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**Getting Clearer on the Concept:
Accountability in the Canadian Health System**

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**A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of**

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We accept this dissertation as conforming to the required standard

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Abstract

As the public sector and specifically the health sector, undergo reform throughout the Western world in order to find systems that work better and cost less, the phenomenon of accountability is of increasing concern to policy-makers. Although the public administration concept of accountability is ancient, and has been debated and described in the languages of many diverse disciplines, little academic work is available on its meaning or application to the Canadian Health System. Without a clearer understanding of the concept, the basis for improving accountability in the Canadian Health System will remain unknown.

This dissertation seeks to clarify the concept of health system accountability and elucidate the issues related to improving accountability in the system. This is accomplished through a concept analysis methodology using two qualitative data collection strategies: a structured review of Canadian literature on accountability from the domains of health policy/administration, professional and popular literature sources; and, an interview process whereby 24 health system leaders from five Canadian provinces were interviewed.

The findings reveal that the concept of accountability, in its current explicit, performance-based form, is relatively new to Canadian health system policy discussions, its use only beginning in the 1980's. Prior to this, accountability was implicit in the delegation of health matters to self-regulating professions. The concept evolved from public administration theory and continues to evolve as a health concept.

An attempt is made to disentangle the concept of health system accountability from its many related concepts and references. The defining attributes of accountability are: a performance assessment according to standards/goals; an obligation to render an account; and an answerability to the community served. Antecedents or pre-requisites to accountability include a renewed culture, strategic direction, citizen engagement, information management, performance measurement and reporting. Consequences of accountability are: a sustainable health system, increased public confidence, improved health outcomes and quality services, added bureaucracy and uncertainty. Although there is a majority view on the defining attributes, there are several conceptions of accountability: as a theoretical or ethical construct; as gesture; as a formal system or set of practices; as an on-going political process; and as desired outcomes or results. Likewise several normative modes or models exist: the historical professional model, the emerging managerial model and the potential citizen participation model. These are all encompassed within the broader political framework. Also, accountability is a multi-level construct: personal, organizational and political.

There are several policy issues related to accountability and democratic governments in today's modern societies. Within the health sector, the key issues identified, by health system leader research participants, as problematic to improving accountability included: a lack of direction and role definition, cultural issues, a lack of citizen engagement, and a lack of appropriate measurement and information with which to evaluate organization and system performance. Although the purpose of this dissertation is not to answer or provide prescriptions to policy issues, several health policy questions are generated.

I trust that the conceptual analysis presented here will assist to clarify our language and understanding of accountability as it continues to evolve in health care, provide a helpful reference point from which to discuss health system policy issues, and prompt further research in an area that has largely been ignored by Canadian academics.

We need to get clear about our language, (so that), our intelligence is not bewitched by our language. (Hodgkinson, 1996, p.144)

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Dedication

To my husband, Mark

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Chapter 1

Introduction

Accountability is an essential ingredient of all our systems of government, management, justice, and democracy itself. It is the working principle of our parliamentary system of government and a process whose effective functioning is essential to our democratic government. (Lambert Commission, 1979, p. 369)

(But)...because of its chameleon-like nature, definitions of accountability tend to be vague, incomplete or convoluted. (Wright, 1996, p. 227)

1.1 The Context and the Problem

As the public sector in general and the health sector in particular, undergo reform¹ throughout the Western world, in order to find systems that work better and cost less, the phenomenon of accountability becomes increasingly important to policy-makers. In Canada, where health care is largely a public program that consumes about one third of provincial budgets, 9 of the 10 provinces have recently devolved much of the service delivery responsibility to regional authorities, with improved accountability as an explicit goal. This new system of governance fundamentally changes the accountability relationships between government and citizens. Regional health authorities have dual accountability relationships: to the public, for quality service delivery, and to government for the appropriate use of funding. In response to these changing roles, provincial accountability framework documents are under development, but attempts at implementation seem to be stalled as different players discuss different perceptions of

¹ Reform in the Public Service has been named "Managerialism" or "New Public Management" defined by C. Pollitt (1996) as a set of beliefs and attitudes, mainly from big business and the military, that are being applied in the public service. Reform in the Health field in Canada has been labelled "Regionalization," and aims for improved coordination and decreased costs in health care delivery, and increased public participation within specific geographical regions.

accountability and what the framework should include. The implementation of accountability is associated with the knowledge of what it means. Until the meaning of accountability is understood from the perspective of key health system participants, the development of meaningful accountability frameworks is unlikely to advance. Thus, in order to make progress in effectively instituting and maintaining accountability in the health field, we need to speak clearly, and recognize different understandings, definitions and images of accountability.

While discussions about accountability seem to assume that there is a common understanding of its meaning, the literature shows this is far from being the case (Leclerc, Moynagh, Boisclair & Hanson, 1996; Day & Klein 1987; Wright, 1996; Gagne, 1996; Cutt & Murray, 2000). The subject of accountability has many contexts and formulations and draws its meaning from a diverse body of literature, including the areas of political science, religion, philosophy, sociology, management, and public administration (Leclerc et al, 1996). Because accountability involves such a range of thought, it is important that its meaning and relevance to the health system be explored. Otherwise, the wide use of vague and confusing terms such as “public accountability,” “social accountability” and “professional accountability” leads to conceptual errors and, worse, to misguided policies and actions.

The problem of accountability in the health field is both theoretical and practical. First, the concept of accountability seems to have many meanings and has not been explored for its applicability to the Canadian health system. Second, as health system restructuring occurs in Canada, an explicit goal is improved accountability to the public. Without a clear understanding of the concept, however, the basis for improving

accountability will remain unknown. This study will examine the concept of accountability and explore its meaning within the health field.

1.2 Research Goals

My overall goal is to clarify the concept of accountability within the health field in order to provide information that may assist in improving communication and application in the health system and to begin to generate theory about the concept of accountability within the health field. A secondary goal is to examine the issues related to improving health system accountability.

An analysis of accountability within the Canadian health system is located within the generic meanings and models of accountability that have originated within public policy and a model of government based on representational democracy. In Chapters 2 and 3, I review the current status of accountability theory and models of practice as a basis for understanding the context within which the current health system's accountability has evolved. Chapter 4 provides a description of the methodology used to explore the meaning of accountability in the health field. The method chosen was a qualitative concept analysis with two data collection strategies. First, a structured review of the Canadian literature on health system accountability was employed in order to examine the use of the concept in professional, health policy/administration and popular literature. Second, an interview process was utilized, whereby 24 health system leaders from five Canadian provinces were interviewed. Chapter 5 describes and discusses the sample, analysis and findings. Chapter 6 offers an interpretation and discussion and Chapter 7 provides a summary, conclusions and implications.

Chapter 2

Accountability: Current Theory & Concept

This chapter provides an overview of the origin, evolution, and the public administration theory of accountability, a discussion of the language surrounding accountability, its economic and political context and a preliminary and general discussion of the concept within the health field. Because a comprehensive and systematic review and analysis of data from Canadian literature forms part of my research methodology and will be included in my findings, the overview found in this chapter is preliminary.

2.1 Evolution of Accountability

Today accountability is considered to be central to our democratic system of government (Day & Klein, 1997; Aucoin 1997, 1998; Gayne, 1996; Wright, 1996). As the Lambert Report stated over 20 years ago, "Accountability is the working principle of our parliamentary system and a process whose effective functioning is essential to our democratic government" (p. 369). The need for accountability arises because government has great power and therefore has the potential to misuse it. "To be unaccountable is to be all powerful" (Day & Klein, 1987, p. 21). Such power is legitimized in the idea that it is delegated to government from the people. "In the Westminster model of government, there is said to be a chain of authority and accountability running from the people to Parliament, from Parliament to the Government of the Day, Cabinet and Ministers, and down through to the individuals working in government at the lowest levels" (Priest & Stanbury, 1998).

The word "accountability" is derived from the old French "compter" or "conter," which means "to count" or "to enumerate" (Matek, 1977). According to the Concise Oxford Dictionary (1989), someone is accountable when they are responsible and bound to give account. In its current usage, to account means to provide a "statement of administration as required by creditor, or of discharge of any responsibility; answering for conduct" (p. 7).

The concept of accountability has a long history (Day & Klein, 1987; Leclerc et al., 1996; Matek, 1977; Normanton, 1971). Leclerc et al., (1996) suggest that it dates back to biblical times, when St. Peter asked of all mortals "what have you done with your talents?" thus providing an early indication of the need to be accountable for one's actions (p. 47). In the field of public life and public policy, accountability can be traced at least as far back as 400 B.C. when it helped shape the election politics and administrative behavior of Athenian statesman (Normanton, 1971). During those times and for many centuries after, the concept, basically equivalent to balanced financial accounts, gave rise to the roles of public accountant and public auditor (Matek, 1977).

Matek (1977) maintained that the first important extension in the public policy meaning of accountability occurred in England in 1866, under William Ewart Gladstone whose Exchequer and Audit Department Act added the idea of regularity in accounting. This meant that in addition to balanced accounts, consistent methods for record keeping were required from year to year and from department to department. Gladstone's innovation spread throughout Western Europe and North America and was followed by budget practices that provided one relatively simple criterion to judge a government's

annual accounts. It also served to prepare the way for the second major extension in the concept, the addition of efficiency and effectiveness as part of the accounting process.

Although the language and legislation on efficiency and effectiveness in the United States go back to the original Budget and Accounting Act of 1921, it was not until the 1950s that economic performance and productivity started to become operational elements in the public policy meaning of accountability (Matek, 1977). This emphasis continued in most Organization for Economic Cooperation and Development (OECD) countries throughout the 1960s and gave rise to such techniques as “management by objective” (MBO) and program planning and budgeting systems” (PPBS)². In 1965, President Johnson ordered that PPBS, the concept of which was pioneered by Robert McNamara in the United States Defense Department, be extended throughout the federal government. According to Pal (1992), these developments spilled into Canada and led to the “Evaluation Movement” or call for more expert advice and analysis in public policy in Canada. Pal notes that Prime Minister Trudeau’s policy-making philosophy of rationalism added force to the evaluation movement and policy analysis industry in the late 1960s and 1970s. Federal government ministries established planning and evaluation units, quasi-independent advisory agencies multiplied, the private consulting industry grew, and universities established institutes with a policy focus.

In the late 1970s, a third major extension in the concept of accountability occurred, with the addition of “appropriateness.” This meant that it was no longer enough to address procedural issues by showing that an enterprise had balanced and regular financial records and management, and efficient and effective ways of accomplishing its

² According to Pal (1992), PPBS is a system that attempts to force explicit comparisons of the contribution of different programs to overall goals, and clearer accounting of budgetary outlays (p.68).

objectives. Appropriateness made it necessary to address goals, policies, values and relative benefits by demonstrating as part of the reporting process that the entire enterprise should have been undertaken (Matek, 1977).

Hood (1995) proposed that these changing notions of accountability meant a shift towards “accountingization,”³ and in a number of OECD countries during the 1980s, this shift was central to the rise of the “New Public Management” (NPM)⁴ and its associated doctrines of public accountability and organizational “best practice.” NPM differs from previous doctrines of public accountability and public administration. Hood (1995) suggests that the basis of NPM lies in reversing two cardinal doctrines of the previous accountability model; “... lessening or removing differences between the public and the private sector and shifting the emphasis from process accountability towards a greater element of accountability in terms of results” (p. 94). Throughout the 1990s, much effort has been devoted to developing language, techniques and institutions of performance measurement, evaluation and reporting. These will be discussed in the following section on accountability practice models.

In summary, accountability as a public policy concept has had several milestone evolutions from balance and regularity (procedural accountability) to efficiency, effectiveness and appropriateness (consequential accountability). Procedural accountability focuses on management procedures, practices and systems, and

³ This is a term coined by Power & Laughlin, 1992, p. 133 and means the introduction of ever-more explicit cost categorization into areas where costs were previously aggregated, pooled or undefined.

⁴ The main themes of NPM can be described as follows: a shift in emphasis from policy making to management skills, from process to output, from hierarchies to competition for service delivery, from fixed to variable pay, and from a uniform and inclusive public service to a variant structure with contract provisions (Aucoin, 1990; Hood, 1991; & Pollitt 1993).

compliance to rules and regulations. This traditional approach assumes that if inputs were satisfactory, the output of intended results are assured. Consequential accountability emphasizes results, eventual outcomes and impacts; in effect, it constitutes an enlargement of the scope of accountability into “value for money” (Leclerc et al., 1996). Developments in the 1980s and 1990s, consisting of the amplification and application of these concepts into practice frameworks, will be discussed later under practice developments.

2.1.1 Public Administration Theory and Accountability

During the evolution of accountability, three common and broad paradigms of public administration were also evolving and no doubt influenced the development of the accountability construct. These are Universalism, Pluralism and Participatory Democracy.

Universalism

Heavily influenced by the principles of scientific management as expounded by Frederick Taylor, this theory relied on several principles to define good administration. These included: specialization, where administrative efficiency is increased by specialization of the task among the group; unity of command, where efficiency is increased by arranging group members in a predetermined hierarchy; span of control, where efficiency is enhanced by limiting the number of subordinates reporting directly to any one administrator; and organization by purpose, process, clientele and place where efficiency is enhanced by grouping workers by those characteristics (Simon , 1947).

In this paradigm, politics and administration are separate functions, tasks are fixed and defined by law or statute, and decisions are made rationally. Accountability is to the law, the hierarchy, and other professionals and technical experts. The focus is external to the individual and there is no recognition that power and authority come into all parts of an organization. (Gerth & Mills, 1946).

Pluralism

The criticisms of universalism, and the writing and thinking about public administration evolved into the promotion of a more pluralistic understanding of public administration. This view moves from the rational scientific modalities of Universalism to the messiness of interest group conflict, conciliation and compromise (Simon, Smithburg & Thompson, 1950). An example of the impact of this paradigm on accountability, is illustrated in the comments of Long :

To whom is one loyal-unit, section, branch, division, bureau, department, administration, government, country, people, world, history, or what? Administrative analysis frequently assumes that organizational identification should occur in such a way as to merge primary organizational loyalty in a larger synthesis... Actually, the competition between governmental power centers, rather than the rationalizations, is the effective instrument of coordination. (Long, 1949, p. 261)

Accountability, in this formulation, results from the interplay of interests within the political system and incremental decision-making. However, just as a core assumption of centralized power is problematic for universalism, so is the assumption of power shared widely among leaders and groups specializing in one or a few issue areas (Freeman, 1958). Power differentials, resource distribution and interest group representation are among the problems encountered. Another concern is that special

interests dominate the decision process and create the product with little or no direct participation from citizens.

Participatory Democracy

This paradigm focuses on the purpose of public organization as participation, representation and the views of citizens, and not just in response to a directive from a superior, or a compromise amongst special interest groups (LaPorte, 1971).

As with all paradigms, there is an influence on the best way to manage. The administrator is viewed as an individual, not just as a part of the hierarchical chain, or as a negotiator between groups. An influential work that served as a precursor to this paradigm is an essay by McGregor (1957) called *The Human Side of Enterprise*, where he encourages a shift away from the traditional top down management approach to one that relies more on an individual's own sense of control and self-direction.

Participatory democracy moves beyond accountability as efficiency, to a concern for organizational impact. It is not enough to be efficient in carrying out tasks and keeping interest groups satisfied, there is a need for measurement of impact and assurance of social equity in program implementation. Writers associated with "New Public Management" provide definitions of public administration which captures this sense of moral responsibility. For example, Laporte (1971) states " the purpose of public organization is the reduction of economic, social, and psychic suffering and the enhancement of life opportunities for those inside and outside the organization" (p. 32). This paradigm then leads to the present day, value for money notion of accountability and the associated developments to measure performance.

2.2 The Language of Accountability

Through the centuries, accountability has been the focus of a great deal of scholarship and debate but each profession has described the phenomenon in its own language (Leclerc et al., 1993). These diverse languages of political science, philosophy, religion, sociology, management and public administration have resulted in miscommunication and an obscure picture of accountability. As well, multiple terms have been used to describe accountability, including public accountability, social accountability, fiscal accountability, process accountability, hierarchical accountability, program accountability, and professional accountability. Matek (1977) suggested that these are cases where a part is being taken as a whole, and although there may be a difference in emphasis, this is not equivalent to a difference in kind. He points out that fiscal, process and program accountability are elements of accountability for public or social purposes rather than individual purposes, and that hierarchical and professional accountability address the object to which accountability is directed and the way it is organized.

2.2.1 Accountability Types

After considering the emergence of the constitutional state from monolithic government structures to a multiplicity of interdependent hierarchies (see Appendix A), Matek (1977) concludes that two distinct types of accountability patterns are needed in constitutional government systems. The first kind is internal or direct accountability which applies within any given organizational system and which involves the direct reporting by subordinates to superiors who hold the power of direct sanction. The second

form is “external or indirect accountability because it involves reporting to persons or groups outside one’s own system or structure” (p. 16). This type involves egalitarian relationships and requires open procedures, publicly disclosed facts, and opportunity for comment and debate on the facts prior to making policy decisions. Here, recourse is indirect, through appeal to some outside structure or system such as another branch of government, a court of law or the informal court of public opinion in the hope that objectionable policies, directions or behaviors will be modified.

Leclerc et al. (1996, p. 56-58) have classified accountability into the following dimensions and meanings which serve to further illustrate the diverse language applied to accountability by the various disciplines.

Internal and External Accountability: *Internal* refers to a rendering of account within a management hierarchy from the lowest echelons to the top. *External* refers to management’s accounting to their governing bodies who serve as owners on behalf of the public.

Political Accountability: *Constitutional* accountability refers to the ministerial responsibility – that of government to Parliament. *Decentralized* accountability refers to the establishment of local authorities, a dispersion of accountability and possible conflicts between the center and the locality. *Consultative* accountability refers to participatory democracy where elected representatives feel obligated to consult the population and special interest groups.

Managerial accountability: *Commercial* accountability refers to when government services are financed by user fees rather than by budget appropriation, and may be judged on their commercial performance as much as on the attainment of their public policy

purposes (e.g., Crown Corporations). *Resource* accountability relates to when resources are indicated for non-market provision of services and can be divided into the management of finances, human resources, and assets. *Professional* accountability refers to the allocation of resources in a public institution to professionals who owe their standards to a self-regulating body. While they owe to the legislator the right to exercise their profession, they appear to operate largely outside the democratic control.

Legal accountability: *Judicial* accountability refers to government allowing reviews of public servants' actions through court cases brought by aggrieved citizens. *Quasi-judicial* refers to a form of recourse where a great deal of administrative discretion is prevalent in the application of the law. A specialized tribunal such as the Tax Court of Canada is an example of an entity operating within such a framework. *Regulatory* accountability refers to the operation of agencies with a large degree of independence, applying broad legislative mandates affecting the individual interests of citizens. The Canadian Radio-television & Telecommunications Commission (CRTC) is an example of an entity operating within such a framework.

Other over-arching terms such as objective and subjective accountability, according to Leclerc, et al. are also used:

In objective accountability, someone is responsible for something and accountable to some person or body in a formal way, through clearly defined rules and mechanisms. In subjective accountability, a person feels a duty towards the profession of public service or a sense of the public good and the nation, which determines and defines conduct even though there are no formal mechanisms through which this accountability can be enforced. (Leclerc, et al., 1996, p. 48)

Recently, Cutt and Murray, (2000), in their study of accountability, performance measurement and evaluation in non-profit organizations, define accountability as "shared

expectations expressed in a common currency” and as “a framework for a set of arguments on improving the information available for decision-makers in programs and organizations in the public sector and the private non-profit sector” (p.2). Accountability is discussed in terms of “administrative accountability which is defined in technical terms about program management” and “political accountability, which is defined as an alternative currency of political support” (p.3). Accountability is described as a purposeful activity by which to define and evaluate the conduct and performance within programs and organizations, as they relate to the achievement of program and /or organizational purposes.

2.2.2 Accountability Patterns

The changing notions of accountability have evolved within the context of public sector governance and management. These institutions have evolved from monolithic government structures into a multiplicity of interdependent hierarchies, each of which is given only a small part of the sovereign power by which the government is to be run and the state maintained (Matek, 1977). Additionally, the public administration model has shifted, from a focus on keeping the public sector distinct from the private sector (progressive-era model of public administration), to the New Public Management (NPM) model which removes the differences between public and private sectors (Aucoin, 1997; Hood, 1995; Pollitt, 1996). Although this shift has occurred, there continues to be a debate about whether it is a positive move, given the different objectives and nature of the two sectors. Mintzberg (1996) concluded that such a shift coincided with the supposed triumph of capitalism and the belief that the private sector is good, the public

sector is bad and the co-operatively owned and non-owned sectors are irrelevant. He refuted the argument that the private sector can serve as a model for society by reasoning that the arm's-length relationship controlled by the forces of supply and demand do not work for services such as health where sellers know a great deal more than buyers, who have a great difficulty finding out what they need to know; that many of the benefits of government require soft judgement and do not lend themselves to hard measurements; and professional management's ability to solve everything is not only a myth, but is also damaging, if bosses are ignorant of the subject of their management.

To illuminate the evolution of accountability in more depth, I will now explore the different paradigms, or patterns, of accountability and the different doctrines associated with the traditional model that Hood (1995) named Progressive Public Administration (PPA), and the more recent NPM model.

Different accountability patterns have been observed in the various models of public administration. Hood (1995) analyzed a pattern or paradigm of trustee and beneficiary as being present under the PPA, where two management doctrines were the focus. First, the public sector should be kept distinct from the private sector "in terms of continuity, ethos, methods of doing business, organizational design, people, rewards and career structure" (p. 94). Second, a buffer system of procedural rules was to be maintained to keep management discretion in check, with the aim of preventing favoritism and corruption. In this PPA model, government was understood to be a complex mix of high trust and low trust relationships, where the accompanying accounting rules reflected degrees of trust. Generally, high-trust relationships were seen to be internal, where there was a convention of mutual consultation or action on the basis

of word of mouth agreements across departments. The costs of these activities were not “accountingized,” given the assumption that “such high-trust, non-costed behavior lowers transaction costs within the public sector and makes it more efficient than it would be if each action had to be negotiated and costed on a low-trust basis” (p. 94). External relationships such as the awarding of contracts, recruitment and staffing, and handling of cash, were considered low-trust relationships. Here, “distrust prevailed and elaborate records had to be kept and audited” (p. 94).

Hood (1995) argues that the NPM model reverses the separation of the public and private sector management practices and places emphasis on accountability for results, rather than process accountability. Further, he suggests that, under this model, public servants and professionals are seen as budget maximizing bureaucrats whose activities need to be more closely costed and evaluated by accounting techniques. In contrast, high trust is placed in market and business methods.

If the paradigm of accountability under PPA was trustee-beneficiary, what is the paradigm under the NPM? In a paper, prepared for the Canadian Center for Management Development of the Government of Canada, Priest and Stanbury (1998) begin to develop an accountability framework based on the Principal-Agent paradigm, or an economic model. In effect, this paper was a response to the trends in modern government or NPM.

The basis of the principal-agent paradigm is that the agent is held accountable in order to “ensure fidelity to the principal’s interests and that the agent meets the performance criteria established by the principal” (p.16) where the principal and agent can be an individual or, more likely, an organization. Although the complexity of organizations as agent and principal was recognized, for ease of analysis these

organizations were referred to as if they were a single or perfectly unified actor⁵. Priest and Stanbury developed six questions to focus an analysis of accountability relationships:

- Who is accountable to whom?
- Who decides that there will be an accountability relationship?
- For what is the agent to be accountable?
- What are the responsibilities of the agent?
- What are the responsibilities of the principal?
- How important is it for the principal to reward or sanction the agent?

This analysis and a review of accountability mechanisms for administrative agencies, resulted in the arrangement of six elements of an accountability mechanism:

The delegation of authority by the principal to the agent; the principal's instructions to the agent; the criteria for measuring the agent's performance; the flow of information to the principal about the agent's performance; the evaluations of the agent's performance (explicit and implicit); and the reactions by the principal (closing the loop). (Priest & Stanbury, 1998, p.25)

Cutt and Murray (2000) elaborated on similar questions and expanded the definitional details and design of an accountability framework for the non-profit sector. The accountability relationships are defined in terms of the technical information required to fulfill shared expectations, including criteria for performance evaluation and communication of information. These relationships and other performance measurement and practice evaluation models based on the principal-agent paradigm, will be discussed in more detail in the section on practice models.

⁵ Within organization theory, the systems view or those of social science persuasion, perceive organizations as lawful structures or open systems with a life of their own. Hodgkinson (1996, p. 147) calls this reification of organization a "biological fallacy" because the organization is endowed with an ontological reality.

2.3 Accountability: the Economic and Political Context

Although accountability is an underlying principle within democratic states, an increased emphasis on accountability generally seems to be linked to the public and health sector reforms that are occurring internationally and coinciding with economic restraints. The following section reviews the economic context of public and health sector reforms.

2.3.1 Economic Context of Public Sector Reforms

The previous one to two decades have been a significant period of international public sector change. Jacobs (1997) identified some of the initiatives that have radically altered the structure and operation of the civil service in various countries, including the “Next Steps” and “Financial Management” programs in the United Kingdom, financial management in Australia, and a quest by the Clinton Administration in the United States to shift to a government that “works better and costs less.” Hood (1995) discusses many other OECD countries that have also undertaken public sector reforms. He described these countries as moving away from a rule-based public service towards private sector models of funding, management and control. Leclerc et al. (1996) refer to initiatives in Canada proposed in the Public Service 2000 report.

In an analysis of public sector reform in the United Kingdom and the United States, Pollitt (1996) provides the economic background leading to reform and a review of the initial impact of such changes. He cites OECD figures showing growth rates for social spending and social expenditure program shares from 1960-1981. These figures illustrate that although, public spending represented by social programs rose

impressively, especially in health, over the 21 year period as a whole, the average rate of increase in the last 6 years of the period was markedly less than for the first 5 years. This reflects the pervasive impact of the world economic crisis following the steep oil price increases of 1973, and potentially what Hodgkinson (1991) would call metavalues of efficiency and cost consciousness⁶.

Pollitt's (1996) analysis of public sector reforms concludes that, in general, the reforms had a neo-Taylorist⁷ character which was narrow in focus and that the initial impacts of these reforms was as narrow as the approach itself. In both, the United Kingdom and the United States, greater cost consciousness was drummed home and significant staff reductions were achieved. Batteries of performance indicators were installed and much more extensive contracting out to private sector providers was encouraged or, in some cases, imposed. Still, although indicators may have shown significant improvement in economy and efficiency, little information was available concerning the overall impact of these changes on the effectiveness or quality of services (p. 189). Pollitt observed that in the late 1980s and early 1990s neo-Taylorism underwent a re-evaluation and the "new public management" consisted of four main elements:

1. A much bolder and larger scale use of market-like mechanisms for those parts of the public sector that could not be transferred directly into private ownership (quasi-markets).
2. Intensified organizational and spatial decentralization of the management and production of services.

⁶ "A metavalue is a concept of the desirable so vested and entrenched that it seems to be beyond dispute or contention. It usually enters as an unspoken or unexamined assumption into the ordinary value calculus of individual or collective life" (p. 104).

⁷ He suggests that neo-Taylorism reforms were "...concerned with control that was to be achieved through an essentially administrative approach – the fixing of effort levels that were to be expressed in quantitative terms" (p. 188).

3. A constant rhetorical emphasis on the need to improve service quality.
4. An equally relentless insistence that greater attention had to be given to the wishes of the individual service user/consumer. (Pollitt, 1996, p. 180)

Several further points from Pollitt's conclusions are worthy of mention here, given their applicability to health reform and the call for increased accountability.

The recent emphasis on quality and on meeting user requirements, even if much of it remains superficial, does at least acknowledge that Taylorian efficiency is an insufficient gospel, both for the public service workers and for the citizens they serve. However, the value structure of the new public service is indeterminate: 'quality' and 'consumer responsiveness' sit alongside a fierce and continuing concern with economy and efficiency. It is not clear which group of values will take priority when (as at some point it is inevitable) a trade-off has to be made. Although some private sector quality gurus insist that 'quality is free' it is hard to see how, in the public services, this could always be so (unless either 'quality' or 'free' are very idiosyncratically defined). Hood (1991) points out that the new public management still prioritizes the 'sigma-type values' of frugality and cost reductions and takes for granted rather than reinforces 'theta-type values' of fairness, rectitude and mutuality. If this is true then there is a danger that, within tight budgets, higher quality for some may be purchased at the price of lower quality (or no service at all) for others. The fragmentation of hierarchies and the spread of market-like mechanisms increase the chances of such 'market segmentation'. (Pollitt, 1996, p.189)

2.3.2 Economic Context of Health Sector Reforms

Health care systems are important components of welfare states and are a large public service spender. As such, they have received a great deal of focused attention for reform within developed countries (OECD, 1999), and the reforms that have been implemented are related to the organization of the health system (Elola, 1996). As illustrated in Table 1 below, Elola (1996), classified the health systems of developed countries according to relations among the type of system and its financing, insurance and provision.

Table 1: Classification of the health systems of developed countries: Relations among type of system and financing, insurance and provision

(There is no pure health care system. This classification addresses the predominant subsystem)⁸

Characteristic	National health system	Social security system	Private system
Financing	Public (taxes)	Public (payroll taxes)	Private
Insurance	Public (universal)	Public (multiple)	Private
Provision	Public	Private	Private

Source: Adapted from Elola, 1996, p. 241, table 2. Reprinted with Permission.

