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Redefining Accountability in the Healthcare Sector

By Bruce Harber & Ted Ball

Accountability is a word that is loaded with meanings that strike fear in the heart and soul of our healthcare system. That's because it has come to mean: "Who is to blame?" And, "How should they be punished?" So why are we surprised when the outcome of this approach is blame-avoidance, blame-shifting, cover-ups, in-fighting, defensive behaviours, anti-learning dynamics and the cause of even further dysfunction in a health system that has already been diagnosed as being among "the least healthy work environments in the country"?

Our bottom-line message in this essay is: the concept, and the process of accountability, needs to be fundamentally redefined within the public sector – from top to bottom.

Our First Ministers chose to make Roy Romanow's recommendations to improve accountability within the health system mean: "Who is in charge?"

Within the traditional political dynamics of our federal system, the issue has become: Who gets to blame whom – when funds earmarked for diagnostic equipment are used to buy a lawn-mower?

Some of the key questions that arise when the issues are framed this way are: How can the federal government punish the province that allowed such a mistake to occur? How can the province punish the offending hospital? How can the hospital board punish its CEO? And, how can the CEO punish the person who actually made the mistake?

We already know the unintended consequences of these types of systems, structures and processes. The whole focus is on blame and blame-avoidance – rather than on accountability for achieving measurable outcomes that may be perfectly reasonable and very desirable.

Accountability is very different than blaming – which means "to find fault with, to censure, revile, reproach." Blaming is an emotional process that seeks to discredit the blamed. But when people work in an atmosphere of blame, they naturally engage in defensive routines – covering up their errors and hiding the real issues that need to be addressed – if the performance of our health system is to actually improve over the next few years.

When our energies are focused on finger-pointing, scapegoating and denying responsibility, the effectiveness of our entire healthcare system – and the organizations and people who work in it – suffers.

Marilyn Paul, a scholar in the field of organizational accountability, says that a blaming culture causes organizations to become dysfunctional because "where there is blame, open minds close, inquiry tends to cease, and the desire to understand the whole problem diminishes."

Blame vs. Accountability

Within the healthcare delivery system, our existing blaming culture generates fear and destroys trust. When we blame, we attempt to prove that others must have had bad intentions, or lack ability. The qualities of

blame are “judgment, anger, fear, punishment and self-righteousness,” according to Paul.

In contrast, accountability emphasizes keeping agreements and performing tasks in a respectful manner. It is all about learning, truth and continuous improvement. Is that not what we really need in our healthcare system today? Are we now ready to learn from our past mistakes? Are we really prepared to change?

It was 15 years ago when the healthcare system flirted with techniques and processes for Total Quality Management and Continuous Quality Improvement (TQM/CQI). We learned back then about W. Edwards Deming’s “93% vs. 7% rule.”

Deming taught us the wisdom of his 60 years’ experience working with organizations that were seeking to improve their performance. He said that 93% of the time, problems in the organizations and systems that he dealt with could be traced back to the design of the systems, structures and processes. He said that only 7% of the time were the problems caused by people – and in half of those cases where there was a “people problem,” the root cause was actually inadequate training or skills.

So, if we already know that most of our problems flow from design flaws in our existing systems and processes, why do we continue to cling to our ingrained habit of “blaming people” in our accountability processes?

It may be too late for the Premiers and the Health Ministers to shift from their traditional political strategy of blaming the federal government, but it is not too late to shift course when it comes to defining the word “accountability” – in respect to the relationships between provincial Ministries of Health and the agencies and institutions that they fund in each province; the relationship between Boards and their CEOs; and between the CEOs and their managers.

Experts like Marilyn Paul advise us that “a focus on accountability recognizes that everyone may make mistakes or fall short of commitments. Becoming aware of our own errors or shortfalls, and viewing them as opportunities for learning and growth, enables us to be more successful in the future.”

Errors, shortfalls and mistakes can of course take place at any point in the system: how provincial public servants designed a particular policy or program; how operational managers implemented a program; how teams of health professionals were organized within systems, structures and processes to deliver the services; or, whether or not service provider organizations are aligned at the service delivery level.

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Paul says that “accountability creates conditions for ongoing constructive conversations in which our awareness of current reality is sharpened, and in which we work to seek root causes, understand the system better and identify new actions.” She lists the true qualities of accountability as “respect, trust, inquiry, moderation, curiosity and mutuality.”

Best practices teach us that “mutuality” is a key success factor in accountability processes that work. But that would require a significant paradigm shift for a healthcare system that is currently rooted in hierarchical command-and-control systems, structures, processes and leadership styles.

Are we now ready for such a mindset shift?

Illusion of Control

The truth is that our health system is still addicted to the mental blinder that Peter Senge calls “the illusion of control.” Having an illusion of control does not mean we actually have any real control over the results we are producing.

