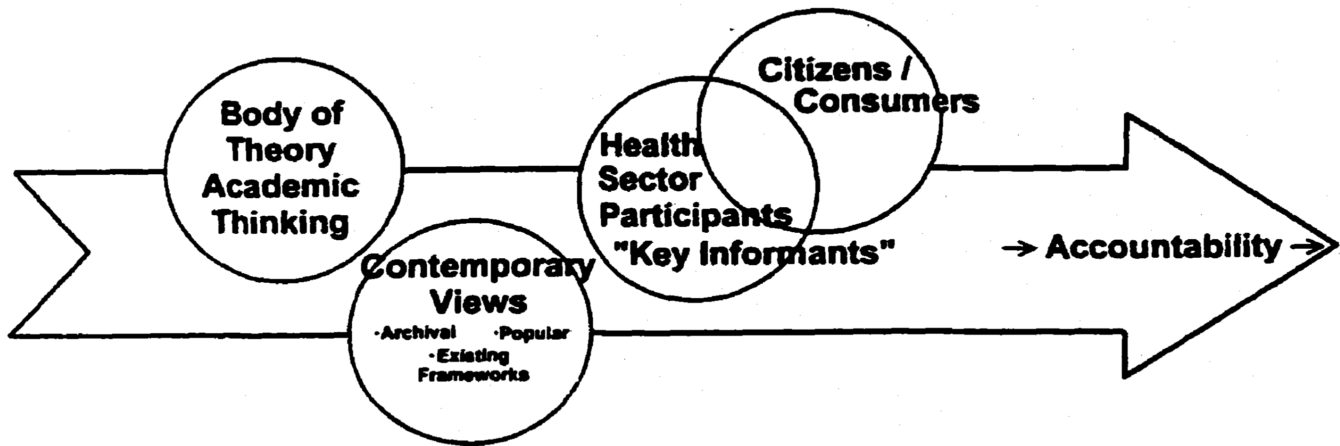


Figure 1:

Theoretical Construct
Development of the Meaning of Accountability

3.2 Research Design

This thesis has used a qualitative research design to explore the definitions, meanings and dimensions of accountability in health care in Canada. This method is best suited to this particular research, which has as its objective the high-level understanding of what meanings and importance are placed on accountability and the arenas in which these ideas are most pertinent. The relationship between values and definitions associated with accountability were explored in such a way as to allow the definition and meaning of the concept to determine the nature of the discussion around dimensions, structures or processes.

C. Marshall and G. Rossman indicate that qualitative methods are appropriate in research in which questions and issues delve into complex processes and where relevant variables have yet to be identified. (1989: 46) In this research, knowledge and opinion, both from the literature and from contemporary comment and publications are examined as contributors to the development of ideas about accountability. The perspectives of participants in the health care system are explored to represent the range of views and expectations that health care providers, managers and policy makers may have. Topics pertaining to accountability include its purpose, importance, dimensions and relative priority.

3.3 Data Collection

The literature was reviewed with several purposes in mind. One was to identify the presence and absence of a critical consideration of accountability per se. In addition, this literature was examined to identify themes and values implicit or explicit in scholarly discussions of accountability. Throughout the review of literature specific attention was directed toward the identification of statements revealing presumed definition and meaning. Similarly, reference to frameworks for understanding, sorting or amplifying issues of accountability (in general and in specific reference to the health sector) were noted and mined for meaning and /or definition.

In the first phase of the research, themes and sub-themes from these frameworks were noted, recorded, sorted and sifted for comparability and grouped where possible to organize them into tools for further examination and exploration with key informants.

A similar process was undertaken with respect to contemporary documentation of accountability and related issues in the current Canadian health care environment. The process of data collection in this area is essentially exploratory with review of materials leading to the discovery of other relevant sources. For the purposes of quantity limitation, the following criteria were applied:

- Materials reviewed are those of public domain. No attention was paid to obscure or restricted access documentation of activity or opinion. No covert investigations

were undertaken. The purpose of reviewing and understanding the content of contemporary literature in this area was to understand its place in the conceptualization of accountability in the health sector and its influence on those active in its practical implementation. While no member of the general public might be consciously aware, its availability in the public domain maximizes the potential (if not the probability) of key informants having been influenced by or being familiar with the kind of thinking represented by the materials, such as those available at conferences, discussions, speeches and other public service forums in the past.

- With respect to government documents, the most weight was given to legislation promulgated or official documents developed and released publicly to address issues of accountability. The main documents reviewed, therefore, were the Framework to Improve the Social Union for Canadians and frameworks for accountability that have been put in place by provincial governments. Provincial initiatives were reviewed regardless of whether they were directed specifically at the health sector or all toward government programs, including health programs. Analysis was comparative to a degree but also sought to identify values, motives and explicit purposes for these frameworks.

Data analysis was undertaken to organize the prevailing ideas, definitions, meanings and values associated with accountability in Canada into a useable, logical frame. Content analysis, "a technique for making inferences by objectively and systematically identifying

specified characteristics of messages" (Marshall & Rossman, 1989:46) was used to identify variables associated with the ideas and practices of accountability. The result was taken as a description of the current thinking on the subject, the development of a working model for an accountability framework

3.4 Key Informant Interviews

Participants in the health care sector in Manitoba were chosen as the unit of study because the Manitoba health system approximates others in Canada and because of its accessibility to the researcher. The Province of Manitoba publicly-funded health care system has participated, like other provinces, in federal/provincial discussions that resulted in the Social Union Framework Agreement and other federal/provincial processes that have witnessed reforms, funding cuts and the development of management strategies directed toward problem-solving within the sector. Additionally, representatives of various sub-sectors have participated and are knowledgeable - even influential - in discussions regarding health sector management at the national level.

In addition, Manitoba lends itself to the research at hand because of its experience with the regionalization of health care (and thus issues of governance in the political model of accountability) and because the provincial Department of Health has promulgated a Framework for Accountability specifically oriented to the health care sector.

It is also noteworthy that over the past several years the health care community has been

engaged both in observing and participating in the process of the Inquiry into Paediatric Cardiac Surgery Mortality. This inquiry came as a result of questionable mortality rates at a tertiary care centre in Winnipeg, Manitoba. The broad nature of the inquiry itself and a considerable amount of media attention have put general issues of health care accountability prominently into the minds of the study's prospective participants.

3.4.1 Selection Strategy

The sampling strategy was "purposeful" rather than random, and permitted the identification of informants that could be helpful to the research, those who were in the best position to contribute knowledge and understanding.

Key informants included management level staff of regional health authorities, representatives of professional organizations, academics, government officials and advisors, appointed board members and representatives of community organizations. Fourteen key informants were interviewed individually.

Another thirteen key informants participated in two separate focus groups, organized specifically for the purpose of discussing this topic. The participatory and consensual decision-making methods of these two community advocacy groups made the use of focus groups desirable from their point of view. From the point of view of the researcher it presented an opportunity to have a discussion with varied participants in the health care sector.

Although these two sets of key informants (one group of thirteen; one group of thirteen) represent different perspectives, they can be considered uniformly elite for the purpose of this research. There was no need or expectation that informants would respond at a technical level to the issue of accountability. The interest of this research focused on the concept and meaning of accountability.

The key informants were called upon not because they are representative of their profession or role but because their position and experience in the health care sector would provide a perspective on the national or provincial health care "system" useful to this discussion. Each, by virtue of his/her current or past experience in the health care sector, would have had occasion to consider issues of accountability in one forum or another, or in one way or another.

Key informants were not asked to speak from the point of view of their employer. It was made clear to each informant that while their perspective on accountability might have resulted from the context of a particular role or jurisdiction and be relevant to the discussion on its own merit, other aspects of experience and knowledge about accountability in the health care system would be equally relevant. In-depth interviews were not "investigative reporting" about the views of a particular jurisdiction or agency.

Key informants were assured of confidentiality and that no attribution of individual comments would be made in the publication of this research. This commitment was made not because there was a need to conceal an agency's position so much as because it was

not considered necessary or helpful to an understanding of the role that accountability plays or could play in the health sector.

3.4.2 Key Informant Interviews

Preliminary interviews were arranged approximately three weeks prior to the interviews being undertaken. In most cases, there was an opportunity at the time that the interview was arranged to discuss very briefly the purpose of the research and the process of the interview. All participants received by electronic mail or fax a copy of the information sheet and participant consent (Appendix A) immediately following this first contact. Key informants were invited to contact the researcher if they had questions or concerns prior to the interview.

Given the privileged communications and discussions in which these key informants participated, the in-depth interview method was chosen to permit the accountability issue to "unfold as the participant viewed it".(Marshall and Rossman, 1982: 82) All interviews were conducted in person with the exception of one that was arranged as a telephone conference as the respondent was located elsewhere. All personal interviews began with a brief introduction by the researcher to provide background and purpose of the research and to review the researcher/informant expectations regarding confidentiality. Consistent with the information sheet and consent, key informants were advised that no direct attribution of comments was to be made in the research report and that, were it necessary, the responses of key informants would be blended to ensure that

comments deemed sensitive could not be attributed to a specific individual. Key informants were requested to alert the researcher to any particular concern throughout the interview. Permission to include names in an appended list of respondents was requested.

To facilitate the frank responses of informants, interviews were conducted using first an open-ended process that sought non-prompted replies about the subject, its definition and the respondent's intuitive understanding of the subject. If this did not lead spontaneously to a free flowing discussion, the researcher directed the conversation with questions, devised out of the review of literature (Appendix B). Questions were developed specifically to generate discussions around particular understandings of accountability, areas of experience with accountability, dimensions of accountability and their prioritization. Such catalysts were limited and provided only as necessary. In the main the purpose of the in-depth interview was not to elicit answers to specific questions or to critique prevailing definitions or models of accountability but rather to acquire "top of mind" associations with the ideas of accountability - to determine what importance was given to the idea of accountability and its application in the health care system. Interviews were scheduled for approximately one hour, and were usually in the course of the business day.

Where time permitted, the discussion extended beyond the regularly-scheduled hour and in those cases the conversation lasted as long as two hours.

These key informant guide framed both the discussions with key informants and framed

the analysis as well. It must be noted that while these ideas entered the questioning, the questions were not necessarily posed directly or uniformly across all key informants. Each key informant interview started simply as conversation about accountability in the health care sector, prompted only by the research information sheet and consent form that was made available in advance and reviewed at the onset of each interview. The purpose of so proceeding was to maximize the possibility that the discussion would elicit the ideas of the informant - that the conversation would reveal the aspects of accountability deemed important or significant by the informant rather than by the researcher.

Interviews were recorded and transcribed within two or three days of the interviews. In two cases, detailed notes were taken by the researcher throughout the interviews, and transcribed immediately following each interview.

3.5 Data Analysis

Transcribed interviews were reviewed thoroughly. Key messages, themes and patterns were identified. Content analysis and constant comparison methods were used to organize and group themes. Absolute frequency measures of words and themes were useful but not definitive indicators of important content. As Marshall and Rossman have noted of qualitative research, data collection and analysis go hand in hand. "The researcher is guided by initial concepts and guiding hypotheses, but shifts or discards them as data are collected and analyzed."(1989: 133) In this case, emphasis was placed on the description of the many ideas associated with accountability rather than the synthesis or

homogenization of them.

Analysis of archival materials relied on content methods including frequency measures but with an emphasis on identifying priority themes and dimensions. These were categorized and sub-themes attributed to them. It was necessary to be thorough at the level of purpose and intent and ideology as well as to identify broad dimensions of accountability in health care, rather than to catalogue issues or mechanisms at the activity level. Similar methods were applied to contemporary materials such as existing accountability frameworks or policy statements of governments. A guide was developed and is attached as Appendix C.

3.6 Ethical Considerations

Because of the researcher's employment in a related policy field for the federal government, a potential for confusion existed regarding the researcher's role for key and informants whose participation was crucial to this research. Care was taken in introductory letters and explanations of the research project so that there was no false perception that the research is being undertaken because of the interest or sponsorship of the federal Department of Health.

Though the researcher's association with the federal government may have facilitated entry, it may also have increased concern regarding the confidentiality of information. It was important to offer and guarantee confidentiality for informants. All those

participating in the research were offered the same assurances that informed consent would be required for any disclosure to occur, that interviews would remain confidential and anonymous, and that documentation of individual comments would be destroyed once the research was complete. Participants were also made aware of their ability to withdraw from an interview or focus group at any time.

Approval of the research proposal and methodology was sought from the University's Health Research Ethics Board, Bannatyne Campus and was granted. (Protocol reference number: H2000:015)

3.7 Limitations of the Research

Several issues of methodological limitation have potential to affect the outcomes of this study and are declared here for the reader to take into consideration.

The purpose of the research was in large part formative and although that precludes the need to identify a sample large enough to provide generalizability, additional key informants, time permitting, would have added to confidence that the views expressed could be more widely held by a larger community of executives and health care leaders.

Informants were prompted at the outset of interviews if they had difficulty in responding to the issues at hand. An interview guide that anticipated this more carefully would have been helpful. In addition, time permitting, it would have been helpful to pursue in a more

structured way the identification of dimensions of accountability in the health care system which would have permitted informants to identify dimensions directly. The nature of the key informant interviews was such that the dimensions were inferred from informant-interviewer dialogue and developed as a part of data analysis. Validation by returning to key informants was not undertaken.

It should be noted as well that the key informants all participate in Manitoba's health care system and in this respect largely share the same contextual backdrop, including the scope of the health care system, the day to day knowledge of health care events, crises, media coverage and the like. Their exposure to such accountability issues as the inquiry into the deaths within the provincial Paediatric Cardiac Surgery Program would be similar if not necessarily even. As such similar research undertaken in another geographical or jurisdictional setting may produce different results, different perceptions of accountability in health care systems and different understandings of the priority of various dimensions. Additional qualitative research to validate or augment these findings would be desirable.

CHAPTER 4

Accountability in Public Administration

> **Despite 20 years of intellectual foment by academics, most practitioners still adhere to a model of public administration shaped in a world that no longer exists.**
>
> **Henry D. Kass in *Responsibility as Paradox: A Critique of Rationale Discourse on Government*, 1995.**

In preparation to the discussion of the literature on accountability in the health care sector which follows in Chapters Five and Six, this chapter will address the meaning and use of the word accountability in public administration. This "primer" is based largely on the work of Paul G. Thomas, Professor, Department of Political Science, St. John's College, University of Manitoba, Winnipeg, Manitoba, whose work on the subject of accountability has contributed to many fora for governmental and private sector discussion of how governments work, the New Public Management and more recently accountability as an aspect of the health care system. His contribution to the 1998 book Taking Stock: Assessing Public Sector Reforms is "The Changing Nature of Accountability," a chapter which charts significant developments in the way that accountability has and continues to be played out in Canada.

This primer will serve to represent not so much the traditional constructs of accountability, though some are implied, as the theoretical and cultural backdrop shared by Canadians
and Canadian public administrators. In the absence of a "health sector-friendly" definition of accountability, the theory and the practical social experience of accountability will prevail in the Canadian consciousness to produce an expectation, appropriate or not, of what accountability is or should be.

In addition, the ideas of accountability that often appear as objective and credible, are likely only so as a result of their common and intuitive association with financial accounting language. Accountability, however, is not an exact science or process and may be only as powerful as the extent to which it draws instinctive, not rational expectations.

Practical applications of accountability change in accordance with societal changes and developments in the operation of both governmental and non-governmental institutions. The result is that accountability is a moving target, both form*ed by* and form*ing* popular perceptions. This inevitably extends to accountability in the health sector in Canada, a sector is which change is far from complete.

The theory of accountability is most often described in the context of governments and their players: politicians, agencies and public servants. "Accountability is at the heart of governance within democratic societies." (Thomas, 1998: 348) Within Canada this broad

context for accountability has direct and important relevance to the health care system which has since the early 60's developed increasingly into a comprehensive program of publicly-insured health care services.

As a result, Ministers of the Crown bear the greatest and certainly the most visible burden of accountability for health service. Within the Canadian constitutional model, Ministers assume both individual and collective accountability for their program policies as well as the operation of their health departments, ministries, legislated agencies and institutions.

The ultimate purpose of the constitution is to protect and promote the rule of law and the fundamental expectation that no individual, leader or government is above that law. Canada's constitution establishes legitimate forms of power and governance and defines the relationship of the governments to one another, the relationship of individuals to their governments and the relationships "that ought to exist among the different institutions of government." (Thomas,1998: 357)

In the "orthodox" form of this accountability, a Minister of the Crown is called upon to resign from the Cabinet "as a result of major policy blunders or serious administrative errors." (1998: 359) In more recent times, however, the impracticality of this expectation of absolute ministerial responsibility has lead, instead, to a general expectation of answerability. "The real sanction behind individual ministerial responsibility has become the loss of political reputation, not loss of office." (1998: 359) Notwithstanding this new reality Thomas contends that "the convention of ministerial responsibility still serves to

promote political accountability, albeit in a somewhat diminished version"(1998:360).

Thomas points out that, in the view of the public, accountability is still associated with "walking the plank" (1998: 386) either for a Minister or an individual operating in an accountability- relationship. He maintains that the Krever Commission demonstrated that people in general do not accept "system fault". Instead, individuals seek a scapegoat, a tangible indication that justice has been served. This sentiment is encouraged by the existing political system and is amplified by the media. Thomas sees a need for more constructive definition of accountability, based not on the objective to blame but one in which decision-making and responsibility is shared, particularly when action is required in uncertain situations.

When the public looks to government for accountability and sees increasingly that Ministers will not "walk the plank", they may conclude that accountability is absent. Beside the decreasing visibility of ministerial accountability, Thomas notes the increasing visibility of senior public servants in accountability fora (Parliamentary Committees and public consultations would be examples of these) that were once the exclusive bastion of Ministers. These new practices are contradictory to our ideas of Ministerial accountability to Parliament and to our ideas of public service tradition, which stresses anonymity, neutrality and relative permanence. (1998: 360)

In addition to preventing the abuse of power, accountability mechanisms generally serve additional purposes: enhancing responsiveness, improving administrative efficiency and

increasing the transparency of decision-making. (1998: 348)

Despite both its importance and its longevity in democratic systems, accountability remains a subject of confusion and controversy. (1998: 348) Currently at work are multiple perceptions of what accountability is, different criteria applied in different settings, different methods and approaches to holding people accountable.[1] There is, further, a difference between personal value systems (individual sense of moral conscience) and the formal idea of accountability as it plays out in government. Accountability is a dynamic process. Far from an easily-identified concept, it is ephemeral and in a perpetual state of development.

Thomas indicates that accountability is usually viewed as a retrospective process, the accounting that takes place after the fact - the constraint.. At the same time accountability used as a tool prospectively has a protective effect - the opportunity. It demands judgements of expectations and outcomes. Together these points of view, which imply accountability for both action and inaction (1998: 354) contribute to a subjective sense of responsibility for the players in the (any) system (1998: 353)

The idea of accountability is often used interchangeably with the idea of responsibility. In a review of the idea and practice of accountability in the public sector, Thomas considers the multi-faceted meanings of accountability and notes that a universally- accepted definition has yet to emerge. He refers to Michael A. Harmon's analysis that accountability is really one of three components of responsibility. Harmon himself sets it

out this way:

> The first such meaning is responsibility as "agency", in which it is presumed that an actor(s) is given a goal and the power to cause events to happen and is guided by a sense of obligation. According to this definition, there are both an objective and descriptive aspect to responsibility and a subjective aspect. The second meaning of responsibility involves "accountability", which consists of an authoritative relationship in which an agent is answerable for performance and is subject to sanctions for failure to meet defined criteria. The third distinct meaning refers to "moral obligation" which can exist separately from an authoritative relationship....We might conclude that responsibility entails the authority, power and freedom to act, as well as the ability to distinguish right from wrong in reaching a judgement. (Harmon1995: 352)

Table 1 illustrates Harmon's analysis.

Table 1

SITUATING ACCOUNTABILITY

HARMON'S ANALYSIS (1995)

RESPONSIBILITY		
AGENCY	**ACCOUNTABILITY**	**OBLIGATION**
"Authors of their actions" (Sartre, 1956)	Answering to higher, usually institutional authority for actions.	Moral action corresponds to principles external to the agent.