In a comparative analysis of the structures, processes and outcomes of the national health and social security systems of western European countries, Elola (1996) cited evidence of important differences that lead to different health system problems, and therefore, to the reforms being implemented (p. 242-245). Although cost control is a common concern for both systems, there are striking differences in the problems encountered by the two groups. The key problems reported by the national health systems are waiting lists, inefficient management of health services (especially in hospitals) and limitations in the choice of provider. For the social security systems, the main problems reported were oversupply, over-consumption and inequities related to their financing and insurance functions. For example, some countries have different sickness funds depending on the percentage of salary paid by employees for their health insurance (p. 245). It is well documented that private systems such as those found in the United States offer inferior population health at a higher cost, with improved access as its main advantage.

⁸ I would classify Canada's health care system as predominately a social security system.

Elola (1996) concluded that the advantages of a national health system are greater cost control, equity, and possibly efficiency in improving the populations health, while public satisfaction is lower than in a social security system where consumers/citizens have greater choice among providers. The main goal of the reforms has been to overcome the trade-off between the outcomes of the two types of health care systems. The convergent trends of health care reform, as shown in Table 2, are a major component in the achievement this goal.

Table 2 : Health care reform in Europe: Convergence trends*

Characteristic	National health system	Social security system
Single payer	Yes	Increasing financial links and homogenization among sickness funds
Supply control	Yes	Certificate of need or the like
Regionalization	Yes	?
Global budgets	Yes	Hospitals & physicians
Technology management	Yes	?
Gatekeeper	Yes	No
Entrepreneurial management	Hospitals, fund holders	Yes
Mixed forms of budgets/ reimbursement	Salary + capitation + fee for service	Fee for service + global
Choice of provider	Increasing choice for physicians & hospitals	Yes
Development of information systems	Introducing	Introducing

- yes/no, most systems already have/do not have the characteristic: ? indeterminate trend.

Source: Elola, 1996, p. 248, Table 6. Reprinted with Permission.

The evaluation of health reforms are at an early stage. There is little evidence to suggest that the goals have been achieved to date, except for the data showing the cost containment trend, mentioned above, that began prior to reform.

2.3.3 Canada's Health System Reforms

Fiscal pressures were the driving force behind health care changes in the 1980s and 1990s. This was in response to the perceived need to slow down the expenditure rates of the 1970s in order to contain and decrease costs.

In 1995, the federal government collapsed existing transfers to the provinces (Established Programs Financing and Canada Assistance Plan) into a single block transfer (Canada Health and Social Transfer) and reduced the overall level of the transfer (Dector, 1994). This change along with the decreasing public and increasing private share of financing, outlined previously, prompted fears about the permanence of Canada's public health system and Medicare principles.

Provincial governments during the 1980s and 1990s engaged in cutting the debt and deficits, as well as dealing with the decreased federal transfers. According to provincial and territorial ministers of health, the federal government cut their share of provincial health spending from 28.4% in 1979-80 to 10.2% in 1998-99 (Provincial & Territorial Ministers of Health, 2000). Health care reform was part of the strategy to deal with funding cuts and took the form of regionalization. This is a process that devolves some authority from government to regional boards to plan, prioritize and allocate funds. Also, within provincially defined broad care services, it centralizes within regional boards the previous authority of hospitals and other provider boards to manage and deliver service. The goals of regionalization are to increase the coordination and integration of health services, to contain cost and improve efficiency, to empower the community, to improve accountability within the system and to the public and to improve health outcomes. According to Lomas, Woods and Veenstra (1997), the provincial

structures resulting from regionalization vary somewhat with respect to the number of tiers, accountability mechanisms, degree of authority and method of funding. However, the only structural element that varies substantially is the scope of services under the authority of the local boards. On the surface, these changes seem to have created a great deal of turbulence in health care. But, in reality, the changes that have occurred and the impact they have had on the system may not be as significant as they might appear.

Minor changes are occurring in health care spending. According to Health Canada in 1998, the three largest categories of health expenditures remained hospitals (34.2%), physicians (14.4%) and drugs (14.4%). The level of spending on hospitals had declined by 0.9% from the previous year, while expenditures on physicians' services increased by 0.6% and drugs increased by 2.7%. The fastest growing categories were public health (3.5%), other institutions (3.5%) and other professionals (2.4%). This may indicate the beginning of a shift to community-based care and alternative medicine.

Users of the health system generally see the changes as cuts to health care and a threat to Medicare. The shift to community care is not yet evident; rather, the effect from my experience, seems to be an increased burden on caregivers.

These changes in health care do nothing to address the inherent inequities within a social security system such as Canada's, where there is a lack of universal coverage for services (other than for physicians and hospitals). For example, the unemployed and elderly do not have access (unless they pay for them) to many services that are available to employed people with extended benefits. There are also many other policy areas of importance (health determinants) to health where the Canada Health Act principles do not apply.

The evaluation of regionalization in Canada tells different stories. A study by Lomas (1999) suggested it is probably both too soon to tell if it will work and too difficult to generalize about 123 devolved authorities in nine provinces. However, Lomas et al. made the following predictions:

- As each regional authority arrives at its own resolution of the inherent conflict between government, provider and citizens' interest, the balance will tip in favour of community empowerment, system rationalization or expenditure reduction.
- An initial assessment suggests a favouring of system rationalization and some success can be claimed in integrating institutions. Progress beyond this will be difficult if boards are not given broader budgetary authority, including at least physicians' fees and drugs (note in appendix 3 that neither are included in the services devolved to regional authorities).
- While boards are trying hard to represent their community (70% felt accountable to local citizens), the future of citizen governance and empowerment is ultimately tied to the issue of elected boards. (Lomas et al., 1997, p. 820)

In 2000, a study by Davidson, summed up a decade of reform in British Columbia as "dynamics without change."

Fundamentally, the health care system in BC remained unchanged. Power was still brokered by professional providers and bureaucrats in a system governed by the rules established in the 1960s by the hospital and medical insurance plans. In short, the fundamental rules of the game did not change; there was only a minor shift in the pattern of winners and losers. (Davidson, 2000, p. x)

Other Canadian researchers suggest that over the past decade health care has shifted, in Canada, from a "cure-care model to a business model" (Armstrong et al., 2000; Gustafson, 2000). These authors suggest that this model is based more on faith than evidence and that it has brought deteriorating health care services. Further, health care reform is viewed as part of the broader restructuring and rethinking of the welfare state (Ralph et al., 1997; Connelly & MacDonald, 1996). Examining the changes occurring in

Ontario, Ralph et al (1997) suggest that the fiscal responsibility is a smokescreen that hides a fundamental attack on democracy and social citizenship. They examine the effects of government policies on societies most vulnerable members: people with low-income, children, women, workers, and ethno-cultural and francophone communities. Connelly and Macdonald (1996) focus on the intersection of health and social-service systems and suggest that, although there has been decreased costs and increased employers' flexibility, that the flexibility and benefits of home-care workers has decreased and stress has increased. They raise questions about what the restructuring will mean for women care-givers.

2.3.4 Political Context of Reforms

Some commentators explain the rise of New Public Management (NPM) and the increased concern about accountability as stemming from the "New Right," who stand to benefit from dismantling the Progressive Public Administration (PPA) model and remoulding the public service in the image of private business. Hood (1995), however, presented an analysis that indicate problems with these conclusions. Organization of Economic Cooperation and Development (OECD) countries were classified as governed during the 1980s mainly by parties on the left, right and center, and their NPM emphasis (based on countries reports to OECD) were scored. This analysis illustrates that the generally held belief that NPM was associated with incumbency "right" governing parties was a misconception. The most obvious misfit was Sweden, which is conventionally taken as the leading example of the social democratic alternative to liberal capitalism. It shows a high NPM emphasis during the 1980s while scoring high for "left" political

incumbency (eight years out of the decade under Social Democratic governments). At the other extreme, unambiguously “right” cases such as Japan and Turkey score low on NPM emphasis. It seems, then, that there is no simple relationship between the political stripe of governments and the degree of emphasis placed on NPM. Could it be that similar measures have been adopted in different political circumstances for different reasons and with quite different effects?

According to Dunsire (1990), much of NPM is built on the ideology of homeostatic control, where goals and missions are clarified in advance and accountability systems are built in relation to those preset goals. However, if as Hood (1995) suggests, “NPM has been adopted for diametrically opposite reasons in different contexts, it may, ironically, be another example of the common situation in politics in which it is far easier to settle on particular measures than on general or basic objectives” (p. 107).

2.4 Accountability and the Canadian Health System

The concepts and theory of accountability within the Canadian health system flow from the democratic system of government. The public votes in a provincial government to govern and manage public resources. The government, in turn, is accountable to the public through the Legislative Assembly to keep the public informed about what it intends to achieve and what it has accomplished. The authority for health is delegated to the Minister of Health who, through the process of regionalization, has devolved funding allocations (within MOH standards/ entitlements) for quality service delivery, to regional health authorities.

Although the structure seems to be straightforward, accountability within the health system is, in fact, complex. Its complexity is illustrated in Appendix B which diagrams the lines of accountability. The language and meanings of health sector accountability carry the same lack of clarity as in public administration (Day & Klein, 1987) and other concepts such as authority, autonomy, and responsibility are used interchangeably with accountability (Lewis & Batey, 1982).

Health sector accountability is heavily influenced by professional accountability. Professionals are subject to dual loyalty: to their profession and its values and to their employer in a health service organization or government. In general, health professionals see themselves to be answerable to their peers. Indeed, the case of medicine is perhaps the most highly developed example of a self-regulating profession, dating back to 1518 in England when the Royal College of Physicians was chartered (Matek, 1977). Its example has inspired other service providers such as nurses, pharmacist, and others in the health field to self-regulate. The growth of professions introduces another element into the debate on accountability, as the values inculcated by professions usually include fidelity to the interests of the client, regardless of who pays. For example, Day and Klein (1987) argued that "Professional accountability is not integrated into the system of political or managerial accountability. It effectively breaks down the circle of accountability, " a series of linkages leading from the people to those with delegated responsibilities via parliament and the managerial hierarchy" (p. 19). Given the dominance of professionals within the health field, it is helpful to reflect on the theoretical distinction between political and managerial accountability in order to clarify the ambiguity around the term "accountability" in the health system.

Political accountability concerns those with delegated authority being answerable for their actions to the people, whether directly in a simple society or indirectly in a complex society (Day & Klein, 1987; Leclerc et. al, 1996; Johnson, 1974). Appendix A provides a visual representation of the lines of accountability in simple and complex societies; Appendix B provides the lines of accountability in a regional health system. Two of the key issues in complex societies are: the linkages between action and explanation must be in place and adequate to the task at hand, including communication and sanctions to compel a justification if needed; and processes must be open with adequate information to assess actions (Day & Klein, 1987).

Managerial accountability, in comparison, is conceptualized as a technical process where those with delegated authority are answerable for agreed upon tasks according to agreed upon performance criteria (Day & Klein, 1987). Thus, from a linear perspective, the melding of political and managerial into a hierarchical model would seem to be simple, with political at the top flowing into managerial accountability, with its various technical definitions and flowing back out to citizens. However, Day and Klein , maintained that this model is based on the following problematic assumptions:

- **that the institutional and organizational links between political and managerial accountability exist, are effective and that the processes do in fact mesh;**
- **that political processes do in fact generate precise, clear-cut objectives and criteria necessary if managerial accountability is to be a neutral exercise in the application of value-free techniques;**
- **that the organization structure is such that the managers accountable to the politicians can answer for the actions and performance of the service delivered. (Day & Klein, 1987, p.28)**

In fact, Day and Klein's research indicate that all three assumptions are doubtful.

First, the links between the political and managerial systems of accountability, forged in the nineteenth century, are ill adapted to the twentieth-century service delivery State. The result is a perception of overload and demands for new links. Second, it is apparent that political processes do not necessarily generate the kind of clear cut objectives and criteria required if audit is to be a neutral, value-free exercise: the dividing line between political and managerial accountability is, inevitably blurred as objectives and criteria are generated at all levels in the hierarchy. The results are demands for opening up the system as a whole to public scrutiny and creating a more complex (but not necessarily hierarchical) system of accountability. Third, and compounding the arguments both for better links and for a more complex system of accountability, the organizational structure of many public programs-such as for example, the health service-is characterized by the fact that some service-deliverers do not fit into a vertical or hierarchical model of accountability; they are an instance of horizontal accountability to their peers. Lastly, and more generally, the imagery of accountability needs to be elaborated and made more sophisticated. (Day & Klein, 1987, p. 28-29)

An added complexity in the Canadian health field and many OECD countries is the dual accountability relationships created with health reforms where authority for health service delivery has been devolved to regional health bodies. That is, the health authorities are accountable to the MOH for health spending and to the citizens within their community for the quality of health services. Also, the definition of quality within this field is a subject of on-going debate and, in and of itself, has generated as much discussion as the concept of accountability.

My research interest lies within Day & Klein's last point - the need for elaboration on the imagery of accountability. I believe the health field could benefit from a clearer conceptual frame of reference for use in accountability dialogues and policy development. As noted in the earlier section on the evolution of accountability discussion, most academic discussions on accountability occur within the field of public administration or within specific professions. The health field has unique characteristics such as professional autonomy and more recently health reform with its dual

accountability relationships. Yet, while there is a great deal of literature on accountability, there is a paucity of research that analyses the meaning of the concept within the Canadian Health System. For example, although Day & Klein (1987) included three British health districts in their research, health was only one of five public services included and the Britain's National Health System has different organizational features than the Canadian Health System. As well, Hartmann (1985) did some work in examining the meaning of professional accountability. However, the meaning of accountability within a regional health system within Canada has not been well researched. Researchers from Queen's Health Policy Research Unit in a paper submitted to Health Canada in 1999 concluded " that Canadian academics have largely ignored the issue of accountability in health care and that a fertile ground exists for future research (p. 8). This theoretical and conceptual work is essential to a stronger foundation on which to build practice models in the health field. Alternatively, we will continue to build practice models on a shaky foundation of confused meanings. Before proposing a research methodology, I will discuss some of the accountability practice models that are emerging within the public and health sectors.

Chapter 3

Accountability: Current Models of Practice

Accountability, in practice, takes place within the context of the current management structures in modern organizations with their issues and inadequacies, and within the political context of government. Increasingly, models of practice are becoming known as accountability frameworks, performance evaluation frameworks or indicator frameworks. Generally, these models refer to the techniques and language of performance measurement, evaluation and reporting. Despite the theoretical and conceptual issues surrounding accountability as discussed previously, there have been several developments on the accountability framework front. This chapter provides an overview of the kinds of frameworks under development at the international, national, provincial and organizational levels. It focuses specifically on health system players' roles and on the attempts to implement accountability framework's in several Canadian provinces as regional health authorities emerge, as a new structure, in the regionalization of health services.

3.1 Overview of Frameworks

Several accountability frameworks are under development at international, provincial, and organizational levels.

3.1.1 International

The World Health Organization (WHO) carried out the first-ever analysis of the world's health systems; this analysis appeared in the World Health Reports 2000 (WHO,

2000). Its framework for health system performance broke new methodological ground by using a technique not used previously for health systems. It compared each country's system to what experts estimated to be the upper limits of what could be accomplished with the level of resources available in that country. It also measured what each country's system had accomplished in comparison with those of other countries. This assessment was based on five indicators: overall health of the population; health inequalities within the population; overall level of health system responsiveness; distribution of responsiveness within the population (how well people of differing economic status find that they are served by the system); and the distribution of financial burden within the population (who pays the costs).

According to Hurst (2001) there is growing interest in international work on performance measurement and improvement. However, many challenges remain. More work is required to operationalise indicators of outcomes, efficiency and equity and to identify the reasons for variations. A far better understanding is required of the best methods to implement improvements. Finally, we need to track and evaluate the cost of performance measurement and improvement activities.

3.1.2 National

In Canada, the Canadian Comprehensive Auditing Foundation (CCAF) took the lead in extending the accountability reporting requirements beyond procedural or financial to include 12 attributes of effectiveness. The framework was developed in 1987 in response to federal legislation to improve accountability in Crown Corporations (Nordel, 1994). A comprehensive definition of effectiveness was provided using the

following attributes displayed below in Table 3. This framework generated some interest and experimentation as a tool of management diagnostics, but did not reach a stage of general acceptance.

Table 3: Performance Reporting Framework: 12 attributes of effectiveness

Planning	Management of assets & operations	Management of results
<ul style="list-style-type: none"> ▪ Management direction ▪ Relevance ▪ Appropriateness ▪ Responsiveness 	<ul style="list-style-type: none"> ▪ Working environment ▪ Protection of assets ▪ Costs/productivity 	<ul style="list-style-type: none"> ▪ Achievement of intended results ▪ Financial results ▪ Secondary impacts ▪ Monitoring & reporting ▪ Customer accountability

Source: Adapted from Cutt, & Murray, 2000, p. 219-223. Reprinted with Permission

The Canadian Council Health Service Accreditation (CCHSA) a peer review organization has traditionally provided a framework based on structure and process standards of quality for hospitals and long term care facilities. With regionalization, CCHSA have moved beyond institutions to health systems and have shifted the standards to an outcomes focus with a requirement for performance indicator development in eight dimensions of quality for health system performance. The eight dimensions are acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency and safety. Indicators are being developed in collaboration with the Canadian Institute for Health Information (CIHI).

CIHI, a federally chartered, non-profit organization, that plays a major role in the development of Canada's health information system, has several projects under a Roadmap Initiative. This initiative is designed to develop information to answer two

questions: How healthy is Canada's health system? How healthy are Canadians? The goal of one of its initiatives, the Health Indicators Projects, is to develop a "Health Indicators Framework". This framework includes indicators in three areas: health status; non-medical determinants of health; and health system performance. CIHI and CCHSA are working collaboratively to develop indicators of health system performance under the eight dimensions of quality framework developed by CCHSA. This is still a "work in progress" but has been endorsed by the Canadian Conference of Deputy Ministers of Health.

CIHI have also taken some steps in partnership with Maclean's Magazine to develop Health Reports for citizens. The first report in June 1999 compared 16 Canadian cities on health care quality; the second report compared the status of health among Canadians in 17 cities. In June 2001, the third annual ranking scored 54 cities giving Canadians hard information on how their access to the health care system compares with that in other regions across the country. This again is a first step towards providing information to evaluate the performance of the health system. As identified by Alvarez the President of CIHI (2001), although we have a great deal of excellent health data, we are still striving for integrated and coherent information systems in the health sector.

3.1.3 Provincial

The Auditor General of British Columbia and the Deputy Minister's Council took the lead in 1996, and developed a framework for government-wide, sectoral level and Ministry/Crown Corporation level application. This framework, which outlines the information required for reporting on government planning activities and results, was

published in a report released in April 1996. The report (Auditor General of BC, 1998) linked accountability information to performance management at an organizational level and provided an implementation plan to improve accountability for performance in government. The extent to which the framework has been implemented is unclear, as there has not been any research that assesses the use of such frameworks by government.

3.1.4 Organizational

Many of the organizational frameworks have been developed by businesses to supplement the traditional financial perspective reporting with three additional perspectives: customers, internal business processes and learning and growth. One of the first frameworks, "Balanced Scorecard" was developed out of Harvard University by Kaplan and Norton (1996). The scorecard was also used in business as a strategic management tool to link a business's long-term actions.

In health care, two professors at the University of Toronto (Baker & Pink, 1996) adapted the scorecard for application to health care by asking four questions and developing measures under each. The four questions asked under the various perspectives were: 1). How do customers/clients/ patients see us? (customer perspective) 2). What must we excel at? (internal business perspective) 3). Can we continue to improve? (innovation and learning) 4). How do we look to funders? (financial perspective).

Several Canadian hospitals, especially in Toronto, have implemented such scorecard frameworks as internal and external reporting formats, but they have been of limited usefulness for external players and citizens. In effect, because each hospital's definitions and information collection procedures were unique to that organization, the

data elements have not been reliable, valid, or comparable. This situation is changing as Health Canada and CIHI have taken a leading role in developing standards, measures and definitions that apply to the health sector in general. The CIHI framework described above is a good example of this direction.

Cutt and Murray (2000), in their recently released book *Accountability, Performance Measurement & Evaluation in Non-Profit Organizations*, expanded on and integrated the six questions posed by Priest and Stanbury (1998) and the CCAF framework discussed earlier to provide a more comprehensive framework. Cutt and Murray characterize their book as follows:

This book is about accountability in programs and organizations in the public and the private non-profit sector. It deals in various ways with how non-profit programs and organizations meet the information requirements of relevant internal and external constituencies in accountability relationships across the chronological governance/management cycle of activities. This cycle begins with prospective activities (planning, programming and budgeting) and continues through on-going activities (implementation, monitoring, and internal reporting and /or audit) to retrospective activities (external reporting, and external evaluation and/or audit). The central focus of the book, descriptively and normatively, is on accountability relationships in terms of technical information. That is on the definition of common currencies for the fulfillment of shared expectations, and corresponding criteria of conduct and performance and ways of communicating that information. (Cutt & Murray, 2000, p.5)

Several other commercial or health-focused frameworks have been developed or are under development, but these will not be discussed here, as it becomes repetitive. In general, the key theme in all of the frameworks is the development of information for understanding an organizations' performance in more than financial terms, and being able to compare that performance over time and/or with others. In other words, these frameworks involve the implementation of an extended notion of accountability that goes beyond the traditional financial and procedural reporting to outcomes reporting.

This section has provided an overview of the technical developments around accountability; the next section will delve deeper into the accountability practices within the health system.

3.2 The Canadian Health System & Accountability Practices

An overview of the Canadian Health System and an examination of key players roles and their accountability activities are found in this section.

3.2.1 Overview of the Canadian Health System

The National Forum on Health,⁹ described Canada's health care system as:

a highly nuanced system with combinations of public and private health insurance, government funded and individually funded services, primary provincial responsibility for organization and delivery, and framed by a general piece of federal legislation—the Canada Health Act—which outlines the basic principles of the system, but also permits considerable variations in the organization and structuring of services and funding arrangements across the country. (National Forum on Health, 1997, p. 1)

The labels “public” and “private” can apply to three main functions: financing (Are services publicly or privately funded?), provision (Are the organizations that deliver health services public or private in nature?), and insurance (Is insurance coverage for everyone or just those who can pay and is insurance the same for everyone (universal) or are there multiple sickness plans where if a person can pay more, they can get extended coverage?)

⁹ The National Health Forum was a national advisory body created in 1994 with the mandate to listen to what the public needs from their health care system.

The financing of Canada's health care system is approximately 68.7% public and 31.3% private. Total health expenditures for 1998 were \$82.5 billion or \$2,694 per capita. Health expenditures accounted for 9.3% of the Gross Domestic Product (GDP), down from the 1992 peak of 10.1% of GDP (Health Canada, 1998). The breakdown of public and private funds is found in Table 4 below.

Table 4: Health expenditure by category and public/private percent

Category	Expenditure (%)	Public/private (%)
Institutions (hospitals)	31.7	90 / 10
Institutions (other)	9.8	70 / 30
Professional (physicians)	13.8	99 / 1
Community (home care, public health & medical devices & other)	17.0	84 / 16
Pharmaceuticals	15.6	37 / 63
Professional (other)	12.1	9 / 91

Source: Health Canada, 1998

According to the National Health Forum, Canada's health system is financed through a combination of the following mechanisms.

1. **Government tax revenues (federal, provincial and municipal):** This includes revenues from the income tax system, sales taxes, "sin" taxes, employer levies, health premiums, property taxes, etc. This is how most hospital and medical services are financed.
2. **Private insurance:** Prepaid coverage is available for services not insured or paid for by government plans, mostly through employer-sponsored plans (e.g., dental care, prescription drugs, preferred hospital accommodation, out-of-country services).
3. **Private out-of-pocket payments:** This includes co-payments and deductibles for various services partially insured by government or private plans, payments for over-the-counter drugs, alternative therapies, room and board in nursing home, etc.

4. **Workers' compensation: Health care costs for employees injured at work are covered by provincial workers' compensation boards, which are funded through employer contributions. (National Health Forum, 1997, p. 2-4)**

In addition, the system relies on a great deal of philanthropy, voluntarism and informal care, especially in the hospital sector. Further, the tax system provides some relief for individuals who incur large private health expenses (medical expense credit, disability tax credit), allows employers to deduct the cost of health benefit plans for employees for tax purposes, and provides incentives for Canadian firms (mainly the pharmaceutical industry) that conduct scientific health – related research. “In the final analysis, there is clearly only one payer—the individual, but, the way in which the funds are collected and distributed throughout the system has important equity and efficiency implications” (National Health Forum, 1997, p. 2).

Although the health system is predominately publicly financed, the delivery system is largely private in that most doctors are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. According to Health Canada (1999), over 95% of Canadian hospitals are operated as private non-profit entities. An analysis of the insurance system, by Sutherland and Fulton (1994), concluded that the system is universal, comprehensive, portable, accessible, and publicly administered for physician and hospital services but not for most other services.

3.2.2 Overview of Key Actors, Their Roles & Accountability Activities

Government-Federal

The Federal government has had a significant influence in the evolution of the Canadian Health System, even though health is, for the most part, constitutionally

defined as a provincial responsibility. For example, the key events in the formation of Medicare, Diagnostic Services Act, the Medical Act and the Canada Health Act, were partially spearheaded by the federal government, which was following the leadership of the province of Saskatchewan (Sutherland & Fulton, 1994).

Federal spending on health care has two components, transfers to the provinces and expenditures on services, which are constitutionally within federal jurisdiction (such as services to First Nations people and veterans). Currently, federal influence over provincial health care policies is being exercised largely through financial incentives and disincentives associated with the Canada Health and Social Transfer (CHST) legislation (1995) and the Canada Health Act of 1984 (Sutherland & Fulton, 1994).¹⁰

The federal government has defined the problem of accountability as an absence of “value for money” information to the public. This was expressed by Health Minister Allan Rock, on February 3, 1999 in the following statement in the media, “ I think it is obvious that when you’re spending \$80 billion a year as Canadians do on health care, there’s a need to know more about what we’re getting for our money.” The policy instruments being utilized are expenditure-based instruments with conditions attached as illustrated by the following initiatives.

First, the 1999 budget allocated \$43 million to Health Canada over three years to develop and implement “a federal accountability initiative focusing on Health Canada’s policies and programs.” The vision is to create an accountable organization that consistently engages and informs Canadians on the performance of its programs, driven

¹⁰ The CHST is the 1995 federal legislation that reduced financial contributions to the provinces. The Canada Health Act consolidated and reaffirmed the five principles of Medicare: comprehensiveness, universality, portability, accessibility and public administration.

by evidence-based and outcome-oriented decision-making (Health Canada, 1999). It appears that some of these dollars are targeted to building the internal research and policy capacity.

Second, this work on policies and programs complements the data gathering project contracted to CIHI ¹¹, (funded at \$95 million) which is designed to improve health service by making its operation more visible to the public. As mentioned earlier, CIHI partnered with Maclean's Magazine to publicize health reports, which ranks health services across Canada.

Finally, Health Canada has been writing language around accountability and transparency into the "Framework to Improve the Social Union for Canadians", a non-statutory agreement between the Government of Canada and the Governments of the Provinces and Territories and is requesting performance evaluation information from the provinces. Work is underway to develop a set of indicators for this evaluation.

Government-Provincial

The provincial governments have the authority to be as dominant as they wish in health care policy. Thirty years ago they provided funds and professionals; it was mainly physicians who decided how to use them. Today these governments are major players in determining how and how much health care money is spent, where it is spent and on whom. They have the authority to regulate data collection, data use, the evaluation of professional decisions, the form of regional planning, the availability of resources, the functions of agencies and professions and the disclosure of information to users.

¹¹ CIHI is the Canadian Institute for Health Information. It is an independent agency, created by federal, provincial and territorial health ministers in 1994, to coordinate health information nationally.

Provinces may also delegate functions and responsibilities to other agencies (Sutherland & Fulton, 1994).

In the 1990s, 9 of Canada's 10 provinces devolved some authority to regional or community health boards with a mandate to contain costs, improve health outcomes, increase the flexibility and responsiveness of care delivery, better integrate and coordinate services and improve accountability. A survey of health sector accountability legislation by CCAF/FCVI¹² found that provincial legislation to set up regional boards largely has enabled transition, that is it has dealt with the legalities of transition for physical plant, the many unions, professional and other contracts, reclassifications, and restructuring of governance. The general patterns found were as follows:

- legislation is silent on performance expectations for management and on management's reporting to the board;
- there are varying degrees of performance expectations for boards, who are still sorting out the balance of their powers, duties, and accountabilities;
- there are few expectations for boards' performance reporting beyond the usual financial statements;
- there are no expectations for minister's accountability reporting; and
- there are provisions for attestation audit of financial statements only. (CCAF/FCVI, 1997, p. 46)

Instead of legislation, provinces developed accountability frameworks document with the overall goal of improving accountability within the health system and defining new roles of health authorities and provincial ministries of health. These documents are non-statutory and developed in consultation with health authorities. This may be because of the newness of regionalization in Canada, resistance from different actors, or a preference for consultation over regulation.