(Michael Harmon, 1995)

Accountability then, in a purist definition, is not the responsibility to *act*, but rather to *answer*. And accountability, once again in this purist definition, is from and to the agent or body that assigned the task. Accountability is limited to the obligation to explain and to justify how responsibility has been discharged. Only in a broader framework of social justice is accountability appropriately associated with the more subjective notions of value and ethics. While the sphere of value and ethics can complement that of accountability, the two spheres, when confused, can diverge from the formal processes of accountability and appear to supplant the need for consideration and definition of ethical issues on their own merit. (Thomas,1998: 7)

Thomas identifies four features of an accountability relationship:

- the assignment of responsibilities, ideally based upon agreed-upon goals or purposes;
- an obligation to answer for the discharge of those responsibilities
- surveillance of performance to ensure compliance with direction
- possible sanctions for non-performance and rewards for successful performance (1998: 352)

In addition (and this seems significant both as a conditioning element and for future reference as the health care sector is more specifically addressed) Kenneth Kernaghan in Canadian Journal of Public Policy, 1990, suggests that the authority and resources necessary to the assigned task must be available. This is by itself a complicating factor.

Thomas defines five dimensions of accountability that dominate public administration (1998: 356). These are displayed in **Table 2.**

Table 2

THEORETICAL DIMENSIONS OF ACCOUNTABILITY

DIMENSION	PERTAINING TO
Political	• elections, platforms, commitments • role of minister vis-à-vis cabinet • responsiveness to stakeholders
Constitutional	• role of minister as individual and in the context of cabinet • taxing and spending
Legal	• legislation and regulation • financial authorities and budget approval • departmental mandates • contractual requirements
Administrative	• hierarchical relationships • exercising financial authorities and reporting • administrative procedure • information production and analysis
Professional	• professional norms and behaviours • self-regulation (peer review) • deference to expertise

(Adapted from Thomas 1998)

This set of dimensions of accountability addresses at least the traditional forms of accountability in the constitutional and governance setting of the existing health care system in Canada. It is necessary to add to this understanding of the dimensions of accountability, the influences that are anticipated as governments alter their ways of doing business.

Accountability is changing. The New Public Management that is described by Thomas (1998: 349) will affect the governance and management of health care systems. As governments are transformed, so too is the common conception of accountability.

Thomas describes the main ideas which characterize the core of New Public Management:

> ... a policy/operations split; the use of the market and the private sector through privatization, contracting out, partnership, and market testing; the granting of managerial flexibility and the insistence upon performance-oriented measures; the adoption of the customer services approach to the design and delivery of public services. (1998: 370)

Together with this general public management transformation, government processes are becoming increasingly decentralized affecting both public perception of governance and the relationships between governmental institutions and public/private organizations. Related to this phenomenon is the expanded role of public servants (particularly those at senior levels) and the roles of the chief executive officers (newly created quasi-public/quasi private roles in decentralized agencies and authorities). These become more visible and more audible as decentralization progresses.

In the New Public Management governments increasingly share functions with the private sector. Partnership arrangements affect the way governments are able to exercise accountability and hold their partners to similar standards of responsibility and transparency. Increasingly, government is expected to show results based on published performance-measures and customer satisfaction standards.

Despite reforms to accountability systems and mechanisms, accountability itself remains a public concern. (Thomas, 1998: 386) Thomas sums up accountability in public administration this way:

> There are currently many faces of accountability. Accountability will remain an elusive phenomenon because it consists of the interaction of numerous formal and informal process, plus a vital underlying moral sense of responsibility.(1998: 387)

These trends in the practice of government are impacting health care throughout Canada during the 1990's. Whatever accountability was or was understood to be in the "old" public management is quickly changing, and changing for the health system too.

Examination of Canadian and American discourse on accountability in health care in Chapters Five and Six will add to the understanding of accountability as it applies to the health care sector in Canada and will assist in the process of creating and describing a framework for future use.

CHAPTER 5

Perspectives on Accountability

in the Canadian Health Sector

Though the published health care literature is generally limited on this subject, it does contain, almost inadvertently, some discussion of conceptualizations of accountability and its dimensions in the health care sector. Other sources of information, particularly provincial legislation, federal provincial agreements and one significant conference add to an understanding of where the Canadian health care sector is vis a vis the idea of accountability. This chapter considers this discourse and offers an analysis of its themes and their significance.

Four sources of discourse are considered: First, Canadian published literature within the health sector; second, provincial accountability frames for the health sector or government-wide initiatives; third, the Social Union Framework Agreement (which speaks in general to issues of accountability and applies to social matters of federal/provincial agreement) and lastly, additional discourse that includes reports of a conference devoted to accountability in the Canadian health sector. These are considered because of their clear relevance to the topic and their prominence as sentinel indicators that show where the process of accountability is going in Canada.

5.1 Discourse on Themes of Accountability in the Literature of the Health Care Sector in Canada

Canadian health care literature does not make use of a singular definition of accountability. As yet, the Canadian governments and the community of health institutions or professions have adopted no clear definition of the word.

At the same time, however, it is apparent from a review of the literature that the absence of a definition of accountability or a coherent understanding of its meaning, does not minimize its use. "Accountability" is indeed an important reference point for discussion of the health care system. The word "accountability" is frequently used - its use without definition serves to emphasize its importance. It is an idea that is employed as a weighty justification for any number of issues and lends itself to a variety of attributions, conveniently placed to support an array of ideas or propositions. Many issues, proposals and intentions can be and are associated with accountability.

If the theory of accountability and its practical functions within the Canadian health care sector are to be understood (and implicitly, its meaning, scope and significance), then the processes and tools by which it is implemented must be assessed with regards to objectives and outcomes and within a larger context. Main themes referred to in this respect include political accountability, with particular attention to governance structures, financial accountability and community/citizen involvement.

In the period of reform of the 1990's, the most prevalent association with accountability in the Canadian health care literature was the dimension of political accountability. Here, the preoccupation has been largely related to governance structures. This preoccupation has not been with the governance of Minsters of Health and their programs and policies so much as it has been with the implications of the newly decentralized, regional health authorities that emerged in most provinces.

As a part of the health care devolution literature in the 1990's, Lomas (1997) discusses accountability as a function of the new models of governance and describes the relationship between community empowerment, representation and accountability. Lomas concludes that citizen or community representation or empowerment are less important than the simple identification of this political dimension of accountability.

In a mid-decade review of the restructuring of Canada's provincial health systems, the Ontario Premier's Council identifies citizen representation as a significant governance issue. In the ensuing discussion issues of elected versus appointed boards are considered as is the role of a governor (either elected or appointed) to represent the whole community as opposed to any special interest or interest group. The boundaries of this accountability are also an issue:

> Are these new regional or community boards accountable, to a greater or lesser degree, to the government that provides their funding and sets provincial standards? Or, are they accountable to the community for whom they manage services and allocate funds? (1995: 17)

At about the same time a special report of the Canadian College of Health Services

Executives made only one reference to accountability with respect to board governance, stating that board members are faced "with greater accountability, both politically and financially." (1994: 5)

The financial dimension of accountability has of course remained an issue throughout the transition from the unreformed to the reformed health care system. Given the opportunity to talk about the Canadian approach to systems of accountability at the 1994 Anglo-American Conference, Canadian economist Robert G. Evans said:

> At a general level accountability is fairly simple. You ask the question "What did you do with money?" And the response is: "What business is it of yours?" "I took the money and I used it properly" or "Next question"!" That is no longer an adequate response in any of our health systems, but it has been an adequate response for most of the history of these systems until they went public, and during most of the period during which they have been public. (1995: 20)

Evans' analysis of accountability was set in the context of the health care system as a whole. His comments were really about of cost and volume measures in response to the current issue of the day, cost escalation. He notes that prior to the 1990's the only accountability rested with the general practitioner: "gatekeeper...accountable for the care of his/her patients." (1995: 20) He refers to this capacity as a driver of utilization and to the need to convince the public of the need for change; he does not however offer any definition of accountability or propose ways that this situation can be resolved, even in its narrowest form.

This debate/discussion took place in the mid-nineties and reflects for the Anglo nations the absence of a way about talking about accountability. The existing theory of

accountability was not brought to bear on this discussion, despite the identification of some interesting themes. The prevailing concerns of the Anglo-American meeting were summed up by Michael Decter, a prominent Canadian and health policy expert/participant:

> I am able to identify five areas where all three countries are wrestling with the same accountability issues: (1) We are all trying to find a way of making what we do in health accountable to a broader health status, or health gain. (2) We are shifting accountability from counting inputs to measuring outcomes, and investing in various types of clinical epidemiology and outcome research. (3) This is a bruising time for physicians in all three countries and there is more scepticism from payers and the public about "leave it to the profession." We are all trying to make research accountable to health goals and, without throwing out the baby with the bath water, in pursuing research. Finally all systems are taking into account value for money whether we call it an internal market or managed care. There is a tension between that quest for value for money and the issues of clinical judgement in each of the three countries.(Evans,1995: 20)

Within the decade's atmosphere of reform, issues of finance received proportionately more attention than issues of governance or professional competence and were addressed by many fora for various reasons. These discussions, however, are few and are limited to issues associated with accountability - a surprisingly narrow (and shallow) treatment of a concept that has had prominence in other sectors.

5.2 Provincial Accountability Frameworks

An assumption inherent in this research is that the views of key informants would be affected by contemporary discourse and the knowledge that they would acquire about accountability and its meaning by virtue of their day to day exposure to the health care

endeavour. It is for this reason that consideration is given here to the efforts of provincial governments to put in place accountability mechanisms specific to the health sector. Mechanisms at the provincial level are reviewed generally, as sources of influence on key informants knowledge and understanding of accountability.

First it should be noted that Provincial Governments are responsible for a multiplicity of activities that have a bearing on the idea of accountability. Even in application to the health care system that each province has the responsibility of managing, the traditional mechanisms for accountability exist and apply.

For example, all provincial health departments are required to report in some fashion on a annual basis to the Minister of Health who in turn is responsible for reporting to the legislature. For five of ten provinces this annual report is now embedded in a business planning process, a mechanism that tends to be more futuristic than retrospective in its approach. All of these reports continue to report financial information and there is a trend to report more against certain specific indicators and targets than previously.

It is also the case that where Regional Health Authorities (RHA's) exist as health service delivery agents of Ministries of Health through legislation, RHA's are required to report either through annual reports to the communities that they serve or through business and strategic planning reports. In a very few, annual reports are not required by legislation, but instead ad hoc reports are requested periodically. Most provinces require annual reports at a minimum and other reports as required on an ad hoc basis.

Provincial auditors also play a role in addressing accountability issues on behalf of governments and in respect of regional authorities. Eight of twelve provinces, through Provincial Auditors, review health departments and their responsibilities annually. Although there has been a focus traditionally on financial management, in several cases this role has been extended extensively to performance measures and other indicators of accountability. Some Provincial Auditors are limited by their legislative mandates to reviewing activities for economy and efficiency.

For some provinces, Ombudsmen provide an oversight of health activity and receive from members of the public questions or grievances as they would in any other subject area of government business. Health ombudsmen per se do not exist except in Quebec, where a Health and Social Services Complaints Commissioner exists.

Five provinces have developed, as of 1999, accountability frameworks that have been designed specifically to address health care.(British Columbia, 1998; Alberta, 1998; Saskatchewan, 1995; Manitoba,1999; Nova Scotia, 1995) These apply to the mandates and operations of health care delivery agents in the provinces. (Other provinces have all addressed issues of accountability in health to varying degrees in general application legislation that pertains to the conduct of business in all provincial departments or agencies.)

The definitions of accountability and some appreciation of their meaning or intent is helpful in developing an understanding of the societal environment in which

accountability for health care is addressed later by the key informants of this research.

British Columbia defines accountability as "the obligation to answer for one's assigned responsibilities"in its Accountability Framework for British Columbia Health Authorities (British Columbia, 1998) and adds to traditional financial expectations, expectations associated with outcomes, outputs, impact of outputs on outcomes and long and short term service goals. The framework is largely a conceptual one that, as of 1998, holds out a promise that measures of accountability will be developed to ensure that the accountability framework can be made real in practice.

Alberta's accountability framework has been set out in Achieving Accountability in Alberta's Health System (1998) wherein accountability is defined as "the obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities." The implementation of the accountability process is through many associated processes including legislation, contracts, business or annual reports, many of which originate in the general practices of government and which were reflected in Alberta's *Government Accountability Act* of 1995.

Saskatchewan's A Framework for Accountability: The Minister of Health and District Health Boards was developed and issued in 1995 and was the first framework specifically addressing accountability issues amongst provincial jurisdictions for health care. The framework, developed jointly by the Minister of Health and the Saskatchewan Association of Health Organizations, has a narrow application to the relationship between

the Minister of Health and District Health Boards in Saskatchewan.

The framework defines accountability as "the obligation to answer to for a responsibility that has been conferred." The framework is theoretical in nature and exists as a guide to the parties of the framework. The expectations of the Minister and the District Health Boards are outlined as are mechanisms for the measurement of progress toward meeting the expectations, including analysis of information and reports.

Manitoba Health published Achieving Accountability in 1999. This conceptual framework focuses primarily on the relationship between the Minister of Health and Regional Health Authorities. Manitoba Health's definition of accountability is identical to Saskatchewan's.

Nova Scotia describes its accountability framework in Accountability in Nova Scotia's Health System (1995) which considers not only the relationship of Community Health Boards to the Minister of Health but also the accountability relationship that other health system players have in the context of the health system. Included are the public, the Department of Health, the legislature, other organizations and the Provincial Auditor in a description of lateral and reciprocal relationships.

In summary it can be noted that the accountability frameworks developed specifically for provincial health sectors do not go far beyond the traditional expectations that one might have of accountability relationships or activities. The frameworks, if anything, serve to

clarify relationships by articulating the relationship clearly but beyond that, serve largely to inculcate strategic and business planning principles and activities into the roles of governments and district health boards. Only in the framework developed by Nova Scotia is there an indication of the depth and breadth of accountability relationships and the complexity of balancing the dimensions represented by each of many players.

5.3 The Social Union Framework Agreement

The government of Canada and the governments of the provinces and territories (excepting Quebec) made what has been called an historic agreement February 4, 1999. A Framework to Improve the Social Union for Canadians (hereafter referred to as the Social Union Framework Agreement or SUFA) consists of seven clauses which confirm principles and practices that are to guide the development and management of Canada's social programs. The agreement calls for a Ministerial Council to support sector Ministers with information and best practices and to receive information from any jurisdiction regarding progress on the agreement's commitments. Governments agreed to review the agreement at the end of a three year period.

The agreement addresses principles of public accountability and transparency as well as other issues including mobility of citizens with respect to social programs, governmental partnerships for social programs, federal spending powers, and dispute avoidance and resolution mechanisms.

It is more about how Canadian governments should do business than what business they actually do. In this respect, the health area is something of an exception. It is a testament to the importance of the health care system to Canadians that a clause of the Social Union specifically references the five principles of Medicare.

On matters of process however, as opposed to content, it is of importance that this agreement gives prominent attention to the issues of accountability. The SUFA particularly refers to social programs of which Canada's health care program is clearly the preeminent one.

Within the Social Union Framework Agreement, accountability and transparency are seemingly inseparable components, both contributing to an understanding of *how* to account rather than what must be accounted *for*. Neither the scope of the accountability or its content requirements are delineated. Nevertheless the SUFA adds content to what the idea of accountability is, inasmuch as the accountability provisions are couched in a general and hard won agreement that establishes a tone of collaboration, mutuality and equality.

The agreement's values-orientation is established at the outset with the initial statement of principles, reading as follows:

> Canada's social union should reflect and give expression to fundamental values of Canadians - equality, respect for diversity, fairness, individual dignity and responsibility, and mutual aid and our responsibilities for one another. (1999:)

The statement of principles goes on to describe equality principles, that is the commitment of governments to treat Canadian citizens in an equal manner and to "meet the needs of Canadians" by ensuring access, providing assistance to those in need, respecting the five principles of medicare, promoting the "full and active participation of all Canadians in Canada's social and economic life" (1999) and working in partnership with citizen and stakeholder organizations.

The content of the Social Union Framework Agreement and in particular its values-orientation is significant for two reasons. First the SUFA was indeed hard-won. Efforts of provincial governments to acquire such an agreement, even for a trial period, were long in negotiation and came to fruition at least in part because of the motivation of the federal government to negotiate terms for health funding. At the same time the SUFA provided an opportunity to further enshrine principles of Medicare and assist the federal government to maintain its leadership with respect to this high profile Canadian social program.

The "fundamental values" of Canadians are both explicit and implied. Their modest enunciation implies a larger, unstated meaning: equality, diversity, fairness, dignity, responsibility, mutual aid. Together with partnership, participation and sustainability these words imply social aspirations and governance that puts principle before practice.

The idea of accountability to the public is tucked in between "informing Canadians" and "transparency." Accountability is assigned the duty of informing and revealing:

"achieving and measuring results," "involving Canadians" and "ensuring fair and transparent practices." The further articulation of these expectations includes provision of performance reports, outcome measures, acknowledgment of funding sources, transparent complaint and appeal processes, third party involvement in program assessment and citizen participation in program development.

The significance of the language of the Social Union Framework Agreement is in the fact that Canadian values are put in a position of prominence. Whether or not they are appropriately articulated in a way that Canadians can relate to them or even agree, they are nevertheless the stuff of the preamble and so set the tone for the balance of the agreement's deliverables. Together with this is the fact that the provisions for accountability are less values-oriented directly. Instead these provisions are method-oriented and place priority on reporting activities and performance.

5.4 Additional Contemporary Discourse

The fourth area of discourse is made up of the Canadian archival record of very recent discussion and activity around accountability in health care. As this discourse develops, definitions, frameworks and mechanisms for accountability are being created informally, tested through debate and discussion - sometimes overtly and sometimes as a by-product of political or administrative processes. These are sometimes associated with the mechanisms for accountability that the public has come to know and has exercised traditionally. At other times they emerge as responses to current issues and questions, to

managerial problems, to the specific (and perhaps vested) interests of main players or in reaction to recent crisis. They may be reflected in expert consultation and collaboration or reflected by political leaders. They contribute to an understanding of the state of the art, so to speak, or the "real world" of accountability in the health care system in Canada.

In the past two years, three national conferences in Canada have focused on the idea of accountability. Two of these conferences addressed accountability in general terms and did not address accountability in the context of health or the health care system. The first considered accountability in general; the second "results-based" accountability and a third, in April of 1999, concentrated its attention on "Achieving Accountability in the Health Care System."

Eleven leaders in health care in Canada presented their views on achieving accountability in the health care system. The conference was "national" in that it attracted participation from across Canada; however the majority of presenters were from Ontario. Only two others provincial perspectives were presented and both from Western provinces. One presenter represented a federal point of view, one represented a national accreditation organization and another represented a patient perspective. One presenter represented an American health care experience.

Definition was not, for the most part, addressed as an issue of importance. None of the speakers dwelt on technical definitions of accountability. Rather, they ascribed importance to related issues rather than the meaning of accountability itself.

The definitions that were offered tended toward the textbook administrative definition: "the obligation of one person or a group to report on the responsibilities that they have conferred on them." (McMillan,1999: 41); "a responsibility to report to those who rely on it and those who pay for it" (Gauthier,1999: 26) and the (non-health) definition of the Canadian Comprehensive Auditing Foundation: "accountability is the obligation to answer for a responsibility that has been conferred." (Taylor,1999: 199) Two provincial definitions were offered, both identifying that accountability is to the agent who originally assigned that accountability: "The obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities." (Alberta Health,1997: 3) Each of these definitions is distinct from the others and implies a different direction for the understanding of accountability. Gauthier, for example, goes on to state:

> Accountability is where objective information is gathered, analyzed and shared so that all partners can be held accountable for their actions - and that decisions are informed by facts.... Accountability is first about data. It is about measuring inputs, outputs, and performance. (1999: 26)

McMillan, on the other hand, stressed the relationships that are critical to accountability, particularly relationships between organizational entities that share accountability for planning, performance management and reporting of results of the health systems. Wong-Reiger's definition emphasizes accountability as "demonstrating to the satisfaction of others" and is patient-centered with dimensions of accountability associated with the (unstated) goals of the system.

There is, however, a striking uniformity in the perspectives put forward at the conference.

All the health care leaders assembled addressed accountability in a managerial model, as a pragmatic response to the need to manage the systems in their care. More than half of the presenters concentrated on the development and implementation of report cards as tools of performance- measurement. For these, there was no need to place report cards in the context of accountability. Accountability was not discussed in the context of political and professional models, despite references to community or patient representation.

It would not be reasonable to assume that the federal Minister of Health, the Honourable Alan Rock, has been the only significant proponent of accountability in the health care system in Canada. It is however reasonable to assume that the profile and position of the federal Minister of Health is such that his voice is heard on this subject and that his influence is felt.

From the perspective of the federal government, the issue of reporting to Canadians and reliance on evidence instead of anecdote became more clear after the report of the National Health Forum. Minister Alan Rock attributed to the Forum's communications to him his words to the September 1998 annual meeting of the Canadian Medical Association.

> We continue to be seriously under-served by an inadequate capacity to measure performance... If we cannot or do not measure system performance, Canadians will remain unable to reliably evaluate the state of our health care system.

The minister in the same address goes on to say:

> Canadians do not want simply to be told things. They want to see it for themselves. And when they ask for information, they deserve more than

> ritual rhetoric: they should get a real report card.

Rock's emphasis is not on accountability per se. However he stresses his belief that accountability of governments to their constituents is achieved through openness and transparency, values-rich words. A year thereafter, in August, 1999 Rock returns to the Annual Meeting of the Canadian Medical Association and states:

> ... most important of all governments should be more accountable to Canadians for the use that we make of taxpayers' money. So we will gather information....

This response to a call for accountability rests on the development of information systems, performance measures and evidence or quality care.

5.5 Summary

Using Thomas's template for accountability dimensions (as displayed in **Table 2**) and applying to it the contributions of Canadian accountability discourse as revealed by health sector literature and contemporary events, an expanded set of accountability-related themes emerge. **Table 3** shows that the recent discourse in Canada related to the health sector focuses largely on what Thomas referred to as the administrative dimension. Here there is a preoccupation with reporting on the products or outcomes of the health service activity and shaping, through administrative arrangements, elements of the federal - provincial relationship in the sector. More importantly, an additional dimension can be identified suggests the importance of stated values as drivers of accountability. In **Table 3** these are identified, for the time-being, under the category of "other".

Table 3

THEMES OF ACCOUNTABILITY - CANADIAN DISCOURSE

DIMENSION \ SOURCE	Canadian Literature	Provincial Accountability Frameworks	Social Union Framework Agreement	Additional Contemporary Discourse
Political	• political		• Ministerial Council	
Constitutional	• governance • regionalization • citizen engagement		• federal spending power	
Legal				
Administrative	• financial • transparency • cost containment	business planning reports meaures	• accountability and transparency • dispute avoidance and resolution • achieving and measuring results • complaint and appeal processes	• accountability associated with "payer" • objective information/data • performance measurement/ data evaluation
Professional	• quality			
Other	**• community**	**community**	**Values:** **• equality** **• diversity** **• fairness and dignity** **• responsibility** **• mutual aid and partnerships**	

CHAPTER 6

Perspectives on Accountability in the American Health Care Sector

While there are significant differences in how health care services are organized and managed in the United States, discussions about accountability in the U.S. system provides insight into issues of accountability in Canada's own health care system. This accountability literature differs from the Canadian literature in two respects. Despite Gamm's assertion that "accountability has received little direct examination in the health services literature" (1996: 74), it can first be noted that there is more published on this subject than is available in the Canadian literature. Although it tends to be focused at the macro level of the national health system and to be confined to a few prolific academics, this literature is both thoughtful and rich. Secondly, the theoretical elements of the accountability discussion in health care have clearly been developed over a longer period of time.

Apart from the volume and longevity of the American accountability discourse three characteristics of the discussion are generally instructive about accountability in health care and contribute to the understanding of accountability in health care in Canada:

First, the definition of accountability is largely implicit in the American literature, as it is in the Canadian literature. However, despite a reliance on the framework of traditional

public administration, the American conceptualization of accountability is less narrow than in the Canadian literature and draws on a set of personal and social values that serve to emphasize the importance of the idea of accountability in health care. Second, the abundance of literature appears to be the product of both realities and anxieties about the way that health care is managed in the U.S., particularly the managed care model that dominates the organization of American health care. Third, the discourse is well-developed with sufficient theoretical discussion having taken place to provide a common foundation for consensus-building around an accountability framework.

6.1 Conceptualization and definition of accountability in the health sector

There is evidence that accountability in health care has been an issue for some time. Amitai Etzioni's work on accountability was undertaken in the mid-seventies as part of a project undertaken by the Commission on Education for Health Administration.(1974) Etzioni's analysis focused on health administration and education and described three concepts of accountability that have not lost their relevance in today's health care systems.

According to Etzioni, the first concept of accountability in health care functions as a *symbol*. In this form it can be manipulative and lacks authenticity. He contends that:

> When accountability is divorced from any systematic efforts to achieve it, the term becomes a thin cover for inaction, a form of lip service. This kind of accountability is often used by boards of trustees, insurance lobbyists, and others in positions of power as a *substitute* for actual accountability. It

> becomes then only a verbal concession with little provision for follow-through ... and which serves only to alleviate the pressure to do something about the situation. (1974: 34)

Accountability in this form can have the purpose of rallying support or educating in general but what characterizes this form of accountability is the absence of real accountability mechanisms.

Etzioni describes a second concept of accountability as *realpolitik*. He uses the hospital administrator and the setting of the hospital to illustrate his point, though the dynamic has broader application in the context of a macro health system. In this form accountability serves to extend the power and authority of the leader by responding to the demands or entreaties of separate parts or partisan interests of the system. "Predicting the behaviour of the administrator, then, is a matter of knowing the strength coefficients of the various groups." (1974: 36). The leader may also have an individual interest that can be advanced through the leadership role. Such a view of accountability can be labeled *realpolitik* in Etzioni's view because "it is characterized by the fact that power is viewed as the only significant variable."(1974: 36) Depending on the setting and the relative power and influence of professions, community groups and other players, accountability is used to disperse advantage and benefit. The model of the organization (profit, not-for profit) plays a substantial role in determining the nature of the realpolitik and how it operates.

The third concept - the *formal and legal approach* to accountability - emphasizes a system of checks and balances popularized in both the fields of political science and

public administration. In this approach there may be many paths of accountability and it is in this approach that dimensions of accountability within health care may have been traditionally identified - financial, professional and the like. The partition of these interests can lead to informal adjustments in the way that business is done. Power might then be taken through sub-processes or, alternatively, interest groups "may have their way via the phenomenon of partisan analysis."(1974: 38)

Contemporary definitions of accountability for health care are, in the main, traditional, taking the meaning of accountability as described in the public administration and political studies disciplines. Most of the few statements that purport to be definitions of accountability for health care remain close to the theory of accountability generically described by Thomas and discussed in Chapter 4. Ezekiel Emanuel, for example, describes accountability "at its most general":

> ...about individuals who are responsible for a set of activities and for explaining or answering for their actions. Accountability therefore entails procedures and processes by which one party provides a justification and is held responsible for its actions by another party that has interest in the actions.(1996: 229)

Emanuel offers that "accountability generally refers to the obligation of one party to provide a justification and to be held responsible for its actions by another interested party." (1996: 240) Less specifically, Larry Gamm simply refers to the process as "taking into account and responding." (1996: 74) Occasionally there is a heightened sense of importance that is attributed to this otherwise text-book definition. It is captured in Emanuel's accompanying description of accountability as a "keyword":

> This single word develops a fundamental role in organizing related ideas on the topic; it serves as a short-hand expression for an entire view; and persons with diverse perspectives affirm its importance. Indeed, the entire topic somehow seems incomplete without that term. In matters of justice, "equality" is a keyword. In medical ethics, "autonomy" is a keyword. In health policy "accountability" has become a keyword ... Notions about accountability are more than descriptions of the current system; they are also normative guides to determine the institutional structures for health care organizations and the type of health care delivery system we should have. (1996: 240)

This heightened importance is supported by Gamm who differentiates between the application of accountability in public, private-for-profit and private not-for-profit organizations. He points out that:

> From the perspective of political institutions and bureaucracy, accountability implies relationships of monitoring, control and answerability to superiors and/or public constituencies by administrators or policymakers. Although obligations of responsiveness to organizational superiors and to society at large appear to be central definitional elements, the notion of "moral obligation" to the public is frequently included as an element of political accountability. (1996: 75)

Private sector accountability is "variously reflected in concepts of the principal-agent role of corporate leaders towards investors, basic stakeholder analysis, corporate social responsibility and both political legitimacy and benefit to society." (1996: 75) Not-for-profit accountability additionally employs "by procedural accountability, to ensure proper use of resources and performance accountability associated with efficient use of resources or, more generally, as *having to answer to those who control a necessary scarce resource.*" (R. Kramer in Gamm, 1996: 75) Gamm acknowledges, like Emanuel, that most of the definitions of accountability "include an explicit or implicit normative element." (1996: 76)

In this health care literature a combination of personal and social values are linked to the development of ideas about accountability in health care. Sometimes they represent very general aspirations for the health care system. Sometimes they operate to implore and to inspire.

An excellent example of this kind of discourse is a publication of the Association of University Programs in Health Administration entitled Accountability for Health Care: A White Paper on Leadership and Management for the US Health Care System (Schneller, 1997). The discussion supports health administration as a discreet discipline within health care. It functions as a charge to the cadre of upcoming health administrators to take a new approach to their discipline through a new understanding of the accountability that is grounded in new leadership values. In introducing his argument, Schneller states:

> The thesis of this article is that the practice of health management must be characterized by professionally trained leaders and managers who...in a *mission-challenged environment,* are able to articulate a clear vision of health systems and what this vision means to their organizations. ... *Accountability* will be highly dependent on managing a process that brings the entire team to articulate the vision and its meaning for their work. (1997: 4)

Eugene Schneller contends that while the health administrator has always been and will continue to be accountable to the "*owners* of the organizations they have managed" (1997: 4) accountability must "transcend organizational barriers" with managers assuming a leadership role to link strategic constituencies and extend the nature of accountability to a full range of interrelated strategic stakeholders. Accountability must be broader in this environment where "there is not, however, unanimity regarding the scope of community or population level activities for which the health care system can or

should be accountable." (1997: 4)

Schneller's white paper generated a discussion and debate about the education of health administrators and also the role of health administration in accountability in the American health care system. Gary Horsfall distinguished between process accountability which he equates with policing-based methods - "nothing more than the traditional method of defining a task, assigning it to someone to do, reviewing the finished product and critiquing the entire process" and "the more ephemeral, though vastly more valuable and powerful, *attitude* of *personal accountability*." (1996:1) The difference is between the bestowed accountability and the assumed accountability.

In a thoughtful reply to Schneller's white paper, Wayne Lerner (1997) notes that the value set that underlies the discussion needs to be carefully represented. He observes that the egalitarian-libertarian continuum is often the basis for analysis for health programs, projects and interventions. And Curtis McLaughlin (1997:1) declares that Schneller has not addressed the key issue of accountability at all, that being "for whom and for what." Despite his observation that market forces dictate the shape of health care, he observes that this (albeit, limited) discussion of accountability in health care lacks sufficient attention to issues of ethics. He attributes this to Schneller's failure "to adopt either a market point of view or a public one."(1997:1)

6.2 Accountability's impetus - the managed care environment

The perception of accountability, the identification of accountability issues and the debates, proposals and solutions to address these in the context of the American health care system, are all inextricably tied to the issue of the managed care model of health services delivery. Discussion around accountability is contextualised by managed care. Further the managed care environment permits accountability in health care to be understood; it illuminates accountability, its meaning and dimensions.

Managed care, offers Allen Buchanan, is a result of the "payer's revolt" against the escalating cost of health care in the United States under the third-party fee-for-service system. (In this system the payers are employers in the private sector who provide health care benefits for their employees, for the federal government through the Medicare program and for both federal and state governments in Medicaid.) "Since the mid-sixties, health care costs have escalated, rising at two to three times the general rate of inflation and consuming a greater portion of the gross national product in the United States." (Hanchak 1996: 245) The health care financial crisis was described by McNeil as "known in varying levels of detail to virtually every American." (1993: 3) Though pervasive across the industry, the largest increases in costs were attributed to physician services which grew more rapidly than did those for hospitals and other institutions.

Managed care organizations appeared as early as the 1960's and 70's but "their popularity in the health insurance marketplace did not escalate until the 1990's." An advocate

argues:

> In the past, consumers believed that they had *earned* medical benefits from their employer or *deserved* them from the government. With no fiscal accountability for the care they sought, consumers often considered more care to be better care. Providers had both a moral and a professional obligation to provide the *best* medical care to their patients; however physicians often interpreted *best* as more, with the greatest financial rewards earned by those who provided the most advanced technological or more complex or more frequent care. These consumer and provider biases facilitated an expansion of the *needs* of medical care by patients and an interest in quick adoption of costly medical technology and services by physicians...Managed care places increased importance on the quality and costs of medical care. (Hanchak, 1997: 245)

Buchanan provides another, more technical, description of a managed care organization as one which combines health care insurance and the delivery of a broad range of integrated health care services for populations of plan enrollees, financing the services prospectively from a pre-directed, limited budget. (1998: 619) Cost-containment techniques are at the core of the mission of managed care organizations. These include such manoeuvres as payment limits, treatment pre-authorizations, "de-skilling" and financial incentives to physicians to limit utilization of care, amongst others.

Several commentators describe the effect that managed care has had on issues of accountability in health care in the United States. By 1998 Peterson states:

> It hardly bears repeating that managed care has become the organizational framework of the new U.S. health care system. To be sure it remains a vague term applied to a myriad and quite distinct arrangements for financing and delivering health care service. Whatever its form, it also dominates the private insurance industry far more than it does publicly financed programs, such as Medicare and Medicaid, although they are rapidly catching up. Nonetheless, whatever one's referent for change - the health services research literature, the popular media, box-office hits, cartoons or the editorial comic pages, or the nightly fare of Jay Leno and

> David Letterman - managed care is on the minds and on the lips of every medical care provider and resident of the United States. (1998: 611)

One by-products of the managed care movement in the U.S. is a focus on accountability. The 1990's is referred to as the era of accountability (Hanchak,1996: 245), mostly in reference to the trend to produce performance measures and other kinds of reports of physician or institution performance. Ribnick has observed that there is an explosion of interest and activity in outcome measurement and quality of care reporting:

> There is a revolution taking place in the health care industry that will have a profound impact on nurses, physicians, hospitals, health plans, payer and patients. In the thirty years since the establishment of Medicare, and as the health care industry continues its transformation to being a business, all health care providers have made exact claims as to the quality of their care and service. During the past three decades all providers have professed to delivering the highest-quality patient care. They have been able to make those claims because there was no acceptable verification process to monitor and report on the quality of care being delivered. That is changing. (1995: 1)

Another outcome of the managed care model is the proliferation of legislation to regulate what came to be regarded as uncontrolled growth and expansion of the managed care industry. "Each time a newspaper identifies another consumer's problem with managed care, legislators are called upon to act"(Riley, 1997: 41):

> By a year ago more than half the states had enacted statutes that regulated various features of health care delivery in managed care settings. About one fifth of the states had passed more comprehensive legislation, often predicated on the "patient bill of rights" advocated by the American medical Association. Legislatures in nearly every state have been deliberating over initiatives to regulate managed care. (Peterson, 1998: 612)

In a different type of investigation it would be desirable, even necessary, to look for

cause and effect between the initiatives of accountability and managed care. Is managed care the result of preoccupation with financial accountability which is, in the U.S. at least, largely profit driven? Is this new accountability concern provoked by the environment of managed care that puts at risk the professional patterns of the past? In the context of this inquiry, the cause and effect relationship is less important than the fact that in present discourse, the issues of managed care and accountability are caught up in one another in such a way as to raise a new set of questions altogether.

6.3 Emerging Frameworks for Accountability in Health Care

Peterson puts the cause and effect relationship this way: The first half of this decade brought us the managed care revolution. The second half "a backlash, albeit short of a counter-revolution":

> We have moved from a seemingly endless series of media-reported anecdotes about the failings of managed care arrangements in individual instances (however representative or unrepresentative they may be of general experience) to concerted action by policy makers at all levels of government seeking to mitigate the resulting fears of patients qua consumers qua constituents. (1998: 612)

The author enumerates a plethora of legislative and regulatory activities to bring both control and standards to the health care delivery system, including state legislation in more than fifty percent of states. He claims that this regulatory efforts together with the initiatives of the industry to prevent further backlash "boils down to widespread concerns among the public and its representatives about ethics, trust and accountability in the managed care environment." (1998: 612)

These themes of ethics, trust and accountability in the context of managed care are explored in a series of three articles published by The Journal of Health Politics, Policy and Law in 1998. This is a relatively new literature that captures many of the themes developed in other literature on accountability. Already referenced in Chapter 2, here these themes are developed inter-dependently. Because it is accountability that can be operationalized the discussion helps to illuminate the idea of accountability and contribute to an understanding of its meaning and dimensions in the health care sector. A review of this literature is tantamount to an examination of the values that underpin the health care systems. The three articles represent the perspectives of three disciplines - philosophy, sociology and medicine.

Ethicist Allen Buchanan points out in his article "Managed Care: Rationing Without Justice, But Not Unjustly" (1998) that managed care cannot be viewed as unethical despite popular arguments to that end. He enumerates three common criticisms of managed care. First, managed care worsens rather than improves access to care. Second, managed care rations, thereby denying care to which patients are entitled. Third, by rationing, managed care interferes with the relationship between physicians and their patients, impeding the patient's acquisition of the best care. Buchanan refutes the validity of these arguments based on the fact that no decisions have been taken by governments or by society in general to "assure equitable access to care for all, articulating a standard for what counts as an *adequate level of care* to which all are entitled." (1998: 617) Buchanan goes on to assert:

> These three misguided criticisms obscure the most fundamental ethical

> flaw of managed care: the fact that it operates in an institutional setting within which no connection can be made between the activity of rationing and the basic requirements of justice. (1998: 617)

Buchanan establishes here the requirement that a statement of purpose or intent must exist before the principle or practice of accountability can be brought to bear.

In a sociological view of managed care, David Mechanic asserts that "the privatization of our health care system and the increased prevalence of managed care practices are significant sources of growing public distrust of medicine." (1998:661) Defining trust in this context as "the expectation that individuals and institutions will meet their responsibilities to us" (1998: 662), Mechanic examines the role of trust in the provision of medical care in a health care policy environment in which issues of cost have taken have become a primary consideration over issues of trust. He identifies five dimensions of trust as 1) expectations about physician's competence; 2) the extent to which physicians are concerned with their patient's welfare; 3) physician control over decision-making; 4) management of confidential information; 5) physician openness in providing and receiving information. (1998: 662,3) The focus of this analysis is a medical one. The affect of managed care is considered particularly in the context of the fiduciary relationship - trust relationship - between physician and patient. The general applicability to a health care system that goes beyond the physician - patient relationship is easily inferred.

Emanuel and Goldman offer a perspective on managed care that notes that "much of the conflict around managed care plans can be viewed as a debate about what constitutes the

appropriate form of accountability for them." (1998: 229) The questions raised by that debate had prompted the earlier development (Emanuel,1996) of a framework for accountability in health care which advanced a political model of accountability for health care over what Emanuel believed to be the prevailing economic model. In it he proposes six "domains" of accountability for medical practice: 1) professional competence; 2) legal and ethical conduct; 3) financial performance; 4) adequacy of access; 5) public health promotion and 6) community benefit.

Not inconsistent with this frame, Gamm has also proposed a model for non-profit health care agencies or institutions that includes four dimensions of accountability: 1) political accountability; 2) commercial accountability; 3) clinical / patient accountability; 4) community accountability. Gamm notes that there is, in the aftermath of the federal government's failed national health care reform, "widespread restructuring within the private health care market" and that "the relatively unregulated nature of this competition and increasing stimuli for creation of competing organized delivery systems for private-insured and government-insured patients are rapidly changing the health care landscape." (1996: 74)

Table 4 distributes these many elements of accountability against Thomas' accountability frame. Here we can observe an increasing "other" component that draws upon the wider considerations that managed care brings to the accountability discussion.