¹² CCAF is the Canadian Comprehensive Auditing Foundation

An analysis of the accountability documents of Saskatchewan, Alberta, Nova Scotia, and British Columbia indicated that the problem of accountability is presented in the guise of a substantially changed context: health reform, restructuring and continued fiscal restraint, and as an opportunity for renewed commitments to answer to the public for large amounts of spending from the public purse. Although the policy tool in all four provinces was information and exhortation of the virtues of accountability, the goals in two provinces were quite broad (Alberta & British Columbia), while those of the other two provinces (Saskatchewan & Nova Scotia) were narrow and focused.

In Saskatchewan and Nova Scotia, the purpose of the document focused on defining the relationship between the Minister of Health and the Health Authorities, given that roles had changed with regionalization. The tone of the Saskatchewan document was collaborative and indicated ongoing collaboration between the Minister and Health Authorities to implement the accountability arrangements. Also, in Saskatchewan, accreditation by Canadian Council Health Service Accreditation has been made mandatory for all regional authorities with the surveyor assessment report to be made public.

In Nova Scotia, an extensive review of elective procedure wait times was released subsequent to the framework, but did not appear to be linked to the accountability framework. For Alberta, the goal was described as a first step in developing a complete accountability framework with the overall goal, as indicated by its title of “Achieving Accountability in Alberta’s Health System.” Consultations included health authorities, regulatory bodies and physicians. The accountability structure included broad roles and relationships for all system players, posed questions for clarification of issues, and

indicated an ongoing consultation process with Albertans and health system players to develop more specific expectations and monitoring systems.

In British Columbia, the first document entitled *Managing for Impact: Realigned Accountabilities for Health Care in BC* outlined broad goals, such as assuring fairness, accessibility and affordability of publicly financed health services, as well as more specific, prescriptive roles and expectations for health authorities in the context of a provincial direction that lacked clarity. For example, authorities were unclear about how the “Better Teamwork, Better Care” direction linked with provincial health goals. Each initiative set a different direction and priority focus for regional authorities (Auditor General of B.C., 1998). The Auditor General also found that not all parties understood what their and others’ roles were to be. After consultation with the health authorities, this document was abandoned by the government and a new framework was developed with one goal: to provide a general picture of Ministry expectations and the kinds of approaches the Minister may take to monitor performance of health authorities, and ultimately to support a better understanding of accountability.

Clearly, these documents serve as a first step to clarifying the shift in accountability relationships brought about by health reform. However, there is a long way to go in developing and implementing a comprehensive accountability framework. Much collaboration is required to define the roles and relationships of system players, to clarify the dual accountability of health authorities to the minister and to citizens, to develop mechanisms to monitor and report on performance and to take a framework from conceptual design to practical application. In a recent assessment of accountability, in a paper prepared for the Commission on Medicare, McIntosh concluded that a new

accountability framework document was required as the previous one no longer reflected the working relationship between the various players and that a different kind of relationship was required for a sustainable system. He also highlighted the importance of a clear understanding of accountability.

A new framework document that begins with a much clearer understanding of what it means to be accountable would allow for a much more transparent enunciation of the roles and responsibilities that each of the actors plays within the system. (McIntosh, 2001, p. 9)

Another recent review of accountability practices, commissioned by Health Canada, concluded that:

The tools that make accountability possible –strategic plans, business plans, performance measures, monitoring, evaluating, and reporting, etc., are being developed, refined and implemented to a greater or lesser extent in all provincial jurisdictions. (Queen’s Health Policy Research Unit, p. 98)

Regional Health Authorities

Regional Health Authorities (some variation across the country in responsibilities) are the newest structure in the health system. They are responsible for the integration of the hospital, community, public health, and other institutions (such as long term care) that were previously operated under separate volunteer boards (there is some variation across the province in responsibilities). As these regional health boards try to sort out the balance of their powers, duties and accountabilities, they are finding that with cost containment pressures, the gap is growing between public and provider expectations and the ability of the system to deliver. The philosophical differences between the acute care crisis mentality and the more long-range focus of health promotion/disease prevention is apparent in the struggle for scarce resources. Although many boards are attempting to

shift some focus to the determinants of health that impact the health of the population, as apparent in the daily news, the service access and health professional issues are predominant.

Some regional health authorities are attempting to understand their dual accountability relationship to the public for quality services and to the province for fiscal accountability and are attempting to develop mechanisms for community consultation and engagement. However, the challenge to integrate the health care sectors outlined below will be difficult, particularly considering that two powerful sectors, physicians and drugs, are not accountable to regional authorities (See Appendix B for complex flow of accountability within regional authority operating environment).

Institutional-Hospitals

Hospitals in Canada are largely funded by public funds and have traditionally operated under a volunteer board at arms length from government (private non-profit model) but are governed by provincial legislation. They are now governed by the regional health board. Hospital services grew in the 1970s after these services were transferred from the private to public sector financing, and after they were protected under the principles of the Canada Health Act in 1984. Hospitals have been a dominant player in the health care network. Although their position is weakened slightly with the increasing emphasis on community focused care, they still receive the largest share of health care expenditures as noted above. Hospital expenditures include acute, extended and rehabilitation care.

Institutional–Other

This sector includes residential care facilities, which are approved, funded or licensed by provincial departments of health or social services. Residential care facilities include homes/facilities for the aged (including nursing homes), for people with physical and mental disabilities, for clients with alcohol and drug problems and for emotionally disturbed children. This sector has been less prominent than hospitals, and has received a smaller share of total public expenditures, with 30% of its expenditures coming from private sources (See Table 4). Since regionalization this sector, for the most part, has been integrated under the health authorities board or is on contract with health authorities.

Professional-Physicians

Physicians, like hospitals are almost entirely funded by the public, and have been the dominant profession within health care. Medical care, like hospital care, falls under the principles of the Canada Health Act. Physicians negotiate directly with the provincial governments to set their fee schedules and receive approximately 14% of all health care dollars. They are authorized under the provincial regulated health professions acts to perform all other profession's controlled acts, except dentistry (Sutherland et al. 1994). For the most part, physicians deliver services within a private/entrepreneurial model.

Physicians are a self regulating profession and have traditionally fought any initiative that threatens their autonomy. They have been criticized in popular literature such as *Operating in the Dark: The Accountability Crisis in Canada's Health Care System* (Priest 1998), for protecting the profession rather than the public to whom they are accountable.

Professional-other

Other professional expenditures include those for dentists, denturists, chiropractors, optometrists, podiatrists, osteopaths, naturopaths, private duty nurses and physiotherapists. These services are generally referred to as alternative services and 86% of them are privately funded (Health Canada, 1998).

Community

This sector includes expenditures on home care, medical transportation (ambulances), medical devices, research and public health, including health promotion. The financing is 70% public and 30% private. Traditionally, provincial and municipal governments and the voluntary sector (private non-profit) have played a role in service delivery. For example, public health nursing, health promotion activities and community mental health were delivered by the B.C. Ministry of Health prior to regionalization, and other public health activities operated out of the Capital Health District (municipal). Further, some of the services such as community mental health were contracted to small voluntary service organizations. This sector has traditionally been less dominant and in competition with hospitals; however, it is beginning to receive more attention as health, not just health care receives more focus. A major difficulty for this sector is that the short term (hospital) crisis drives out the long term planning for public health.

Pharmaceutical

Expenditures on drugs represent approximately 15 percent of health care expenditures and 63% of these expenditures are privately funded. This includes prescribed drugs, non-prescribed drugs and personal health supplies, which are bought in retail stores (Health Canada, 1998). Large multinational companies research, develop and

supply drugs, and market their products within the medical and health care system in ways that are said to influence prescription practices. Drugs are funded directly by the province (Pharmacare), not by the regional authorities.

Voluntary

The voluntary or private non-profit sector is extremely diverse, ranging from small societies such as Victoria Hospice Society to large professional agencies such as the British Columbia Cancer Agency (BCCA). These agencies raise money, fund research, administer health care programs and institutions, evaluate health care, collect and analyze data, operate educational programs and advocate for various causes and populations. They are financed mainly through public or membership funds and fund raising activities. Many of the agencies within this sector overlap with some of the previously mentioned sectors and it is not clear how some of the larger ones like BCCA relate to regional health authorities. Smaller agencies, such as Hospice Victoria, are under contract with the regional authority.

The Public

The National Health Forum (1997) found that there is widespread support among the Canadian public for medicare and the values and principles embodied in the Canada Health Act, but that many people worried about the affordability of the system. There is also growing concern among citizens about access and waitlists. Public confidence in the system has been eroded with the publication of poor outcomes and the lack of system accountability, such as in the tainted blood scandal. Public opinion polling shows that the gap between expected performance and perceived performance is widening. Ten years ago 60-70% of citizens perceived that their expectations would be met by the system. A

recent poll suggests that 30% of citizens anticipate that their expectations would be met (Lewis, 1999).

In 1998, Lisa Priest an award winning journalist, published a book on the lack of accountability in Canada's health care system. She suggests the following themes emerge in the system: There is no accountability to patients and taxpayers; there is little information publicly available so that patients can make informed decisions; and the job has been left to doctors and hospitals under the motto "we know best" (p. 296).

In summary, improved accountability was a goal of health restructuring. This is a laudable goal, given that according to Health Canada's website, \$95 billion was spent on health services in 2000. However, it is an understatement to say that it will not be easily accomplished!

Although there are many technical improvements occurring to improve the information available for internal and external organizational assessment, evaluation and reporting, there is a need for more collaborative problem definition and policy formulation. However, this will be difficult given the diverse roles and views among health system players. A synthesis of the key accountability relationships in the Canadian health system is provided below in Table 5.

Table 5: Synthesis summary of key accountability relationships in Canadian health system

Player	Responsible to	Key Mechanism
General Public	Society	Exercise rights
Federal Government	Public via Parliament	Electoral
Provincial Legislature	MLA's, MPP's to party and constituents	Approve legislation, budgets, receive audits, electoral process, party discipline
Executive Council/Cabinet	Caucus, legislature and public	Electoral, regulations, Provincial Auditor
Minister/Ministry	Exec. Council, Minister via Deputy	Regulation, policy, standards, reports, plans
Provincial Councils	Minister/Dept	Advisory reports
Regional Health Authorities/Boards	Minister/community	Mgmt accountability processes, stewardship reports, community consultation
Regional Hospitals	Community	Community consultation
Community Health Councils	Minister or Regional structures	Planning and advisory reports
Hospitals & Institutions	Board of Governors, Regional Authorities, Provincial Government	Mgmt accountability processes, stewardship reports
Health professionals	Regulatory bodies, employers	Licensing, peer review, complaint investigations, Instit bylaws, regional reg's
Citizens	Society, self	Personal care awareness

Source: Queen's Health Policy Research Unit, 1999, *An Inventory and Analysis of Accountability Practices in the Canadian Health System*, Kingston, On: Author, p. 101. Reprinted with permission.

Pal (1997), would describe the policy field as rich and dense with many powerful players all seeking to have an influence on policy. Perhaps a starting point may be to gain more clarity around the various players' perspective on accountability in the health field. Chapter 4 describes the methodology used to study the perceptions of Canadian health system leaders on the meaning of accountability in the health system.

Chapter 4

The Methodology

In order to address my primary and secondary goals, I required a methodology that is oriented toward clarification of the concept, its attributes, and its current use in the health field. The approach that best meets these requirements is a concept analysis method. Before describing this approach, I will outline the assumptions that I bring to this research project.

4.1 Assumptions

It is now recognized that whether stated or not, all scientific investigation is affected by the interests, values, attitudes and beliefs of the investigator (Bogdan & Bilken, 1982; Hodgkinson, 1986b; Kuhn, 1970; & Silverman, 1993). Since this orientation affects the choices made during the investigation, I have outlined my general guiding assumptions and interest in the topic at hand.

My interest in studying accountability is based on my own personal experience as a manager in a regional health system where restructuring is occurring and an expectation of improved accountability is present. Having worked in the health system for 20 years, I have been dissatisfied with the obscurity of decision-making criteria and the overall lack of accountability within the system and to the public who fund it. Also, since one of the objectives of health reform is increased public participation, I believe that a broader accounting to the public is necessary if there is to be meaningful participation by citizens in the planning, resource allocation and evaluation of health services.

As a citizen, I do not think the health system is accountable to the public. According to Friedman (2000), last year, the Institute of Medicine (IOM) issued the first report on Quality of Health Care in America. This report claimed that more people die as a result of medical error each year than from AIDS, breast cancer or auto accidents. It estimated that 44,000-98,000 patients die as a result of medical errors each year, 7000 of them from medication errors. Few patients are aware of such risks. Further, patients are unaware that some health settings are unsafe. For example, another United States study, cited by Friedman, showed that deaths from liposuction procedures performed in physicians' offices were 60 times more common than deaths from all surgeries performed in hospitals.

There are many reasons for such patient safety issues, but I agree with Friedman, that accountability is at the heart of the issue. In healthcare, as in the larger society, accountability is inextricably linked with malpractice attorneys. Additionally, power relationships and organizational characteristics contribute to a culture of fear where people avoid accountability. Chambliss (1996), in documenting the world of contemporary nursing in modern hospitals, detailed the power relationships and organizational characteristics that diffuse responsibility and create cultures of fear where mistakes are hidden, rather than reported, so that preventative measures can be taken. Of course, these accountability issues are not confined to health care but seem to be prevalent in our society.

My research approach is influenced by my educational background in Nursing Science and Public Administration, and my intellectual journey during doctoral studies to become more fully aware of the assumptions upon which my own theoretical perspective

is based, so that I might understand more fully alternative points of view. Recognizing that the foundation of my schooling was predominately functionalist, involving organizational theory and quantitative research methods, I set out to understand other worldviews and qualitative research methods.

While the journey continues, I locate my current basic beliefs about the nature of science, society and inquiry as evolving from positivism towards the post-positivism column as described by Guba and Lincoln (2000) in *The Handbook of Qualitative Research*. In sociological terms, Burrell and Morgan (1979) called this a “functionalist paradigm”, and it is consistent with my interest in understanding accountability from the point of view of various health system actors. This view is also consistent with my proposed research design, which, although it is qualitative, leans towards the more structured research design end of the qualitative research continuum. Denzin and Lincoln (2000) suggest that the positivist, post-positivist, constructionist and critical paradigms dictate the design of qualitative research along a continuum from rigorous and structured design principles, to emergent and less structured directives. Also, the evolutionary concept methodology is based on the postmodern view that there is no absolute and eternal truth. I believe with Rodgers (1993), that concept development is an ongoing process with no realistic endpoint. “Attempts to delineate clear boundaries, to distinguish a concept from its context, or to view it apart from a network of related concepts, as is often done with concept analysis, are not consistent with this view” (p. 77).

On an organizational level, I struggle with the extremes of the reality debate and agree with Hodgkinson (1996) that the simple truth about reality, organizational or otherwise, is that it is not that simple. As Hodgkinson stated:

One side of the reality debate leads to general system theory and neo-scientific management while the other leads to unclear methodologies and vague humanistic outcomes; the one dispenses with the value problems in administration as Simon, Katz and Kahn, and the systems theorists generally have done, the other remains profoundly bothered by problems of will, choice, and morality. (Hodgkinson, 1996, p. 144)

Hodgkinson's value paradigm offers a way out through a triplex rather than a dualistic analysis. He suggests three realities.

Reality III represents the empirical domain of science, the deterministic world of matter and substance, cause and effect, the world of hard tangibilities, and the stuff and furniture of the senses, mechanics, technology, and engineering. Here propositions can be predictive and falsifiable, taking the form of laws such as falling bodies accelerate at 32 feet per second squared. Our sense of control over nature depends upon the body of knowledge as construed by science at any given historical time. It represents our reality parameters, our temporarily immutable givens.

Reality II is the appropriate province of social science. Here propositions are less rigorously shaped, more probabilistic and cast in such forms as organizations which have a high degree of goal specificity and will have a greater degree of effectiveness than organizations which have a low degree of goal specificity. In this reality, there are no rigidities, only discernable tendencies and correlations. Nevertheless, as with Reality III in which it is embedded and by which it is constrained, the more propositions, verified or unfalsified, that social science can deliver, the better for our sense of administrative and organizational control.

Reality I is the perspectivist subjective phenomenological realm of individual experience. This internal realm of meaning admits of imagination, interpretation and, in an existential sense at least, the phenomenon of will where each person is an island and there is no truth save by individual interpretation. Propositions at this level therefore, while constrained by the "lower" or "harder" realities and falsifiable by them, are not scientific but rather philosophical. We need not so much more propositions but as more ordering and validating of the propositions that already abound. And we need to get clear about the language games of the three realities taken jointly and severally so that, pace Wittgenstein, our intelligence is not bewitched by our language. (Hodgkinson, 1996, p. 144)

My objectives in studying accountability are to clarify the language of accountability in the health sector for the purpose of theory building, and to assist our understandings of the concept during our practical discussions on policy and application.

In political analysis, the concept analysis method is termed “semantic analysis” (Dahl, 1976). This type of analysis is used to deal with problems of definition to clarify language, and assist understanding of the meaning of statements contained in policy analysis, normative analysis, and empirical analysis.

4.2 Research Design: Qualitative Versus Quantitative Research

Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities, the social sciences, and the physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the multimethod approach. They are committed to the naturalistic perspective and to the interpretative understanding of human experience. At the same time the field is inherently political and shaped by multiple ethical and political positions.

Qualitative research embraces two tensions at the same time. On the one hand it is drawn to a broad, interpretative, postmodern, feminist, and critical sensibility. On the other hand, it can also be drawn to more narrowly defined positivist, postpositivist, humanistic, and naturalistic conceptions of human experience and its analysis. (Denzin & Lincoln, 2000 p. 7)

According to Denzin and Lincoln (2000), qualitative and quantitative research differ in five significant ways:

1) “Uses of positivism and post-positivism”: Both qualitative and quantitative perspectives are shaped by positivist and post-positivist traditions in the physical and social sciences, but vary in the degree to which these traditions influence the research methods used;

2) “Acceptance of postmodern sensibilities”: The use of quantitative, post-positivist methods and assumptions vary among qualitative researchers. While some view them as no better or worse than any other method (they just tell a different story),

other members of the critical theory, constructivism, poststructural and postmodern schools reject postpositivist criteria when evaluating their own work;

3) "Capturing the individual's point of view": Both are concerned about the individual's point of view but qualitative researchers think they can get closer to this perspective through detailed interviewing and observation. Quantitative investigators rely on more remote inferential empirical materials and regard the softer interpretive methods as unreliable, impressionistic and not objective;

4) "Examining the constraints of everyday life": Qualitative researchers are more likely to confront the constraints of everyday social life by seeing the world in action, embedding their findings in it and committing to an ideographic case-based position. Quantitative researchers, on the other hand, abstract from this world, rarely studying it directly; they seek a nomothetic science;

5) "Securing rich descriptions": Quantitative researchers, with their nomothetic commitments are less concerned with the detail of the social world whereas the qualitative researcher believes that rich descriptions are valuable.

Because accountability is a complex and value-laden concept, I chose to employ qualitative methods rather than quantitative measurements, as the best way of understanding accountability and communicating my ideas and findings. Although some people question the scientific nature of qualitative research, I think this issue is best addressed best by Nobel Prize-winning physicist P.W. Bridgeman as quoted in Bogdan & Biklen :

**There is no scientific method as such... . The most vital feature of the scientist's procedure has been merely to do his utmost with his mind, no holds barred.
(Bogdan & Biklen, 1982, p. 39)**

4.2.1 Concepts and Concept Analysis

In keeping with my transitional perspective from positivism to post-positivism, the method I chose is an evolutionary one. The method of concept analysis was utilized to address my goal to clarify the concept of accountability within the Canadian health system. Concept analysis is a qualitative, analytical and descriptive design (McMillan & Schumacher, 1997). It is inductive (findings-driven) rather than deductive (or theory-driven). The method is used extensively in nursing and psychology and is aimed at the clarification of concepts to characterize phenomena of interest, to describe situations, to communicate effectively and to develop knowledge (Rodgers, 1993; Morse, Hupcey, Mitcham, & Lenz, 1996).

Concept analysis typically involves an assessment process that uses various approaches to explore the description of a concept in the literature or to develop a concept from observational and/or interview data. Concepts are explored for their level of development or maturity as revealed by their internal structure, use, representativeness, and/or relation to other concepts (Morse et al., 1996). My analysis was based on a systematic literature review to clarify the concept, its attributes and its current use within the health system. Following the literature analysis, purposive interviews were employed to enrich literature findings and fill information gaps. Flick (1998) asserted that such a combination of data collection methods or triangulation adds rigor, breadth, richness, complexity and depth to any inquiry and reflects an attempt to obtain an in-depth understanding of the phenomenon in question. It is an alternative to validation; not a tool of validation since objective reality can never be captured. "We can know a thing only through its representations" (p. 230).

Traditionally, popular views of concepts and concept analysis have been based on a philosophical position of essentialism, where the concept was defined in terms of its critical attributes or essence, appearing as a set of conditions both necessary and sufficient to delineate the domain and boundaries of the concept. Consistent with this philosophy, the concept was viewed apart from its context or relationships with other concepts and a concept analysis type of inquiry gave the impression that the concept was universal (without contextual variation) and unchanging (Rodgers, 1993; Silva, & Rothbart, 1984)¹³.

Today, different views are presented in philosophical discussions. Concepts are considered to be dynamic, rather than static; fuzzy, rather than finite, absolute and crystal clear; context-dependent, rather than universal; and of pragmatic utility, rather than as an inherent truth. Rodgers (1993) suggests that this contemporary view has gained considerable support from empirical research in the field of psychology.¹⁴ This view is consistent with postmodernism which recognizes there is no absolute truth forever (Bauman, 1999).

Debate continues regarding the adequacy of methods for assessing and developing concepts and the utility of these methods for the acquisition of knowledge. Wilson (1996) developed the method of concept development which was introduced to nursing by Walker and Avant (1983), Chinn & Kramer (1991) and others. The Wilsonian method of concept analysis uses constructed model cases that support or contradict the

¹³ This view is consistent with the logical positivism (empiricism) school of philosophical thought which views science as a product, composed of concepts, theoretical assumptions and empirical generalizations, whose goal is the logical explanation of the nature of scientific knowledge.

¹⁴ This view of concepts is consistent with the historicism school of philosophical thought which views science as a process composed of concepts, scientific theories and research traditions, whose goal is the historical explanation of the nature of scientific knowledge.

concept or represent a hypothetical ideal. Other scholars such as Chinn & Jacobs (1983), Walker & Avant (1983) and Schwartz-Barcott & Kim (1986) have developed variations on this approach. However, these forms of concept analysis have been criticized for their lack of clearly defined methods, inadequacy of data, lack of overall research rigor and research agendas that are inconsistent with the purpose of the method of inquiry (Morse, Hupcey, Mitcham & Lenz, 1996; Hupcey, Morse, Lenz, & Tason, 1996).

Rodgers' evolutionary method (Rodgers & Knafl, 1993), attempts to compensate for these limitations by discussing the philosophical foundations of the method, focusing on the selection of literature to be reviewed, emphasizing an inductive inquiry, and providing for the use of qualitative techniques for data collection. According to the evolutionary view, a concept is considered to be an "abstraction that is expressed in some form" (Rodgers, 1989, p.332). Concepts are formed by the identification of characteristics common to phenomena and the abstraction and clustering of these characteristics, along with some means of expression (most often a word). The forms of expression, whether discursive (words) or nondiscursive (e.g., artistic expression) that are acquired along with a concept enable an individual to share his or her concepts publicly with others. These expressions provide access to an individual's concepts and reflect his or her use of the concept. The development of a concept for a person takes place within the social context, and as contextual factors vary, there will be variations in concepts over time or across situations. Galante (1991) believed that the philosophical basis of this evolutionary view is consistent with Wittgenstein's view of language and concepts, that is, "meaning is use" (p. 29) and the focus of inquiry should be directed toward identifying and explaining differences in meaning found in use contexts. By analyzing such use, it is

possible to identify the attributes of a concept and thereby decrease ambiguity and provide a foundation for further knowledge development (Rodgers, 1993).

Ebersole (1996) concluded that analysis of the use of words can be done in two ways. The first is an internal assessment involving identification and description of the characteristics or features of the phenomenon to which the word applies that is consistent with identification of attributes. The second is an external assessment involving identification and description of the context of use, including what variables determine when, where and how a word is used; who uses it; and under what circumstances it is used. This second method is consistent with the identification and discussion of surrogate terms, antecedents, consequences, references and related concepts, that are products of analysis resulting from identification and description of the context of use. Concept analysis, then, uses both methods to achieve clarification of meaning.

The current significance of the concept of accountability to health policy is reflected in the various ways it is being applied to and within the health system. Its attributes, scope, and situations that are characterized using it, become clear through its application (Rodgers, 1993). Consequently, the current application of the concept of accountability made it ripe for analysis, to reveal the strengths and limitations of the concept and generate directions for further development.

This analysis is focused on the use of the concept of accountability, and is oriented towards clarification of its attributes. By identifying a current consensus and or divergence regarding the concept of accountability, the analysis provides a foundation on which to further develop the concept. My focus was on an inductive approach to

analysis, as I sought to identify similarities and differences in the use of the concept, rather than impose any strict criteria or expectations on the analysis.

4.2.2 Sample

Literature-based

The concept of accountability was anticipated to be of interest to the following domains within the health system; nursing, medicine, health care administration, and governance. Consequently, my literature sample was selected from these domains and also from the popular literature, such as Maclean's Magazine and books by M. Rachlis, L. Priest, M Decter and other Canadian health system writers. Since many people gain a considerable amount of information regarding health and health care through the popular media, these sources undoubtedly shape individual concepts. The criteria for inclusion was that the material be Canadian and that it address the topic of accountability in the health sector.

After consultation with a librarian, several literature search databases were targeted to provide Canadian literature within the domains of interest. Medline and CINAHL were searched for the domains of Medicine and Nursing; Health Star was searched for health policy and administration information; and Canadian Business and Current Affairs, Can News DISC, CPIQ Canadian Periodicals Index and EBSCO host Canadian Mas were used to scan for Popular literature. Additional searches included, Periodicals Content Index, Canadian Research Index and Dissertation Abstracts. Further, interviewees acted as an expert panel to advise on unpublished Canadian material developed within last five years. During the interviews, each participant was asked if they

were aware of unpublished literature on accountability within the Canadian health system. Literature Search databases and the corresponding timeframes are outlined in Appendix G.

Indexes, computer databases, dissertations and Canadian government documents were used to identify the total indexed population of literature in each domain. Because the numbers of articles and books were small, the total number was used rather than a random sample (see table 6) .

Interviews

Interviews provided a secondary source of data to fill gaps and to corroborate and enrich the literature. The sample for interviews included 24 health system leaders holding policy/administration, professional and community development type positions.

These leaders were chosen based on the following criteria:

- That they be knowledgeable about the Canadian health system as evidenced by an executive level position (current or recent past) in health organizations;
- That they have given some thought to accountability in the Canadian health system as evidenced by presentations or writings on the topic; and
- That they be knowledgeable about professionalism, health policy /administration or community development (citizen advocacy) as evidenced by their positions in these areas.

Thus, health system leaders who are decision-makers or ex-decision makers (now consultants) who have or have had organization-wide responsibilities in nursing and medical professional organizations, health regions, and government were targeted.

Marshall and Rossman (1995) referred to this process as “elite interviewing” (p 83),

where influential and well-informed people are selected for interviews based on their expertise in areas of relevance for research. The advantages to interviewing elites are their overall view of an organization and their familiarity with legal and financial structures; a distinct disadvantage is that they are difficult to reach, given the many demands on their time. I relied on my many connections within the health system for sponsorship, recommendations and introductions in making appointments with these individuals and found them to be most generous with their time. As mentioned previously, each interviewee also acted as a expert panel to provide current Canadian literature on health system accountability.

4.2.3 Data Collection

The primary source of data collection was the literature reviews to identify data relevant to the attributes, antecedents, consequences, surrogate terms, related concepts, and references of the concept of accountability in health care. According to Rodgers (1993), the identification of the attributes of the concept represent the primary goal of concept analysis. She asserted:

When the attributes (definition) that comprise the concept are unclear, the ability to communicate and categorize phenomena is severely limited. Analysis of the common use of the concept, by examining means of expressions, enables the researcher to identify the cluster of attributes that constitute the concept and, hence, to define the concept. (Rodgers, 1993, p. 75)

The antecedents and consequences refer to situations, events, or phenomena that precede and follow, respectively, an example of the concept. Surrogate terms are other means of expressing the concept of accountability. Related concepts bear some relationship but do not share the same set of attributes (Rodgers, 1993).

Interviews provided the secondary source of data. These were used to fill in gaps in information and provide another source of information (triangulation) to further test the attributes of accountability, through documenting the perceptions of key health system participants. This data proved to be the richest source of information and enhanced my analysis by capturing the individuals' points of view.

The process of interviewing can vary on a continuum from structured to unstructured. Structured interviewing involves a series of pre-established questions with a limited set of response categories; unstructured interviewing takes the form of informal interviewing during participant observation in the field (Fontana & Frey, 2000).

Although my questions were structured to reflect and follow-up on data collected in the literature, as outlined by my concept analysis methodology (see Appendix C), my interviews also included open-ended questions to provide for openness, flexibility and some content to be in the hands of the interviewer. Questions were pre-circulated to interviewees, and in most cases, I took on a directive role in getting through the questions. However, a flexible approach was taken, and in a few cases the interviewee proceeded from one question to the next without any prompting. Although a couple of people chose to meet with me at my home, usually, I met people in their office. I would categorize my interview questions as semi-structured.