6.4 Summary

The American literature that addresses accountability in the health care sector not only addresses definitions of accountability and the dimensions of health care (with several frameworks proposed, still largely in the medical context) but suggests as well that accountability in the sector has to do also with defining the purposes of the health care program and the purposes of the health care sector in American society. An important backdrop for the discussion is the managed care model of health care that permeates the American health care "system" in the late eighties and throughout the 1990's. It may be that this broad accountability discussion that has begun has much to do with the social vs. economic dilemmas that are brought into such sharp focus by managed care.

Table 4

THEMES OF ACCOUNTABILITY - AMERICAN LITERATURE

DIMENSION	ATTRIBUTES/ELEMENTS
Political	• "realpolitik" (characterized by the fact that power is viewed as the only significant variable) • moral obligation
Constitutional	
Legal	• checks and balances • regulation
Administrative	• "realpolitik" • managed care; health care transformed into business • "transcending organizational barriers" • "policing-based methods"
Professional	• physician competence • concern for patient welfare • control over decision making • info sharing • confidentiality • ethical conduct
Other	• ethics: market view or public view • values: trust • "keyword" • "normative guide" • symbol "lip service" • interest group: partisan analysis • community benefit • mission/vision • attitude of personal accountability • adequacy of access

CHAPTER 7

Key Informant Findings

The fourth body of knowledge examined is in the form of expert perspective. This particular inquiry explores how health care executives and administrators conceptualize accountability in the health care sector, what dimensions they deem pertinent and what significance they attribute to them.

The key informants are the "qua patients, qua consumers, qua constituents" to which Peterson (1998: 611) refers in his discussion about trust and ethics in the American health care system. In this research, however, the key informants are also "qua leaders." They are positioned in their roles in governments, in health agencies, professional associations and institutions, and in the community to contribute to the thinking around accountability, to reflect on and advance its state.

Three lines of inquiry were taken in these interviews in order to give shape to the discussion and to the information elicited from key informants. These are outlined here not as questions to be answered directly in the report of findings, but rather to guide the general conversation and lend form to later discussion of the research findings. The three streams of inquiry are:

What are your ideas about the existing notion of accountability in general and, more

specifically, in the health care sector? Is there something of a definition for accountability in this sector and is it different in any way from the way that we think about accountability in other areas of Canadian life or societal endevours?

Are there definable dimensions (sub-sets) to the idea of accountability in the health care sector? What are they and what is their relationship to one another?

In the absence of an overall agreed-upon approach (or framework) for health care sector accountability, is there an approach that would be advantageous now and if so, how?

The results of key informant discussions are organized against a composite framework of dimensions drawn from theory, the Canadian literature and contemporary discussion, and the American literature relevant to accountability in the health care sector (as discussed in Chapters 4, 5 and 6). An ostensible framework seemed to reveal its own existence as respondents tended toward several distinct and identifiable factors. Their recurring references to certain categories pointed to themes which had already been presumed as absolute points of reference.

7.1.0 Establishing Purpose: Understanding the Meaning of Accountability in the Health Sector

This first dimension of accountability is best described as *theoretical* and is intimately associated with the perceptions of key informants regarding accountability as a value and a

process. The application of this dimension of accountability to the health sector in Canada is shaped by three relatively discreet areas:

- Rejection of the Status Quo: Key informants share the perception that way(s) in which accountability in the health care sector is understood is tainted, with confusion that results from a history of unclear definition and ineffective execution; existing and historical accountability mechanisms no longer serve their intended purposes; Accountability is not sufficiently understood as a principle that should be, but is not, applied pervasively throughout the sector and amongst the sector's players;

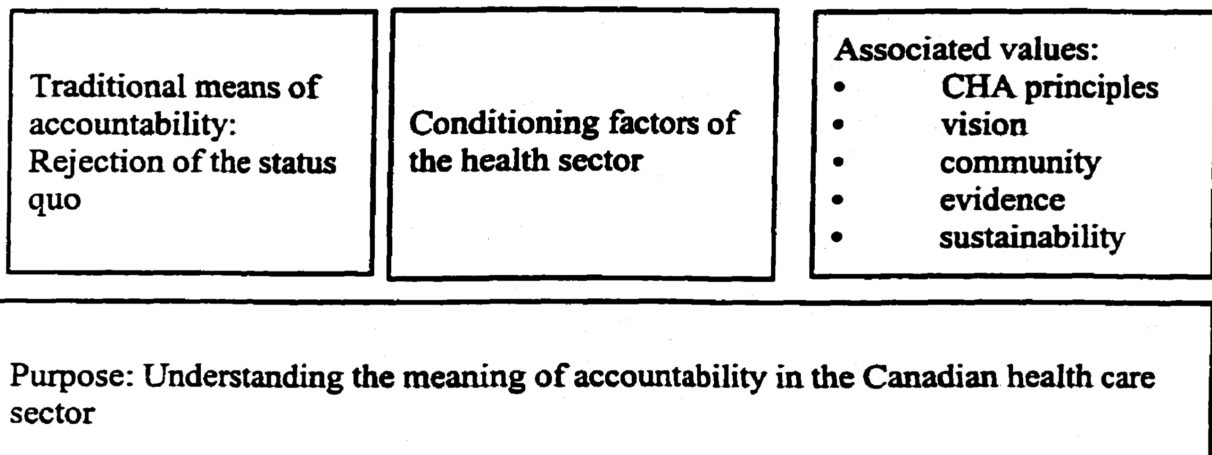
- The health sector is different from other sectors in identifiable ways and these "conditioning factors" affect the ways in which ideas of accountability need to be approached;

- Certain values are intrinsically associated with health care and with health care in Canada, particularly. These contribute to the conceptualization of goals for the health care sector.

This construct is illustrated in **Figure 2.**

Figure 2

UNDERSTANDING THE MEANING OF ACCOUNTABILITY IN THE CANADIAN HEALTH CARE SECTOR



Discussion of key informants' contributions to the discourse around accountability in the health care system begins with this area of meaning and purpose.

7.1.1 Rejection of the Status Quo

Concern and discomfort about the nature of accountability in Canada's health care sector are pervasive amongst key informants. The subject prompts much consternation; key informants convey a sense of disappointment and loss that the idea of accountability is as yet unrealized and that its practice falls so short of the expectations they have for it. Informants viewed the existing conceptions of accountability to be inadequate and observed that accountability as a general responsibility in the health care sector has yet to be achieved..

It is noteworthy that little attention was directed to the *definition* of accountability, per se. Rather, discussion with key informants usually assumed a theory of accountability in very general terms as well as its relevance and importance to both public and private sector enterprise. "The fundamental thing about accountability is that it speaks to the core of the democratic process" said one informant. Another agreed: "I don't know of too many environments where you are given something for no expectation whatsoever". The respondents concurred with the assertion that accountability necessarily includes "answerability" but to reduce it to the single aspect of "answering to that which is conferred" undermines the importance of accountability as a whole idea. Respondents were familiar with and conversant with mechanisms for accountability in the health sector

but brought to the discussion more than an appreciation of the mechanistic level. Their insight into the strengths and weaknesses of these commonplace mechanisms of accountability brought to light an expectation that accountability should exist more at the level of principle within the health care system and less at the level of machinery.

Respondents stated or implied that there was a considerable amount of confusion about the theory and practice of accountability. This was true even for informants who operate within an environment that is occupied with the accouterments of accountability daily. The confusion results from and is demonstrated by a continuing contradictory descriptions of accountability. The reality suffers by comparison.

This view that the idea of accountability in the health care sector is tainted is related in the minds of key informants to the existence of two different realities of accountability. There is an disparity between the large-scale and public picture of accountability that is promulgated by governments or organized providers and their institutions and the practical reality of accountability which is not grounded in objectives or activities that share the same declared intent. While the former intends or pretends action based on principle, the latter is lacking a plan of action and mechanisms to achieve this end. An informant who had previous experience within government noted:

> See, one of the difficult things you recognize when you work in government long enough is that there are two different worlds: There's the public world in which you say you do things and there's reference to it everywhere and in every document somehow, but if you look at the practice of accountability, whether it be financial, it doesn't matter what it is, it isn't really accountability.

The informant goes on, now more specifically about the political processes of accountability, to say:

> Now , with accountability comes certain consequences, which we tend not to talk about. When we isolate accountability, we don't determine that there are certain consequences that one expects. But we don't talk about that. You don't see anything about that. Now what happens is that in a political sense, the Minister is accountable and has to acknowledge ... although this won't be done publically in any way - there are some consequences relative to the measure of accountability that he or she has, relative to what goes on in the department. Now in the public sector ... we then get into political posturing, we then get into the, you know, one-upmanship, we get into face-saving ... So that, in fact, the accountability that the Minister has means nothing because, at the end of the day, if he or she just stands and tries to deflect responses from specific answers, tries to deny the reality of what's happened, ultimately the practice of accepting the accountability then isn't clear because of their unwillingness to accept the consequences. It goes into the political arena and the whole issue of accountability is diffused. In the public sector accountability is really found in what bureaucrats do ... The actual practice of accountability isn't very clear ....The practice is now so embodied in theatre that it doesn't matter.

In keeping with this dichotomous perception of accountability, the idea is regarded as too "popular", sometimes existing as a fad and sometimes falling out of favour as a priority of the day. This is often represented in the practice of accountability as a technique of organizational behaviour in a hierarchical management environment.

> One day it's in; the next day it's out. One day making mistakes is in and all they do is tell you you're supposed to allow your staff to learn from their mistakes and to develop and grow and not to penalize them, and the next day you've got to keep your staff accountable for every decision they make. .... On the other hand, obviously by definition, any institution and any organization is responsible for what it does so why would we have a conversation about it?

There is confusion as well about whether accountability is absolutely a *positive* value. "Accountability is typically viewed in terms of who gave you the bucks. Who puts out the money has the right to insist on accountability." The notion of accountability that prevails

in government - institution-agency relations in the health sector and minimizes accountability by focusing exclusively on the financial dimension:

> So the provincial government insists that we spend (their money) on what they want us to do. So we will have to lay out everything we intend to do. They are reciprocally giving us their operational money. That's not accountability. To me that is negative accountability. That's real world *this is the way you get the money* ... but there is no legitimate sense of accountability.
>
> They want to extract the accountability ... that we will not come back for more money. They do not care particularly what outcomes are accomplished with the resources we got or they would have asked for more information about what it is they're going to get from (the resources).

One informant talked about the experience of joining a health care sector management team in a leadership capacity:

> And one of the things that I was confused by and concerned about was that the accountability was related to the bottom line, all discussions ended on the balance sheet. There was really no room for this (other) conversation; it was tolerated, but eventually I think that it was just found to be extraneous.

One informant commented on the history of accountability initiatives and leadership in general and observed that in Canada, at least from the point of view of theory and practice of accountability, the federal government had taken the lead with efforts in the 1970's and 1980's to develop new models of accountability. These took the form then of management by objectives, program-based planning and budgeting, zero based budgeting - "you know ...what are we spending and what are we getting for it?" He indicated:

> So in a sense the federal government has been in the forefront of defining accountability structures and how you evaluate programs. ..It seems that they are very good at theory but in practice they have sort of dropped the ball on that...

This respondent applied this history to more recent events in government and in particular with respect to the health system. "You can have all the accountability models that you

want, but if they are not utilized, put into practice, monitored, followed up, they're not worth the paper they're written on." Failure to follow through with much of this theory and many of the related management practices promulgated in the 1970's was attributed at least in part to the next major policy driver - the cash crunch of the late 80's:

> So suddenly how public servants spent their money, somebody took it seriously, so provincially, for example, you had treasury board going from what I would say was a phase of micro-management to the other extreme of macro-management. Suddenly every dollar was expanded and someone was looking at it from three different ways.

The effect of this era was to increase reliance on internal and external management and accounting consultants, to abandon strategic planning in favour of internal audit and ultimately to consider what benefits could be accrued from the private sector. During this period assumptions, driven by economic interests, were made about the relevance of private sector practices in the public arena and also in the health sector.

There is also a general conviction expressed that existing processes of accountability are no longer adequate as they had once been deemed. Traditional mechanisms for accountability have lost their ability to safeguard the sector. Often they have been largely unscrutinized and have ceased to fulfill their original purposes. At other times, they have not been adapted to accommodate the evolving structures and needs of the health care sector and its objectives. In very general terms the annual reports and audited financial statements that form the backbone of the traditional practices of accountability are inadequate to the current environment. While business plans and five year plans based on needs assessments have begun to change how and what organizations report progress, there is not yet comfort that over time these mechanisms will improve our understanding

of the outcomes of effort and resources.

Two examples supported the view that the old ways of implementing and demonstrating accountability in the sector are inadequate.

The first example is the circumstances surrounding the deaths of twelve children, patients of the Paediatric Cardiac Surgery Program of the Health Sciences Centre in Winnipeg, Manitoba. This case is the subject of a judicial inquiry, with the report of Justice Murray Sinclair pending at the time of writing. The events of the case brought to light many inadequacies in process and substance of patient care all of which will be reviewed in Justice Sinclair's report. In the view of key informants, all of whom rank at least as interested bystanders, the case has many implications for accountability in health care systems. In the words of one informant:

> I think that it was a situation where complacency was a big factor. Different groups thought that different groups were doing different things and at the end of the day you found out that certain things were not being done. When that was discovered you got a situation of finger-pointing. The finger-pointing escalated to organizational considerations. When it came down to organizational considerations then it came down to the issue: Who is responsible for this mess? When you get into the organizational level, the next step is , who created these organizations? Who are these organizations reportable to? Who are they accountable to? Who are they answering to? So you could see the sequence of events, where at one time, there may have been some very good monitoring, some accountability structures were in place...We had assumed that those accountability structures were in place. During the course of the four and a half years we all found out that our thoughts were wrong.

A second example is that of regionalization of health programs through the creation of Regional Health Authorities in Manitoba. There is widespread agreement that it has yet to

be determined whether regionalization is a means of delivering health services in Manitoba that increases local accountability for health services delivery. Certainly any expectation following regionalization that the existence of regionalized health authorities would deflect accountability for day to day management and service issues from the provincial Minister of Health has been dashed. The Minister of Health has continued to be the focal point for concerns and complaints about the health care system. What does seem to be clear is that given the relative development of authorities after some three years there is little belief that accountability has been effectively delegated to regional boards. With respect to government one informant observed that: "The skills to fully articulate expectations and then hold regions accountable for those expectations has not been fully realized." From the point of view of service providers, on the other hand, "(the Department of Health) really likes to control and the way that they control is through the budget."

It would be fair to say that even when informants expressed concern about the mechanisms of accountability for new delivery structures, there was optimism that over time RHA's would develop capacity to become more fully accountable for their mandates over time. In the meantime however, and until such a time as accountability shifts take place, the Minister exercises authority in day to day problem-solving that detracts from the authority and accountability of regional authorities. The shift to regional accountability is perceived as a positive accountability wherein RHA's assume responsibility and accountability in a way that empowers them to take action in the context of their mandate:

> When the old government... sold the rhetoric over the reality and the

rhetoric sounded so progressive...but then they discovered the reality of the matter ...they realized that they did not want to do things differently. They had no intentions of really changing the structure in a major way... You really need to correct, not just tinker with the old....But that reshifts power, reshifts responsibility, reshifts where the minister is at....I think over time, for better or for worse, the public will hold the RHA's as being accountable for what happened to health in their region, in their population. You would never find that in the old structure. A hospital cannot be responsible for health ... Today's model has a greater probability of the system being held accountable ... Inherent to this arrangement is a systems accountability that is different from the old one.

The desired accountability includes more than answering for dollars allocated but points to a larger and collective sense of responsibility for group well-fare.

Informants largely held the view that accountability, its understanding and application, is the responsibility of all participants in the health system. In order to experience the full benefit of accountability, the principle must be observed to operate at the level of the individual, at the level of the health care system and at the level of society in the broadest context of societal choices. The idea of accountability has been too narrowly conceived and too narrowly adopted. Not all of the players in the health care system that have duty in this respect, have been called to act in accountable ways.

Informants pointed out that accountability rests first with the individual, with the citizen, the prospective patient and that this level of accountability neither exists nor is being developed in support of the Canadian health care system. One informant attributed this lack of accountability to the existence of Medicare:

People in Canada have not taken seriously their own responsibility for their health. First of all people have to take their own accountability ... Medicare has contributed to people's belief that they can wait until the system cures

> them. When you talk about that to people they get very angry... Because of the way the system has evolved the public has an unrealistic expectation, using scarce resources for things that are unnecessary or a low priority.

Further, informants noted that citizen accountability is partly a function of the degree to which the public understands how the system works. In this context one informant expressed "..in terms of understanding the whole system, who can really explain it?" And another: "I think that the public is more educated (about health care). However I'm adamant about this, that I think that the public does not understand how the health care system works". This informant continued:

> If you and I go along in our daily lives and have no incidents or requirements to use the health system, it would be the farthest thing from our minds. However if you and I had a sick child and we showed up in an emergency room, it would be our expectation, as parents, that the health care system would respond to that need immediately, and provide the best medical care available. That's how you and I would think, walking into that emergency department. My kid is sick; I need and doctor and I need that doctor now. It doesn't work that way. You and I walk into an emergency room. Sometimes at some facilities a triage nurse will look at a child and assess whether or not he is a priority, within the context of all the other kids that are in that emergency room. If it is a priority then the best medical care will be applied to that situation. If you're not a priority then the kid has to sit and wait with the parents who are anxious. ..The perception is "My kid is sick and not getting the care required." Whereas the system says "We acknowledge your kid, but in the context of everyone else who is here, your kid is not as sick as the others ..." One of the realities of the system is that you are not always going to get the care that you *think* that you should get.

Because of this the public may not contribute responsibly to the dialogue about accountability:

> Where the public *perceives* that accountability rests, in fact it may not. So unless we begin to kind of redefine within the health care sector, where is accountability? And unless we have some clear parameters around the consequences ... We all hold some rights but don't want to take responsibility for anything.

Apart from accountability at the level of the individual for personal health, appropriate use of health care services and a knowledge (and presumably appreciation) of the complexity of the system and how it works, the accountability of practitioner players in the health care system is also at issue.

Depending on what activities are said to be related to the practice of accountability there could be debate about what players in the health care system exercise accountabilities proactively or adequately. One informant pointed out, for example, that in many respects it is the area of physician practice (accountability to the patient, adherence to standardized practice such as quality standards, practice guidelines, protocols, expectation of quality care) that has made the most advances in terms of accountability. Yet from a different perspective other informants pointed to the unwillingness of provider groups to be accountable at the level of the health care system for their actions.

One informant, for example, related the story of a professional group that released a report indicating public dissatisfaction with a reduction in service level that had actually occurred at a time outside of the period that the report studied. That group, he says, was never held accountable for this misinformation. "When provider groups make inaccurate statements that result in a sense of panic in the public - where is the accountability for that?"

This phenomenon of non-accountability, indeed a refusal to be accountable as a part of a system, is not unique to provider groups:

When you think about health and accountability, I guess you start thinking

about all the people who feel no sense of accountability with anybody central...people who see their independent thinking as being an essential element of what their job is - doctors who just want to do it their way and hospitals that do not want to be part of a sharing system - such that they don't want to be held accountable to government or to the funding. ...We should be holding ourselves and them to working together for some common goals.

At the societal level, understanding the health care system and having reasonable expectations about its capacity is an aspect of accountability too. "We'll never have enough money to do what everyone wants," said one informant, pointing out that Canadian society has not chosen to define carefully the parameters or boundaries of the health care sector. "We haven't really thought about how much emphasis the system should place on health, quality care and access to services and delivery." Additionally the place that the health care sector holds in a set of other priorities and systems that demand resources has not been determined.

7.1.2 Conditioning Factors for Accountability in the Health Care Sector

In the understanding of informants, the health care sector in Canada is a unique environment in which accountability and its practice must be conceived, designed and executed in unique ways. There exist important considerations for accountability in the health sector that do not exist in other sectors.

There are several reasons why this distinction between health care and other sectors is made. The use of public resources is one of them:

> Why is accountability different for health care? Because a huge proportion of the GNP is invested in health. The use of so many dollars increases the

accountability - money that cannot be spent in other places.

Health care, by virtue of its cost to Canadian society, demands more diligent accountability, accountability shared by individuals, providers and society in general. At the same time informants noted that these substantial resources are scarce in their own context, this the result of increasing demand for service and the increasing cost per unit of service. "You're going to have competing interests because there is a limited amount of money." The fact that there is a limited amount of money to be directed toward health care (and the belief that this is how it should be) was not disputed.

This was not the only explanation offered in support of special consideration for accountability in this sector. A different way of understanding or approaching accountability in the health sector is necessary also because of the fact that health care, medicine, the science of it all, is not precise. It is the sector to which "you wish that the science was mostly stringently applied, but it is not exact". Unlike the debits and credits in banking, black and white for the most part, "health care is not a single point transaction. It's a continuum. It's the overwhelming complexity of the health care system ... everyone tries to force it into that black and white decision point. And it's not that easy."
And, says another, "it's just not that easy to measure outcomes".

Why is accountability different for the health care sector? Not unexpectedly another point of view offered was that health care is simply the most important endeavour, that its societal value is high, that it is necessary in the kind of society that we aspire to achieve and that it contributes to the development of optimal social conditions and economic

prosperity. The stakes are high:

> Those of us who are involved in health care are sort of biased that this is really the most important sort of activity, and therefore accountability for health care must be more important...."This is what we are responsible for; this is what we have done about our responsibility" .... In health care we would not just accept our accountability to spend dollars wisely and get the best value, but we have to look at what the is whole purpose of health care and be accountable to not just what it is currently achieving but, to science then, for what we hope it could achieve.

Another critical difference about the application of accountability to the health care sector results from the fact, or the belief, on the part of informants that the recipients of care are vulnerable. Their reliance on advice and guidance, often ultimate decision-making, (notwithstanding the increasing capacity of patients in general to learn about health and participate in decision-making about health care) places disproportionate responsibility for accountability both on direct care-givers and the system as a whole. The client/customer in this sector enters not by choice but by need. "I am giving myself to you to fix" represents the posture of many patients in the opinion of one informant. Their attitude reflects their situation that they are often in no position to do otherwise. The informant points out that "the real accountability in the health sector is shared amongst the well" and not by those who are ill. Indeed, under such circumstances, individuals may not actually be allowed to make decisions inasmuch as the choices available to them are *presented.* Directions plotted for care come biased at the onset by providers trained and conditioned to know, or to believe that they know, the outcomes that are desirable. This phenomenon is reminiscent then of Mechanic's observation that "the patient borrows (the medical posture of omnipotence), clothes his nakedness in it until such time as his own becomes whole again" (1998, 662).

7.1.3 Values Associated with Accountability

As a part of the voluminous work of the National Health Forum (1997) a report was made on Canadian values and their relevance to a national health system. This report offered that values "broadly refer to the relatively stable cultural propositions about what is deemed to be good or bad by a society" (Report of the National Forum on Health: Making Decisions: Evidence and Information, 1997: Vol 5, 352).

Key informants identified issues of values and areas of the accountability in respect to the health care system that are value laden. These issues and areas were not particularly distinct and were frequently enmeshed with other dimensions of accountability as drawn from the literature and discussed by informants. Nevertheless these issues and ideas were clearly important for informants, offered both cautiously and passionately, and illuminating the continuum of choice between what is good and what is bad now and for the future of the health care system in Canada.

Informants identified the "given" values of the health care sector in Canada as the principles of the *Canada Health Act* (*CHA*, 1984). These were referred to by many informants and not disputed. By the same token they were referred to *en passant*, not in a way which would emphasize their importance, but rather in such a way as to assume their pre-existence. This was noted specifically by one informant who said that the values associated with the principles of the *CHA* were "intrinsic more than stated". He elaborated with "In the Canadian system, it's sort of a given that these are the values that you will

follow, for ever and ever and that's it. You hear about them once and away you go." Another informant asked incredulously "What is really guiding us here? *CHA* and its core values? What are they?" Another informant indicated that the very existence of Medicare had given the public license to abandon their own responsibility and to "wait for a cure". He contended that there was no perception on the part of the public that they were indeed accountable for anything at all in the health care system. The *CHA* principles of accessibility, universality, comprehensiveness, and portability were not addressed in any particular depth by the informants. The *CHA* principle of public administration was, however, raised in several different contexts and prompted more comment.

Referring to American models of managed care one informant asked: "Is the discussion of values associated with a managed care system a cry for help on the part of the individuals within that system, saying *Maybe we have taken this profit thing too far?*"

Quite apart from these *CHA* principles, informants referred to four other principles which in their view, are relevant to shaping the work of the health care sector and is its accountability. These are vision, community, evidence and sustainability.

The first and most compelling area, the area which was volunteered by informants most often was the idea of vision, more accurately, ***VISION:*** emphasized to establish its overriding importance in identifying the purpose of the health care system and the goals of the sector, and establishing the foundation for the terms of accountability.

Asserting that accountability is a "huge issue of our time, both for individuals and the collective", one informant associated accountability with "how you bear witness":

> It's how you bear witness, bear witness to your battles and bear witness to your vision. What do you want to see? Whether you're happy with the status quo or want to see things changed. ..you're accountable for what you believe, in the battles that you stand for and you're accountable for how you want to change that.... If we stuck to that narrow view of accountability - not just the accountability to spend the dollars wisely and get the best value but we have to look at what is the whole purpose of health care and be accountable not to just what it is currently achieving but for what we hope it could achieve...There is an accountability to do better.

Another informant called this "moving the markers," " the responsibility for moving toward something better."

This vision was not compared favourably to the current reality in which accountability is for "spending the money" not spending it "on the right thing". "All other considerations of accountability for quality or accessibility in all of those things were secondary issues." This higher road is characterized as follows:

> Keeping to visions and keeping to values is to check in that one is operating at the level of principle and not of pragmatics...vision...desiring a better state...The vision underpinning or overpinning of the health care system needs to be clarified: Do we believe in it? What do we see as the strategies and then how do we articulate these very clearly? ...As we begin to understand the interconnections of health and so many other areas of our lives - that will need to be reflected. There needs to be monitoring systems, not related to expenditure, but related to outcomes, outcomes of concern. The outcomes that should be on the lips of every major politician should be levels of immunization, the degree of child poverty. How many kids go to school without a lunch?

This sentiment was reiterated by another informant who observed that reform of the health care system is not over, and that, despite this, governments are not taking the time to find out what it is we really want.

Another theme associated with values came to light as informants discussed the **community** and its various roles in health care. This area of discussion covered wide ground and slipped in and out of other subjects such as the political dimension of accountability, governance and public participation, even the idea of population health. So was it true that the views of informants covered a broad spectrum. "You can hardly argue that there is no accountability! Most governments have changed, because of, or mostly because of health care." was the view of one, but this view was seldom expressed. Another saw both the need and the difficulty of involving the public in the complex decisions about health care systems. In addressing how the political leaders can call professional groups to account for their participation in the health care system, one informant noted that:

> ...it could only be done if the public agreement was in tune with relative accountabilities of colleges versus associations. But engaging the public in that kind of education...well I don't know if its achievable...I don't know how we would begin to do it... The problem with educating the public is that there is no such thing as the homogeneous public.

The preponderance of opinion was however that political accountability did not satisfy the need of the public to participate in decision-making or public education about health care. "The political game of accountability is a divisive tool" said one informant, "this is one of the problems that we have at the current level of state of democracy...the notion that you will get accountability through a partisan system." Setting aside this disappointment with existing political accountabilities, some informants saw potential for increasing participation of the public and communities in decision-making about health systems that would have the affect of making better choices for the provision of health care services from limited resources and over time educating communities to look beyond the health care system to improve population health. As one informant noted:

> ...You could engage communities in what the outcomes were and what they ought to be...you could begin to engage a community empowerment process that would transform how much ownership people have of their health status - what we would get is the beginnings of improvements in the health care system.

The role of regionalization in the provision of health care services was cited as one example of the power of citizen participation with respect to accountability:

> There is clearly, in the current structure, a much larger sense of accountability for all populations in the area....The fact that the founding definition of regionality as responsible for the health and well-being of all of the population in the defined area. So the recipients can now hold the RHA accountable in a different way than they could in the old structure, no question about it.

This public participation through regionalized health authorities is viewed here as an opportunity for investment and likened to the time spent in the garden -"our challenge is to make it work." At the same time informants acknowledge that the process of community participation and accountability can be "done in such a way as you have a shell of it but not the reality as well." This "shell" can be created at the regional level or it can be perpetuated by political processes that...

> ... as soon as there's a problem they get out their white horse....the Minister keeps dragging in this political control...the sense of power remains at the centre so that you cannot visualize what it is that is your own responsibility.

Ultimately informants agreed that governance in whatever form is a "certain expression of the values of the community." This is accomplished with varying degrees of success.

Fundamental to this process of community participation and its outcomes with respect to accountability is the notion of community resilience. One informant said "You know the stuff - that weak communities don't have the power to improve their conditions. Strong

communities have the power to improve their position. But this same informant added a condition to the idea of community participation, empowerment, resilience and accountability and that is the third of four values-related areas addressed here: evidence.

Getting the facts - making decisions that are based on something other than political theatre: acquiring **evidence** to support decision-making is a theme that is viewed as a means to de-politicize health care decisions and to restructure inequities of various descriptions.

Informants do not see evidence as being synonymous with "report card". Indeed no informant defined evidence per se. Evidence is not a specific answer that results from a specific process and no informant subscribed to a particular system, template or calculation that would by itself constitute sufficient evidence for a particular decision. Instead evidence exists as a principle that has the potential to level the playing field and to permit less arbitrary and more defensible decisions about systems to improve health status of the population.

The idea of evidence as a component of accountability has come a distance from the first and still predominant means of accountability , that being financial. One informant referred to "the fairly narrow sense" of accountability of the American health care system as "the bottom line." In the description of outcomes this same informant noted that this trend to develop disease specific report cards "flows north" from the Unites States and that while it is not unreasonable to expect that the public would want to have information

about how successful interventions have been, and asked the question "is that the main effort that should be made about accountability?"

Informants agreed that "mechanisms exist" in Canada and that there is an understanding that the issues of accountability are not as simplistic as what the private sector influence of the United Stated might imply. "I expect that some people might see this as accountability" said one informant.

It is not within the scope of this report to discuss evidence, the content or the process of acquiring it, so while numerous informants gave examples and talked about various forms and applications of evidence, these issues are not particularly relevant. Except to say perhaps that evidence is viewed in many ways and as having many purposes from the micro-management of diseases and conditions, health care delivery methods and outcomes and at the bigger picture level of the population's health. What was relevant about the informant's contributions about evidence is the sentiment and importance that is associated with it and which functions as an important underpinning of accountability.

One informant expressed a fear that the idea of evidence-based decision making, which reached a peak in the health care system rhetoric around the time of the National Health Forum, was now becoming "passe" despite the fact that it had enjoyed so much attention for a while. But despite the perception of evidence's declining popularity there exists still a sentiment "that we need to really look at what's going on"; "to develop a better system for monitoring". One informant tied evidence to the needs of regional health authorities to

meet the needs of the communities they serve. The informant indicated that the availability of evidence establishes a contract with the community and gives the community "confidence in working with us that we won't go where the evidence doesn't lead us. Where we go is where the evidence does lead us."

> Having access to the information that defines the needs in your area is another way to be accountable. When you come back to make a decision, you are expected to have the evidence, Now where's your evidence?

Evidence is the compass:

> We just never forget that, comfortable or uncomfortable; you just do not leave your evidence behind...the value that comes, the extrapolating value that comes from being evidence-based, really becomes the singular value that you hang on to.

The fourth and last value that informants subscribed to, raised frequently - is **sustainability**.

Sustainability is, in the view of one informant "the highest degree of accountability" because it ensures that the health care system "will last and work." It is test of the leaders is to put it all together and make it work Political leaders, it was said, failed this test. An example given is the response of governments to the National Health Forum. Several informants declined to speculate on the reasons behind their perceived lukewarm responses to the Forum's report in 1997. But they had seen in it the building blocks of sustainability and saw in its aftermath that governments chose to set the recommendations of the report aside.

Another informant saw sustainability in light of the realities that governments face. "The

limiting factor in all of this is the amount of money that is available and the priorities that the government has for spending it." Added another: "How do they priorize health care spending when they have other responsibilities?" Given the existing scope of health care programs in Canada this informant saw the expectation of continued and constantly increasing funding to be unrealistic.

> I don't think that is what is going to happen. I don't believe that it's realistic. Not to the extent that it's needed. There won't be sufficient funds to meet the demands of all of the aspects of healthcare...Unless we cut back on people's expectations.

The sustainability of the health care system was associated for one informant with individual responsibility that cannot be "thrown to the government." This is turn was associated with the public's expectation that the assertion that "we will never have the money to do everything that people want."

Purpose, meaning and values associated with the accountability in the health care sector has been the subject so far. Other area or dimensions of accountability were explored with informants as well. The method of the research permitted the informants to volunteer dimensions of accountability and to some extent, given the theme of this research, their contributions were concentrated on the meaning of accountability, rather than its mechanisms. In other dimensions identified, many of which tend to mirror those presented in the literature and popular discourse, informants tended to provide critiques of the potential of those dimensions to fulfill what it was that they perceived as the fundamental purpose and meaning of accountability. Accordingly the areas identified here and the observations attributed to them are more brief.

7.2 Governance Dimension

Governance is the set of acts intrinsic to being governed; authorities and actions that are a part of directing and controlling (or influencing and swaying) the actions of a people or an enterprise. It can be either despotical or constitutional; can include laws and regulations and can extend its scope to include administration and management. For the purpose of this analysis and taking into account the nature of Canada's health system (also the framework that informants implied in their discussion of accountability) the scope of governance is bounded by that which is law, policy and politics, including agreements of governments acting together. Issues of management and administration are left to a later discussion.

Informants identified components of governance to include matters pertaining to the law, including constitutional and legislative for the two significant levels of government, provincial and federal, political activity; intergovernmental agreements such as the Federal/Provincial/Territorial Framework Agreement on the Social Union. This dimension of governance includes laws in the federal jurisdiction, particularly the *Canada Health Act,* and in provincial jurisdictions, with informants most often referring to provincial legislation created to define regional authorities for the delivery of health care services.

To the extent that the issues of governance were addressed as a dimension of accountability in health care systems, they were frequently addressed as a part of the vision and values of accountability and to some extent have already been reported as

informants' views. There is an element of repetition here that illustrates the limited degree to which governance mechanisms are relied upon to ensure a system that is comprehensively accountable.

> The fundamental thing about accountability is that it speaks to the core of the democratic process ....but there is a lot of confusion in peoples' minds about the way in which it fits in... I actually believe that a government is elected to govern and that means it's the job of every public servant to support that.....And also in the context of what is leadership...what has been approved by the legislature and what the government has within its power. Given that the government has been duly elected and is dually responsible to the legislature....that means not just the letter of what government wants but the spirit of what the government wants to achieve...

The observation that accountability rests with politicians has already been made and further, in the view of one informant, that this accountability is "lost in the arena of political fear". Despite this the "buck still stops at the political door." The nature of political accountability is therefore fundamental to accountability within the health sector but is, in the view of informants, fundamentally flawed. Accountability is found "more in the stuff that bureaucrats do, not in parliament".

Referring to the concept of the new public management, one informant noted:

> ...its purpose is to deflect accountability. What they are doing is they are ultimately responsible and accountable and are so held as the custodians of the public purse. But they are creating mechanisms and modalities whereby they can use other bodies to say 'Really, it wasn't our problem. It was theirs and they are the one who are now accountable'. But ultimately the people they point to don't have the authority. So there is this game of accountability that is going on and partisan politics is one of the most divisive tools and it's inimitable...this is one of the problems we have in the current state of democracy, is the notion that you will get accountability through a partisan system.

Another informant observed that political accountability for the health care system does

bear well the pressures of crises ("fires") and interest or pressure groups. These get political attention "where accountabilities that are obvious are not achieved." The informant further illustrated this point, noting that the political response to problems within health care systems is to provide additional funding: "There's not an elected official that could say in honesty that we need more money but it takes political will." This informant asserted that the highest form of accountability for the health care system would be to sustain it, because "the system works and it needs to be made to last." The evidence for a lack of accountability on the part of politicians who have a responsibility for this sustainability is the fact that "we're not being honest about how far we've gone to embrace a two-tiered system." "The general public has put people (elected officials) *in trust.*"

Informants' views of the Canadian constitution and its relevance to the Canadian health care system are shaped by their views of partisan politics and the effects that they see partisanship having on decision-making and accountability. Similarly, with respect to agreements between governments, those informants who were aware of the Social Union Framework Agreement (SUFA) did not view it as an agreement that would ultimately alter accountabilities in the health care system in Canada. Its focus on report cards as a means to create accountability in the health care system could instead have the effect of "distorting (the public's) understanding of health services."

One informant thought that while the SUFA drew on important concepts - "pulls on the right words" - "you can never be sure that those words weren't put there in order to provide security that they all weren't giving away something to another order of government."

The relationship that is created between governments as a result of legislation is a feature of accountability in the health care system at levels other than that of the national and provincial governments. In the 1990's many provinces regionalized their health care systems and always with the effect of creating new accountabilities. Some observers have postulated that a purpose of regionalization was to deflect accountability away from the political level and while this may or may not have been the intent it is surely true that the creation of regionalized authorities "has changed the accountability mix":

> The power to require accountability for the regions is really quite high. The Minister can replace boards, remove Unfortunately all of that power ends up being a blunt instrument in terms of making change. boards, remove chairs; he can remove funding or increase funding and he has all that power.

And because the instrument is a blunt one:

> ...interestingly enough, the shifting of program responsibility to the regions has not removed or reduced the minister's political accountability one speck. It's made the minister's job, in many respects, harder. He now continues to be responsible, through the legislature, for every single thing that may or may not go wrong in the health care system. But he has less control over health care....

7.3 Professional Dimension of Accountability

For the most part the informants would likely describe themselves as professionals in one

sense or another. These leaders, executives and academics are professional either by education or training or would consider themselves to be professional managers or perhaps professional public servants. What they brought to this discussion about accountability in the professional dimension is an understanding of some of the issues of the dimension and the challenges that these pose for accountability in a more general way. Where does the dimension of professional accountability stand with respect to other dimensions of accountability?

Notwithstanding the fact that all of the informant participants in this research may have considered themselves professionals, the discussion of the professional dimension of accountability really focused in the main on the understanding and place of physicians and nurses. In fact, to go further, if there was an emphasis in one place or another, it was not unexpectedly on the accountability issues and roles associated with physicians as individuals in the health care sector and physicians in their organizations.

One observation that was repeated several times was that, despite the difficult questions and challenges associated with the professional dimension of accountability and here specifically related to the role that physicians play in the health care system, it is clear that this dimension for physicians has been recognized and developed over the long history of physicians as healers and decision-makers and that, whatever the limitation, pros and cons of the state of the art, these general and specific ideas of the accountability of physicians have generally served societies well. This is no less true in the Canadian health care environment than in other countries. One informant put it this way:

Accountability in the health care system is more complex than , for example in banks, which is presumably easy if you can look at the bottom line. We haven't really thought about how much emphasis should be put on health, quality care, and access to services and delivery...and I do not se a whole lot of attention going to it, except for financial accountability. But we do have professional accountability where people are expected to do a responsible job and be responsible to their patients. In that sense there is accountability to deliver the best care possible.

Another, "acknowledging that accountability meant different things to different people" talked about the "accountability story" most important to physicians, that being the trust relationship that exists between physicians and their patients, with the physician in the role of "trustee", "the strongest relationship that exists in law." The informant stressed the significance of early judicial decisions in Britain that established the idea of the trust relationship and its contemporary relevance to physicians confirmed by court cases as recently as 1994. The public, aware of this trustee relationship and responsibility, does not hold the physician, but rather the "system" accountable for access to service in general and for the appropriate use of available service. The perceived role of the physician as a "gatekeeper" for the health care sector/system is, in the view of this informant, a significant problem. "The professional dimension of the health care sector is only one piece of an interrelated quagmire of accountabilities.."