With permission, I audiotaped the interviews to ensure accuracy and a natural flow of conversation (see Appendix D for the consent form). This allowed me to listen and respond with greater accuracy during the interview and listen afresh during transcription review. The interviews were transcribed verbatim and a copy of the transcription was provided to participants for their verification or for changes to more

accurately reflect their perceptions. Most people did not require changes to the transcript. Three people made some minor editorial changes.

4.2.4 Ethical Considerations

My research proposal was reviewed and approved by the Human Research Ethics Committee at the University of Victoria. This included a review of the material now found in the appendices : the Introduction & Request for Participation, the Consent to be Interviewed and the Interview Schedule. The consent form, which dealt with confidentiality, minimal risk, procedure and purpose was signed by interviewees prior to the interview.

4.2.5 Data Analysis

The evolutionary view of concept analysis, where concepts are viewed as developing in an evolutionary manner within a social context, was utilized for data analysis. The method was primarily a process of identification of the use and application of the concept and involved the following activities: analysis of the data to identify the attributes, references, antecedents and consequences of the concept; and, comparative analysis across the various disciplines or domains and identification of implications for practice and for further development (Rodgers, 1993).

Contrary to the concurrent analysis that is necessary to provide further direction for most qualitative research, in concept analysis, it is more effective to delay formal analysis until near the end of data collection. This was helpful in avoiding premature

closure, or jumping to conclusions, and in dealing with the difficulty of seeing beyond the early impressions.

According to Rodgers :

Concurrent analysis also seems to lead to a premature belief that the data are saturated when considerable redundancy is discovered. Invariably, however, the next article or book examined provides a new insight or, at least, a suggestion of a better way to express ideas related to the concept of interest. Consequently, there are considerable benefits to delaying extensive analysis until near the conclusion of data collection. (Rodgers, 1993, p. 86)

Thematic analysis is the procedure I chose to use. Articles were read and re-read, and similar and divergent themes were developed according to the following categories, which are based on Rodger's (1989) method of concept analysis. The specific categories for this study were attributes of the concept, surrogate terms, antecedents, consequences, related concepts, and references. These categories as defined by Galante (1991) were used to guide the coding of data.

Attributes: Attributes are the descriptors or defining characteristics that explain aspects or components of a concept. Taken together, these aspects/characteristics/components, build a "picture" or definition of the concept.

Antecedents: Antecedents are the events or phenomena that generally proceed the occurrence of a concept.

Consequences: Consequences are the events or phenomena that generally follow or result from the occurrence of the concept and reflect the outcomes of the use and application of the concept.

Surrogate Terms: These are substitute or alternative terms used to refer to a concept, as concepts are usually employed in association with several other terms that serve as manifestations of the concept.

Related Concepts: These concepts that are related but different in that they lack one or more of the attributes of the concept of interest. These concepts provide a means of recognizing the actual and potential inter-relatedness of concepts in general and the likelihood of their change over time.

References: These comprise the range of events, situations or phenomena over which the application of the concept is considered to be appropriate. Appropriateness is a function of the common and accepted use and application of the concept. (Rodgers, 1989, p. 76)

The interview data were also analyzed, categorized and grouped using the above categories. Direct quotes from participants were utilized to enrich the text, and all efforts were made to ensure interviewees meanings were conveyed. I used numbers to identify each participant. These numbers are used in direct quotes, in the next two chapters, to differentiate and reference direct quotes from interviewees.

Data from the literature and interviews were subjected to a minimum of three readings for the purposes of analysis; inquiry then proceeded in an inductive manner utilizing text segments (words, phrases, or sentences) as the unit of analysis. This technique of repeated readings and inductive analysis enhanced the identification of recurring themes regarding the concept of health system accountability. In such an approach, the identified themes emerge out of the data rather than being imposed on them prior to data collection and analysis (Rodgers, 1987). Each relevant text segment was categorized in relation to the specific categories of concept analysis and copied onto a page relating to attributes, antecedents, consequences, surrogate terms, references and related concepts. The coding form used in this analysis is presented in Appendix F.

The literature and interview data were also examined to identify similarities and differences among professional, policy / administration and popular views. Finally, the interview data were analyzed to identify the issues related to improving accountability in the Canadian Health System.

Surveying the use of the concept of health system accountability in Canada did not produce a large sample of literature. This supported a finding by Queen's Policy Health Research Unit (1999) that Canadian literature is scant and limited in the range of issues it deals with. Given the limited literature, this study drew extensively on the expertise of 24 health system leaders to further understand the concept and related issues.

4.2.6 Rigor Provisions

To strengthen the rigor of this study, I followed Flick's (1998) and Lincoln and Guba's (1985) suggestions for enhancing trustworthiness and rigor. Their framework includes: credibility, transferability, dependability and confirmability. Credibility is akin to the conventional validity and refers to how worthy the findings are. Several factors add to the credibility of this study. First, the combination of literature and interview data increases the likelihood that the study findings were truly reflective of the common use of the concept of accountability in the Canadian health system. It also serves to enhance the degree of structural corroboration generally equated with validity or credibility.

According to Guba & Lincoln (1981) structural corroboration occurs when data are used to establish links that eventually create a whole that is supported by the bits of evidence that constitute it. Evidence is structurally corroborative when pieces of evidence validate each other, the story holds up, the pieces fit, it makes sense, the facts are consistent.

Flick (1998) asserted that such a combination of data collection methods or triangulation adds rigor, breath, richness, complexity and depth to any inquiry and reflects an attempt to obtain an in-depth understanding of the phenomenon in question. It is an alternative to

validation; not a tool of validation since objective reality can never be captured. “We can know a thing only through its representations” (p. 230).

A second factor contributing to the credibility of this work is member checking. All interviews were transcribed verbatim and provided to participants for verification or correction. Third, interviewees acted as an expert panel in providing unpublished literature, thus, ensuring comprehensiveness of the Canadian literature on accountability.

Transferability is likened to the conventional criteria of external validity or generalizability (Lincoln & Guba, 1994). Thick descriptions of the participants verbatim allow those interested in the findings to make a decision about the extent to which the explanations assist in understanding and illustrating the phenomenon under study.

Dependability is similar to reliability and takes into account factors of instability and design-induced change (Lincoln & Guba, 1985). This was enhanced by repeated readings to identify themes and the coding of data into the categories of concept analysis. Also, memo's, emails and chronological notes serve as an audit trail, allowing the research process to be followed.

Confirmability refers to the objectivity or neutrality of the data. This was supported by explicitly stating my own views and background and also, by the ability to follow my process through the procedures stated above. Thus, although complete neutrality is not possible¹⁵, identification of attributes, references, related concepts and other characteristics of the concept of health system accountability was attempted without reference to a priori hypothesis.

¹⁵ According to Smith & Deemer (2000) all knowledge is framework dependent, there is no possibility of “a view from nowhere, no God's-eye point of view” (p. 879). “Knowledge is a human social production. As finite beings, all we can do is construct social and educational realities for which we are morally responsible” (p. 891).

4.2.7 Research Strengths

The most typical data collection strategy used in concept analysis is literature samples. An advantage of the evolutionary method is that other forms of data collection are valued. The addition of interviews in this study provided a richness of perspective that could not be found in the literature. Health system experts also provided the latest unpublished documents that represented the most current thinking on the matter.

This research provided a comprehensive synthesis on the concept of accountability as it is used currently, within the Canadian Health System and identifies areas requiring further research. This is an advantage in clarifying the language surrounding accountability and may lead to a better understanding of the concept and its related policy problems.

4.2.8 Research Limitations

The Canadian academic literature on accountability is limited; therefore, the literature that was reviewed was of variable quality. Some of the literature, while emphasizing the importance of accountability, neither defined nor presented practical details of how it would work. Other literature focused on professional or organizational roles in achieving accountability. Policy descriptive articles discussed tools such as auditing or performance measurement and theoretical articles either reviewed general frameworks for an understanding of the concept or examined specific aspects such as the role of ethics.

Because of time limitations and travel costs for the researcher, health system leaders from only five Canadian provinces were interviewed. Likewise, the voices of all

players involved in and affected by health policy, were not represented. For example, union leaders were not approached given the job action within the province, and front line professionals or middle managers were not interviewed. The perspective gained was that of health system leaders, in other words, the executive perspective from policy/administration, professional (medicine/nursing organization) and community development in health regions.

Chapter 5

The Concept of Accountability in the Health System: Sample, Analysis and Findings

To improve our understanding of the concept of accountability in the Canadian Health System, I selected a concept analysis methodology, which as previously described, is a technique of analytic philosophy used to clarify the use of a particular concept and ultimately to enhance the theoretical soundness of knowledge. Two data collection strategies were used. The first was a targeted literature review focusing on accountability and health care in Canadian literature. The second was a purposive sample of twenty-four Canadian health system leaders. They were interviewed to gain their perspective on the meaning of accountability in the Canadian health system and to identify the key issues in improving accountability.

5.1 Sample

The structure of the literature search was as follows: Accountability and Health Reform, or Health Policy or Health Economics or Health Planning or Health Services Administration or Health Care Quality or Health Professions. The numbers of books and articles are summarized in Table 6.

Table 6: Results related to search and selection of literature

Journal/document citations	Professional	Policy/Admin	Popular
Population identified	94	504	72
Canadian sample selected	11	8	27
Additional items from experts	4	19	0
Book citations			
Population identified	2	3	1
Canadian sample selected	0	2	1
TOTAL SAMPLE	15	29	28

The majority of the literature was from the United States, followed by Britain and then Australia and New Zealand. Because the number of Canadian articles was small, the total sample of literature was included and secondary data were obtained through interviews with 24 health system leaders. Health system leaders also acted as an expert panel in providing additional unpublished literature sources.

Thirteen interviewees worked in health policy/administration in health service organizations or government. Seven were from professional organizations (medicine or nursing) or worked in predominately professional capacities. Four people worked in community development or community health service delivery capacities. Two people knowledgeable about community development/citizen advocacy declined to be interviewed. It was not possible to obtain a union perspective because of nurses' job action in the province at the time of data collection.

Health system leaders were from five Canadian provinces: Newfoundland, Ontario, Saskatchewan, Alberta and British Columbia. Not all provinces were included because of travel costs for the researcher. Eleven interviewees were female and thirteen

were male. Their roles included: Chief Executive Officers & Vice Presidents of Regional Health Boards, research and accreditation organizations, Presidents of health/ research consulting firms, Deputy Ministers of Health, Chief Nursing Officers, Directors/Deans of Schools of Nursing/ Health Sciences, Medical Health Officers, Community Development Coordinators, Senior Information Analysts with regional and Canadian health organizations and senior staff with provincial medical organizations. Given the formal positions of participants, I can term my approach “elite sampling.”

5.2 Results Related to Research Objectives

The main research objective was to clarify the concept of accountability within the Canadian health system by utilizing a concept analysis methodology to identify the surrogate terms, related concepts, antecedents, consequences, references, and attributes for the concept of health system accountability.

The second objective was to gain insight, from the interviews with health system leaders, into the issues surrounding efforts to improve accountability in the Canadian Health System.

5.2.1 Clarifying the concept of accountability according to concept analysis categories

Attributes

Attributes are the descriptors or defining characteristics that explain aspects or components of a concept. Taken together these aspects/characteristics/components, build a “picture” or definition of the concept. A first level of analysis from the literature and interview data indicate that there is more than one conception of accountability. In fact,

five perspectives of accountability emerged. That is, accountability as (1) a theoretical and/or ethical construct, (2) a formal system, process, or set of practices (3) an on-going political process (4) a symbolic gesture, and (5) as outcomes or desired results.

Accountability as a theoretical or ethical construct refers to moral or ethical behavior and the articulation of frameworks for a general understanding of the concept. A formal system of accountability refers to processes, tools or institutions, including professional institutions for achieving accountability. A contrasting view of accountability is as an on-going political process where power is viewed as the significant variable and only a change in relative power will produce a significant change in accountability. The hallmark of accountability as a gesture is that it is pure norm with little or no instrumentality attached. Accountability as an outcome or desired result represents areas of interest within the health system that require improved accountability.

The policy/administration and professional literature focused mainly on the perspective of accountability as a theoretical or ethical construct, a formal system/process and as an outcome or desired result. Popular literature focused mainly on accountability as an on-going political process and on accountability as a gesture. The predominant views among interviewees were the formal system, process or set of practices and outcomes/desired results. Table 7 provides examples of data under each perspective. Miles and Huberman's (1994) use of matrices is utilized to display the qualitative data instead of text and quotations, because it provides for the incorporation of maximum data to illustrate the different perceptions.

Table 7: Perspectives of health system accountability

Perspective	Examples of literature and interview data
Theoretical and/or ethical construct	<ul style="list-style-type: none"> ▪ Moral character and associated personal standards ▪ A construct describing organizational, ethical and political relationships ▪ Responsibility to law and ethics ▪ Social contract...responsibility to society ▪ A choice – thoughtful commitment ▪ A values-based ethical construct ▪ A fundamental value behind Canadian Health System ▪ Social justice and fairness ▪ The scaffolding we use to make choices and decisions in our work
Formal system, process or set of practices	<ul style="list-style-type: none"> ▪ Accountability as shared expectations expressed in a common currency ▪ Obligation to render an account for discharge of responsibilities assigned & affecting others in important ways ▪ A system of measurement and reporting that will allow you to improve services, with the objectives being set out by a definition of quality ▪ A framework that articulates values, principles, relationships, roles and responsibilities at all levels of the system ▪ Accountability is an institutional or organizational phenomenon (not individual), with explicit sets of expectations and a set of graded responses if objectives not met ▪ A set of professional standards, outcomes and maintenance of standards of practice ▪ Being clear about intentions, measuring and understanding results and making necessary adjustments to strategies and programs ▪ A contract between two parties ▪ A process of Quality Assessment ▪ Enforced responsibility
On-going political process	<ul style="list-style-type: none"> ▪ On-going dialogue about the big picture...direction ▪ Accountability requires a shift in power...from providers to patients ▪ Sharing ownership with the public on tough choices ▪ About being real, fallible and understanding that doctors and hospitals do not have all the answers ▪ Requiring sanctions or the ability to revoke the mandate ▪ Whose interests and values get attention and results ▪ Accountability seen as inclusion of all members to present and justify views ▪ Shift from a culture of blame to corrective action ▪ Answerability to the community served ▪ Checks and balances on power and authority

Accountability as gesture	<ul style="list-style-type: none"> ▪ Justice is offended if people at the top of bureaucratic structures are not held responsible for their actions ▪ Polls show mistrust of government Medicare spending, ▪ Providers and public want accountability ▪ Lack of accountability alarming ▪ A crisis of accountability
Accountability as outcomes or desired results	<ul style="list-style-type: none"> ▪ Value for money ▪ Improved quality, decreased medical error ▪ Improved responsiveness ▪ Systematic not isolated solutions ▪ Ethical conduct ▪ Clearer expectations, acceptance of responsibility and consequences at all levels ▪ Reduction of health inequalities ▪ Focus on population health as well as medical care ▪ Public Safety ▪ Sustainable health system ▪ Respect of one's colleagues

Although there are several conceptions of accountability, there is some convergence on the attributes. Many articles and interviewees did not provide explicit definitions of accountability, but the data revealed a number of categories relevant to the attributes of accountability. Specifically, these included: an obligation to answer for the responsibilities conferred, performance assessment according to standards /goals, and justification of decisions/ answerability to communities served.

An obligation to answer (render account) for the responsibilities conferred

An obligation to answer for one's responsibilities was frequently reported in professional and policy /administrative literature and also by interviewees as a characteristic of health system accountability. The provincial accountability documents developed during regionalization frequently used this definition of accountability and often defined the responsibilities of key system players. For example, Alberta's framework (1999) defined accountability as "being expected to answer for your actions

through a formal arrangement” (p. 2) and then went on to define roles and responsibilities of the various players in the health system. Professional literature often referred to being accountable for professional responsibilities. Some referred to being answerable as a key component of professional practice. Many interviewees included a similar phrase in their definition of accountability. One interviewee described accountability as “you are accountable to somebody for carrying out your responsibility.” Another stated “accountability ultimately means people feeling responsible for delivering services that they have agreed that they’re going to provide.”

This attribute is widespread throughout the general accountability literature and is sometimes referred to as the essence of the concept (Cutt, & Murray, 2000; Leclerc et al. 1996). There is a presumption of at least two parties, one who assigns it and one who accepts it with an understanding that a reporting is required. There seems to be an assumption of a hierarchical relationship and an absence of an internal or personal level of accountability, where to feel accountable, one’s responsibilities need to be aligned to individual morals and values. This notion of accountability is perhaps linked to the public administration theory of “universalism” where reliance is upon rational decision-making, science, and a chain of command (hierarchy and legal structure) to do the right thing (Simon 1946; Gustafson, Cats-Baril & Alemi, 1992).

Performance assessment according to standards or goals

Performance assessment was frequently discussed in the literature as an important aspect of accountability but the reference point often varied by type of literature. The professional literature data most often referred to performance in light of professional standards or codes of ethics. Policy and administrative data generally referred to the

attainment of goals and objectives for a program or the system. Interviewees frequently used them interchangeably. A deputy minister suggested that to be accountable,

There needs to be some established objectives or criteria or standards or whatever that foundation is - that those are established, they're declared, they're linked to some evidence and preferably research or scientific evidence - not somebody's opinion, but evidence (6).

A CEO said:

Accountability is setting goals, figuring out how you're going measure whether you achieve it, making changes to allow you to move towards it, and if you're not achieving it, making more changes (15).

Frequently, the literature data and interviewees raised the need for quality and quality assessments within healthcare. A prominent health service researcher stated:

I think the recognition that we can't buy our way out of our problems will force a look at quality and therefore accountability. ...I think there are several kinds of accountability, one is the conventional kind, which is just a simple reporting on what the system does..., its mandate, its principles and what generally are people entitled to get and what is delivered in terms of volume and to whom and so on. But there are many richer concepts of accountability.... a living concept ... quality, which has 2 dimensions - error rates and so forth which is like a kind of a negative accountability. But the positive one is, for want of a better term, continuous quality improvement. Is the system able to demonstrate that it is constantly seeking to innovate... that the quality in all its dimensions is getting better (8).

The literature on performance assessment, quality assessment and the broader concept of performance management is prolific. It relates to tools, mechanisms and performance management frameworks and was covered in Chapter 2, in the section on accountability practices. An underlying premise is shifting the focus of organizations from processes and activities to intentions and results. Information needs are examined across the management cycle and emphasis is placed on a common language for the fulfillment of shared expectations among stakeholders, corresponding performance

evaluation criteria, and the means of communication (Cutt & Murray, 2000). This notion of accountability is likely linked to the public administration theory of “pluralism” which suggests being responsible and answerable to a diverse set of interest groups.

Justification of decisions/answerability to communities served

This aspect of accountability was frequently referred to in the policy /administrative and popular literature. It was also a common element expressed by interviewees. One health region CEO stated:

To me, accountability is more than just performance management; it's also an answerability. So parts of our public boards meetings for example, even if we're not doing a good job or a good enough job of reporting out, we are answerable. And that's part of accountability as well, that people know where the decisions are made and they know they can contest those decisions on the spot (21).

This notion of accountability is perhaps linked to the public administration theory of “participatory democracy,” which suggests that public administrators should be responsible and answerable in a socially equitable way to the citizenry (Laporte, 1971).

Characteristics

Further to the attributes of accountability, two other characteristics of accountability, multi-level and multi-dimensional are evident and worth reviewing here.

A multi-level construct

Most literature and interviewees viewed accountability as a personal concept (subjective), when referring to accountability as a values-based or ethical construct; and an organizational and political (objective), when referring to accountability as a formal system or process. Also, one needs only to listen to a conversation about health policy for

a few minutes before the words “responsible” or “accountable” are used in reference to a policy, a person’s behavior, or the behavior of a health organization. Mosher provides an eloquent description of the two meanings of the construct and the inherent conflict between the two:

Responsibility may well be the most important word in all the vocabulary of administration, public and private. But it has a confusing wealth of different meanings and shades of meanings, of which I identify two. The first, objective responsibility connotes the responsibility of a person or an organization to someone else, outside of self, for some thing or some kind of performance. It is closely akin to accountability or answerability. If one fails to carry out legitimate directives, he is judged irresponsible, and may be subjected to penalties. In a broad sense, the dichotomy between policy and administration depends upon objective responsibility; it assumes that the administrator will carry out policy determinations decided upon elsewhere, whether or not he or she likes or approves of them. Responsibility is also essential to predictability. If a person does not behave responsibly, his or her behavior cannot be predicted. (Mosher, 1982, p. 9)

He goes on to say that:

A quite different connotation attaches to the second meaning of responsibility, which is subjective or psychological. Its focus is not upon to whom or for what one is responsible (according to the law and organizational chart), but to whom and for what one feels responsible and behaves responsibly. This meaning is more nearly synonymous with identification, loyalty and conscience than it is with accountability and answerability. And it hinges more heavily upon background, the processes of socialization and current associations in and outside the organization than does objective responsibility. Subjective responsibility, if one concedes its legitimacy as an element in government at all, raises immediate and obvious questions about the strength and reliability of objective responsibility. If one feels responsible in one direction (which feeling is counter to the directives received from above) and modifies his or her behavior accordingly, what reliance may be placed upon objective responsibility to the superior. (Mosher, 1982, p. 11)

Today, the majority of interviewees viewed these two levels as legitimate and some literature adds a third level, lateral accountability to colleagues, which is discussed under “references.” However, this area has been the topic of an ongoing

debate in public administration, as reflected in the discussions on ministerial responsibility. Also, while the majority of interviewees expressed a multi-level view of accountability there is some dissention. One health region CEO emphasized the personal element:

Personal ownership, not because you said I should do it. But because I say, "this is part of the work I have committed to doing". ... you can't make me accountable. The word "hold" immediately is oxymoron in the context of accountability. You can hold me responsible but you cannot hold me accountable; I hold myself accountable – it's a very important difference. I mean it is one of the profound parts of this whole thing about accountability that becomes critical if you begin thinking about this (23).

Another CEO of a research organization viewed accountability as only an organizational concept.

I see accountability as an organizational, not an individual phenomenon. So the picture I have is, as a whole organization, I exist within a bigger picture in which there is not necessarily any - easily usable direct levers. So a good example, two examples - one would be as a Provincial government I fund the hospital, if I fund the hospital I could say, "well that's fine, if they do anything wrong, I'll shut them down", with an extremely blunt tool and therefore the basis on which I want to deal with that hospital is I want that hospital to be accountable for some expectations and performing objectives that I will put in place. So to me accountability is (A) between institutions or organizations, the leveling of a set of explicit expectations and objectives and (B) having in place a measured and graded set of responses depending upon how far you fall short of those (17).

So, although in practice, accountability operates at multiple levels there is not conceptual agreement that it should be the term used. Some literature data and interviewees used responsibility and accountability interchangeably. Others referred to responsibility and supervision as relevant to the internal workings of an organization and accountability as relevant to inter-organizational relationships (as above). This is inconsistent with a public administration view that responsibility is the keystone premise of the political

system, while accountability is the machinery (processes, institutions) whereby responsibility is assured. However, there is also confusion within the public administration literature as to how the two concepts relate to the delicate balance of politics and administration; and in particular, the role of the politician vis a vis the bureaucrat (Brown - John, 1992).

The Lambert Commission made a useful attempt to explain the concept of accountability.

We see accountability as the activating, but fragile, element permeating a complex network connecting the Government upward to Parliament and downward and outward to a geographically dispersed bureaucracy grouped in a bewildering array of departments, corporations, boards and commissions. Accountability moves through the network like the current in a circuit but always in some sort of relation to the control center, the Cabinet. (Lambert, 1979, p.14)

Lahti (1998), in studying accountability in performance-based contracts found that the personal level of accountability was critical to the program and system levels of accountability.

A multi – dimensional construct

Accountability is a term used when referring to democratic ideals, organizational relationships, structures, processes and outcomes. One interviewee suggested , “there are probably 8 or 9 dimensions of accountability. Some of them are just procedural and some of them are much more substantial” (8). Procedural accountability is often used to describe the institutions, techniques, and language of performance measurement, reporting and evaluation. Substantial accountability refers to the consequences or desired outcomes (Cutt & Murray, 2000). Accountability is also a morally charged term. As a principle of democratic government, it strikes the ear with a deeply affective resonance

and produces a mood of acceptance. At the same time, as a formal system of justifying (empirical or value-based) choice, action or performance it can cause fear and trepidation if the culture is one of blame. The references discussion also illustrates the multi-dimensional nature of the concept.

Antecedents

Antecedents are the events or phenomena that generally precede the occurrence of a concept. The antecedents to Canadian health system accountability identified in the analysis included: a renewed culture, strategic direction, citizen engagement, information management, including performance measurement and public reporting.

A renewed culture

The culture of health care consistently emerged from the interviewees and the popular literature data sources as an important prerequisite to accountability. The popular literature suggested that “medicare is placed on a pedestal” and is therefore, “weaker than it should be because people take an uncritical view of it” (Priest, 1998, p. 23). There was also the suggestion that health care has too much focus on secrecy and blame and not enough focus on improving the system.

Our culture of secrecy, I think we tend to cover up the medication errors, we tend to cover up any sort of misadventures. We, don't have a tendency to surface issues and say "lets deal with it and get better".... we need a cultural change, and I keep coming back to measurement for a learning culture rather than measuring for judgement culture. I still think most of the measurement that we do in society is about good, bad, whose better than me and I, I don't think that's really very helpful in this (2).

Further,

Our culture is provider-focused and not client-focused and focused on volume not quality (5).

This was linked to the self-regulating professionals and their autonomous practice tradition within the health system.

A major barrier is a pretty autonomous practice tradition. People don't like to be accountable, you know, its sort of the old proverb, "when you want money, you claim to be evidence-based and scientific and when you want to protect yourself, you say this is art, not science, it's shrewd intuition, not transparent, accessible" and so on. And our system is based on historical patterns, and how we have considered all professions self-regulating and self-disciplining. There isn't a whole lot of, I guess across the board transparency in the system and people are nervous about it. So we don't have a very sophisticated way of thinking about it either, we tend to think of it as punitive rather than as a quality improvement. So our whole culture hasn't been attuned to it and probably that's the biggest barrier of all. If there's a real grass roots demand, particularly on the provider side, but also on the public side, for a real, a thick sense of accountability, I think we'd have it, I think that's just starting to develop (8).

Another element of culture was focused on developing a culture within the leadership of the system.

I think some of this stuff has to be top down. That is, if your board and your senior management don't require it, if you say we believe in evidence-based decision making, yet you continue to make decisions without any evidence, people will see it. So, I think they will have to get that straight. That's another training process, frankly. This is amateur hour at the Board level still in health care - right? I mean, compared to a lot of other places, you get all sorts of people on health boards who aren't very knowledgeable and they don't invest and I think we have to do the Mao approach - send them to the countryside figuratively, and educate them about what the deal is here (8).

A culture, where at all levels the focus is learning and improvement not blame and punishment, was seen to be a prerequisite to an accountable health system.

According to Spath (2000) the study of human errors in health care is a relatively new field with researchers still trying to define boundaries, terminology, and taxonomy.

Nevertheless, a basic understanding of error along with an attitude of improvement can help us take a systematic approach to designing better systems that improve patient safety and shift the culture to one of learning and improvement. Connors and Smith

(1999) suggest that for evaluation to succeed, attention must be paid to creating an entire 'culture of accountability' where acceptance of responsibility is not seen as threatening, but is energizing and seen as an incentive to learn and change.

Strategic direction

Health administration/policy literature and the majority of interviewees stressed the importance of clearly defined vision, mission, goals and targets that are aligned at all levels of the system. One executive stated:

I think it (accountability) does need to start with some sense of vision, mission values, sort of critical success factors and sort of goals. What has bothered me, in my 30 years I've been around the health care system is governments have spend a lot of money, and I'm spending a lot of it on their behalf in the executive positions. I've never been clear about what it is we're trying to achieve (2).

We really do have to have more concrete goal setting around which there should be some consensus. Because without it, then you're really just accountable for process which as you know, is an inferior, intermediate step on the way to true accountability, and I don't think we have been very persuasive of our goals, we haven't been willing to commit to much (8).

Others pondered whether the goal of the health system was to promote health or to cure illness.

The other difficulty we have in the health system is, in order to have clear accountability, you must have, besides roles clarified, you must have goals and objectives clearly identified. We have not decided whether the health system is to produce better health or just to produce more health care. Hopefully, the goal of the health care system is better health (24).

Also, strategic direction included clearer roles, responsibilities and standards for players within the system.

You need clear delineated lines of accountability so people understand what they're accountable for. We do not have clearly delineated roles for, and lines

of accountability in the health system. And when you do not have clear lines of accountability; then you have situations where there is no accountability (5).

Most suggested that the system lacks clear goals and long term planning, which is necessary to anticipate the growing pressures on health services delivery and the changing healthcare needs of Canadians. Some suggested that Alberta was the leading Canadian province in articulating expectations of the outcomes to be realized, and in developing measures to indicate progress.

Citizen engagement

Much of the literature data suggested citizen involvement was presently inadequate, but was generally silent on solutions. One article by Lomas (1997), examined the various roles for citizens when providing input into decision-making, the common problems and some recommendations on the way forward. Most interviewees suggested citizen engagement as a key prerequisite to accountability, but acknowledged the difficulties of finding effective strategies. A deputy minister of health stated,

We need to engage the public more in what it is that they think they can't get information about. I think one of the things we should do is, we should talk more to the public about what they mean when they say accountability....what is it that you want to know that would make you feel that you have the data and information that you need in order to make a decision about whether the system is accountable or not (6).

A chief executive officer of a health region suggested that accountability was more than accountability to the Ministry of Health.

But I also think we're accountable to the regions we serve.... its not very well understood, but certainly not just using every different interest group that comes, but accountability to the community and that means involving them in decisions and all sorts of things. I certainly didn't think like that five years ago but having sat through a couple of regions and complex environments surrounded by stakeholders - you get a pretty compelling sense that accountability is more than just back to the province (21).

A community development coordinator stated:

So an effective dialogue where there's real meaningful participation by citizens in – not determining the details, more just determining the scope - the big picture of where they want the health care system to go. So that there was that ongoing dialogue that, you know, that we can sort this out and it will change all the time as new demands are put on the system, new technologies are developed, new health innovations are recognized and researched - so that those things can be a matter for informed conversation between the publics and the system.... not necessarily the mainstream way of looking at what we want to achieve. So certainly integrating all those perspectives and that's why the plural publics is important, I think. Including all those perspectives into the direction (10).

According to Wharf and Mackenzie (1998), representative government can be supplemented effectively with greater public participation by drawing on the best of direct democracy and sectoral interest negotiation. They suggest an effective example is the shared decision-making processes pioneered in British Columbia to negotiate long term, sustainable uses of public resources and other natural resources.

Shared decision making means that on a certain set of issues for a specified time, those with authority to make a decision and those affected by that decision are empowered jointly to seek an outcome that accommodates rather than compromises the interests of all concerned. Parties distinguish between their interests and their demands or positions that fail to take into account the needs of others. Because different groups will value different things, clear self-analysis, communication and understanding of others' interests can lead to a package solution that provides better outcomes for each party than if the groups were simply competing on their own. (Wharf & Mackenzie, 1998, p.84)

Most interviewees viewed a democratic process with full public participation as essential to an accountable health system and some viewed regionalization as having contributed to this. One chief executive officer said:

Regionalization, to try and get better integration of services and avoid fragmentation. But one of the other things that it's done, is it's brought health services closer to the community. And by getting people in the community more involved, that's tended to promote accountability as well because they're asking questions (15).

However, many suggested that the system was still not sufficiently accountable to the public. This is an area where other OECD countries have more experience than Canada. In the United States, the approach of public release of health performance information has had limited success in engaging citizens. Studies indicate (Marshall, Shekelle, Brook & Leatherman (2000) that report cards have little influence on consumers' decisions to choose health providers. However, these studies suggest that public reporting influences provider organizations to improve their performance and outcomes. Other countries are experimenting with citizen juries and quality councils with citizen participation.

Information & Performance Management & Reporting

Information management, including performance measurement and reporting, was discussed extensively as an antecedent to accountability. Performance management was also occasionally used interchangeably with accountability. The popular literature focused on public reporting of hospital and regional data and consisted mainly of the comparative data published by Maclean's magazine. The professional literature focused on performance information (competence review and disciplinary action) related to self-regulation. Administrative and policy literature focused on the value of performance measurement and the shortfalls of the existing health information. Interviewee discussion on information and performance management ranged from the under-investment of the information infrastructure to the value of performance information to support decision-making and accountability processes such as public reporting. One senior health information official stated:

I'm sure you've come across this notion that health care system in Canada, you know in total, accounts for 96 billion dollars - 10% of the economy. The amount going into information is maybe 1 or 2% of that and any other major

information intensive industry whether it be the banks, insurance, the airlines – invests something of the order 10-12% in information. So we're in a highly information dependent industry that is grossly under-invested in the information it needs to run it (18).

Others agreed as follows:

We spend very little money on measuring things in the health care field. So we have to make much bigger investments - you know in the banks they spend 12% of their budget on information systems, we spend 1-2% of our budget on information systems so it's not surprising we don't have good information to measure what we're doing. On the research side, a lot of research that's been done really doesn't relate much to accountability, it relates.... it's more basic research, it's coming up with new treatments or even understanding cellular interactions so it's a long way from accountability (15).

One of the major barriers is information systems because, you know, we spend maybe 2% of the health budget on IT. Really good HMO's (Health Maintenance Organizations) is non-profit in the States, spend 6-8%, easily. Our whole information systems have been geared to administrative payments and so forth and simple counts rather than substantive outcomes and the relationship of inputs to outcomes, outputs and outcomes. So I think that whole area as many have called for has to be re-thought and it's going to take money - a lot of money to do it (8).

Information requirements were focused on performance measurement and reporting and were linked to clear goals for improvement.

We'd have to have better information systems - we'd have to get better data. So the first thing is, we'd begin to have those data and they would be much more in the public realm so we would raise public consciousness about the issues and I think that's the key thing. The expectations that certain outcomes will be realized; that the resources will be provided to do those; and there's a process of measuring that and following up on it for improvement (18).

As indicated in Chapter 2 on accountability practices, performance measurement and management begins with explicitly established goals which are reflected in the adoption of specific performance indicators, followed by analysis and actions aimed at producing change to improve performance in a variety of dimensions (equity, access, efficiency etc.) So the application of performance indicators may involve reporting data to actors for accountability purposes or it may involve, in addition, taking action to

stimulate change.

Consequences

Consequences are the events or phenomena that generally follow or result from the occurrence of the concept and reflect the outcomes of the use and application of the concept. The consequences of achieving or improving accountability in the Canadian Health system fall under two broad themes desirable and undesirable. Desirable consequences included improved health outcomes, public confidence in the system, and a sustainable health system. Undesirable consequences identified were added bureaucracy and increased uncertainty. The literature data in all categories remained silent on the consequences of accountability, so this section is limited to interview data.

Improved Health Outcomes & Service

It was suggested that improved accountability would mean a better informed public who would be more selective about the services they received, leading to improved outcomes. This is based on the evidence from organizations such as the Institute of Clinical Evaluative Studies (ICES) that suggests there is a wide variation in the supply of some treatments without corresponding improvements in the outcome and also wide variations, by geography, of survival rates for certain diseases like cancer.

So what I think we would see is more data, a more informed public and ultimately I think that will take us to two things. I think it will lead us to savings in the system and could lead us to better outcomes. And I firmly believe that that's still possible (18).

Others made the distinction between better outcomes and better service and suggested improved accountability would lead to improved service.

Now at the level of institution to institution, one of the consequences of not having good accountability between say a regional health authority and it's

member organizations and institutions is far too great a tolerance for poor quality of care and bad service. I think that one of the overwhelming realizations of the last decade of the Canadian Health Care system has been the outrageous quality of service independent of, I'm not talking about quality of care as it relates to outcome, I'm talking about quality of service so independent of it's impact on health outcomes, the people who have to come back 3 separate occasions for 3 diagnostic tests in the same institution; the people who are left in the waiting room for 4 1/2 hours when they had an appointment and so on. All of those pure service-oriented elements, I think are a consequence of not having much accountability in place in the system (17).

Another approach was that the accountability debate was about performance improvement and therefore would lead to improved outcomes.

And presumably, the debate is important because we think there are opportunities to do better. So we must, I believe, that we actually can if we adjust our systems, or maximize our systems have a better health population, have better health outcomes, use our resources more wisely (13).

I think we'd get better quality, because I think we have real quality problems and there's lots of room for improvement. I think we would get greater efficiency because I think part of accountability is, I mean you can define quality as achieving the best outcome you can for the least resources possible, you know I think it does have a second dimension - people argue about it and I think that's important and also I think it would allow for an expansion for the scope of the system because we would have eliminated a great deal of the inefficient, ineffective and harmful stuff like ineffective prescribing, inefficient deployment of human resources - you know way too much done by unnecessarily high level of professional (8).

A final rationale was that accountability focuses on clearer goals which targets performance improvement and better outcomes.

I think ultimately, if you have good accountability, it can help you decide where you need to put your emphasis and what your objectives should be because it will point out to you where you've got some gaps or weaknesses in the system and then you can work on those (4).

There is evidence from the United States that provider organizations are responsive to publicly disclosed performance data, resulting in significant improvements in clinical outcome performance (Marshall, Shekelle, Brook, & Leatherman, 2000).

Public Confidence in the System

Many interviewees suggested that the public confidence in the system has been shaken by high profile incidents such as the “gone awry pediatric heart surgery program at a Winnipeg hospital,” the variable surgery and survival rates as publicized in Maclean’s ratings, and public media stories of over-prescribed drugs. One example of unnecessary surgery quoted was a study done by a British Columbia physician.

I imagine you saw that study that Charles Wright released a couple of weeks ago. He is basically saying that 25% of cataracts don't need to be done in the first place and the 25% of people getting cataracts are worse after their operation. Now that's powerful information (18).

The public are very concerned that the system is not doing the job. So there's a growing distrust and skepticism of the system (5).

There's not a sense (as citizens) that we're getting the results that we're paying for (23).

The stories of waitlists and backlogs in emergencies were also seen to be raising concerns and contributing to a lack of confidence.

I'd say access, wait times and emergency rooms - they're the hot spots in the system for sure (18).

It was suggested that improved accountability would lead to an improvement in quality and efficiency, leading to improved outcomes and access to services, thus increasing public confidence in the system.

I think we'd get better quality, because I think we have real quality problems and there's lots of room for improvement. I think we would get greater efficiency because I think part of accountability is achieving the best outcome you can for the least resources possible (8).

I would see more evidence-based decisions about where we put our resources and consequently, potentially better health outcomes for that investment. We

would have lower risk of harm occurring to patients during their treatments or an even safer system.... increased public trust in the system (9).

Evidence from the United States suggests that, with quality methods as much as 35- 40% of costs can be reduced while quality is increased (Berwick 2000). Also, polls suggest that the public perceive medical error rates to be alarmingly high and methods are recommended for a systematic approach to improving patient safety (Spath, 1999).

Others suggested that public confidence in the system is an important consequence of accountability and that improving accountability would increase transparency, enabling citizens to better assess government actions, thereby increasing confidence.

Public confidence. That one is sort of so overwhelming that I almost hate to think of lesser ones. If you don't have accountability in the system, how do you have public confidence in a public health system (14).

Another outcome that I think is important, would be the confidence of citizens, that in fact they are being provided with open, transparent information about how their health services are doing. How do they compare to the best practices on the globe? It is primarily the tax dollars that go into paying for these health care services and so the citizenry should be extremely, well versed and understanding that they are getting the best value for their dollar. So, health outcomes, financial reporting, so that we're confident that money is being spent wisely. And then people being conscious of how well their government is doing is another one (3).

Improved accountability would lead to a better public understanding that their 9.6% investment of the gross national product in health care delivered a return that was at par or better than other regions spending about the same amount of money (21).

It is suggested that public confidence in the system is also linked to changing public values and expectations. Decker (2000) suggests that provider domination in health is giving way to empowered consumers, as citizens reach out to the internet to obtain

health information. He indicates that this is changing expectations about quality, speed and appropriateness. Public opinion polls support this contention and show that the gap between expected and perceived performance is widening. Ten years ago, 60-70% of citizens perceived that their expectations would be met by the system. A 1999 poll suggests that 30% of citizens anticipate their expectations would be met (Lewis, 1999).

A sustainable system

Many interviewees suggested that given the concerns about costs and quality that the sustainability of the Canadian health system was in jeopardy unless accountability was improved.

If we don't make any changes we will have a system that will continue to deteriorate, continue to cost more, and continue to see an erosion in trust by the public. And we will then likely see a private sector for those who can afford it.... I mean eventually, I'm jumping.... If we don't achieve real accountability, I do think the system will have trouble with sustainability within in the next 10 years (5).

There's concern about the sustainability of the system and of course, there's lots of evidence right now that accountability and the quality which I define as, I would define quality as minimizing issues of over-use or under-use of the system. That's impacted sustainability (15).

Ultimately, the sustainability of the health system rests with the public in a democratic society. It is assumed that all citizens value fairness; that is, they expect the health system to treat them without bias. It was suggested that improved accountability would result in fairer decisions.

It would impose some discipline on our decisions and it would also, I think, just on the provider/supply side, I think it will also add, it would create a sense of equity and team work and transparency because instead of resources being allocated on the basis of 'squeaky wheels' and people making their un-transparent arguments about why they need something; if everybody's got the same accountability rules, it's much easier to see why you would allocate your resources here or over here (8).

Finally, interviewees discussed the lack of sustainability in relation to increasing costs but suggested that improved accountability would provide better information for best practice work that would lead to increased acceptability and sustainability.

We've been spending more than 40% of the budget on health care in this province(22).

The consequences of not achieving accountability I think is a continual downward spiral where we put in more money, we get less out, the public demands more service and they eventually migrate beyond the Canadian health care system as we know it (21).

I think basically a better model of accountability would see it do more sort of best practices-type work throughout the system. It would point to areas of under and over resourcing in the system and it would give us a platform to which people, province to province, jurisdiction to jurisdiction, but also on an international scale, as well in a more engaging and acceptable way (24).

Improved accountability was suggested to improve quality and efficiency, produce fairer decisions and raise public confidence in the system, thereby increasing the sustainability.

This is supported by the Saskatchewan Commission on Medicare (2001), which suggested that a sustainable system did not need more funding to “prop up the status quo.” It was recommended that reinvestments be directed to managing change and creating a “quality – oriented health services culture” (p. 3).

Added Bureaucracy

Two interviewees raised the concern of potential unintended consequences, suggesting there could be an added burden on providers for further documentation and a demand within the system to develop indicators with questionable benefits.

I would really like to see a level of trust in the system that doesn't constantly demand professionals to provide yet further documents about what they've been spending their time doing cause that seems to be the way it always shakes down to - is that any improvement in accountability, it's always about providing

a document of account of basically what they've been doing with themselves and/or their professional decision making? They fill them in, in ways that they imagine whoever it is that has given them the form, wants it filled in. And they make all kinds of adjustments say for debt to put down a whole lot of stuff that they've actually spent quite a lot of time doing cause there's no space on the form for writing those things in and I think that there is underneath it all, a kind of constant suspicion of the knowledge that they bring which is undermining to them in a really negative way (19).

You start to get the emphasis on things like indicators. And so now, all of a sudden we just have an explosion of requirements for indicators. You know, the province wants indicators, the Federal/Provincial group wants indicators. In Ontario, we get the Ontario hospitals report cards, you get the McLeans report, you know - it's just everybody now wants some measurable indication of what's being done in health care organizations. ...we've seen a mind shift where people now believe that they need to demonstrate accountability in some kind of concrete way.... But the flip side of that for health care organizations, is that they're now being bombarded from all directions for indicator data and you know, this is an extremely expensive proposition to collect all this data. But more importantly, organizations are just not using it; there's so much of it, that you can't possibly use it effectively, so we've almost gone now to overkill – collect everything because it may help you to answer questions but in reality we're not using very much at all. And you know, the information systems in many organizations are not developed enough to allow it to be used so we're just in my mind, we're just swinging back and forth.... there is a real lack of clarity on what is required to demonstrate accountability (16).

These consequences of an explicit approach to accountability are documented in the psychological literature and to a degree in the public administration literature on effectiveness evaluation (Cutt & Murray, 2001). There is also a relationship to the discussion on culture and direction. Clearer expectations for the system, with an alignment of direction at all levels would perhaps mitigate the above unintended consequences.

Increased Uncertainty

One interviewee suggested that a good consequence to not achieving accountability was more certainty.

I think there are some good consequences which are, if you do not achieve

accountability because of this ambiguity, then you do in fact leave one to adapt to changing values and circumstances in a far less thoughtful and conscientious way. If you imagine that we had to go in and reform and revise the Canada Health Act every five years - it would open things up to a lot of uncertainty and disruption in the system to have to be constantly re-negotiated with the Canada Health Act. So if you put in the Canada Health Act a very clear set of expectations and objectives with the provinces and a set of graded responses and then you discover a decade later that these are no longer appropriate for the circumstances we find ourselves in so you know, in order to be able to do anything with that, you have to open the Canada Health Act again. You're opening up a huge amount of uncertainty in this country if you open up the Canada Health Act. But by leaving it somewhat ambiguous, I think we do not achieve the kind of accountability that we might want in the best of all worlds but on the other hand we do achieve the capacity to adapt our accountability part, inadequate accountability, over time (17).

This uncertainty is presently being experienced in Canada and many other OECD countries as the foundational health system principles are under examination.

Surrogate Terms

Surrogate terms refer to substitute or alternative terms used to express a concept. By far, the most common term used to mean accountability, in both the literature and interviews was responsibility. Although used interchangeably by many, there were also strong opinions on the differences between the two terms. Some explained the difference as “one is responsible for something but accountable to someone.” One interviewee viewed responsibility as linked to supervision and internal to an organization, whereas accountability was seen to be an organizational concept only. Others viewed accountability as “enforced responsibility.” Another differentiation was that responsibility refers to a moral sense of duty to perform appropriately, while accountability assumes institutional authority to call an individual or group to account for their actions. A final view was that responsibility concerns the processes of work, while accountability concerns the outcomes.

Brown-John (1992) discussed some of the public administration confusion around accountability and responsibility. He addressed the issue by suggesting that “responsibility is the keystone premise of the political system” and “accountability is the machinery, the processes, whereby responsibility is assured” (p. 67). This however, does not conform with some views expressed above. Perhaps the most inconsistent view was expressed by a prominent Canadian health services researcher, who viewed responsibility as a “within organization” concept linked to supervision and authority, and accountability as an inter-organization concept between powerful actors without authority over each other. Here, accountability was seen to be synonymous with coordination, as discussed below.

Other terms used to refer to accountability were stewardship, answerability, coordination and transparency. Stewardship is most often used to implicate governments as stewards of the people’s money, in other words, financial accountability. A much broader definition of stewardship though, is employed by the World Health Organization (WHO). “Stewardship is ultimately concerned with oversight of the entire system, avoiding myopia, tunnel vision and the turning of a blind eye to a system’s failings” (WHO, 2000, p. 3). Answerability was used to explain the health region’s responsibility to provide the rationale for and answers to the community that it serviced. It has also been differentiated from accountability in that answerability is a requirement to provide answers or explanations without enforcement mechanisms while accountability can be enforced through sanctions and rewards. Transparency was defined as the disclosure of decisions and the rationale for them and was linked to the answerability of health regions.

Coordination referred to accountability between the various components of the health system. It was explained by a CEO of a health research organization as follows:

You should be able to have accountability between powerful unconnected organizations. If I am delivering in one area of the city, sorry, in one area of service in the city a home care service and there's another agency also delivering a home care service and we have no accountability to each other, then what stops us from delivering the same service to the same person on the same day? What stops us is.. you know you need accountability between parallel individuals where there maybe no authority at all but it's just a coordination in the sense of sometimes used as an accountability element, I'm comfortable with that. So, the words I hear used as synonym for it? I hear responsibility, I hear coordination, I'm comfortable with coordination, I'm less comfortable with concepts of responsibility or authority, supervision (17).

In this case, accountability was viewed as an organizational or institutional concept, not as a concept to be used at an individual level.

A final phrase that has become prominent in discussions of accountability, and in some cases is used to mean accountability is performance measurement and management. This literature relates to tools, mechanisms, measurements and performance management frameworks and was covered in Chapter 2 in the section on accountability practices. The frameworks tend to be linked to shifting the focus of organizations from processes and activities to intentions and results and include information needs of organizations across the management cycle. Many interviewees used performance management to mean accountability. For example “ accountability is a system of measurement and reporting that will allow you to continuously improve your services, with the objectives being set out by a definition of quality” (2). Others linked performance management to accountability through describing some of the issues in achieving accountability such as a lack of information and measurement to understand the performance of the health system, its relationship to quality outcomes and quality services. Some interviewees suggested that this notion of accountability began in health care in the 1980's.

Related Concepts

These, define concepts that are related to accountability, but different in that they lack one or more of the attributes of the concept. They may be used, however in association. They provide a means of recognizing the actual and potential inter-relatedness of concepts in general. Ethics, distributive justice, autonomy, governance, and evidence-based decision-making, were the five concepts most commonly related to accountability. Each concept will be described as it relates to health system accountability.

Ethics

The literature was rarely explicit about ethics in relation to accountability, except for a few minor references to the importance of ethical standards in the professional literature. However, all interviewees considered ethics as intricately linked to accountability because moral choices and behavior (ethics) are implicit in responsible behavior, which is part of being accountable. People in health administration / policy tended to speak about the ethics of resource allocation or ethics as the broad defining principles of the health system within which an accountability framework would be established.

Ethics is a really interesting issue and I think ethics is very much a part of accountability. Peter Singer is the head of the ethics center for UIT and all the teaching hospitals; he's been trying to help hospitals deal with the ethics of resource allocation, which to me is sort of the heart of accountability (15).

I see improved accountability as being ethical or more ethical...carrying out one's role/ responsibilities. Accountability is an ethical term or its value laden (12).

So coming back to what I was talking about at the very beginning, if the most important thing in accountability is to have your sort of over-arching principles

established and to me, in lots of ways, that's the same thing as the ethic. So I think of the ethics of health services as being the sort of, over-arching piece. And then the accountability framework being inside that sort of, accountability inside that ethical framework or as principles you have an accountability framework that sort of would flow from your principles and your ethics (4).

People in professional organizations generally focused on ethical practice and professional codes of ethics, and identified the problem of codes of ethics not dealing with everyday practice issues. One senior official in a medical organization, for example, contended that the

Ethics of the particular practice or issue have to be determined broadly in society. It's interesting, increasingly there's a gap between what individual professions may have as a code of ethics and what is needed in the actual work place and interface between members and profession and people who they treat so, you know the Canadian Medical Association writes up a code of ethics for doctors but it's silent in relation to a lot of the issues that doctors are actually encountering in their day-to-day lives and so, then you find a need at the local level to have more broadly-based ethics committees that bring into play different humanities and different societal perspectives so it isn't the profession deciding what's ethical. And I think ethics, when we decide for instance, when a physician has reached a particular ethical norm, or increasingly sensitive to what societal standards are so just to use an example for instance, there use to be a high level of tolerance for, frankly abusive behavior of physicians in the workplace and I mean, to use as an extreme example, you know the surgeon who would throw an instrument, or would shout at staff or belittle people in front of others and that was either accepted or overlooked on the basis that well, these poor doctors are so burdened with responsibility, and they're so hard worked that you have to allow them some slack. Now of course where there's a position of virtually zero tolerance on workplace harassment and inappropriate behavior, that's come up sharply against the old traditions in medicine and in this Province, for instance the Occupational Health and Safety Act casts on the employer responsibility to prevent workplace harassment. So, now when a doctor does these things, the Regional Health Board or District or whatever it's call in the province has a responsibility to deal with that doctor and if they can't, then they are referred to us. So, in a space of probably just the last 7 or 8 years what we had been considering sort of mildly annoying is now absolutely unacceptable and the ethics there have significantly changed. So I think ethics are most probably determined by the community at large (9).

Ethics is defined in the Oxford Dictionary (1982) as “the treating of moral questions.” Professional groups in health care have created codes of ethics, that are generally concerned with aspirations and avoidances and represents a desire and attempt to respect the rights of others, fulfil obligations, avoid harm and augment benefits to those they interact with (Luke, Krueger, & Modrow, 1983). These codes are the key accountability instruments used by self-regulating professions. These codes of conduct serve to compensate for obscure accountability links or to reinforce them.

Distributive justice

Distributive justice is about the allocation of resources and goods within society and it is assumed that all citizens value fairness; that is, they expect the publicly funded health system to treat them without bias.

I think a generalized view of ethical resource provision or ethical issue management, or ethical prioritization would include ideas about how to get the greatest good for the greatest number - how to balance off priorities in a way that address both individual needs and collective needs. Could you be accountable without being ethical? I don't think so (21).

Also, many interviewees viewed this concept in relation to accountability and ethics as evidenced by the quotes above on ethics and resource allocation.

Autonomy

The autonomy accorded health professionals represents a general societal recognition, that to be carried out effectively, the work of health professionals must be conducted in an environment of patient-provider confidentiality and trust. This autonomy is granted by society if assured that its interest will be protected by self-regulation and peer review monitoring. In other words, the expectation is that professionals will be

accountable for their actions. Changing societal expectations can lead to the strengthening or levying of restrictions on that autonomy (Luke et al., 1983).

The Canadian literature on accountability made no mention of professional autonomy in relation to accountability. Interviewees had several views on the relationship between the two concepts. Some suggested autonomy could be in conflict with accountability or perhaps problematic.

There can be a conflict if accountability is too rigid. I mean if its unreflective, if it's just a crude form of measurement and if it doesn't acknowledge the substantial gray area that will always characterize health care, then it's unfair and it's unconstructive and it doesn't lead to improve quality - it's just a hurdle. So, you know, we have to use accountability sensibly. And, you don't want people to be rote practitioners. Every part of health care that you can actually describe as an algorithm, isn't actually in the strict sense, isn't a professional activity anymore - it's a robotic activity. I think we have to be sensible about it and what it means. It will evolve, there'll be a temptation by some to use it too rigidly but on the other hand, as you've seen it evolve in the best circumstances in the States (8).

I think, if by autonomy we were hearing arguments around the need for clinicians to remain in, you know isolated in their practices without, you know being accountable to somebody for what they're doing, I think that would be problematic. I think we're rapidly moving to a time when that kind of autonomy is exactly the problem. It's the notion of the cottage industry that has driven our profession for a long time. So I think there is room for a notion of autonomy where within a context of using evidence-based clinical guidelines - the practitioner makes the best decisions for an individual client. I mean, I think that's fair, that's a form of autonomy that I think is compatible. It's just that the idea that they would mask somehow being related to a broader evaluating framework (18).

Others thought autonomy was a necessary condition of accountability, that the right to self-govern and make decisions about one's practice is an essential part of being accountable.

If you don't have autonomy as a nurse, if you're pushed to do more than really you're capable of doing, you don't have autonomy; you can not make the best decisions. And I think the lack of autonomy is one of the slippery slopes in terms of accountability. It's pretty difficult to be accountable as a nurse if you're overloaded all the time. It's pretty difficult to be accountable if you don't have the information you need and you don't have access to somebody who will give you

the information (7).

Some viewed autonomy to be linked to ethics, where ethics was expressed as the over-arching framework or structure.

And then the autonomy piece can again sort of fall out of that. Once the ethical structure is established and the principles are established and then the roles are established in an accountability framework, then there's lots of scope for autonomy. But the autonomy inside the established framework if you know what I mean (4).

Another view was that autonomy was earned by demonstration of accountable behavior.

And in a sense, I think autonomy is earned by a demonstration that you adhere to the ethics and the evidence and the general ethos of accountability that obtains in the system or in your organization. In other words, I will trust my provider to be very autonomous if I know my provider to be interested in evidence-based decision making; is going to be a discloser rather than a concealer of error; is devoted to things like quality improvement; has some sense of stewardship of resources; and I'd say, "yes", that's what a professional is - a professional embodies all those things. But I'm not so happy with autonomy where it's just a license to do what ever the hell he wants without any reporting, without any performance measurements. So, it's a two-way street (8).

Still others suggested that autonomy was misplaced in the interdependent practice of health services.

Autonomy I struggle with because... let me describe it differently. I'll go to Stephen Covey's work, about dependence, independence, interdependence. To me autonomy is liken to independence when we need interdependence. And if everyone has professional autonomy - does that mean we all act independently? Is that what it means? I don't think so. So, to me it is about the context of, again how we bring these interdependencies together to work towards a common good (23).

Some of the views expressed challenge the traditional and implicit accountability mechanism within the Canadian health system, the self-regulation of professionals. This will be examined further under discussion and interpretation. Autonomy is also referenced as part of governance and in relation to the levels of accountability.

Governance

Over the last decade, the concept of governance has been used extensively in scientific literature and in public discourse and has resulted in a proliferation of definitions. The Canadian Health Services Research Foundation (CHSRF) definition of governance is used here. "Governance is about the manner in which decisions are taken and implemented in social or administrative networks" (1999, p. v).

In the literature on accountability, governance is mainly discussed in relation to health system reform and specifically in relation regionalization in Canada. However, there is a recognition of the importance of governance to improved accountability. Regional health structures are new and evolving. A common concern that was referenced in several provinces accountability documents is the lack of clarity around roles of the health regions in relation to the ministry of health. The problem was expressed in one provincial document as follows:

The health districts and provincial association feel that Government has consistently undercut the autonomy of the District Health Boards. Districts feel that the Minister and Department have a tendency to "micro-manage" the system and override decisions taken by boards in any number of areas. There is also a persistent belief that the government has under-funded the system in a manner that makes it more difficult for districts to carry out their responsibilities with regards to service delivery.

For their part, the Minister of Health and her/his colleagues in Government are often frustrated by the fact that they are asked to be accountable for the decisions taken by individual health districts. In some cases, this is because the district has taken the position that the responsibility lies with the Government because of lack of funding allocated to districts. The Minister of Health is also frustrated by a sense that some districts are often unable to coordinate the delivery of health services; to effectively bargain with health sector employees; or to deliver health services without running a deficit and incurring debt. (McIntosh, 2001, p 5)

Governance then, is the organizational structure and context within which accountability relationships are defined. One health researcher suggested that health governance education was needed to improve role clarity, role-modeling and hence accountability.