Another informant had a more difficult time describing the accountability relationships of physicians, and raised several concerns:

...there has really been from a health care point of view - and speaking specifically about medicine - a really contracted sense of accountability. In many ways what characterizes our relationship is a social contract ..... between organized medicine and society, that has been largely characterized by negotiation and often poor relationships based on remuneration. This is the social contract where the physician as a health

care giver is the agent of social change and is pushing at the margins of that particular social activity... If accountability is to be seen as broader - not just taken in the narrow stream of what it is that you are remunerated for - we have a larger social accountability than what we get paid for as a profession....Because we as a profession, profess to do something. And that it separate from the contract to get paid for it. We profess to heal; we profess to be involved with health care; we profess to helping society become healthier..... Do we have an accountable system, for example in the medical profession, to carry that out? I would argue that to a large extent we don't. We have a limited doctor-patient interaction, fairly well characterized, but as far as the responsibility that we have collectively, to society - I am not sure that we have that at all.

The changes that have occurred with respect to the physician's role in society, as an individual or in organizations, have been significant in the recent development of the health care sector in Canada. As the informant pointed out, the method of remuneration, for example, alters the physician-individual-societal relationship. The informant noted that:

> it's been anomalous in the history of medicine that all the bills are paid, that there is not a portion of the physician's activity that is seen as altruistic, philanthropic and without self-interest. But now in Canada, every physician gets every bill paid. Thirty years ago that didn't happen.

There are some changes in the conditions under which physicians work in Canada that contribute to this changed accountability relationship. Physicians are, for example more mobile and their increased mobility effects their relationship with a community of patients:

> There isn't as much of a connection to the community and to a sense that the physician is a resource to the community. Even family practice, particularly urban, is very fragmented. The physician lives in the suburb. He may have a population in another area or scattered, and there is no definable relationship to those other things that are involved in society.

The informant sums it up this way:

> It's a concern because in some ways the patterns by which physicians get

> paid shape our behaviours and in many ways shape the articulation of responsibilities and therefore shape our accountability. If you are paid on the basis of an interaction with an individual, you become very much focused on the accountability for that interaction. If you do not get paid for interaction with the community, there is little accountability for that activity because it is not seen as valuable... One of the pillars of family medicine for example is the fact that a physician is a resource to a defined population. There is this notion that the whole discipline is community-based and yet the accountability is very much an individual interaction.

Informants were acutely aware of the disparity between the history of the idea of accountability for these professionals, the professional ideals that have been and are promulgated, and the current reality. Just as the idea of accountability in the health care sector is generally seen as tainted, so too is the idea of the professional dimension of accountability mired in confusion and disappointment.

This sentiment was reflected in the comments of other informants who discussed the extent to which the theoretical trust relationship is reflected in reality. One informant pointed out recent polling information that had shown physicians to be second by far to nurses with respect to the trust that could be invested in them. Another stated the belief that "seventy-five per cent of doctor-patient relationships are not trust relationships at all. People move, docs move; they get you in, they get you out." The same view was articulated by an informant who spoke of the more equitable relationship developing between physicians and their patients:

> The aura of a physician, the putting the physician on a pedestal, the all-knowing, the all-powerful... If you go back in time, my parent, your parents, that is what they thought... some universities thought that way...I am not trained to challenge the doctor, to change what he orders me to get done. All that has changed radically...I don't know exactly when.

The role of other professions has had an impact on those changes. "Nurses have been

empowered to challenge physicians...other groups are closing the gap between the all-knowing and the un-knowing, in the professional sense."

Informants were nevertheless respectful of the ways that physicians, as individuals and in their organizations, have increasingly responded to issues of accountability. For example it was recognized by one that the relationship between physicians and nurses is changed somewhat. The informant cited the example of whistleblowing capacity that has been recognized in some settings and institutions and which equalizes the roles of oversight that health sector practitioners can have for health care processes and outcomes.

At the level of relationship between sub-sets of the health care system, between not the individuals but the organizations, between, for example, government or institutions and provider groups (the relationship that is often captured so well by the media), the issues of trust for and accountability of provider groups was viewed as very contentious.

Speaking in particular of health care professionals working within the public service, an informant commented:

> (They) sort of had this notion that, because they knew professionally, what was the right thing to do, they sort of had the sense that they had a higher accountability directly to the public than they did to the government in power.

This "higher accountability" was alluded to as well with respect to provider group organizations. For some informants profession accountability is a thin cover for non-participation in the accountability of the system as a whole. One informant went so far as

to say that "professional accountability is a sham":

> If you ask a physician if he is accountable to the board or to the CEO, I think that most physicians would very likely say, "No, I have professional accountability". Same thing with nurses. "I have my professional body". But at the same time they say that they are accountable to patients. So what is real? Are professionals accountable to their various professional bodies? Are they accountable to the institution? Are they accountable to their patients? In the area of accountability, in my personal view is that you cannot segment accountability to say that you are only accountable to the medical profession or the nursing profession....I do not think that any professional group has seriously thought this through. ..Have you ever seen anything anywhere that talks about the language of accountability? I don't mean that as a rhetorical question. Are you aware of such a thing?

Another informant raised the issue of scope of competence and noted that physicians do not, on the other hand, limit their influence to the boundaries of their medical expertise. Informants gave the example of provider groups claiming that there is not sufficient funding provided for the health care system:

> There's clearly no accountability-basis for engaging in that kind of discussion, publicly. That's self serving. Basically that activity is one that you would expect from the association, the union, because clearly they represent the interests, the financial interests of their particular professional group.

Noting that this sector occupies enormous financial space in the activities of government, one informant generalized:

> ...you start thinking about all of the people who feel no sense of accountability to anything central at all. People who do not want to be accountable; people who see their own independent thinking as being an essential element of what their job is, such that they don't want to be accountable to the government or to the funding or to anything.... In a sense we should be holding ourselves and practitioners to working together for common goals. That's the image that I would rather have of accountability in health... (rather than the one of) practitioners who just want to do it their way and make their own practice and of hospitals that do not want to be part of a sharing system, that want to be able to pursue their own goals....

Said another:

> It's particularly true for people who are professionally designated ...because then a bit of conflict starts to creep in ...their training makes them think of themselves as having a duty direct to the public...

This informant associated the idea of accountability to the idea of "scope of competence" and drew the conclusion that because these professions knew professionally what was the right thing to do, "they had a sense that they had a higher accountability directly to the public."

7.4 Managerial Dimension

When informants talked about accountability they referred to a set of processes, functions and structures that can be labeled as managerial activities. These managerial activities include the traditional managerial functions associated with hierarchical managerial structures or functions closely associated with these traditional functions, some revised to fit the period of health care reform in the 1990's. Some of these functions overlap from time to time with issues and ideas that are associated with the professional dimension but even so, they are essentially managerial, notwithstanding their application to professional roles. (An example of this might be the idea of quality improvement or the identification of best clinical practices.) These managerial functions are outside of the boundaries of the dimension of governance wherein governors are appointed, by virtue of the constitution or legislation, as agents of the Crown to develop and to see to the implementation of policies for the design of health care programs and their delivery.

The managerial dimension theoretically includes line management functions, operations,

staff functions, planning and evaluation, information management, administrative and financial functions, the latter playing an imposing role in the development of policy for health care delivery.

Within this broad scope, informants tended to comment on several managerial functions that stood apart from the rest and appeared to have an important bearing on accountability of the health care system throughout the period of health care system reform of the 1990's.

With respect to planning, and in particular strategic planning, one informant noted that there is in general in the health care system an absence of strategic planning:

> We've shot ourselves in the foot in that in the early nineties...during times of financial crisis or downsizing, the first to go were the strategic planners...the capacity to do the future thinking. We could say what we were spending, but where were we *investing* in the system? Were we making an investment or were we "applying resources to an issue"?

Another agreed that the scarcity of resources relative to growing needs and growing costs of health care services contribute to the inability of those responsible for the delivery of health care services to prioritize health service activities. Given the breadth of activities that must be supported financially and the "competing interests," there is little room to establish or fund innovation or emerging priorities. "Accountability" said this informant is "how you prioritize the budget when you have many responsibilities." This question implies a futuristic point of view that is seldom achieved in the course of year to year funding.

There was something of a consensus amongst these informants that financial and

economic considerations in accountability dominate accountability efforts in the health care system. The public frequently see it this way and in the view of informants, so too do political leaders and governors of health care systems.

The period of reform that resulted from increasing health care costs in an environment of diminishing revenues created managerial environments wherein "all discussions ended on the budget sheet." "And the whole purpose of accountability ... is seen as being for spending the money."

One informant described the affect of this accountability orientation on health care services as a whole. The informant stated:

> ..in some respects some governments blundered into quality control and began to blunder into the practice of medicine.... The government simply does not have the tools to and abilities to control all of the myriad of complex facets of medicine. It's unreasonable and unrealistic.....Suddenly it's no longer the physician that's accountable for practice outcomes.

Another example cited in this same vein is that of early discharge, the practice of identifying patients who can be safely discharged from a secondary or tertiary institution and cared for, either at less expense or at no expense (to the health care system) in a non-institutional setting. This practice resulted from "undue emphasis on financial accountability" when the health care system "went overboard to compensate" for what was perceived as inefficient practice patterns.

The "dominancy of financial accountability" was likened by several informants to the market-based approaches to health care that characterize American health care service

models. These were made more prevalent in the Canadian health system during the 90's, the period during which the prevalent questions was "is there anything in the public sector that we can transfer to the private sector, to do a good job?"

> ...The private sector makes up a bigger portion of the American system and they tend to put the emphasis on accountability in a fairly narrow sense, which kind of relates to the 'bottom line.'

This informant indicated that accountability is construed differently in Canada in the health care system:

> In a sense we have accountability to a global budget, and to live within the budget and to provide the best possible care. So we have these mechanisms, but we are not as simplistic as we think of accountability as in the private sector ...A much bigger portion of the American budget is taken up by accounting for things than the Canadian budget. Therefore I would expect some people to see this as accountability.

Closely associated with this financial and economic notion of accountability is the notion of report cards as a mechanism for describing and quantifying accountability:

> In the US it's very interesting. To some extent the preoccupation is going toward a much more complex model where there is much more attention, much more spent administration and more spent on keeping track of things because of the kind of system in place: the Health Maintenance Organizations, the Diagnostic-Related Groups: the insurance system requires a whole lot more accounting for things than the Canadian budget.

The influence follows:

> In Canada a lot of things flow north. Certainly there has been a lot of the outcome information - New York and Florida ...by-pass outcomes published on the front page of the New York Times and Los Angeles did it by hospital and one of them by surgeries, their deaths per one hundred patients for the last year... The problem is it sounds so reasonable. It sounds like it makes sense. You're putting this huge investment into the health care system. Shouldn't we know whether one institution is doing better than another?

Another perspective is also revealed regarding the idea of evidence, closely associated in

many minds with the phenomenon of report cards:

> Report cards and auditor reports. All they are, are tools to reassure stakeholders. All hindsight. The question is not what did we do, but what did it buy us? This is the dimension of accountability that has not been explored.

The conclusions that can be drawn from report cards are not necessarily the correct conclusions. Another informant notes:

> The argument has shifted from 'we do not have enough money' to 'we do not have enough information.' Report cards may distort the understanding of health services. You can hardly argue that there is no accountability. Most governments have changed because of, or largely because of, health care. Report cards are a red herring.

Others assert that report cards, while not necessarily the sole answer to accountability, make an important contribution to the management of health care services. Not the end perhaps, perhaps the beginning. "Report cards are just a starting point," to be augmented with other efforts such as "the development of a sense of responsibility for peer performance."

"We do not appear to be very good at using evidence to drive decisions" said one informant who distinguished evidence from the content and purpose of report cards. "Report cards" he said, "are something that measures your personal performance... something you get at the end of a term, summaries, final judgements." Political leaders shy away from such a thing. An emphasis on outcomes of care, an idea intrinsically more positive, "could be used to engage citizens in a discussion about what they are compared to what they should be."

7.5 Community Dimension

The idea of community as a dimension of accountability is really more of a construct of ideas that include community and public involvement apart from the public's involvement through various forms of governance, community and public education and the idea of population health as a driver for the health care system or not. Informants established the two way flow of interaction - from the community to the creation of health care services and from the health care service back to the community in appropriate forms of preventative care, acute care service, and patient education.

Public involvement and community participation was implicit in the views of several informants. In some respects it was the flip side of the accountability that comes through governance models, implied by disillusionment with the political aspects of accountability - the realization and acceptance that political forms of accountability are far-removed from the kind of immediate accountability that citizen engagement or public/community involvement brings to the operation of a health care system.

One informant discussed the consultations undertaken by the National Health Forum in this context, as a departure from the accountabilities that governance models provide at the national level:

> ...in that forum ... in a number of consultations, there was a real sense that they had to be listening ... this was not a group of academics and others, sitting around and making it up. You would have to listen to sort out the issues, the things in the context of what the public thought of them.

And another reflected on what used to be a participation of the physician in the community

as a part of the physician's role in the provision of health care services at the local level:

> ...there is not as much of that connection to the community and to the sense that the physician is a resource to the community. Even family practice, particularly urban, is very fragmented. The physician lives in the suburbs. He may have a population in another area, or scattered, and there's not definable relationship to those other things that are involved in society.

One informant who discussed the accountability of the health care system in general called for a public that is more engaged in the critical decisions of health care delivery and more aware of the participation in it of various powerful, vested, interest groups. Using the illustration of the influence of the medical profession (in the informant's view the less than progressive influence) in the planning and operation of the health care system, the informant asked:

> Who controls it? Who can tell the medical association that this particular area (*of comment or influence*) goes beyond what you are supposed to do as a Medical Association? Who says that? The government? And who tells the College about the areas that they want to walk around: That's clearly your responsibility - now carry it out! I think that can only be done if the public is in tune with the relative accountabilities of the College and the Medical Association.

Informants reflected on the need for community education about how the health care system works and the structures of decision-making that are part of the system. There was a recognition of the need, but also a concern that the kind of public education that would prompt involvement would be difficult to achieve:

> The reason that I am saying that accountability is a sham is because, well, engaging the public in that kind of education...I do not know if it's achievable...There are so many things when it comes to educating the public that God-knows how you can begin to do it... The problem with educating the public is that there is no such thing as a homogeneous public...

The status quo is such that:

> So when we talk about involving the Canadian public, let's be blunt about it: we are talking about communicating for the most part with the middle class, upper middle-class people and that's where the essential communication is. However if you want to focus on health care, or any kind of social activity - the people most in need are the poor.

Other informants spoke also of the challenges associated with educating the public and the community about health, health care, both at a personal level and at the level of the health care system. One associated education to the promulgation of evidence about outcomes of health care system efforts:

> I believe that from the first time that I saw the Oregon benchmarks, I really believed that they were attached to something good. That once you had outcomes, once you could report what outcomes were, and then engage the community in a sense of what those outcomes ought to be (and those are two separate steps) you would begin to engage a community empowerment process that would transform how much ownership people have over health status and therefore - that would be the beginning of some improvement in the health care system - .... recreational agencies, seniors' clubs believing that they have a role to play in fixing a particular outcome that is happening within their community.

Another informant linked "evidence" to this process of public education and to the relationship of the health care authority to the community that it serves:

> The community understands the evidence and it gives them confidence to work with us that we will not go where the evidence does not lead us.

Building community confidence in what? The evidence, in the process of decision-making, in community empowerment or for another informant:

> ...community resilience. You know the stuff: weak communities do not have the power to improve their conditions. Strong communities have the power to improve their position. They have no power except in the evidence and if you have the evidence, you have the gold.

Informants drew connections between evidence and education, education and empowerment, empowerment and public involvement, public involvement and making

progressive changes to the health care system at the community level or at the national level. One informant noted finally in commenting about accountability in the health care sector:

> In many ways the challenge for Canada in terms of the health care system, I mean, we, with some local exceptions, have it better than almost anywhere else in the world. And our healthcare system is fine...really. You know, it's not much to lose sleep over. ... The problem that Canada has is that we have got to get our heads out of the trench and see where and how we are contributing to global health....our international obligation to a universal health care system.

The informant added, now returning the the meaning of accountability associated with the purposefulness of the health care system:

> The underpinning or overpinning of the vision of the health care system still needs to be clarified. Do we believe in it? What is the vision and then the strategies need to be clarified. Both the wider strategies as we begin to understand the interconnections of health and so many other areas of our lives that need to be considered and then there needs to be monitoring systems, not related to expenditures but related to the outcomes of concern, the outcomes that should be on the lips of every major politician - levels of immunization, the rate of child poverty, how many kids go to school without lunches? Success rates at every level of the educational system should be every bit as important as whether or not our budgets are in balance or not.

7.6 Summary

In the context of the Canadian health care system, key informants identified elements of accountability that loosely sorted into five powerful dimensions. **Meaning and purpose for the health care system** established that the vision of the system, its goals and boundaries are fundamental to understanding appropriate accountabilities and mechanisms for accountability in the system. Informants expressed concern that this task has not yet been undertaken in a thorough way in Canada and that much of our anxiety about health

care and accountability results from this omission.

Governance was identified as a fertile area for establishing and monitoring accountability in the system, but its limitations were also identified clearly, as was the loss that has been experienced in this dimension because so much of the potential for accountability in this dimension has been unachieved, even wasted.

The area of **professional accountability** functions like a double-edged sword. It represents an important and powerful foundation of the caregiver - patient relationship and in this respect is the most significant accountability relationship that the public can appreciated personally. That same powerful relationship can impede, on the other hand, the development of broader accountabilities that take into consideration goals of the health care system that may be broader and with the potential to fulfill societal goals that go beyond the needs or wants of a single individual.

Managerial accountability gathers a plethora of activities for which accountability is critical in the operations of health care systems: financial, human resource functions and organization, planning, reporting and the use of evidence to aid in decision-making. Areas of managerial accountability do not however represent primary accountabilities but function rather as subordinate accountabilities in the context of larger purposes for the health care system.

Accountability with respect to the **community** is a dimension of accountability in the

health system that includes citizen engagement and public involvement, the understanding of the community's needs and capacities, educating the community and the goal of optimizing population health using and influencing the determinants of health. This dimension accepts that the systems of governance are separate and apart from this community dimension; both are necessary, either one alone insufficient.

CHAPTER 8

Findings: Meaning of Accountability from the Perspective of Service and Advocacy Groups

The purpose of the informant interviews with members of community-based service and advocacy groups was to determine in a preliminary way what agreement or congruence exists between executives and informed representatives of health care delivery agents and advocates in the community regarding accountability in the health care system, its meaning and dimensions.

The decision to undertake this research in the form of focus groups rather that in in-depth individual interviews came about as a result of the desire of the groups to reflect the consensual participation of professional and non-professional team members who work together on the agency and advocacy efforts. For one of these two groups the process of discussing the meaning of accountability in the health care system was welcomed because of the group's interest in exploring the meaning of accountability and in generating a process to address the agency's accountability mechanisms.

8.1 Meaning of Accountability

With respect to the purpose, meaning and value of accountability in the health care system, informants in these groups noted that this accountability in the Canadian

environment is different and more difficult that accountability in commercial endeavours. One informant noted:

> I think that it's more straight forward in businesses other than health...there are so many value-systems that if you sat people around the room I bet they would all have different standards to apply to accountability in health care.

Another informant acknowledged the values issues associated with accountability in the health care system but at the same time noted that, apart from the issues of competing values, there is no evidence that accountability is a hallmark of the system as a whole. This informant decried the dearth of visible accountability:

> My sense is that at the macro-level (accountability in the health care system) is chaotic, erratic and inconsistent and not very transparent. It's very hard to find out even who is responsible for what. The decision-making is so huge....I do not know what's going on in the rest of the system ...

From the point of view of service providers:

> Who knows what accountability is? You are responsible to so many people for so many things. How is the health care system to balance all of that? ...to the client that you are responsible to...to the governing body with its regulations... the legislature, the funders, the special interest groups within the community. They all think that you dance to their tune. How do you ever decide?

Another informant noted that despite the apparent absence of accountability, there is a contradictory yet powerful expectation, on the part of the public and on the part of participants in the health care system, that means of ensuring accountability are necessary:

> Well, there is no accountability. But people have expectations. They want to know how it is and why it happens and there is not any answer...The buck has so many places to stop that you do not know where it is that you go to say 'Well, why?'