If your board and your senior management don't require it, if you say we believe in evidence-based decision making, yet continue to make decisions without any evidence, people will see it. That's another training process, frankly. Boards are going to be democratic one way or the other. Well, let's get them on the same page and let's manage their change process and talk about the difference between an accountable organization and one that isn't. This is amateur hour at the Board level still in health care - right? I mean, compared to a lot of other places, you get all sorts of people on health boards who aren't very knowledgeable and they don't invest and I think we have to do the Mao's approach - send them to the countryside figuratively, and educate them about what the deal is here (8).

The new health governance structure, regionalization, which is unfolding in nine of ten provinces is seen by some, as a solution that will enhance coordination among the disconnected components of the health system and also will make the system more accountable to communities served. However, there are no comprehensive evaluations to date that indicate this is occurring.

Evidence-Based Decision Making

Evidence-based practice in medicine has emerged in the 1990's. It was an attempt to find the best practice, reduce variation among medical interventions, and find the best outcome for the condition at hand.

There is a movement in health care towards better use of evidence and best practice. Health in the past has been more of an art than a science, there's very little, in fact, the people tell me here there's only about 20-30% of what physicians do that has any evidence to support it. So you know, there's a lot being done there, it's just that's the way it's dealt with, without there being good clinical trials to prove that it's actually the right way to do it or a better way of doing something else. But I think there's just been more of an interest academically placed on trying to better understand what works in health care (15).

However, like performance management there are a host of issues and conflicts related to the practice. There is also the argument that if doctors are expected to base their decisions on the findings of research then surely politicians should do the same. This, of course, is easier said than done given that the nature of social policy is all about choosing directions, where choices are clouded by conflicting values and where facts and information cannot be marshaled to establish clearly that one choice is superior to all others (Wharf & Mackenzie, 1998).

Nevertheless, this concept is linked to accountability in that it provides information that is seen to be an important part of transparent decision-making and outcomes focus, both of which are important to improving accountability. It is also value laden, in that evidence based-decisions are considered to be superior to values-based (political) decisions. However, one interviewee suggests that an accountable system requires a balance of both evidence and values-based decisions.

In some cases, some of them (types of accountability) are more prominent than they ought to be because we don't have the other types. Political accountability, for example, is extremely powerful, as is interest group accountability but that's because we don't have good performance measurement. So when you only have anecdotal opinion and expression, then you're going to get essentially small or large P political cases made about accountability. And it is a democracy so there will always be political accountability, which makes perfect sense because a lot of our decisions will be value-based. It is simply a value to say you should have a population health standard or accountability perspective compared to a morbidity and sickness care one. Well, there's no science to tell you to do that, that's just an understanding, which is based on your idea of equity and so forth (8).

What we need down the road is a discussion of what should the relative weights be? And at the end of the day, if people say you should de-politicize the system - it's a pipe dream, it's public resources, 40% of Provincial budgets and it's an issue of key public concern. So, I would argue it should be political. The political, in the more sophisticated sense, that is, let the political accountability, let the political debates really be about values and about well, "are the quality standards high enough?" You know - what is an acceptable error rate or failure rate; and what is the threshold for intervention? Those are essentially public policy

decisions. Let's not have them grandstanding about "do we have a crisis in the ER" and all that stuff, those should be much more technical. They should be measured and there should be no argument about those once we have transparent data and decent kinds of reporting mechanisms (8).

Evidence-based decision making is linked to the performance-based notion of accountability and is prevalent in current health system discussions. While I agree that improved information will provide grounds for improved decisions on technical matters within the health system, some decisions are values-based and inherently political. Therefore, the dream of an apolitical health system is unlikely to turn into a reality.

References

References are events, situations or phenomena over which the application of the concept is considered to be appropriate. Appropriateness is a function of the common and accepted use and application of the concept. As Hunt (1991) stated: "One difficulty with accountability is that it is one of those words, like justice or autonomy which is so big almost anything can be squeezed into it (p. 49). The references to accountability in the literature and interviews cover a wide range of philosophies and mechanisms governing the relationship between the health system, governments, providers and citizens. As such, references to health system accountability include accountability relationships among key players, accountability processes, accountability types, and accountability instruments, accountability levels and accountability frameworks. All of these references are referred to as procedural accountability which focuses on management procedures, practices and systems and the compliance to rules and regulations. The other main area that was referenced is known as substantial or consequential accountability (Luclerc et al.

1996). Consequential accountability emphasizes desired outcomes/results around issues of health policy and health services delivery and it responds to the question: What is the health system is accountable for? Key accountability relationships within the Canadian Health System are described in Chapter 3 on accountability practices so will not be discussed here.

Literature and interviewee data identified the types of accountability and the associated accountability processes seen to be key to the health system. They include the following.

1. Financial accountability is most commonly expressed by the following accountability processes: constitutional practice, provision of information, review functions, legal contracts, legislation and managerial functions.
2. Constitutional accountability is expressed through legislation, constitutional practice and political activity.
3. Political accountability is expressed through citizen involvement processes, political activity, constitutional practice, provision of information, and legislation.
4. Managerial accountability is expressed through provision of information, review functions, managerial functions, legal contracts, legislation and Accreditation and credentialing.
5. Clinical accountability is most commonly expressed through delegated activity, legislation, accreditation and credentialing, complaints procedures, and ethical judgements.

6. Ethical accountability is expressed through ethical judgements, complaints procedures, provision of information, delegated activity, legislation, accreditation and credentialing.

The principal instruments used to operationalize these processes are detailed below in Table 8.

Table 8: Principle Accountability Instruments Associated with Accountability Processes

Process	Instruments
Citizen involvement	<ul style="list-style-type: none"> ▪ Consultations ▪ Board service
Political activity	<ul style="list-style-type: none"> ▪ Elections ▪ Legislature transparency
Constitutional practice	<ul style="list-style-type: none"> ▪ Ministerial responsibility
Laws	<ul style="list-style-type: none"> ▪ Public accounts committee ▪ Legislation
Provision of information	<ul style="list-style-type: none"> ▪ Business & strategic plans ▪ Annual reports ▪ Access to information ▪ Quality performance reports
Delegated activity	<ul style="list-style-type: none"> ▪ Independent review boards ▪ Self governing professions
Review functions	<ul style="list-style-type: none"> ▪ Auditor General & provincial auditors ▪ Comptroller general
Managerial functions	<ul style="list-style-type: none"> ▪ Program evaluation ▪ Guideline development ▪ Report cards ▪ Performance indicators ▪ Quality assessment & improvement
Legal contracts	<ul style="list-style-type: none"> ▪ Personal service contracts ▪ Purchase service agreements ▪ Performance agreements ▪ Partnerships
Accreditation & Credentialing	<ul style="list-style-type: none"> ▪ Regional & facility accreditation ▪ Professional licensing
Complaint procedures	<ul style="list-style-type: none"> ▪ Ombudsman ▪ Patient representative ▪ Professional disciplinary

	committee <ul style="list-style-type: none"> ▪ Litigation
Ethical judgements	<ul style="list-style-type: none"> ▪ Implicit social standards ▪ Individual conscience ▪ Professional standards

Adapted from: Queen's Health Policy Research Unit, *An Inventory and Analysis of Accountability Practices in the Canadian Health System*, Kingston, On: Author, p. 109
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Three levels of accountability were identified from the literature and the interviews: external, lateral and internal (personal). Mitchell, (1992) describes external as upward to the source conferring responsibility and downward to the groups or individuals served. Lateral is to colleagues and the authority structure of the organization and internal is to one's conscience and the ethical standards of society. An interviewee adds another element to internal or personal accountability, specifically, accountability as personal ownership for outcomes.

Personal ownership, not because you said I should do it. But because I say, "this is part of the work I have committed to doing". And people – you can't make me accountable. The word "hold" immediately is oxymoron in the context of accountability. You can hold me responsible but you cannot hold me accountable; I could hold myself accountable – it's a very important difference. I mean it is one of the profound parts of this whole thing about accountability that becomes critical if you begin thinking about this (23).

Another reference is the accountability framework. Generally an accountability framework defines three components. I have added a fourth component. Within the Canadian Health System the components of accountability, adapted from Emanuel & Emanuel (1996) are as follows:

Who – The Locus of Accountability: At least nine parties can be held accountable or hold others accountable: federal and provincial governments, regional health

authorities, health providers, professional associations, voluntary organizations, private payers, drug companies, individual patients and lawyers and the courts.

What – The Domains of Accountability: A domain refers to an activity, practice or issue for which a party can be held accountable. The general domains within health care are, professional competence, legal and ethical conduct, financial performance, adequate access, public/population health, and community benefit.

How- The Procedures of Accountability: There are many procedures, processes and institutional entities as outlined previously. However, generally, the procedures fall into two categories. The first is assessment and evaluation of compliance to success criteria for specific content areas; the second is the reporting of the evaluation and responses or justification to those to whom accountability is owed. Much of the emphasis in Canada is on the development of information for reporting, for example, the reports on the performance of the system developed by the Canadian Institute for Health Information (CIHI).

Why- The Values: There are many players and different normative models of accountability within the health system. I have added this component to prompt questioning, understanding and transparency regarding conflicting values and decisions about which values take priority. Otherwise, values debates gets dismissed as ideology and undisclosed interests stand in the way of implementing improvements.

The final reference to accountability is the desired outcomes / results. This is the subject matter of accountability and is a part of the accountability framework discussed above. This substantive focus is also referenced under consequences of accountability.

Use of the Concept

Use is the most general level of discussion of a concept. The evolutionary approach to concept analysis recognizes that the identification of use and change over time can contribute significantly to understanding the origins, development and functions of a concept (Rodgers & Knafl, 2000). This is essential to a broader understanding of the concept, as it elucidates the normative models at play and contributes to my objective of increasing the conceptual clarity of the concept of accountability. As documented previously in Chapter 2 on the concepts and theory, accountability has had several milestone evolutions within public administration, from balance and regularity (procedural) to efficiency, effectiveness, and appropriateness (consequential). The health system literature and interviewee data also portray changes in the concept as applied to health. Further, this developmental perspective identifies that there are several normative models of accountability at play, as this concept develops within the Canadian health system. Prior to the 1980's, accountability within the Canadian health system was an implicit concept limited to financial audit and the delegated activities of professional self-regulation. It was assumed that there was one best scientific treatment for a particular health problem and that this was provided by professionals. This is explained by a health system chief executive officer:

Going back to 1978-79, the Lambert Commission in Ottawa focused on the public sector accountability generally. But for some reason or another health seemed exempt from that. And then you had people with the Comprehensive Auditing Foundation sort of turning the corner a little bit - but still - health was too mysterious. I think too much driven by providers. People had a sense that it was an insurance program, that the providers would do the right thing for the patient, that only one treatment worked every time, and so it was a simple matter of funding the provider to do the right thing for the right people and what could be more accountable than that? I think that basically was in the mainstream of Canadian thought up until somewhere around the late 80's and then you start

seeing little signals coming out of Federal/Provincial meetings that they're thinking more of health as an investment. So at that point to me, the corner got turned into more of, a performance management concept - not accountability one. So all right if we're investing - what are we getting for our investments? Could we be investing those \$ somewhere else? I think that health care tumbled off the 'we are above accountability pedestal', with things like the treatment variation studies, where all sorts of evidence came in that we weren't a system of "one treatment, first time, every time, it works" and all that sort of stuff. So we fall off the pedestal, people are thinking of health as an investment, which is in best of terms an accountability (21).

With health being viewed as an investment, driven by economic concerns and the public sector direction of "New Public Management," more attention was focused on the performance and accountability of professional institutions with the realization that little evaluation had been occurring. The assumption of measurement, evaluation and the best treatment every time was challenged. A senior official, working in a provincial professional physician organization explains:

I suspect a lot of citizens, general citizenry, were reliant upon assumptions that there's all sorts of measurement going on, with controls and things in place. And I think two things have changed that whole dynamic and one is the, the increasing public awareness of variation in intervention rates, or you know, common conditions, variation in outcomes. You know the work done by the Institute of Clinical Evaluative Studies (ICES), in terms of a "practice atlas" and then the Canadian CIHI information now about the chances of survival post MI that vary significantly in different parts of the country. I think that leads people to naturally ask questions, "why would that be, what are the factors?" And I think there is increasing public awareness. Then the fact that we have put less effort into actually measuring outcomes and benefit for investment in the health care system than probably most other sectors for the degree of public expenditure (9).

As well as the studies showing variation in outcomes, high profile medical mishaps (Winnipeg, Bristol) raised questions about the safety and accountability of the health system to citizens. Concurrent with the questioning of the professional model of accountability, the health system design was also being examined. A prominent Canadian researcher suggests that accountability became a concern for the following reason.

I think it's the fact that we have grown a health system in this country, which is relatively unconnected, piece-to-piece. For instance, unconnected between what physicians do and hospitals do, between what community services are offered and what institutional services are offered; and unconnected with the management structure in a region and a management structure for community services. And Provincial governments under Medicare back to when they introduced Medicare - effectively the Medicare pack until about the early '90's said, 'you provide the money (as in government), and we in the system will spend it, and trust us - we'll do a good job.' So that disconnect was almost built in fundamentally to the relationship between government and providers in order to get the providers to be part of the system. So, I think the big fuss behind it is the realization that as we have grown a system, each piece needs to be accountable to the other. And as we have gotten to the point where the accountability structures were realized to be almost by negotiation - no essence between providers and Provincial government - we had to built in some kind of accountability structure and therefore we've got the pressure for accountability (17).

The policy response to deal with issues of design and coordination was regionalization within 9 of 10 Canadian provinces, with improved accountability as a foundational principle. Regionalization in most provinces moved forward with a re-organization approach to improve coordination among the components of the system and to improve upon the professional model of accountability, by adding requirements for more explicit goal setting, targets and measurement. This focus is advocated in New Public Management and reflects a managerial model of accountability. Provincial accountability frameworks suggest that Alberta has moved the furthest in this regard.

British Columbia, however, initially, took a different direction with regionalization in the early to mid 1990s. According to Davidson (2000), the NDP government, having had some success with community development strategies in forestry and environmental sectors demonstrated their ideological colors in health reform in the form of left-populism and citizen participation. Their "New Directions" policy attempted to reform the distribution of power within the health sector. "Rather than develop the

reform within the bureaucracy, which in effect means close consultation with the client groups of physicians and unions, the government deliberately established a parallel process that excluded the BC Medical Association and Ministry of Health officials” (p. vii). This departure from pluralist politics unleashed a lot of energy (positive) in the form of community activism, and (negative) in terms of the reaction of organized interests and suggests that a community control/participation model of accountability was desired. Davidson (2000) advises that colliding principles ran through the reform and in the end, political needs, administrative rationality, and efficiency trumped local accountability, flexibility and diversity. The “New Directions” policy was abandoned in 1996/97 for the policy of “Better Teamwork, Better Care” which took on the re-organization format as in other Canadian Provinces.

The entry of accountability as an explicit concept within the Canadian health system thus, began in the late 1980s and, according to health system leaders, was related to several factors. First, the general economic conditions coupled with a focus on information about the health system’s value for money.

Well, I think probably it stems from the general economic situation in the country. And I think it's because of our large debt and because those that are responsible for the debt are primarily you know, government and government spending and I think several years ago the ‘penny dropped’ that we really needed to take a close look at what we were getting for our money given that we were so much in debt and the country was not going to likely to tolerate any additional tax or we'd have a tax revolt (16).

Is the fact that the health system costs 90 billion dollars in expenditures and we know remarkably little about how it performs or what it actually does in terms of value for money (13).

Okay, my own of perception of this is that the interests in accountability in the Canadian health system, was driven by a lot of the fiscal realities that the country and the different provinces faced in the late 80's – mid to late 80's. And so I don't

think it was coincidental that that's when you saw significant attempts from the different provinces to first examine their health care system (22).

Second, interviewees suggested that public confidence, expectations and values are changing and thus creating increased demands for accountability.

It seems to me there's become in recent years, a real lack of confidence in the health care system. And from what I've seen, not a lot has changed. I think our system is as good or better as it has ever been. People's health and people's health status, population health status, all those things continue to improve. So all of the really high level measures of health would suggest that we're healthy and getting healthier. And yet, there seems to be a crisis of confidence on the part of public (4).

We're seeing changes in our society, moving from what used to be in the past controlled to today, empowerment of individuals. We are moving from a power-based structure to one based on accountability and trust. And we're moving from a society of secrecy to a society of openness. And these are values changes in the global society... a whole shift in society values. We are no longer respectful of so called "experts", we are questioning them and we should (5).

I think there's a whole alternative care consumer movement that people are more concerned with being personally responsible and invested in understanding what is happening to them. And I mean, I think that came out of some very healthy community movements, the women's health movement, the environmental movement, you know the citizen activism about being consumers and I think it's an important stream in our communities - not always supported, but I think the people are saying, they keep telling me that I'm personally responsible for my own health but part of being personally responsible for my health is saying 'how much is this, how much does this cost, what benefits will be to me' and so there's a pressure from citizens to say, what do I value here (10).

These changing expectations and values were linked to improved access to information about the performance of the health system.

The other factor that's behind the current interest and concern, I think, is the information systems are getting better and we're starting to measure. You can hardly pick up a paper these days....almost daily articles of research coming out This mornings Globe and Mail, "Over Use of Antibiotics for Children's Ear Infections, Ear Drops are Just as Effective." The public's reading this and they're saying "the health system is not accountable, the health system is not giving quality"(5).

And so I think it's the broadening education, the information that's available to people. Thirty years ago, people didn't use those words. The doctor was the answer to everything and the system was going to work and if it didn't, it wasn't your business (1).

Others suggested that public demands for accountability had not increased and that public accountability was a sham to cover for the interest of politicians.

A large majority of the public really misperceives what the health care system is really all about; how it really works; what it costs; and so on. And so for those people in the public who actually have contact with the health care services, their assessment is remarkably positive - it's still very high how health care responds to their needs. But for all those other folks who don't have a lot of contact - they have either on their own created a perception or have been easily lead by the media and other vested interests who believe in that the "sky is falling" and that the health care system is in major trouble and it won't be there when they need it, etc. So I don't think the accountability is necessarily coming from the public as directly as people want to make it sound. I think it's coming from other places, mainly government and politicians (22).

Now to return to the thing about accountability to the public being a sham. I think the big thrust around accountability to the public, number one it's mis-specified that part of the public want to get all of this information.... the real desire for accountability is between the Federal Government and the Provincial Government; between Provincial Governments and Regional Authorities or hospitals in the case of Ontario. No one is willing to admit that the other is the boss of one or the other. And therefore the common denominator that they are willing to agree on is they'll report to the public because that's motherhood. Whether or not the public's interested in being reported to is a completely separate matter. It's a very useful mediating audience that everyone can then say, "well we're not reporting to each other, we're reporting to the public" and can then be used for reporting to each other (17).

Some research (Adams, 1998) on Canadian values support the view that values are changing and that Canadians have become less deferential to institutional authority and elites. They are therefore more likely to demand accountability from institutional authorities like health organizations. Also, public perception polls in five OECD countries, including Canada, overwhelmingly stated that health care systems needed "fundamental change or a complete overhaul" (Leatherman, 2001).

5.2.2 Understanding The Issues Surrounding Accountability

The second research goal was to gain an understanding of the issues and solutions related to improving accountability within the Canadian Health System. The Canadian literature on accountability and interview data provide the source for the issues that follow.

Lack of Direction for the System

Interviewees pointed out several directional issues that stand in the way of improved accountability. The first was the lack of role definition, clear goals and coordination of the various components of the health system.

The other difficulty we have in the health system is, in order to have clear accountability, you must have, besides roles clarified, you must have goals and objectives clearly identified. We have not decided whether the health system is to produce better health or just to produce more health care. We see examples day in and day out where we do, well work done is work paid for. But we've no idea whether it contributes to the goal. Hopefully, the goal of the health care system is better health (5).

We really do have to have more concrete goal setting around which there should be some consensus. Because without it, then you're really just accountable for process which as you know, is an inferior, intermediate step on the way to true accountability, and I don't think we have been very persuasive of our goals, we haven't been willing to commit to much (8).

The lack of a system. The lack of recognition, I mean I think the regional health authorities are starting to move us towards some solutions in this area but within a Canadian context, I mean there is no formal relationship or set of expectations leveled between different elements of the system. There's no relationship between the general practitioners in the community, the home care nurses in the community, and the institutions in the community. There is no system. So the biggest area is the lack of any integrated force that defines the boundaries around the system; what are the relative roles of all the elements within those boundaries; what are the expectations of those different roles and; what are the graded mechanisms for enforcement of those expectations (17).

A second issue is that essential players, who consume large portions of health care

resources remain largely outside the jurisdiction of the health system. This lack of alignment of resources with the publicized goals serves to undermine and create confusion about the direction.

Now we're moving towards being able to have that within some of the regional health authorities now but the biggest barrier is the lack of capturing of crucial elements inside - that should be inside those boundaries but aren't... Physicians and Pharmaceuticals for instance. What are the accountability structures for the Pharmaceutical industry, those who supply pharmaceuticals to the health care systems? They have a simple accountability, which has nothing to do with the health of the population - have a simple accountability to shareholders. So they cannot by definition be incorporated as part of the accountability structure within the boundaries of the health care system. Physicians, they could be but they currently aren't. The biggest single barrier therefore is a lack of clearly defined set of boundaries around what is the system; who are the organizations; what are their goals; what are the mandates? Therefore, now I can define the relative set of expectations in the relative rate of mechanisms of sanction (17).

While some suggested that regionalization would bring some coordination to the disintegration, others suggested that confused roles between the provinces and regional authorities was limiting any success.

There's fractured accountability between the Minister and the Boards who operate the system; there's a confusion as to who is accountable for what. Then you get into, when you come into a regional authority and you have weak accountability of your professions on utilization, utilization of resources through to the Board (5).

The issue of confused roles and lack of a clear direction for the system was supported by the British Columbia Auditor General (1998) in a review of regionalization. More recently, McIntosh (2001) raised the issue in a review of accountability in the Saskatchewan health system. This is further supported by the (IRPP) Institute for Research on Public Policy (2000) in a policy paper that made recommendations to First Ministers. Solutions advocated to deal with these issues, include revisiting and revising the principles of Medicare and the goals of the health system, disentangling the blurred

roles of the various health system players and dealing with incomplete devolution by re-allocating responsibilities, and establishing strategic planning to anticipate the growing pressures and changing healthcare needs of Canadians.

Culture of the system

Several cultural issues were seen to be barriers to accountability. First, the culture of the health system was seen to be based on volume and blame instead of on quality and improvement.

And historically you have seen Boards focus more on protecting volume than protecting quality and you've seen nurses and management people, who shy away from dealing with quality issues because they know the Board's not gonna support them (5).

So as long we have this culture of blame, I don't know of any system of accountability.... staff blame politicians for problems, politicians insist managers cause problems, politicians blame staff. They talk about the victim of the week and, and it's the doctors who are causing this... that leads the patients to be critical, they blame the systems, managers, boards and senior staff and when things really get bad in an area, they fire the boards and fire the executive staff. The health care system leaders and staff, the doctors and nurses blame the public often times. Expectations are too high, so all we need to do is educate them about lowering our expectations, or we seem to think the solution to it, high expectations is to cause them to have lower expectations of our ability to perform. The public don't know who to blame but I think generally blame politicians, they like to have confidence in their doctors and the nurses.... A good accountability system should allow people to, to be much more focused on how we get better at what we are doing (2).

Traditionally, hospital boards have been in the position of needing to calculate the local impact of decisions. Value has been placed on the volume of service available, given the absence of information on quality of services available. Emerging evidence about the varying quality of services and the impact on outcomes may be influential in shifting the culture to one of quality and improvement.

A second, element of the culture viewed to be a barrier to improved accountability is that the system has been provider focused, based on a model of professional accountability through self-regulation. Secrecy, instead of transparency and a system approach to error reduction was seen to be problematic.

So what stands in the way of achieving accountability, I think our culture of secrecy, I think we tend to cover up the medication errors, we tend to cover up any sort of misadventures. We, we don't have a tendency to surface issues and say "lets deal with it and get better". I think there's a, this is related to the lack of transparency in the system so then, it's hard to talk about accountability and, when, when the system isn't transparent. I think there's a poor measurement, which, which I think sort of reinforces this lack of transparency (2).

I guess the other major barrier is a pretty autonomous practice tradition. And our system is based on historical patterns, and how we have considered all professions self-regulating and self-disciplining. There isn't a whole lot of, I guess across the board transparency in the system and people are nervous about it. So we don't have a very sophisticated way of thinking about it either, we tend to think of it as punitive rather than as a quality improvement. So our whole culture hasn't been attuned to it and probably that's the biggest barrier of all. If there's a real grass roots demand, particularly on the provider side, but also on the public side, for a real, a thick sense of accountability, I think we'd have it, I think that's just starting to develop (8).

Third, developing a culture of learning and improvement within the leadership of the system was seen to be a requirement.

I think some of this stuff has to be "top down". That is, if your board and your senior management don't require it, if you say we believe in evidence-based decision making, yet you continue to make decisions without any evidence, people will see it...need to take a stand about "what does it mean to you to be accountable; and what does it mean to you to be transparent; That's another training process frankly (8).

Need a cultural change, and I keep coming back to this measurement for learning culture rather than measuring for judgement culture, which I, I think, I still think most of the measurement that we do in society is about good, bad, whose better than me and I, I don't think that's really very helpful in this (2).

This view is supported by Decter, (1992) during his tenure as Ontario deputy minister of health. He stated,

Accountability does not just happen-appropriate mechanisms need to be developed and put in place. It is not something that trickles up to the board-it needs to be led, insisted upon and carefully nurtured by the board and equally supported by management and professionals (p. 3).

According to the Saskatchewan Commission on Medicare (2001), dealing with cultural issues will require taking a critical view of the health care system but at the same time recognizing that quality is not an individual problem but one of system design. The report also suggests research is a pillar in transforming the system to one of quality because evidence-based practice, not tradition or anecdote, is needed to ensure quality. Further, some different institutions of accountability are being recommended. One such organization is a provincial Quality Council, with a broad mandate to develop standards, analyse and report on performance, and depoliticize decisions. Less emphasis on the political impact of decisions will allow the system to respond more effectively to changing science and understanding.

Lack of Effective Citizen Engagement

Much of the literature data suggested citizen involvement was presently inadequate, but was generally silent on solutions. In one article by Lomas (1997), the various roles for citizens when providing input into decision-making were examined and common problems and some recommendations were identified. Many interviewees acknowledged the difficulties of finding effective strategies.

A deputy minister of health stated,

We need to engage the public more in what it is that they think they can't get information about. I think one of the things we should do is, we should talk more to the public about what they mean when they say accountability....what is it that you want to know that would make you feel that you have the data and information that you need in order to make a decision about whether the system is accountable or not (6).

A chief executive officer of a health region suggested that accountability was more than accountability to the Ministry of Health.

But I also think we're accountable to the regions we serve..... its not very well understood, but certainly not just using every different interest group that comes, but accountability to the community and that means involving them in decisions and all sorts of things. I certainly didn't think like that five years ago but having sat through a couple of regions and complex environments surrounded by stakeholders - you get a pretty compelling sense that accountability is more than just back to the province (21).

A nursing school director stated:

I think that citizen participation is a really crucial It really does need to be very carefully thought out. Where is the most appropriate location in the system for that input so that it doesn't risk just becoming token (19).

Most interviewees viewed a democratic process with full public participation essential to an accountable health system and some viewed regionalization as having contributed to this. One chief executive officer said:

Regionalization, to try and get better integration of services and avoid fragmentation. But one of the other things that it's done, is it's brought health services closer to the community. And by getting people in the community more involved, that's tended to promote accountability as well cause they're asking questions (5).

However, many suggested that the system was still not sufficiently accountable to the public. This is an area where other OECD countries have more experience than Canada.

In the United States, the approach of public release of health performance information has had limited success in engaging citizens. Studies indicate (Marshall, Shekelle, Brook & Leatherman (2000) that report cards have little influence on consumers decisions to choose health providers. However, it does indicate that public reporting influences provider organizations to improve their performance and outcomes. Other countries, like the United Kingdom, are experimenting with citizen juries and quality councils with

citizen participation.

Lack of Information Measurement & Management

Several interviewees focused on the inadequate investments in information systems.

The other reason is information - the barriers to the achievement of useful information systems. We spend maybe 2% of the health budget on IT. Really good non-profit HMOs in the States spend 6-8% - easily. Our information systems have been geared to administrative payments and so forth and simple counts rather than substantive outcomes and the relationship of inputs to outputs and outcomes. So I think that whole area, as many have called for, has to be re-thought and it's going to take money - a lot of money to do it (8).

Measurement, difficulties in measuring things in the health care field. We spend very little money on measuring things in the health care field. So we have to make much bigger investments - you know in the banks they spend 12% of their budget on information systems, we spend 2%, 1-2% of our budget on information systems so it's not surprising we don't have good information to measure what we're doing (15).

Others focused on some of the measurement difficulties.

But one of the biggest challenges, I think, there's two major challenges that we haven't already talked about. One is that we need a lot better, I think, information. Part of our accountability framework is so that we can achieve improved health outcomes and improved quality of life. From my experience in the system, we have sort of both a benefit and a curse. We have just a tremendous amount of data, coming to the health care sector. But collectively, besides from a few academics, I don't think we've really done a good job about turning that data into meaningful information (4).