At the same time informants from these advocacy groups indicated the importance of the health care system and the accountability that Canadian society as a whole shares for it.

Canada's health care system was credited with playing a significant role in establishing a national identity: "We define ourselves with our health care system. It's part of the Canadian identity," said one informant:

> That's why in many ways its very different from a commercial operation.. We are not health care consumers. Maybe 'patient' isn't the right word either but this is not simply a commodity to consume.

Another expanded on this idea to assert that the health care system is necessary to the democratic nature of Canadian society:

> ...the other part about the difference in health care is that the very health of the nation depends upon the health care system. ... In fact, along with compulsory free education, it is one of the bedrocks of democracy. If you do not have a health care system, if you do not have egalitarian access to health care, then you do not have one of the key pieces in a democratic society - if the poor people are unable to keep themselves healthy - we have to have healthy people to continue as a healthy nation.

The way that accountability guarantees the achievement of this requirement for democracy is, however, difficult to define:

> My vision of a democracy cannot be maintained without medicare and you cannot have it without federal, provincial and civic responsibility - and accountability ...How one holds government to that, I don't know.

Informants by and large expressed the view that the meaning of accountability in the health care system is not clear and that the mechanisms that exist fail to provide the degree of accountability necessary. Accountability in the health care system is both vague and complex.

Informants noted that health care system accountability must include in its scope the population's health at the same time as it upholds the right of individuals to receive direct care that is in the best interest of the individual. The failure of governments - "accountable

bodies" - to do so is a result of the failure of leadership and the failure to articulate a vision for the health care system: "Look at the kind of vision that came out of the Lalonde Report, way back. That's accountability."

8.2 Governance Dimension

Involved intimately as they are in the work of health care at the community level, informants from these two agency/advocacy groups did not comment, top of mind, on the constitutional or jurisdictional aspects of accountability. They expressed though a fairly high degree of consensus around the idea that accountability is abdicated through the political process and through the structuring of the health care system, particularly through measures of off-loading and regionalization. At the most senior levels of governmental influence on the Canadian health care system, informants noted that:

> ... there is less federal power in decision-making. And you have a different generation of people....who don't realize what it would be like without medicare. Politicians reflect that; politicians come out of an upper middle-class background by and large, and have choices.

Further their accountability can be misplaced. Using the illustration of Canada's extension of patent protection legislation for pharmaceutical companies to twenty years, an informant observed:

> When the government confuses who it is accountable to, which I believe it did in 1991 (they are aware as much as I am that this is a deliberate choice that they made) it's confusing who they are responsible to ... The citizens elect them; they're accountable to the citizens...and those kind of decisions are a betrayal of their accountability. If it is going to negatively impact on the health of the citizens of Canada ....then they've missed the boat on accountability.

For other informants the nature of such a decision explains a general lack of transparency in government decision-making in respect to the health care system:

> Decisions are being made by health ministers behind closed doors and by first ministers with no real public consultation at all. They do not want the public to debate the issues and they want to give the impression that they have no other alternative about what they are doing.

Summed up by one informant, the problem is that "all political parties are in this politic of power, rather than the politic of change."

Many informants focused on the structural aspects of governance when they talked about its relevance to accountability and observed that the financing of health care services, both from the federal level of government to the provincial level and further from the provinces to local authorities through pervasive regionalization, had altered the reasonable expectation of citizens for equitably distributed health care:

> It didn't use to really matter whether you came from a poor province or you came from a wealthier province, but now the individual (provincial) government is going to have to raise the money to provide the health care for the region. Then if they do not have the money there is going to be more problems with their accountability, not just their accountability toward health but education and whatever.

Yet there is an absence of clarity about what standards and practices must be applied to health care services and what level of government is able or willing to guarantee that they are available:

> And who is responsible? Are the feds still? Even though they are not paying much? Are they the ones responsible for the *Canada Health Act*? Are they the ones who are going to tell you what you can do or do not do? Or are they going to say 'it's your regional health authority that is providing your money so they are the ones that are going to make the rules.'

Regionalization of health care that occurs in most provincial jurisdictions has exacerbated this accountability problem further:

> The questions that used to go to the federal government, then to provincial ministers, were off-loaded to the regional bodies and they have to decide based on how they look at things.

To whatever extent regionalization had others purposes, these and their realization remain unclear:

> My own experience in regionalization, as much as I really believe in it is that no one has actually helped medicare in its challenge...I think that it's a show that costing millions of dollars.

These other purposes of regionalization represent what might have been expected in the minds of some informants. The process that approximated regionalization in Quebec in the 1970's illustrates some of the more desirable outcomes that have not been realized in other provinces:

> .... having regionalized, having (a system) of community health clinics they would have a far more educated population around "What is health care? What is health education? What is your right to health care? That was a follow-through of accountability in the province that other provinces did not do. ... There was a vision for a more egalitarian system of health care and they did it. ...The government took some responsibility to develop a system and have control over it. ... It wasn't just regionalization. It was the implementation of a community health care model and we're not there - we're not even talking about that. These community health organizations have their own boards which are elected boards, so it's a democratic kind of thing.

Instead in their experience of regionalization, these informants share the view that:

> Here it just looks like putting another step between the people and the government. It lessens accountability because the Regional Health Authorities say that they would do 'this' but 'we're not getting enough money from the provincial government and you talk to the provincial government and they say 'Talk to your RHA'. ... the additional step is just a sort of oversight of existing services, not the re-creation or organization of services.

8.3 Professional Dimension

Informants expressed a range of opinions about the place that professional accountability holds amongst the several dimensions of accountability. Several health professionals shared the view that professional accountability, while not without its internal conflicts, still provides the clearest accountability framework:

> ...as physicians we have professional accountabilities. We have accountability to the College and to a set of regulations as professionals. We have accountabilities to our patients or clients and we also have some accountabilities to use our health care dollars in the best way, knowing that they are limited ...

Another informant described the vagaries of professional accountability that are affected by underlying personal values not necessarily defined or even transparent:

> In trying to cope or to find the best or most economical way to proceed on a particular problem you might consult with a colleague...it's who you chose, too. Who you feel accountable to most often is partly a matter of personality. Sometimes physicians feel comfortable in trusting a client to direct the choice; some are very tied to the system; some feel that the financial is what I am accountable for above all. Other physicians are very much: 'My goal is to make this person's life as good as possible'. Sometimes you make that choice consciously, sometimes not...

One informant held the professional code of ethics responsible for "the underlying way that you react to everything." Still another noted that this cannot be equated with the client automatically getting what s/he wants:

> You have to be accountable to the system because your client is only one client. It would not be consistent with my professional code of ethics make sure that everyone gets what s/he wants.

On the other hand, an informant noted that the accountability to which the profession holds the care-giver, might over-ride what may be better for a client. "The accountability

that a co-worker holds you to might inhibit some care that might be good for the patient."

Alternatively, the accountability that a professional health care provider may feel to the population as a whole might create risk for one individual. The informant offered immunization as an example:

> ..the reality is that one out of maybe thousands will have a bad reaction and potentially die or be damaged for life...but in the context of the whole society, if you do not have herd immunity then you are going to have disaster for a whole community, right? So what then is your accountability to this woman sitting there with her baby? ... As I said, I hold my breath after every immunization.

Non-physician informants expressed less confidence that the accountability required in the health care system is exercised by physicians appropriately. The system, one said, has insufficient means of holding physicians ultimately responsible for health status:

> Are doctors accountable for whether or not their patients are better two years down the road than they were two years before? No! Not at all. Doctors aren't accountable...but when they err, they are accountable to their colleagues. But as far as making the patient healthy? No.

And in a larger context the system fails to provide the structure that maximizes the opportunity for physicians to work in accountable ways:

> Maybe the treatment is not one that should be used. Maybe another health care professional could provide more appropriate care. There's no standard for that. You can have highly trained pediatricians seeing a baby every three months for injections, for immunizations. What for? Why are pediatricians giving immunizations to babies? We have nurses who are supposed to do that and they could do the health education as well or better. We have never set up a system with standards that health care providers have to meet. .... We have nothing that says a psychiatrist has to see people with acute mental illness...A psychiatrist can graduate, be trained, by and large from the public purse, and see people with minor neuroses their whole lives.

This is less the failure of individual providers than the failure of "the system" that is directed by governments and accountable to citizens:

> The system needs to use physicians in a good way. And it needs to use nurses in a good way. And they need to set up a system that is not only good as a medical model, but also look at health maintenance and health standards.

8.4 Managerial Dimension

The managerial dimension of accountability for these informants touched on financial accountabilities and the use of evidence as a support for decision-making in health care. It was clear from the comments of many informants that the boundaries between professional accountabilities and financial accountabilities had blurred over the last decade. Informants referred to the professional obligation to "use the health care dollars in the best way", "to proceed in an economical way":

> It's within the last decade or so that physicians have been pushed, more and more, to think about the financial implications of the tests that they're ordering... before it was 'these are the tests that you need when you think that this is what it is' but it's in the last decade that it has been pushed to the individual physician. You are the ones that are going to make the difference to the bottom line of health costs...You're the one, if you order too many tests... You're accountable for the financial realities of our health care system and it wasn't like that before.

This same informant acknowledged that "we should be practising in the best knowledge that we have and we should be ordering with a purpose in mind." Still, the accountability that is properly placed in one sector of the system is misplaced in another.

> Going back to the example of health care resources and the doctors have had it beaten into them from a cost and payment point of view... I would argue that the cost and finance people are taking over the lead for this (appropriate allocation of resources) when there is twenty years of literature out there that suggests that over-medicalization and over-treatment makes some people as sick not being treated.

Confusion then is created in the accountability by the misapplication of accountabilities

and the exaggerated attention given to quantifying services, two forces that often exist in contradiction:

> The issue of how we are accountable...All they care about is 'give us your numbers!' When you try to give them something different in a different way...The system has not yet found a way to pick up something other than numbers...One of us talks to fifteen women about menopause but that counts for very little. The things that the system puts value on to ensure that we are accountable to our funders, are not necessarily the things that are particularly useful...You are not rewarded for how much money you save because that is an indefinable amount ....By educating someone who now has the information that they need, you can't calculate a cost-saving.

Because "the traditional way of holding physicians responsible has been with fee-for service and with numbers" the activities that can best promote health are de-valued and subject to disincentives:

> The funding for the next fiscal year is based on what you billed, so then you lose and you have less people to work in the agency. The direct service is one aspect, but we put a lot of resources into the education and counseling, and trying to bring people in the community together, things that the system does not know how to handle.

Despite government rhetoric to advance population health goals in the health care system generally, systems of physician payment and agency remuneration, even Regional Health Authority funding, in the view of these informants, protect old and perverse cost and service drivers in the health care sector.

> It's all about numbers! It's not necessarily about accountability at all and how do these people do in time, or valuable services or outcomes. It's all about numbers...Divide this into the amount of money that we're giving you.

It is in this managerial dimension that issues of evidence are addressed and critiqued in the context of the system-drivers (and absence of drivers) that remain from the early days of Medicare:

> There is such an increase in technology and knowledge and information systems that are not necessarily validated as to how worthwhile they are. Ideally medicine is supposed to be evidence-based but many of the things that we do are the things that we have always done and there really is not any evidence for it at all...Evidence-based stuff is really dumb because you go to your doctor and we will treat you for whatever you have in twenty minutes!

One informant noted that the area of technology development was creating pressures on the health care system and its cost, given that governments have neglected to establish standards for the use of high-tech equipment. This phenomenon is associated with the fact that physicians control access. Because the system is based on a "private practice model where no one can challenge anyone - no doctor challenges any other doctor - they do whatever they want and there are no standards set about how one should practice."

Accountability for these informants includes management decisions taken by governments to organize and control the health care system and to ensure the outcomes that are desired:

> It's the design of the system. Designing and maintaining control of the health care system. ... Governments, just like small communities have to design and implement a whole system. ...You have to do that on the macro level and it is the responsibility of the federal government to decide on its role and then for the provincial governments to do the same.

When necessary, and in the view of these informants it is necessary now, governments must assume responsibility for broad structural revision that goes beyond governance:

> It includes goals ...but it also includes models of health care delivery... The federal government must design a system to work for the benefit of all of its citizens, designing it so the provinces also have a role in determining how they are going to implement that system in their province.

Efforts to pursue accountability through report cards, quantifying outcomes, activities and comparing the systems of one jurisdiction or institution to another, are insufficient:

> The system cannot be changed very much without re-jigging how the whole

> system works. What's being done all the time is they just tinker. They tinker with this and they tinker with that. Like report cards. Some of the standards in report cards are helpful. It's helpful that they tracked it and some are just little tinkers that aren't going to make a difference to anything.

8.5 Community Dimension

Informants appreciated the challenges associated with engaging citizens or communities in processes to develop the scope and goals of the health care system. By definition, these community-based service and advocacy groups saw responsiveness to the community's needs and agenda to be at the core of their mission. Informants would generally concur with the statement that "there has to be a public debate about shaping the kind of health care system we want." Notwithstanding this fact, some informants appreciated the conflict created by the middle-class expression of need and right:

> I'm worried because the people, especially the middle-class want it, believe that they deserve it, they've earned it, so give it to me!... it's an example of what our generation has done with medical care, right? We've managed to flip it over,,.as the baby-boomers start to engage with the health system - drugs, devices, tertiary care - I'm nervous because I think that we still have a sense of me, not we.... As a woman working in the advocacy community and with women and on poverty...how do we facilitate a public interaction? develop the skills and knowledge in the community to understand that? Otherwise it's going to sound like the state or an HMO or the doctor restricting access to something. We don't want that.

Consultation with the public is therefore an important component of community responsibility and accountability:

> People need to know the reality as well, where you say okay, here's what we have; here are the decisions that have to be made. If we do this, you lose service; if we do that, you gain this but you lose that. ... Part of the difficulty through the whole system is that we speak the words of accountability, but we do not walk the talk.

Informants also identified that an aspect of accountability to the community is the adoption of a population health approach in the health care system. Informants form the advocacy and agency sector also acknowledged that good health results from conditions and initiatives outside of the health care system. One said:

> If good health is the outcome that we want, then that's even harder for the health care system to achieve, because there is so much more to it, like education. You have these other systems that impact as well.

8.6 Summary

The dimensions of accountability that were identified in Chapter 7's analysis of key informant interviews were sufficient to group the views of community and advocacy informants.

With respect to the **meaning of accountability** as it applies in the Canadian health care system informants saw the fundamental meaning and purpose of the system to be less system-specific and more a values statement of Canadian society, democracy and identity. At the same time these informants were cognizant that these values attachments of the Canadian health care system were being lost in the debate of the health care system and being replaced by other arguments and debates about health care systems, their organization and cost.

With respect to the dimension of **governance** informants here expressed similar ambivalence to the key informants in Chapter 7. More affected by governance close to home, at the provincial and regional levels, these informants decried the apparent absence

of accountability in existing governance models and the absence of congruence between the promises held out for accountability and the realities observed.

The dimension of **professional accountability** revealed many contradictions. As many of the community and advocacy informants participated in caregiving roles, they were occupied by the different sets of accountabilities that were emerging as additions to the traditional set of patient - provider accountabilities. Financial accountabilities have been mixed up with professional ones and the physician's role has assumed gatekeeper functions beyond entry to the system alone. Still the clarity and purposefulness of the fundamental caregiver-patient accountability to do the best for the patient at hand is sufficiently powerful that other statements or visions of accountabilities, poorly articulated or not articulated at all, are uninspiring by comparison.

With respect to managerial accountabilities, a certain cynicism existed in this dimension that was less apparent for the key informants of Chapter 7. Associated perhaps with the subordinate role that community health care providers and advocacy informants seem themselves as playing, in a role less powerful and elite, views of the managerial accountabilities were expressed with more scepticism and less confidence that the day to day managerial accountabilities demanded of them were credible or useful.

The area of accountability is relationship with the community served came easily to these informants. The principle of responsiveness to the community, involvement of the general or defined public served is built in to the operation of these community and advocacy

agencies. The perspective of informants in this dimension of accountability accommodated though the challenges that are intrinsic in this area, challenges that include patient and community education, the gap between the vision of today's health care system and creation of a health care system vision that could offer more long term sustainability.

CHAPTER 9

Discussion and Conclusions

The research has undertaken a review of literature with the purpose of establishing the meaning of accountability and beginning the process of applying this meaning to various dimensions of accountability that are relevant to the health care system and sector in Canada. The research has been conducted in the Manitoba health care community but has drawn as background on literature and contemporary discourse that is likely to be known by key informants, or at the least, would contribute to the current cultural and sectoral environment in which key informants live and work.

The theory of accountability, as we have found in the general political science literature, together with some of the imminent changes in its conceptualization and conduct has been reviewed as has applicable literature in the health care field in Canada and the United States. In the Canadian environment additional contemporary discourse has been considered, in the form of provincial legislation, federal provincial agreement and conference proceedings. American literature on accountability in the American health care sector has also been reviewed and has, in the end, brought to the discussion about accountability some useful ideas relevant to the Canadian health care system as it undergoes many changes.

Key informants in executive and administrative roles in the health care sector participated

in in-depth interviews about accountability, its meaning, importance and relevance in dimensions that they identified.

The idea of accountability in the health care system is important. Probably the singular most important overall conclusion that can be drawn regarding accountability in the context of the Canadian health system is that the idea of accountability is important and that the confusion, real and perceived, that currently exists around it is a problem that requires attention. Key informants identified the topic of accountability as an important one. Many referred to it, as we have seen in Chapters 7 and 8, as central to the sustainability of the national health system and as an important and lofty aspiration that would correctly apply to all participants and institutions in the system and which would supply the driving force on which to re-build a national health system.

It would be incorrect to say that accountability was the foremost issue in the minds of the informants in this research. On the contrary, the subject of accountability seemed a bit of a surprise to many of the informants. Not infrequently the initial response of informants to the prospect of a discussion on this subject was to claim that they were not best suited to participate in such a discussion - not expert. This was not a rule but it happened more than once. Having said that, informants did not approach the topic with reluctance. They seem to have welcomed the opportunity to talk about accountability. Setting the issue of their own expertise aside, they uniformly expressed the view that the topic was of considerable importance and of considerable difficulty.

There is ample evidence from what is said and what is not said about accountability in the Canadian health care system, that the issue of accountability needs more exploration and understanding. The Canadian literature on this subject presents a narrow view of accountability, largely fixed in the traditional public administration framework for accountability and failing to address the new accountability requirements that emerge from a more educated and informed public. In addition, the New Public Management that Thomas has described, and which promises to alter our governance systems, hierarchical and business relationships and the relationship between private and public enterprises, promises to change our capacity to plan and manage health systems. Our understanding and approaches to accountability in health systems will become increasingly inadequate to the challenges that face Canadians and Canadian governments.

The idea of accountability as articulated by key informants supports the view held by Emanuel that accountability is indeed a "keyword". Emanuel's description of a keyword includes the fact that "it serves as a short-hand expression for an entire view" and its attributes "serve as a normative guide" (1996:240). This contention was born out by the assertions of key informants, who frequently focussed on the subjective meanings of accountability rather than the objective, and appeared to be knowledgeable about, but not dependent on, the traditional or contemporary mechanisms of accountability to establish their understanding of its meaning and intent.

A striking aspect of key informants' contributions was the emphasis on the values of Canadians, values of health care and the uniqueness ascribed to health care that makes its accountability requirements different from those that might exist in relation to other

societal enterprises. Sceptics might say that this is part of the mumbo-jumbo of the discussion about health and health care, the crack in the door to permit unscientific thinking to creep in, to quash the rule of "evidence" as it applies to health care or to muddy the waters with sentiment. But the fact remains that discussion about accountability did indeed lead informants to pursue a discussion about values. It inspired discussion about the ultimate purpose of health care, its equalizing affect in society in Canada, the health care system contributions that help to shape our morality, our compassion, our sense of equity and fairness.

So what are these values?