Better information is required to measure performance beyond the traditional financial dimension. According to Leatherman (2001), the cycle of performance measurement and management begins with explicit goals, which are reflected in the adoption of specific performance indicators, followed by analysis and actions aimed at producing change to improve performance in a variety of dimensions such as equity,

access, effectiveness, efficiency, appropriateness and safety. This information is also reported publicly.

Health Canada has been taking a lead in the investment of a health information infrastructure and has a national vision and four year plan to modernize Canada's health information system. Organizations like the Canadian Institute for Health Information (CIHI) and Statistics Canada are playing a critical role in this development. The intent is that this initiative will provide a foundation for measuring performance and outcomes linked to health care and a better understanding of the non-medical determinants of Canadians' health. An inability to measure and report clearly and comprehensively guarantee's freedom from accountability.

Overall, perhaps, the issues related to accountability in the Canadian health system are best summed up by an interviewee.

Until there is excellent political cooperation, and until the professions begin to realize that they have an obligation to support the system as well as defend their interests, and until system leaders become genuinely concerned about improvement- being good, not just looking good, and until we measure what is important and meaningful, not just what is readily available, and until we have created a learning culture which will replace our blame culture, I'm not optimistic that we will be able to develop a an effective accountability system (2).

However, in spite of the issues, the majority of interviewees expressed optimism that we were on the road to improved accountability and that this would continue. Many suggested that regionalization would help bring coordination to the previously disconnected components of the system. Investments in information development was seen as promising although it was acknowledged that much larger investments would be required. The interest by the federal government in building accountability requirements

into the Framework to Improve the Social Union for Canadians was also seen as positive. Provincial efforts at defining accountability relationships with regional health authorities was seen to require more work on role definition and clarification. Some also suggested it was time to revisit and redefine the principles of Medicare.

Well, I mean as far as we're actually starting to work more effectively at the regional authority level ...and at the level of Health Ministers Accord last Fall... I'm relatively optimistic that we're going to see significant improvement, we are seeing significant improvement - we might as well go on. We will never achieve the nervana of accountability but I would have to say that within the last few years we've started to move very significantly from a system that was largely unaccountable across it's different organizations and move to one that is seeing the need for it; is engaging more and more in rhetoric of it; and we're actually starting to see some of the glimmerings of the actual reality meet that rhetoric (17).

I think our chances are increasingly better because I think the ball is rolling and we can't stop it. I do think the information systems are going to get better. I think, especially large health authorities are starting to build in some real analytical capacity. I also think we're getting a new generation of leaders that are less stodgy and hide-bound and coasting (8).

Absolutely. And I think it's moved a significant distance already. I think with the efforts of CIHI and the development of national health goals would be a major initiative on that front. I think, there's no question that the Canada Health Act needs to be re-written and needs to be tidied up... We have 17 regional health authorities in Alberta, which have now manifested 17 business plans for a 3-year period. They are clearly identifying what their challenges are and very clearly identifying what goals they're working towards and explicitly looking at those being shared publicly (3).

In summary, this chapter has been devoted to the analysis of the concept of accountability within the Canadian health system. The method used was a concept analysis. The concept was clarified by disentangling it from related concepts, examining its development and evolution within the health system and defining its attributes, consequences and antecedents to better understand its meaning.

CHAPTER 6

Interpretation and Discussion

The findings of this study reveal that the concept of accountability, in its current explicit performance – based form, is relatively new to Canadian health system policy discussions, its use only beginning in the 1980s. Prior to this, accountability within the health system was an implicit concept embodied in the delegation of health services to self-regulating professionals. Heightened awareness and concern about accountability grew throughout the 1990s as most Canadian provinces underwent health system restructuring. At that time, Regional Health Authorities were created and most health service delivery functions were devolved from provincial governments to the regional bodies and accountability discussions focused on matters of health reform. Although government documents and public media reveal that thought is being given to accountability in the Canadian Health System, academic literature is scant in Canada. What is available is focused narrowly on accountability and health system reform or specific tools of accountability such as report cards, except for a few unpublished synthesis reports commissioned by Health Canada. Yet, although a new concept in health, accountability as a public administration concept has a long history and has evolved alongside theories of public administration. The concept of health system accountability flows from the public administration concept and becomes embedded into and influenced by the health system and its issues. It also appears that other Organization for Economic Cooperation and Development (OECD) countries, in particular, the United Kingdom, Australia, New Zealand and the United States have contemplated the concept of accountability to a greater degree than we have in Canada and have begun to change

institutions of accountability in response to accountability concerns. This may be related to earlier health reform initiatives in Australia, New Zealand and the United Kingdom and a fundamentally different health system in the United States.

Accountability is a complex concept with many related concepts, and is susceptible to many different interpretations. It is multi-dimensional and is conceptualized in several ways: as a theoretical and ethical principle to justify goals and explain personal actions; to describe formal processes, systems institutions and mechanisms to attain desired results and enforce certain behaviors; to explain and justify desired results and outcomes; and to explain, justify, or react to political action or inaction. Also, it is a multi-level concept, operating at personal, organizational and political levels, and between the needs of individual patients and the needs of society.

Although there are several conceptions of accountability, there is some convergence on the attributes. Many articles and interviewees did not provide explicit definitions of accountability, but the data revealed a number of categories relevant to the attributes of accountability. Specifically, these included: an obligation to answer for the responsibilities conferred, performance assessment according to standards /goals, justification of decisions/ answerability to communities served. The antecedents to accountability include strategic direction, citizen engagement, a renewed culture and information management, performance management and reporting. The desirable consequences of accountability are public confidence, improved health outcomes and service, a sustainable system. The undesirable consequences are added bureaucracy and uncertainty.

My previous analysis served to disentangle the concept from others and examine

the meanings associated with accountability as it evolves within the health system; however, inherent within those meanings are normative purposes and modes of accountability. In this section, I reflect on the context (ascribed motives) behind the emergence of accountability as a policy problem in health, elaborate on the normative models (the desirable purposes and modes of accountability) and policy questions related to health system accountability; and finally, compare the normative models using the concept analysis variables of antecedents, consequences, surrogate terms, related concepts, and attributes. This discussion will clarify the primary focus, areas of consensus and conflict among the normative models.

6.1 Context Behind the Concern for Accountability

In order to more fully understand the concept of accountability, it is necessary to provide a summary of the context within which the concern has developed. This involves an examination of the motives behind accountability as a policy concern. Various motives have been ascribed to the increased concern about accountability. The most popular is related to the general economic conditions throughout OECD countries. All interviewees provided this rationale for the increased concern about accountability. As with most western countries, during the 1960s through to the 1980s, Canada experienced rapid growth rates in health care expenditures. Total spending on health care rose from 5.4% of GDP in 1960, to 7.5% in 1980. It peaked at 10.2% before dropping back to 9.1% by 1997 (OECD, 1999). As health economist Robert Evans (2000) points out, the growth in health spending slowed after 1980, but the economy slowed even more. With the slowed economy, health spending dropped below the 1980 level.

Several effects are attributed to the rapid growth and increased costs. A study done in (1995) separated these effects into economy- wide (64% of total cost rise) and health-specific effects (36%). The economy-wide effects on costs were attributed as follows: 75% (of the 64%) to general inflation, 20% to population growth and 5% to population aging. The health-specific effects were as follows: 50% to sectoral inflation that exceeded overall inflation, 25% to service intensity per task, 17% to treatment intensity per patient, and 8% to numbers of contacts with the system (National Nursing Forum, 2000).

The policy response was focused on curtailing budgets. At the federal level, this was accomplished by cutting transfer payments to the provinces. According to provincial and territorial ministers of health, the federal government cut their share of health spending from 28.4% in 1979-80 to 10.2% in 1998-99 (Provincial & Territorial Ministers of Health, 2000). As fiscal restraint and cutbacks became the touchstone of the 1990s, health services eroded and decreases in other areas such as social services indirectly raised the burden on the health system. For example, rising homelessness is linked to increased illness. As citizens became concerned about access to service, governments were called on to be accountable.

Concurrent with the cost containment, there were growing questions on the part of governments about whether the health system was performing adequately. Thus, a second motive attributed to the rising concern about accountability is inadequate standards and performance. The Quality Management movement in the United States generated publications stating that there was a 30 % waste built into health care processes. At the same time, Canadian organizations such as the Institute of Clinical and Evaluative

Studies (ICES) were publishing reports on variations in procedure rates of similar populations. In the words of one interviewee:

I think that health care tumbled off that 'we are above accountability pedestal', with you know things like those variation studies, where all sorts of evidence came in that we weren't the 'one treatment, first time, every time it works' and all that sort of stuff. So we fall off the pedestal, people are thinking of health as an investment, which is in best of terms an accountability (21).

The policy response that is perhaps most closely linked to inadequate performance and goals of increased accountability has been regionalization,¹⁶ which has been introduced across most Canadian provinces. The verdict on the success of regionalization is mixed. While a Canadian study by Lomas (1999) concluded that it was too early to tell, a recent British Columbia study concluded that the reform effort was "dynamics without change." The achievements of British Columbia's decade of reform was summed up as follows:

First and foremost, health services were centralized and integrated at the regional level. Second, those services were brought more closely into the orbit of the ministry through its strict funding and policy protocols. Third, the major health care unions, through provincial bargaining arrangements that they won from the government by bargaining over regionalization, gained substantial power. Fourth, the organizational prerequisites were finally in place for a drive to service integration, improved efficiency and more management information.

Fundamentally, though, the health care system in BC remained unchanged. Power was still brokered by professional providers and bureaucrats in a system governed by the rules established in the 1960's by the hospital and medical insurance plans. In short, the fundamental rules of the game did not change; there was only a minor shift in the pattern of winners and losers. (Davidson, 2000. p. x)

Other Canadian researchers suggest that over the past decade health care has shifted, in Canada, from a "cure-care model to a business model" (Armstrong et al., 2000). These

¹⁶ Reform in the Health field in Canada has been labelled "Regionalization," and aims for improved coordination and decreased costs in health care delivery, and increased public participation within specific geographical regions.

authors suggest that this model is based more on faith than evidence and that it has brought deteriorating health care services. Further, health care reform is viewed as part of the broader restructuring and rethinking of the welfare state (Ralph et al., 1997; Connelly & MacDonald, 1996). Examining the changes occurring in Ontario, Ralph et al suggest that the fiscal responsibility is a smokescreen that hides a fundamental attack on democracy and social citizenship. They examine the effects of government policies on societies most vulnerable members: people with low- income, children, women, workers, and ethno-cultural and francophone communities. Connelly and Macdonald, focus on the intersection of health and social-service systems and suggest that, although there has been decreased costs and increased employers' flexibility, that the flexibility and benefits of home-care workers has decreased and stress has increased. They raise questions about what the restructuring will mean for women care-givers.

The final motive is ideological and relates to the public sector reforms of NPM.¹⁷ According to Pollitt, managerialism is the agenda of new-right thinking concerning the state and that:

better management provides a label under which private sector disciplines can be introduced to the public services, political control can be strengthened, budgets trimmed, professional autonomy reduced, public service unions weakened and a quasi-competitive framework erected to flush out the natural inefficiencies of bureaucracy. (Pollitt, 1993, p 49)

However, Pollitt does comment that given the public service expansion, referenced above, the productivity logic has a power of its own which is independent of the right wing political agenda. This is also supported by Aucoin:

¹⁷ Reform in the Public Service has been named "Managerialism" or "New Public Management" defined by C. Pollitt (1996) as a set of beliefs and attitudes, mainly from big business and the military, that are being applied in the public service.

Managerialism, in contrast to the traditional bureaucratic ideal of administration has developed in the public sector for the same reason it has emerged in the private sector, namely an increased concern with results, performance and outcomes. Hence higher priority is given to the management of people, resources and programs compared to the administration of activities, procedures and regulations. (Aucoin, 1988, p. 152)

6.2 Normative Models of Accountability

The examination of the evolution of a concept is important to the overall understanding and clarification (Rodgers & Knafl, 2000). As the evolution of the use of accountability is examined within the Canadian health system, three desirable purposes or modes of accountability emerge. These models are first discussed, and then compared by using the concept analysis variable of attributes, antecedents, consequences, related concepts, and surrogate terms.

6.2.1 Professional Model

The traditional model of health system accountability is the professional model where control rests mainly with professionals or professional administrators. This model is the most common in health care systems of OECD countries. According to the King's Fund, the good old days are recalled differently by doctors and nurses. "Nurses remember when the hospital was controlled by the matron" (King's Fund, 1996, p.9). Doctors, however, remember when the hospital was run by the medical superintendent, who had absolute authority over every aspect of the operations. The matron was his helpmate, and the administrator, if there was one worked as his aide. Regardless of whether nurses or doctors held ultimate authority, it was a professional model of accountability. The ultimate authority model has evolved with specialization in the health

field throughout the 1950s and 1960s, and although it was shaken by the managerialism of the 1970s and 1980s and the continued concern about the quality of health services, the professional model of accountability remains integral to the health system. Because medicine is still the most powerful sector of health care providers, my focus in this section will be on physicians.

The professional model consists of two main loyalties: to the profession and its values and to individual patients. Accountability has traditionally focused on competence, ethical and legal conduct which is somewhat akin to the values of public administration universalism. Professional institutions establish the content areas and evaluation criteria and propagate them through education, licensure and certification and discipline of those who deviate. This process is more reactive than proactive in that it relies mainly on complaints to monitor physicians. An informal process of conferences, consultations, peer review of hospital privileges etc. is relied on to invoke affirm and enforce professional standards. Through definition and enforcement of standards the profession is said to be autonomous. That is, physicians are simultaneously the regulators and the regulated and, as such, are infrequently subjected to external standards or enforcement by laypersons, government, or nonprofessional bodies. The main focus of this model has been accountability to colleagues, as illustrated in the following quote.

A professional who yields too much to the demands of clients violates an essential article of the professional code: Quacks, as Everett Hughes once defined them, are practitioners who continue to please their customers but not their colleagues.
(Starr, 1982, p. 23)

Over the last few decades, accountability to patients has become more prominent.

One interviewee summed it up as follows:

So, if you even look at the work that the College of Physicians and Surgeons do, it wasn't all that long ago that most of us worked with them behind closed doors, there was no public members and governing councils, there was no public members on hearing committees, on complaints resolution committees and there was an era in which I think the public quite genuinely accepted that, "I'm sure those people are doing in what's in our best interest behind closed doors," and of course the whole public attitude has changed. Large institutions, even government is regarded with a lot more skepticism and so I think transparency is a large feature of accountability – that's another word that come to my mind. So that people can actually see what's going on, if in fact something happens to them and they are in contact with the health care system that is different than they expected - they want a full explanation as to why that happened, What could be done to make it different for them or other people in the future (9).

Most professional associations now have citizen members as part of the board of directors, and some provinces are moving to proactive audits. Yet, some interviewees indicated that this is not enough. We should be moving to other institutions and models of accountability like those occurring in other countries. The following excerpts illustrate the point.

I don't think self-regulation works. I think it's too much driven by the professions themselves and I think they protect themselves more than they protect the public. And I've seen that - the College of Physicians and Surgeons is under tremendous pressure here in Ontario. All sorts of examples of bad practices where they just gave people slaps on the wrists and I remember when I fired 6 nurses (here) because of what they were doing to patients and that really got me looking at what the College of Nurses does in Ontario to nurses who slap patients, pinch them and yell at them and punch them and they did nothing. I mean it was just bizarre to me how little accountability there actual was. It almost seems to get tied up in these professionals have a right to earn a living and if you do anything drastic to them, you take away their right to earn a living (15).

Professions cannot just accept responsibilities that they want out of the overall mandate. A good accountability system would have built in autonomy within the scope of authority and accountability (16).

CEO's of a say, a hospital trust, a large secondary tertiary hospital in the UK is held accountable for you know, like the post operative mortality rates, the wait times, all this stuff. If they don't take it very seriously - they could loose their job. It's a very immediate sense of accountability because it's high and centralized in the UK. So they've created a whole new set of institutions over there, the National Institute for Clinical Effectiveness which sets clinical guidelines and a

Council on Health Improvement which is charged with actually evaluating whether or not those guidelines and outcomes are being met. So it's institutionalized accountability in a whole new way over there.... in Canada, traditional accountability has been sort of the one-on-one clinical accountability of the doctor or the nurse or the providers - right? And this is the remedial arm of the accountability loop - went through the professional colleges -right? So the equivalent of that in the UK is the General Medical Council - it's about to die. They say the professional (model) is post – mortem.... they're about to kill it.

R: So self-regulating professions?

Not self-regulating. It's like the physicians and nurses and the providers will be imbedded in organizations that will be evaluated by these national level institutes and they will be looking, and of course there's a change of course in the whole quality movement to not focusing on individuals and individual blame. Trying to induce an environment or culture of quality so that.. but where there was clearly some blame that was appropriate or to be assigned then that would be acted upon by these outside agencies, rather than leaving it up to professional self-government (18).

It appears, then, that the professional model of accountability, traditionally a mainstay of the health system, is under threat in some OECD countries. The professional model as it is currently constructed has the effect of isolating physician practice from other professionals' practice, making coordination of care between physicians and other professionals cumbersome. Also, the link to health authorities for effective use of resources is weak or absent in the case of physicians who do not have hospital practices. (see Appendix B)

6.2.2 Citizen Participation Model

A second model of accountability is a citizen participation model. There is a definite desire for more citizen participation and control of the health system as evidenced by the following quote from an interviewee. This model seems to parallel the public administration theory of participatory democracy.

I think that citizen participation is really crucial It really does need to be very carefully thought out. Where is the most appropriate location in the system for that input so that it doesn't risk just becoming token I feel like their purpose is to sort of serve as the breaks on professional power. I think actually that that's where they can serve a role. But that is so full of problems that I think where they end up going instead, rather than tackling that because it's just too hard, and they're too afraid of putting themselves at risk and anybody that they might know because I think when it comes to one's own health, you're in a pretty vulnerable position (19).

This goal of increased citizen participation was also a stated goal of health reform and in British Columbia, according to Davidson (2000), it was an ideological model attempted by the NDP government during the New Directions program. The NDP government having had some success in overcoming entrenched interests in the through community development strategies in the forestry and environmental sectors, demonstrated their ideological colors in health reform, in the form of left-populism and citizen participation.

Some argue that attention to citizen inclusiveness in policy making is one of the most important reforms needed in the human services. It is important because service users experience the reality of service issues, a reality that is often foreign to policy makers. Many times, policies formed without this knowledge are incomplete and inappropriate (Wharf & McKenzie, 1998). At a practice level, a partnership rather than a relationship where the client is dependent on the professional, is seen as ideal in improving accountability. Sallis (1979) in discussing parent teacher relationships suggests that three components should be present: a consensus on the objectives, an exchange of information about methods, their limitations and implications, and some dialogue to discuss the success of what has been done. This assumes that there is parity between providers and clients and that information is adequate to assess objectives and

outcomes. In healthcare, neither is present. The interviewee quoted directly above noted the power differential existing between clients and providers and one of the key issues noted by health system leaders is the lack of information and good measurement to assess outcomes.

At a policy level Davidson suggested:

That several colliding principles ran through health reform. Local democratic accountability collided with efficiency and administrative rationality. Flexibility and diversity collided with commitments to uniform terms and conditions for comprehensive health service delivery. Equity reinforced administrative rationality in opposition to the mutually supportive values of flexibility and local accountability. Perhaps most significantly, devolution collided with ministerial accountability (and political survivability). Experience was to show the minister could not, much as she/he would like, distance her/himself from poor ambulance response times, surgical waiting lists, hospital service disruptions, facility closures, or spectacular medical misadventures. Bitter experience showed that politicians needed detailed information about, and the means to control decisions at the periphery. In the end, political needs, administrative rationality and efficiency trumped local accountability, flexibility and diversity. (Davidson, 2000, p. viii)

New Directions was abandoned after a review of regionalization and the next direction was named Better Teamwork, Better Care. Needless to say, the citizen control/partnership model of accountability, to date, has not been achieved in Canada's health system.

6.2.3 Managerial Model

The third model of health system accountability is managerial and entails the use of authority by elected officials, bureaucrats and health managers. Its main formal characteristic is a management hierarchy, an element of universalism. Bureaucratic accountability has been typified by Jacques (1976) as being derived from contracts:

The employment contract fixes the central feature of bureaucratic roles, namely the accountability of employees for the work they are expected to do..... accountability calls for human judgements as to whether assigned tasks have been satisfactorily discharged; judgement in turn calls for authority- the authority of one person to assess another's competence. (Jacques, 1976, p. 26)

With increasing specialization and differentiation between components of work in health care, the need became greater for the integration and management of the entire process. Also, as health care came to be seen as an investment during the cost containment era, managers began to focus on value for money and evaluation of outcomes. Thus, most health organizations are headed by a Chief Executive Officer who may or may not be a professional administrator. Contracts or job descriptions apply to all non-physician health professionals. As discussed previously, the accountability link of physicians to employers is weak, if it exists at all (see Appendix B).

This model is linked to New Public Management (NPM) and improved management accountability usually focuses on: all levels having clear objectives; a means to assess and, wherever possible, measure outputs or performance in relation to those objectives; well-defined responsibility to make the best use of resources and value for money; and the information, training and access to expert advice when it is needed to exercise their responsibilities effectively. This model also emphasizes quality and citizen participation, but it is too early to attempt a definitive evaluation of NPM (Pollitt, 1996).

As noted above, some interviewees viewed the managerial model as a better alternative to the professional model and referred to the restructuring to this model within the National Health System in the United Kingdom as the preferential mode. Clearly, this is the predominant model of accountability defined by interviewees and the predominant

model written about in the policy/administration literature. The excerpts that follow illustrate the point.

So, to me, accountability ultimately means people feeling responsible for delivering services that they have agreed that they're going to provide. But the whole establishment of what those should be has to start with, like the sort of guiding principles, or tenants to provide the contacts for that articulation. So, I'd start with, and by principles I mean things like are currently written in the Canada Health Act principles and they probably need to be, if not updated, I would argue updated, but they certainly need to be debated and re- debated and those sort of, principles re-established. From there I would go to, articulation then of specific goals and specific priorities. And that would then lead to having established those goals and those priorities and having sort of, with your community agreed on what those things are, then the accountability piece sort of kicks in. For me, when there is clear role definition about who is going to play what role in working to achieve those goals and those priorities? And that to me, is what accountability's all about and it sounds so simple and it so hard to do (4).

First of all, you know accountability is a requirement to explain first, to explain and accept responsibility for carrying out an assigned mandate and then there are important parts of the definitions in light of agreed upon expectations. And that's the first time we start to see this is a two-way street - that responsibilities can be conferred; but if there isn't a clear understanding of what's expected, then we don't really have true accountability or you can't have. And I think that is a key today to where we are, is that there seems to be a lot of stuff being conferred with no clear direction or no indication of clear acceptance of what that responsibility actually is and what it entails. And that's where I think a lot of our confusion in health care is (16).

This model can be seen to encompass the above two models. It includes professional aspects in its' focus on quality and citizen participation in its attempt to be inclusive of citizens views. However, given the pluralistic approach, it is anticipated that conflicting values and ideologies will result in conflicting goals and tension of obligations as seen above in Davidson's description of regionalization in British Columbia. As such, it will be important to identify values conflicts and choose the value(s) that trump others. This will call for courageous choices if accountability is to be improved in the Canadian health system.

6.3 Comparison of Models

To further clarify the primary focus, areas of consensus and conflict, a comparison of the three normative models is presented in Table 9 below. The comparison is made using the previous analysis and the concept analysis variables of attributes, antecedents, consequences, related concepts, and surrogate terms.

Table 9: Normative models & Concept Analysis Variables

Concept analysis variable	Professional	Citizen	Managerial
Attributes/conceptions	<ul style="list-style-type: none"> ▪ Assessment to professional standards ▪ Obligation to render acct to colleagues/individual patients ▪ Theoretical or ethical construct ▪ Ongoing political process 	<ul style="list-style-type: none"> ▪ Assessment to goals ▪ Obligation to render acct. to community ▪ On-going political process ▪ Symbolic gesture 	<ul style="list-style-type: none"> ▪ Assessment to goals/standards ▪ Obligation to render acct. to community /gov/providers ▪ On-going managerial/political process
Antecedents	<ul style="list-style-type: none"> ▪ A renewed culture ▪ Strategic direction 	<ul style="list-style-type: none"> ▪ Citizen engagement ▪ Strategic direction 	<ul style="list-style-type: none"> ▪ Performance management & reporting ▪ Citizen engagement ▪ Strategic direction ▪ A renewed culture
Consequences	<ul style="list-style-type: none"> ▪ Improved health outcomes & quality service ▪ Sustainable system ▪ Added bureaucracy 	<ul style="list-style-type: none"> ▪ Improved health outcomes & quality service ▪ Increased public confidence ▪ Sustainable system 	<ul style="list-style-type: none"> ▪ Improved health outcomes & quality services ▪ Increased public confidence ▪ Sustainable system

Related concepts	<ul style="list-style-type: none"> ▪ Autonomy ▪ Ethics ▪ Shared decisions 	<ul style="list-style-type: none"> ▪ Governance ▪ Ethics ▪ Shared decisions ▪ Distributive justice 	<ul style="list-style-type: none"> ▪ Governance ▪ Ethics ▪ Evidence based decisions ▪ Distributive justice
Surrogate terms	<ul style="list-style-type: none"> ▪ Responsibility ▪ Transparency 	<ul style="list-style-type: none"> ▪ Responsibility ▪ Transparency ▪ Stewardship 	<ul style="list-style-type: none"> ▪ Responsibility ▪ Answerability ▪ Stewardship ▪ Coordination ▪ Performance Mgmt.

A comparison of the attributes across the three models indicate that there may be a different primary focus even if models share the same attribute. For example, although all three models share the attribute assessment according to goals /standards, the prime focus for the professional model has been professional standards. A citizen model would likely focus on community goals, while the managerial model is attempting to balance both. Likewise, the attribute, an obligation to render an account is common to all models. However, the parties to whom an account is owed takes on a pluralistic focus in the managerial model whereas it remains a more singular focus in the other two models. This raises the question of which party will take priority, and poses a potential conflict. The comparison of antecedents shows areas of consensus across the three models. However, again, within a renewed culture there is room for each model to place an emphasis on different values. Also, performance management is predominantly a managerial model value. The consequences valued across the three models have two prime areas of consensus, the focus on improving health outcomes and services and a more sustainable health system.

This comparison is not all-inclusive; rather, it attempts to demonstrate the areas where the three models overlap and where there are differences and potential conflicts or colliding principles, given the values that I believe would trump within each model. These models are emergent and require research in practice, in order to test out and further develop.

In summary, these three modes or models of health system accountability exist within a larger framework of political accountability. The political model of accountability is based on the primary relationship between citizens and government. In Canada, this accountability flows from the representative, democratic system of government. The public votes in a provincial government to govern and manage public resources. The government in turn is accountable to the public through the Legislative Assembly to keep the public informed about what it intends to achieve and what it has accomplished. The authority for health is delegated to the Minister of Health (MOH) who, through regionalization, devolves funding allocations (within MOH standards/entitlements) for quality service delivery, to regional health authorities. Although the structure sounds simple, it is not. The complex linkage of the political system to the health system is illustrated in Appendix B which diagrams the lines of accountability.

6.4 Policy Problems of Accountability

There is no doubt that policy problems exist regarding accountability in the health system. Not only do present health ministers declare there to be one, but there is also concern among health professionals, administrators and the popular media. Also, the

concern is not limited to the health system but includes public services in general. One interviewee pointed out the link between democracy, governance and health and the general decline in the belief that government and public service embodies the public interest.

I guess realizing that the health system or public sector is really a microcosm of society. What I believe brings us at the realization that we have to go back to the basics of accountability, is a crisis that exists at the moment. There is a crisis of confidence – confidence in leaders at all levels starting with the President of United States and the Prime Minister of Canada, the leader of the opposition, the Premier of this Province, and you go on and on. But that's not limited to the public sector, look at the Royal Bank in their investment section, look at Nortel, look at the Hospital for Sick Children, they are -I'm talking of the Chief Pathologist who was involved in the autopsy of three different cases where they fouled up royally and had the gall to proclaim that he was the best in the world. Look at the federal system in the States, the FBI lost boxes of documents. If you cannot trust the FBI or the Chief Pathologist of the Sick Children's Hospital, or the leader of two countries, people become disenchanted, cynical and that has a ripple throughout government systems, public institutions, throughout the school systems, throughout the students and patients, the public . Who do we trust if we cannot trust these people (7).

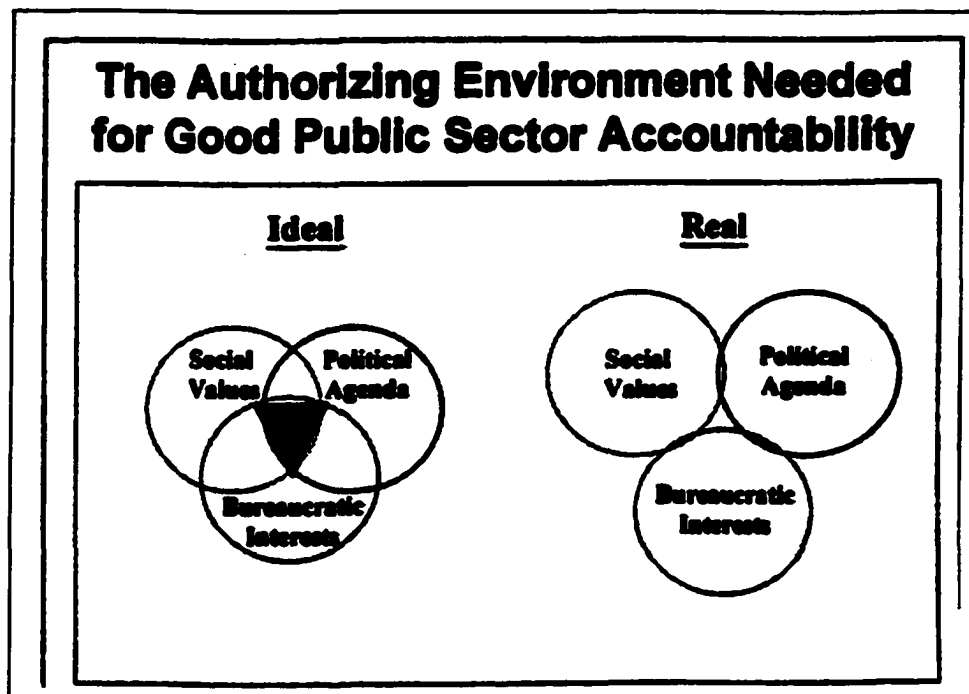
Day and Klein (1997) suggest that a first set of problems relate to the increasing complexity of society and government. They trace the models of accountability from Athenian societies, where accountability flowed simply and directly from the Assembly to the whole body of citizens, to our complex and modern societies, with their multiple levels of government and agencies of government. (A visual illustration of this complexity in the health sector is provided in Appendix A.) Thus, today, although health services are financed and sponsored as a public activity, they are offered in modern institutions or agencies which are largely closed to public scrutiny and difficult to supervise from the outside. Avenues of citizen participation in public service delivery (regionalization & elected boards), and delivery of services through the private sector

(performance based contracting), continue to evolve to compensate for the indirect and distant accountability between government and citizens. Although the public administration theory of participatory democracy, recognizes the need for citizen participation, as noted by interviewees, effective means of citizen participation is an on-going issue as effective citizen engagement strategies are sought.

A second set of issues concern the location of accountability. Where is the authority and how are health system players held to account? As discussed above, there are three normative models within the health care system, all of which are encompassed within the broader framework of political accountability. With the introduction of the managerial model, attempts have been made to link the models of accountability hierarchically. However, as Day and Klein (1987) suggest some of the assumptions may need re-examination. First, professional accountability remains largely outside the hierarchy, especially in Canada. Second, managerial accountability and political accountability do not flow in a linear fashion. Third, there are technical problems around generating the information so that managers can answer for the actions and performance of service delivers. Cutt and Murray (2000) offer a potential solutions to some of the information problems by defining information requirements for non-profit organizations. Further, a set of strategies have been adopted within the National Health System in the United Kingdom that changes the institutions of accountability and aligns the accountability of professionals with managerial and political accountability. Research and evaluation will be required to determine effectiveness and suitability of such strategies to the Canadian Health System.

A final set of problems relates to the difficulty of translating citizen preferences on policy and getting the policy implemented. Public intervention results in some people winning and others losing as it is based on majority rule and heterogeneous values. According to Preker and Harding (1998), “accountability means that government action accords with the will of the people it represents” (p.4). Preker and Harding identified the effect of such public accountability in terms of intractable procedural issues related to the electoral process, taxation policies, contents of public spending programs, and vested bureaucratic interests as follows. First, ballots are blunt instruments that cannot capture a full range of issues or the intensity of views on any one issue. Since election promises are often not kept, public spending policies are at best a very imprecise reflection of social values. Second, majority rule, even with democratic society safeguards may not deal with minority interests. Third, public servants may have conflicts between assigned responsibilities and their own interests. Their political overseers may have vested interest different from those of the society they represent (p. 4). Therefore, the intersection (authorizing environment) of social values, the political agenda that reflects such values, and vested bureaucratic interests needed for good public sector accountability may be as small as that illustrated in Figure 1 below.

Figure 1:



Source: Preker, A. S. & Harding A. (1998). *The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organizational Theory*. HNP Discussion Paper (p.4). Washington : World Bank. Reprinted with Permission.

Preker suggests that the health field has a further tension within the authorizing environment needed for good public accountability: the desire of individuals for some sovereignty over their own health. As a result, during rationing of care or application of programs by the majority, difficult dilemmas arise that infringe on perceived minority group rights or individual survival. Individuals who may agree with social values of rationing in theory often loose commitment when confronted by resource constraints in the face of serious personal or family illness.

Lewis (2001) states " that we make health policy with our head (rational) and we

implement in response to peoples fears and hopes (emotional)". The choice, he suggests is to admit this is inevitable or confront and overcome the dynamic.

These policy questions require debate, and further research and cannot be answered in an analysis of accountability. Further research is required related to the issues of public administration in general, and specifically to compare and evaluate the different models of health system accountability. Outcomes research is required on the benefits of the health system model of accountability in the United Kingdom, where it appears that some alignments have been made between professional, managerial, and political accountability.

Chapter 7

Summary, Conclusions & Recommendations

This dissertation is a conceptual analysis of health system accountability, a concept, that has evolved from public administration theory and practice. Although this public administration concept is ancient, and has been debated and described in the languages of many diverse disciplines, little academic work is available on its meaning or application to the Canadian health system. Without a clearer understanding of the concept, the basis for improving accountability will remain unknown. An attempt has been made to bring some conceptual clarity to the meaning of the concept and answer the question: What is accountability in the health system?

Clarification of this complex concept within the health system is essential for two reasons: to shed light on how it is constructed and to allow us to begin to build theory within the health field. In more practical terms, having a clearer understanding of the uses of the concept, assists in daily discussions of policy and practice issues and may lead to fewer misguided policies and practices.

7.1 Summary of Concept Analysis Findings

The findings of this study reveal that the concept of accountability in its current explicit, performance-based form, is relatively new to Canadian health system policy discussions; its use only beginning in the 1980s. Prior to this, accountability was implicit in the delegation of health matters to self-regulating professions. Heightened awareness grew throughout the 1990s as most Canadian provinces underwent health system

restructuring. At that time, Regional Health Authorities were created and most health service delivery functions were devolved from provincial governments to the regional bodies and accountability discussions focused on matters of health reform. Although government documents and public media reveal that thought is being given to accountability in the Canadian health system, academic literature is scant in Canada. The literature that is available is focused narrowly on accountability and health system reform or specific tools of accountability such as report cards, except for a few unpublished synthesis reports commissioned by Health Canada. Yet, although a new concept in health, accountability as a public administration concept, has a long history and has evolved alongside theories of public administration, like universalism, pluralism and participatory democracy. The concept of health system accountability flows from the public administration concept and becomes embedded into and influenced by the health system and its issues. The issues raised by health system executives suggest that Canadian practice has not kept pace with theory. It also appears that other Organization for Economic Cooperation and Development (OECD) countries, in particular, the United Kingdom, Australia, New Zealand and the United States have contemplated the concept of accountability to a greater degree than we have in Canada, and have begun to change institutions of accountability in response to accountability concerns. This may be related to earlier health reform initiatives in Australia, New Zealand and the United Kingdom, and to a fundamentally different health system in the United States.

Accountability is a complex concept with many related concepts. An attempt has been made here to disentangle it from its many related concepts and references, and identify the converges and divergences. Although, there is a majority view on the

attributes or defining characteristics of accountability , there are several conceptions of health system accountability: as a theoretical and ethical concept; as a formal system or institutional entity; as gesture; on-going politics; and as desired outcomes or results. There is also some confusion and ongoing debate regarding accountability and its most common surrogate term, responsibility, in both public administration and the health sector.

Attributes or Defining Characteristics

There are many definitions of accountability; these often reflect the author's interest as much as they provide a unifying concept of what it means to be accountable. The most common attributes were: the obligation to render account – report; performance assessment according to standards/goals and answerability to the community served. These attributes, however, do not recognize the differing conceptions of accountability and deal mainly with accountability as a formal performance based process which arguably is the most common practical application. My definition attempts to encompass the various conceptions of accountability and its most common attributes: Accountability is a multi-level and multi-dimensional concept, operating at a personal, organizational and political level. It is a theoretical construct describing ethical, organizational and political relationships, a dynamic strategic planning and performance management process when applied to governance and management, and gesture when used to emphasize desired outcomes.

Antecedents and Consequences

Antecedents or pre-requisites to accountability include renewed culture, strategic direction, citizen engagement, information management, performance measurement and reporting. Consequences of accountability are: a sustainable health system, increased public confidence, improved health outcomes and quality services, added bureaucracy and uncertainty.

Surrogate Terms

Surrogate terms refer to substitute or alternative terms used to refer to a concept. By far, the most common term used to mean accountability, in both the literature and interviews was responsibility. Used interchangeably by most of the interviewees, there were also strong opinions on the differences between the two terms. Some explained the difference as “one is responsible for something but accountable to someone.” Accountability was also seen as “enforced responsibility”.

Another differentiation was that responsibility is a moral sense of duty to perform appropriately, while accountability assumes institutional authority to call an individual or group to account. A final view was that responsibility concerns the processes of work, and accountability concerns the outcomes. Other terms used to refer to accountability were stewardship, performance management, answerability, coordination and transparency.

Related Concepts

These are concepts that are related but different in that they lack one or more of the attributes of the concept of interest. They provide a means of recognizing the actual

and potential inter-relatedness of concepts in general and the likelihood of their change over time. Ethics, autonomy, governance, distributive justice, and evidenced based decision-making were the five concepts found to be most commonly related to accountability.

References

References are events, situations or phenomena over which the application of the concept is considered to be appropriate. Appropriateness is a function of the common and accepted use and application of the concept. As Hunt (1991) stated: “one difficulty with accountability is that it is one of those words, like justice or autonomy which is so big almost anything can be squeezed into it” (p49). The references to accountability in the literature and interviews cover a wide range of philosophies and mechanisms governing the relationship between the health system, governments, providers and citizens. As such, references to health system accountability include, accountability relationships among key players, accountability processes, accountability types, and accountability instruments, accountability levels and accountability frameworks. An accountability framework defines the three components (I have added a fourth) of accountability within an organization or system. Within the Canadian Health System the components of accountability, adapted from Emanuel & Emanuel (1996) are as follows:

Who – The Locus of Accountability: At least nine parties can be held accountable or hold others accountable: federal and provincial governments, regional health authorities, health providers, professional associations, voluntary organizations, private payers, drug companies, individual patients and lawyers and the courts.

What – The Domains of Accountability: A domain refers to an activity, practice or issue for which a party can be held accountable. The general domains within health care are, professional competence, legal and ethical conduct, financial performance, adequate access, public/population health, and community benefit.

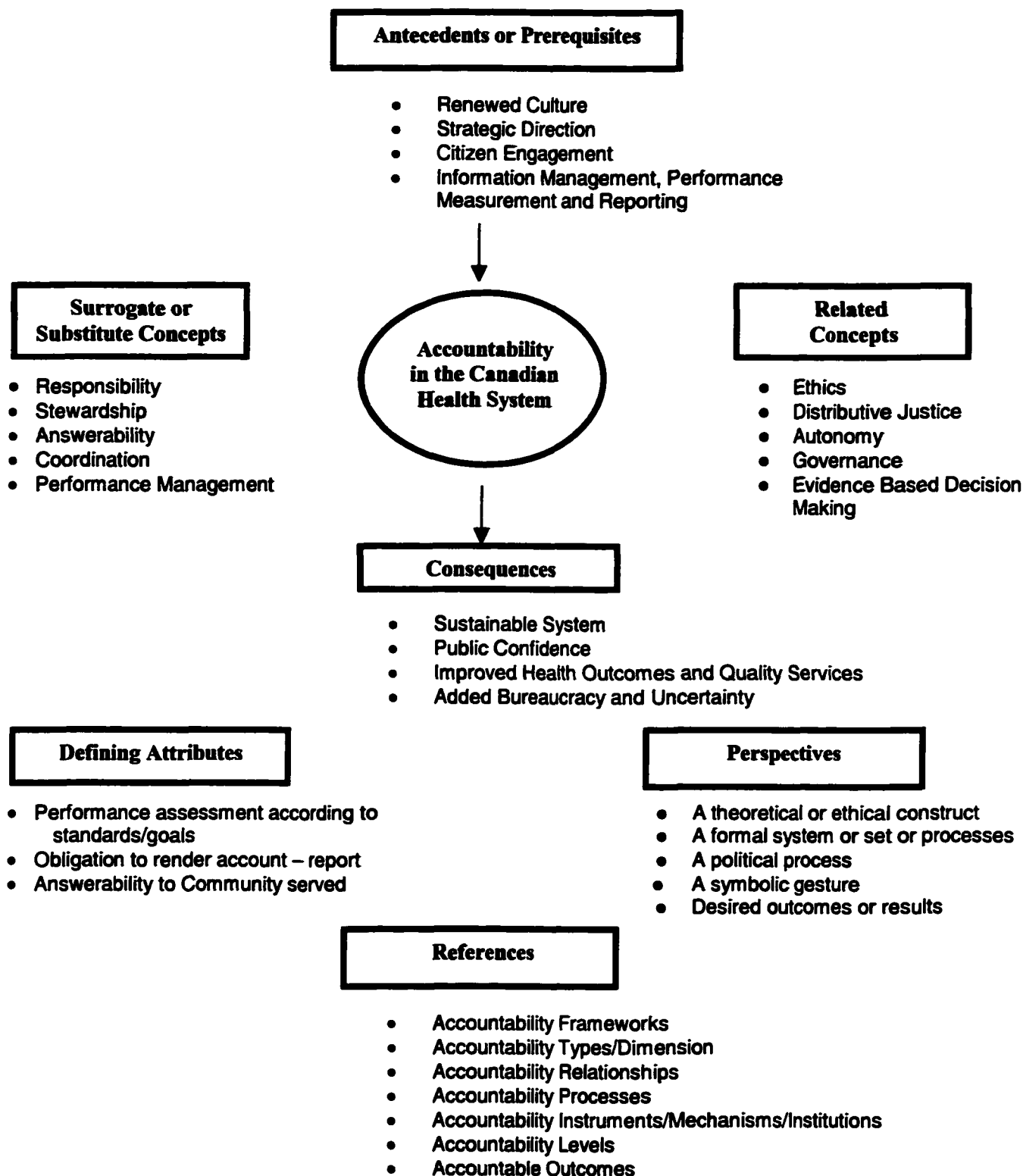
How- The Procedures of Accountability: There are many procedures, processes and institutional entities as outlined previously. However, generally, the procedures fall into two categories. The first is assessment and evaluation of compliance to success criteria for specific content areas; the second is the reporting of the evaluation and responses or justification to those to whom accountability is owed. Much of the emphasis in Canada is on the development of information for reporting, for example, the reports on the performance of the system developed by the Canadian Institute for Health Information (CIHI).

Why- The Values: There are many players and different normative models of accountability within the health system. I have added this component to prompt questioning, understanding and transparency regarding conflicting values and decisions about which values take priority. Otherwise, values debates gets dismissed as ideology and undisclosed interests stand in the way of implementing improvements.

Figure 2, below provides a visual representation of summarized findings.

Figure 2.

Summary: What is Accountability in the Canadian Health System?



7.2 Normative Models

Three normative health system accountability models have emerged during the evolution of the concept, all of them at play within the broader political model of accountability. The historical normative model is professional. A citizen participation model was attempted in one of Canada's provinces but failed to be implemented. The managerial model is emerging across Canada as regionalization is implemented. This model has made even further inroads in other countries, especially the United States and the United Kingdom.

To further explain the primary focus, areas of consensus and conflict, the three models were compared using the concept analysis variables of antecedents, consequences, surrogate terms, related concepts, and attributes.

7.3 Policy Issues

The policy issues related to accountability concern citizen participation in what have become large complex institutions carrying out goals of government. These institutions have evolved in a modern society and do not enable direct accountability between government and citizens as was the case in simpler societies. It has become much more complex for citizens to evaluate government actions in these modern day institutions with lengthy hierarchies of command. Also, these institutions have complex lines of accountability, which make it difficult to locate accountability. Finally, individual perceptions of accountability as a desired result or outcome can complicate policy implementation.

The key health policy issues within the health system as identified by the health system leaders who were interviewed include, a lack of direction and clear roles, cultural issues, a lack of effective citizen engagement strategies, and a lack of appropriate measurement and information to evaluate organization and system performance. Despite the issues identified as problematic, most health system leaders were optimistic that health system accountability was beginning to improve and that it would continue to do so as more investments are made in information infrastructure and management.

According to a review by Queen's Health Policy Research Unit (1999), all provinces are using accountability as a guiding rule for systems management as they seek to devolve direct service delivery to regional organizations that are at arms length from government.

7.4 Implications for Future Research

Accountability within the Canadian health system has followed the evolution of accountability within public administration. Within public administration, the concept has evolved in relation to the issues of economics, politics and public administration theories (universalism, pluralism and participatory democracy). Although the theory of participatory democracy assumes effective citizen engagement strategies, this has been identified as problematic within the health system. Some countries, like Great Britain, are experimenting with strategies such as citizens juries. Research is required to determine the effectiveness of such methods and their application to service delivery within the Canadian health system.

Accountability is a complex concept with a long history and a lot of baggage.

While this dissertation unbundled and organized the contents, it identified confusion and debate about the meaning of and relationship between accountability and responsibility. This seems to be linked to the public administration debate about the role of politicians versus bureaucrats and has on-going implications for confusion in public administration practice and therefore health practice. Further research is required to continually integrate theory with practice.

Performance management was found to be a predominant defining attribute of accountability and has become the trend in public administration practice (New Public Management) and within the health system (Regionalization). The focus is on measuring the outcomes of public programs. As identified in the issues, there is insufficient information to identify what works, under what circumstances, and with what intended and unintended consequences. The costs for information infrastructure are daunting, and the complexity of the health system with its multitude of actors and audiences means any one approach will not work. This implies the need to learn through researching what is effective in other countries and employing a careful blend of approaches with complimentary effects.

There are several perspectives of accountability and likewise several normative models which imply different values. Although a democracy is about debate and the policy-makers' role is to make choices among competing values, generally, values debates get dismissed as ideology. However, values awareness and debates are necessary. Otherwise, moving forward with only one model or set of values is a bit like the three blind men feeling and describing an elephant : one only gets a partial view based on partial knowledge and experience. While the managerial model appears to

incorporate the professional and citizen participation models, this requires further research to examine success in countries where implementation is more advanced.

Accountability is a multi-level concept. It is viewed as a personal concept (subjective), when referring to accountability as a values-based or ethical construct; and as program, organizational (objective), when referring to accountability as a formal system or process. Research is required to understand what motivates personal accountability and how it aligns with program and overall system accountability.

Accountability within the health system has largely been ignored by Canadian academics and is ripe for further research. More knowledge is required on the policy problems of accountability and how other countries, especially the United Kingdom is progressing with new models and with what outcomes.

This research examines the perspectives of health system executives to clarify the concept and more fully understand policy issues. Research is also required to examine the perspectives of front line health providers, as this would be helpful in understanding the practice issues of accountability.

7.5 Conclusions and Recommendations

Until there is excellent political cooperation, and until the professions begin to realize that they have an obligation to support the system as well as defend their interests, and until system leaders become genuinely concerned about improvement - being good, not just looking good, and until we measure what is important and meaningful, not just what is readily available, and until we have created a learning culture which will replace our blame culture, I'm not optimistic that we will be able to develop an effective accountability system (2).

This interview quote from a health system leader serves as a reminder of the complexity of understanding and improving accountability within the Canadian health system. This dissertation serves to illustrate the complexity of the concept as it evolves within this system.

There is no doubt that there is a policy problem in Canadian health system accountability. Not only do present health ministers declare there to be one, but there is also concern among health professionals, administrators and the popular media. Yet, Canadian academics have largely ignored the issue of accountability in health care and so a fertile ground exists for future research.

Although the purpose of this dissertation is not to answer or provide prescriptions to the policy problems of accountability, it does raise the following health policy questions:

- 1. Are the existing modes & institutions (inclusive of processes, mechanisms) of accountability adequate to meet our current expectations?**
- 2. What are the values and principles of the system, and are Medicare principles still relevant?**
- 3. Do we want a national health system or are we satisfied with the national hospital and physician system?**
- 4. Do we want to create equal opportunity for minority groups, like First Nations to enjoy the same level of health status as other Canadians?**
- 5. How safe are, and what level of quality do we expect from, our health services?**
- 6. What is the right balance of public / private sector service delivery?**
- 7. What role should the federal and provincial governments play?**

Such policy questions are being examined presently by the Senate Social Affairs, Science and Technology Committee, which is reviewing the role of the federal government and by the Romanow Commission on the Future of Health Care. There are also numerous prescriptions being advocated by national and provincial professional, union and health associations.

The debate around these issues is partly emotional, partly rational (evidence-based) and the emotional divide is exacerbated by the lack of good evidence. My research has addressed the quantity, quality and accessibility of evidence – in short, issues of accountability – from the perspective of senior health administrators, one of the major groups of stakeholders, whose evidence-based perspectives must finally be synthesized in a solution to the policy questions. Better accountability can bring more light to the debate and therefore reduce the heat. With this in mind, the following recommendations emerge from the research.

Recommendation One: That further research is supported within the areas raised above, so that we can further understand the means to improving accountability within the Canadian health system.

Recommendation Two: That we remain ever mindful of clarifying the language of accountability during the current health policy debates. Although it is an ancient concept, it remains elusive, evocative and contentious and the potential for misguided policies and practices are high if language and communication are unclear.

Recommendation Three: That the current debate in health care provides an opportunity to address one of the key ingredients of accountability, strategic direction for the Canadian health system. If the federal and provincial governments reach consensus

on values and associated foundational principles regarding policy questions, this will provide the basis for the development of management methods to address the other key issues of accountability: culture, information management and effective citizen engagement strategies. Agreement on the fundamental ends of the health care system would make it possible for subsequent evidence-based debate to focus more on means. Such a debate is more likely to be constructive and even to find common ground.

Recommendation Four: That as we move to a new model of accountability, we remain mindful of, and retain the beneficial aspects of the current model. There are babies in the bath water.

Recommendation Five: That research on improving accountability move on from the perspectives of senior administrators to those of other stakeholders, not the least patients.

Recommendation Six: That, given the current prominence of performance measurement and the challenges of measurement in public services, we exercise caution in the development and use of measures and ensure that adopted measures meet the test of improving accountability on a sustainable basis.

7.5.1 Contribution

The goal of this dissertation is to elaborate on the imagery of accountability by utilizing a concept analysis framework, the current Canadian literature and the wisdom of Canadian health system leaders to clarify the concept and elucidate the policy issues and questions of health system accountability.

I trust that this conceptual analysis will accomplish several things. That is, it will assist to clarify our language and understanding of accountability as it continues to evolve in health care; it will provide a helpful reference point from which to discuss health system policy issues; and it will prompt further research in this area that has largely been ignored by Canadian academics. In short,

We need to get clear about the language, (so that) our intelligence is not bewitched by our language. (Hodgkinson, 1996, p. 144)

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APPENDIX C

INTERVIEW SCHEDULE

1. What do you see as the main factors behind the current interest and concern re accountability in the Canadian Health System? (context)
2. There seems to be a lot of ambiguity on what accountability means. Could you tell me about your definition or picture of accountability in the health system?
What would achieving accountability look like? (attributes of the concept)
3. What do you see as some of the necessary conditions/circumstances required before accountability can occur in the system? What stands in the way of achieving accountability ? (antecedent conditions)
4. What would be the consequences/outcomes of achieving accountability. What are the consequences of not achieving accountability? (consequences)
5. What other words or phrases have you heard used in the health sector to describe accountability? (surrogate terms)
6. What do you see as the relationship between accountability and ethics? Other concepts related to accountability? (related concepts)
7. What are the types of accountability? Which ones are key to the health system?
(references)
8. What do you see as the biggest challenges to achieving accountability? (context)
9. What are our chances of success in achieving accountability in the health system? (context)
10. Do you have any other comments on accountability that you would like to make?

APPENDIX D

CONSENT TO BE INTERVIEWED

Title: Conceptualizations of Accountability in the Canadian Health System

Student: Christine Penney, Ph.D Candidate, School of Public Administration

Advisor: Dr. James Cutt, Professor, School of Public Administration.

You have been asked to participate in a research study. Participation is entirely voluntary. You are free to refuse to answer any questions, can request any taped information to be erased or notes to be destroyed.

Purpose:

The purpose of this study is to clarify our understanding of the concept of accountability within the Canadian Health System.

Procedure:

You are being asked to participate to share your perceptions of accountability within the health system. If you consent to an interview, the interviews will last approximately one and a half hours and will be tape recorded. A time and place will be set up that is convenient for you. At the completion of the study I will provide a summary of the findings.

Risks:

There are no anticipated risks.

Potential Benefits:

You will not receive any direct benefits from participating in this study. However, it is anticipated that the results will assist in enhancing our understanding of accountability in the Canadian Health System.

Monetary Compensation:

There will be no monetary compensation for participating in this study.

Confidentiality:

Any information resulting from this study will be kept strictly confidential. All documents will be identified by only a code number and will be kept in a locked filing cabinet. The notes, audiotapes and interview transcripts will have all identifying information removed and your name will not be used in the research reports. At the end

of the study the typed transcripts will be kept by the interviewer and audiotapes will be erased.

If you have any questions or concerns you may contact Christine Penney or her dissertation supervisor, Dr J Cutt to seek further information or clarification.

I have read the above information and have had an opportunity to ask questions to help me understand what my participation will involve. I freely consent to participate in the study.

Signature of participant

Date

APPENDIX E

INTRODUCTION & REQUEST FOR PARTICIPATION

Dear

Re: Research Study

Perceptions of Accountability in the Canadian Health System

I am a doctoral student at the University of Victoria, School of Public Administration. My dissertation research seeks to clarify the concept of accountability within the Canadian Health System.

As an organization - wide decision maker of an organization that represents key players within the health system, I am interested in your views on accountability and am inviting you to participate in an interview with me. The intent of the interview is to learn about your perspectives on the meaning of accountability within the Canadian Health System. This information would be used to fill gaps and enrich my literature analysis.

If you are willing to be interviewed, the interview would last approximately one hour at your convenience and would be strictly confidential. In order to collect accurate information for analysis, I ask that you allow your interview to be tape recorded. Interview materials will be kept secured with only myself as the researcher having access.

Thank you for considering my request. Your participation will be an important contribution to helping us better understand the concept of accountability in the health field. I will be contacting you in the next two weeks to find out if you are willing to participate. In the meantime, if you have any questions, you may contact me at cpenny@caphealth.org or 658-1485. Thank you for your consideration.

Sincerely,
B. Christine Penney, Ph.D Candidate

APPENDIX F

DATA CODING FORM

- **Factors Behind Concern re Accountability**
- **Attributes**
- **Antecedents**
- **Consequences**
- **Surrogate Terms**
- **Related Concepts**
- **References**
- **Definitions**
- **Issues and concerns**

APPENDIX G

KEY LITERATURE SEARCH DATABASES

Medline (1966-present)

The US National Library of Medicine's premier bibliographic database, covering medicine, nursing, dentistry, veterinary medicine, and the preclinical sciences. Citations and abstracts from more than 3,700 journals as well as chapters and books from selected monographs. Journal articles are indexed using MeSH, a controlled vocabulary. Medline contains all citations published in Index Medicus and corresponds in part to the International Nursing Index.

HealthStar (1975-present)

The result of merging two separate National Library of Medicine databases: HSTAR and Health, produced jointly with the American Hospital Association. Includes journal articles, monographs, technical reports, meeting abstracts and papers, book chapters, government documents and newspaper articles.

Coverage includes evaluation of patient outcomes; effectiveness of procedures, programmes, products, services and processes; administration and planning of health facilities, services and staffing; health insurance; health policy; health economics and financial management; laws and regulations; personnel administration; quality assurance; licensure and accreditation.

CINAHL (1983-present)

Nursing and Allied Health Literature. Primarily journal articles; some coverage of healthcare books, nursing dissertations, selected conference proceedings, standards of professional practice. Equivalent to Cumulative Index to Nursing and Allied Health Literature. Covers all English language nursing journals and the primary journals in 13 allied health disciplines, consumer health and health sciences librarianship. Selective coverage of journals in biomedical, behavioral sciences, management sciences, management, and education.

Canadian Business and Current Affairs

Citations to articles in more than 200 Canadian Trade and business journals; 350 popular, special interest and academic journals. The database corresponds, in part, to the print publications: Canadian Business Index 1982-1992, Canadian News Index 1982-1992, Bibliography of Works on Canadian Foreign Relations 1982-1991 and Canadian Index 1993 to date.

Dissertation Abstracts

Contains bibliographical citations with abstracts (since 1980) to doctoral dissertations, and citations with abstracts (since 1988) to masters thesis, completed at accredited North American colleges and universities as well as 200 institutions worldwide, in all subject areas.

Appendix H

Literature Sample

Policy/Administration

Alberta Health. (1997). *Achieving accountability in Alberta's health system. A draft for discussion*. Edmonton, AB: Author.

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