The "values" of the *Canada Health Act* were almost always referenced by informants. Not surprisingly the values or principles of the *CHA* were known to informants. Throughout discussion they were raised as examples of what accountability should be about. At the same time though, informants did not dwell on these "principles" or their value content. The principles and the *CHA* in general were somewhat taken for granted, passed over as givens. No informant challenged their importance or their appropriateness and there was a general consensus that the *Canada Health Act* had achieved its purpose in establishing a universal, publicly administered program of health services. The principles prompted no particular debate. On the other hand, the principles were also spoken of as though they had lost some of their intrinsic meaning. As principles, they somehow fell short of the mark of operating as "guiding principles".

Informants shared little knowledge of provincial frameworks for accountability and although the Framework Agreement for Improving the Social Union was known to most informants, its provisions and requirements for accountability for all of Canada's social programs were largely unknown. SUFA's statements regarding values were not familiar to most informants.

Canadian literature has not addressed the meaning of accountability and except for the contemporary call for evidence-based decision making and improved performance reporting, the literature has not undertaken a debate or analysis of accountability at all. The American literature has addressed accountability in a more complete way and has offered some examples about how and in what terms accountability can be considered and discussed. Definitions, meaning, elements and dimensions are all a part of the American discussion of accountability in the health care system over the past decade and demonstrate that the discussion about accountability as a fundamental aspect of managing health care systems can indeed be broached to some advantage.

Informants implied in virtually all interviews and focus groups that existing conceptualizations of accountability do not meet an increasing need for clarity and that the absence of this clarity impedes important progress. At one extreme, and this was applied mostly to the political dimension, the prevailing notions and practices of accountability were viewed as fraudulent. In this extreme position, politicians at many levels were thought to be divided in their attention, priorities and accountabilities. Where accountability was required with respect to health systems, this accountability could easily

be set aside for the sake of political longevity, real or pretended considerations that could be construed to take priority over issues of health, health systems or health status. This might take the form of hiding behind cabinet solidarity, putting other systems and objectives to the forefront (the economy might be an example) or using communications ploys to discount or ameliorate public anxiety.

At the other extreme, some informants welcomed the creation of information management strategies to produce evidence for health care system decision making, performance measurement or institutional/provider/provincial report cards (including those informants who simply acknowledged their utility). Informants thought of these strategies as necessary but insufficient to the objective of increasing accountability within and for the Canadian health care system.

In general, existing conceptualizations of accountability and certainly current accountability practices are viewed as inadequate, or not workable, or not contributing sufficiently to the system's management and improvement.

Another aspect of the importance of accountability for the health care system was the issue of choice. Accountability for the health system as a whole and for health care at the level of the provider and of the individual receiving care, is related to the idea of making decisions about what the health care will be. Informants were cognizant that choices at the macro level were required: choices, for example, regarding scope or entitlement to care in a universal, publicly funded program of health services, or choices about how much of the

nation's wealth should be allocated to health care as opposed to other societal, health-producing initiatives. This continuum of choice emerged as a reason to make early decisions about accountability, its underpinning in values, and its implementation in processes.

Accountability within the health care system can be organized around logical dimensions. In the analysis of informant interviews it soon became clear that a logical framework for health system accountability could be created by "sorting up" the contributions and issues of key informants into a set of discreet (and inter-related) dimensions.

Five dimensions flowed logically both from the frameworks for accountability in public administration theory and from the data acquired from key informant interviews. **Table 5** illustrates the dimensions of accountability produced by discussions with key informants. A discussion of each follows.

In the context of the health care system **the purpose of the system or program cannot be separated from the meaning of accountability**. These are inextricably intertwined. The idea is that accountability comes from a shared understanding amongst governments, citizens, providers of what the purpose of the system is, what its goals are, what its effects are intended to be. The absence of these goals, purposes and intents eliminates any possibility that accountability for the whole or the part can be achieved in any real way. Similarly it is equally useful to understand what the program of services is not intended to

Table 5

DIMENSIONS OF ACCOUNTABILITY IN THE CANADIAN HEALTH CARE SECTOR AS IDENTIFIED BY KEY INFORMANTS

DIMENSION	ELEMENTS
Purpose	• definitions; subjective meanings; macro-accountability • unique conditioning factors in the health care sector • values: CHA principles, vision, community, evidence, sustainability
Governance	• constitutional • statutory • other governance • political
Professional	• professional • clinical
Managerial	• economic • financial • information/data • hierarchical relationships • administration
Community	• public involvement • community • population health

produce. Current conceptualizations of the health care system in Canada do not lend themselves to any real accountability and impede accountability for discreet dimensions as well.

This need for purpose or meaning for the national health system may explain the ambivalence of key informants toward the principles for the *Canada Health Act.* While acknowledging the importance of the principles, and for many informants, sharing a commitment to them, their effect had been lost as the health care system has grown up and around them. The application of *CHA* principles to acute care services which were sometime ago lost in the midst of additional, non-acute care services, makes them less meaningful than they once were.

A description of the scope of the health care system, or more specifically what is in and what is outside the boundaries of the health care system, is essential to the idea of accountability. Similarly the products and outcomes of the system need to be described so that processes of accountability can be created and applied in critical areas.

It should be noted at this point that establishing the purpose of the health care system at the macro level requires consideration of macro issues. If the health care system is to do its limited part in the improvement of health status of Canadians, in the larger context of a population health - or health determinants - approach, then financial resources of the country need to be put towards other determining initiatives. Macro objectives are required that have sectoral implications described clearly. Attendant limitations on health care

system spending need to be clear.

The discussion of the macro level, where the health system fits in, what part of national resources it consumes, what priority is ascribed to it in the context of other needs and demands, is fundamentally based on the understanding of the values of Canadian society. What is it that Canadians value? Is it, for example, the prolonging of human life, beyond any other societal goal, that drives continual spending and pre-occupation with the health care system? Because if it is, then this needs to be said, and it implications understood. If it is not, then the boundaries which are required to describe the choices about health care within the national health care system also need clarification in our health care policies and legislation. To say that this requires an understanding of and a consensus about the values of Canadians for the health care system is an understatement indeed. But to ignore it denies the complexity of the decision-making that lies ahead for Canadians and their elected leaders.

One of the reasons that this discussion or consultation with Canadians has to arrive at the answers to these questions is that the content and inter-relationship of other dimensions of accountability in the health care system is determined by this over-arching understanding of the system's purpose.

The traditional dimensions of accountability in public administration, as described by Thomas include political, constitutional and legislative (legal) dimensions. For the purpose of discussing accountability in the health care system, these components of governance

can be combined into one area under the general heading of **governance**. The components or elements of governance are nonetheless important but their understanding would likely benefit from being considered together. This would, for example, help to distinguish the accountability dimension of governance from the accountability dimension of community. It would help to demonstration that the involvement of citizens in the health care system by exercising democratic rights to elect or to access programs or services that are mandated serves a different purpose than participating as a citizen in the development and maintenance of programs for maintenance of personal or community health. It would similarly help to demonstrate that the existence of one dimension of accountability neither replaces or alters the existence or need for the other.

The dimension of governance brought the most concern, frustration and disrepute to the discussion about accountability in the health care system. In part this seems to be related to the fact that so much emphasis is put on the potential of this dimension of accountability to affect change in the health care system and so little change is realized. For accountability in respect of the health care system to be maximized, the limitations of this particular dimension need to be understood, so that emphasis can be better placed to achieve desired accountabilities.

The dimension of **professional accountability** creates the most ambivalence for key informants. Regardless of the informant's role in the health care sector, the dimension of accountability appeared to illustrate both the highest hopes for accountability and the gravest concerns.

The accountability that professionals understand as their own accountability to the patient and to the community which they serve is often described in ways that are inspirational. “The professional” commits to acting in the best interests of an individual patient and to the goal of preserving the health and dignity of the individual. The fact that this goal (or goals) is fundamental to the nature of this professionalism implies a set of values that are often hard to reconcile with what might be considered other areas of societal accountability to which professionals might reasonably be expected to defer.

In the absence of other transparent or accessible processes of accountability, this is the single area proffered as accountability to which the public is likely to attach. It is this dimension of accountability, once again in the absence of purpose and meaning for the health system more broadly articulated, that is the shelter in the storm for many participants in the health care sector and for Canadians as individual health care-receivers. This phenomenon appears to function not unlike what Peterson described when he discussed trust as fundamental underpinning of the physician-patient relationship - as the “cloak that conceals the nakedness” of the vulnerable patient. The power of professional accountability to function as the accountability bell weather for the health care system (with all of the attendant pressures on cost and the inherent danger of vested interest) will exist until other dimensions of accountability are better developed and more articulately communicated to the public.

The framework for accountability in public administration would refer to this dimension as administrative. The **managerial dimension** represents a catch-all for many regulations,

procedures, hierarchical relationships that we have regarded as the stuff of management in the twentieth century. The elements of this dimensions would include but not be limited to hierarchical decision-making, reporting, management information, performance measurement, administration, evaluation, evidenced-based decision making processes and supports and of course, financial accountability. The elements could and would change, sometimes with managerial fashion, sometimes as a function of technology, the availability of resources and other factors. This dimension serves the higher purpose and meaning of the health care system. It is subordinate to other dimensions but must remain transparent.

This **dimension of community** accountability distinguishes itself from the dimension of governance in part at least by its lack of relationship to the latter dimension. Not withstanding processes of governance that are by nature political or hierarchical this dimension reflects the view of informants that the accountability of the community and the accountability of the health care system to the community in general, its interests and needs, stands separately from the requirements of governance. This dimension addresses the needs of the community that cannot be addressed through the governance dimension and which cannot reasonably be expected to be addressed through the governance dimension. It represents not the failure of the dimension of governance to guarantee a certain kind of accountability, but a recognition that the accountability that is characterized by elections at all levels of governments, appointed or elected health care service boards, legislation, constitutions and regulations, does not serve the same purpose as the community dimension that has the potential to prescribe the nature of the health care

system's relationship with the community it serves.

This dimension of community accountability, its terms and elements, has to be reconciled with the dimension of purpose and governance and to a lesser extent to the dimension of professional accountability.

The dimensions do not automatically sort themselves hierarchically and instead require horizontal congruency. Apart from the fundamental importance of purpose and meaning attributed to the health care system - the answer to the question of what the system's vision is - what is the relative importance of the dimension of professional accountability compared to the importance of community accountability or governance? Key informants did not address these issues specifically and no conclusion can be drawn about the relative priority of the dimensions. It is intuitive that the vision, goals and purpose of the health care system must first be established. It may be just as intuitive that the elements of the managerial dimension of accountability exist to support the other dimensions of accountability. The relative importance of the professional, governance or community dimension is left to future research. But it is clear that the process of defining the elements of each of these dimensions cannot be undertaken without reference to the purpose and elements of the other dimensions. Further it must be true that the mechanisms for accountability, the accountability practices, must be developed so as to complement one another.

It is interesting to note that it is this aspect of the accountability puzzle that is the most

significantly short-shrifted by the Canadian literature. The Canadian literature has failed to identify the dimensions of accountability in the health care system in Canada and has failed to observe the relationship that exists between these dimensions even when they are not directly associated with the accountability construct.

An understanding of the American conceptualizations and practices of accountability in a managed health care environment are useful to the Canadian experience in health care systems. The American literature informs decision-making about accountability better than does the Canadian literature. This may result from the angst experienced in the U.S. regarding managed care and the perverse effects that the model has had on accountabilties, real and perceived.

Key informants and community/advocacy informants were aware of managed care models and aware of the debates and dilemmas that the model has generated. Informants noted that increased attention to accountability in the American health care system flows logically from the American way of life and culture where independence, self-actualization in economic terms and competition are valued highly. Informants noted that the health care system in the United States has developed as a private enterprise and shares with business enterprises, business values and economic drivers. The existence of these characteristics in the U.S. health care system and their recent regulation (necessitated by high-costs particularly for employers) has forced a discussion of accountability in the U.S. Canada's immature discussion reflects the relative safety and security that a universal and publicly administered health care system affords. The increasing tendency for

governments in Canada to direct its health care system like a single managed care model (albeit publicly funded), prompts a new consideration of issues of accountability that until now have been eluded.

Issues of globalization will further drive Canadian governments to act in a managed-care way. Without the safety of well defined parameters for publicly funded health care the anxiety of Canadians about their health care system will increase. At the same time this trend will prompt the creation of accountability mechanisms and proposals that will drive single dimension accountability proposals to earlier development and less balanced approaches to accountability of the overall health care system in the context of Canadian society.

Key Informants share a sense of powerless ness. Regardless of the position that an informant holds with respect to the organization hierarchy of the health care system in Manitoba, key informants revealed a sense of powerlessness regarding the health care system and how it might be influenced to be more accountable. Informants expressed this sense of powerlessness in the context of two powerful forces: political forces and professional forces, both perceived to rely on well-established and traditional means to guarantee that their vested interests are safeguarded in future health care systems. Informants were aware of the lack of capacity to re-examine the roles of these groups in the health care system and the challenge of creating new accountability constructs and balances without their participation.

The accountability of the individual in acquiring and maintaining good health and their accountability for participation in the health care system must be further explored. The accountability of the individual for his/her health status and his/her participation in the health care system has not been addressed by this research. It remains thought that this area could indeed benefit from additional research, with particular consideration given to the individual's relationship to the health care system as opposed to one particular caregiver or institution.

Accountability might reasonably be considered a principle of the *Canada Health Act* or a principle of future health related federal legislation. Additional qualitative research might be able to establish whether the issue of accountability can be understood and articulated sufficiently or conceptualized appropriately to warrant its inclusion in the set of principles that governs Canada's national health care system through federal legislation. Does the idea of accountability carry the weight required to warrant inclusion? Can the dimensions of accountability in the national health system or in a provincial health system be described in such a way as to further fashion a national health care system and contribute to the establishment of purpose, the balance of accountabilities of participant groups and to ensure the development of managerial mechanisms to support the accountabilities in action?

APPENDIX A

INFORMATION SHEET AND PARTICIPANT CONSENT

DIMENSIONS OF ACCOUNTABILITY IN THE HEALTH CARE SECTOR IN CANADA

Charlotte Johnson

What is the study about?

Since the beginning of the 1990's provincial governments in Canada have reformed their health care systems to address issues of rising costs and efficiency. In most provinces significant changes have taken place especially in the area of governance, with Regional Health Authorities assuming more authority and accountability. Despite the fact that a period of reinvestment has followed years of financial restraint, there is still concern that the quality of health care is not what it should be, that access to care is not timely and that costs are once again increasing. Debate continues around the question of what the Canadian health system is, what it should be, and what health care system is sustainable.

In response to these concerns there has been an increasing interest in the idea of accountability in the health care sector. The federal Minister of Health has spoken about accountability as it applies to the resources of the health care system, the management of the system and it results. The federal government, along with nine of ten provinces, has agreed to strengthen Canada's Social Union by "enhancing each government's transparency and accountability to its constituents".

Although mechanisms of accountability have always been a part of Canada's health care system in one way or another (eg. the annual report of the provincial health department, the annual financial statements of health care institutions and the self regulation of health professions) accountability as an idea is receiving more attention from the public and more

effort is being made by health care leaders, managers and professionals to understand how it applies in the health care sector.

You are being asked to participate in a research study that will examine the meaning of accountability in the health care sector in Canada. You are asked to share ideas that may be personal or professional; they may or may not be related to your current role in health care. Questions in the interview will ask you to think and talk about various dimensions of accountability and what their importance is. Your answers might reflect your experience as a citizen, leader, manager or observer. All of these perspectives are of interest.

Your participation

If you decide to participate you can expect the interview to take about an hour. (Focus group participation might take longer but will not exceed two hours). I would like to tape the interview so that I can review your comments at a later date and ensure accuracy of my notes. If however you would prefer that the interview not be recorded, I can rely on my notes instead. In either event I would expect to take notes throughout the interview.

You are free to withdraw from the interview or focus group at any time or you may choose, at any time, to refuse to answer any of the questions. By participating you will contribute to the understanding of how the idea of accountability is applied to the health care system in Canada.

Anonymity and security of information

Your anonymity in any published reports of this research is guaranteed. In the event that a comment might be easily identified with one of the informants, the researcher will blend replies in order to guarantee anonymity while preserving content. Your name will be recorded only in an alphabetical list of key informants. During the research project all consent forms, data and tape recordings will be stored in a secure location. Data will be accessed by the researcher only. Data will not be used for any purpose other than this study, which is to be published upon its completion. No data will be available to any third party for any other purpose.

PARTICIPANT CONSENT

The purpose of the research project has been explained to me and I have had an opportunity to review the description of the research above. I am aware that the research is being undertaken by the researcher independently to fulfill the requirements of the University of Manitoba towards a Master's of Science in Community Health.

By signing this consent I indicate my agreement to participate in the study and agree that my answers in the context of this interview may be used only for the purposes outlines above.

_______________________________ _______________________________

Signature of Participant Date

I have explained the nature of the research study described above. I attest that to the best of my knowledge the participant understands the nature of the research and how the researcher intends to use the participant's contribution through this interview.

_______________________________ _______________________________

Signature of Researcher Date

APPENDIX B

KEY INFORMANT / FOCUS GROUP INTERVIEW GUIDE

- Do you have a personal definition of "accountability"? How would you describe it? Does it fit into any larger scheme of things in your mind?
- In your role as a citizen, where does the idea of accountability fit into your understanding of society?
- What is your own experience of accountability in the roles that you have had in your work life? Have you come across ways in which accountability was described or applied that left an impression on you?
- What do you think accountability has to do with health care in Canada?
- With respect to the health sector have you been involved directly in any discussions about accountability? Can you elaborate? Did you have a sense of these discussions hitting or missing the mark?
- If you were to apply your understanding(s) of accountability to health care, in what areas do you think that the principles of accountability are most importantly applied?
- Are you familiar with any particular models or frameworks for accountability for health care? Can you comment on these in terms of strengths or weaknesses?
- Do you have thoughts about how accountabilities for the health care system in Canada should be determined?

APPENDIX C

GUIDE TO DATA ORGANIZATION AND ANALYSIS

Definition

General Orientation / Context or Drivers

- Values Models, Social or Otherwise
- Ideological Model
- Economic Model

Perspective

- Government
- Provider(s)
- Citizenry
- Consumer
- Financier

Identification of Dimensions

- Quality Care
- Accessibility
- Management Issues: (finances, planning, organization, citizen participation)
- Ethics of Care System
- Equity
- Timeliness
- Provider Performance
- System Performance
- Outcomes of Health Care Interventions
- Health Status

APPENDIX D
KEY INFORMANTS

Paul G. Thomas	Professor Department of Political Studies St. John's College University of Manitoba
Dr. John Guilfoyle	Director, Residency Program Department of Family Medicine Faculty of Medicine University of Manitoba Former Chief Medical Officer of Health Manitoba Health
Dr. Michael Moffat	Professor and Head Department of Child Health Faculty of Medicine University of Manitoba
Ms. Mary Scott	Board Member Winnipeg Regional Long Term and Community Care Authority
Mr. Tom Carson	Deputy Minister Manitoba Health
Mr. Ulrich Wendt	Senior Policy Advisor Intergovernmental Relations Manitoba Health
Mr. Helmut Friesen	Retired civil servant Manitoba Health
Dr. Sharon Macdonald	Vice-President Community Health Programs Winnipeg Regional Health Authority

Mr. Frank Maynard	Consultant Formerly Deputy Minister Manitoba Health
Ms. Sue Nielson	Executive Director Manitoba Association of Registered Nurses
Dr. Noralou Roos	Co-Director Manitoba Centre for Health Policy and Evaluation
Dr. Bill Pope	Registrar College of Physicians and Surgeons of Manitoba
Mr. Tom McCormack	Senior Policy Advisor Manitoba Health
Ms. Sally Thornton	Director, Accountability Implementation Information Analysis and Connectivity Branch, Health Canada

Key Informant Focus Group
Women's Health Clinic
Winnipeg, Manitoba

Ms. Barbara Wiktorowicz

Ms Madeline Boscoe

Ms. Sheila Rainonen

Ms. Barbara Goldman

Ms. Jody Thomson

Ms. Deb Kozak

Dr. Carol Scurfield

Dr. Lisa Naylor

Ms. Carolyn Clarke

Dr. Catherine L. Wiebe

Manitoba Medicare Alert Coalition

Ms. Ellen Kruger

Ms.Valerie Price

Ms. Shirley Lord

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