In British Columbia, reducing the number of health authorities from 52 to 6 does not mean that the BC Ministries of Health actually have better “control” over the quality and effectiveness of healthcare delivery in that province.

Structural “quick fixes” like the Regional Health Authority Model do not, by themselves, improve quality and effectiveness – indeed, by themselves, simple structural solutions like Health Authorities, mergers and networks can sometimes lead to a reduction in quality and effectiveness. Having fewer Boards does not change much on the front lines of care delivery – where the real outcomes of the healthcare system must be achieved!

Across the country, public servants – few of whom have any practical operating experience in complex service delivery organizations – are being assigned the task of drafting or redrafting “Performance Agreements” that in many cases seek to “micromanage” and “control” healthcare agencies and institutions – in a belief that a centralized approach will make healthcare provider organizations “more accountable.”

Our intentionally provocative question is: Are we doomed to continue to repeat the mistakes of the past – or, are we ready to fundamentally rethink how accountability is actually designed into our systems and processes?

Are provincial politicians and their public servants prepared to give up the illusion of control? And are local Boards and CEOs ready to accept their accountability for achieving measurable and agreed-upon high-level outcomes?

Six Principles for Accountability

As an authors’ team, we have had extensive dialogues on what we have learned from our respective experiences in linking accountability with an organization’s *Balanced Scorecard*. From the available research, and from our own reflections and experience, we suggest six key principles that we think should be embedded in a new accountability system.

1. You can’t be accountable for anything over which you have no control.

A best practice Accountability Agreement must be a fair business bargain. It is a personal promise to achieve measurable results. But people can’t keep their promises if circumstances beyond their control change.

That makes sense, doesn’t it? If a CEO is being held accountable for improving staff/physician moral, and the provincial government is engaged in highly emotional disputes with unions and physician organizations, how can the CEO be held accountable for the results that such an atmosphere will produce?

However, CEOs should certainly be accountable for demonstrating improved outcomes with their own organizations’ unions, staff and physicians that they are able to attain from the processes that they put in place to achieve measurable results locally.

If a manager is being held accountable for an outcome that can only be achieved if a certain barrier is removed – such as the lack of a skills development program, or the lack of equipment or technology – and nobody removes the barrier, why should that manager be considered accountable? How can a manager possibly deliver on that promise if he or she is not given the support required to succeed?

Best practice Accountability Agreements list the “supports required” to achieve the outcomes for which a person is willingly accountable. If people don’t get the support they need, they can’t be held accountable. It’s that simple.

That’s where this concept of mutual accountabilities comes into play.

At the operating level, a manager with an Accountability Agreement must be able to hold his or her boss accountable for providing the supports they mutually agree are required to achieve their outcomes. An Accountability Agreement is therefore a tool for people to mobilize the support they need to make them successful. It's a manager's best friend, not a worst enemy! When we redefine accountability, we'll end the "blame game" – and shift our cultures towards the way true *learning organizations* think and behave.

Between the provincial governments and the agencies and institutions they fund, there also needs to be an explicit and "fair business bargain." What are the high-level outcomes or results that the province will hold a Board accountable for, and what supports from the province can a Board hold its Ministry of Health accountable for providing?

While many would accept that such thinking is perfectly reasonable and fair, our traditional cultures in hospitals, health agencies and provincial Ministries of Health are still very much stuck in the "blame game." It is ingrained in our culture – how we think and behave.

Our second key principle for best practice approaches to accountability:

2. Accountability for outcomes means that activities/efforts and processes are not enough.

Think of the mindset shift required here. Our healthcare system is characterized by a complex set of rigid bureaucratic processes designed in separate silos holding different assumptions. Unfortunately, bureaucratic processes create jobs with turf boundaries to protect – at the operating level of the system, and between the public servants and the organizations that receive funding.

It also creates turf boundaries between service providers and the separate silos within each Ministry of Health. The truth is that our fragmented healthcare system is the product of isolated silos within our Health Ministries. At the moment, fragmentation is designed into the system.

The real focus of the existing system is on the rules, regulations and bureaucratic processes – not on achieving outcomes. Should we not be accountable for achieving measurable results from the next \$27 billion that our health system is expecting to receive from the federal government over the next five years?

Best practices would suggest that holding people accountable should be done only in the context of clearly defined outcomes or results. These outcomes must be understood and adjusted regularly to reflect new realities as they emerge in a constantly changing and chaotic environment.

Not only must everyone understand what is expected of them and why; they must also have the necessary resources, conditions and skills to achieve the outcomes for which they are being held accountable. Is that not a reasonable "fair business bargain"?

In a best practice accountability process, no one is given points for "following the process." The only thing that counts is getting the results. If the process design does not produce the results required, we need to change the process. Better yet, we need to design processes that are focused on achieving the results that are required – right from the start!

So let's start now, by honestly reflecting on the unintended consequences of the way we currently define and practise accountability in the healthcare system – and in the public sector generally.

A new blockbuster report on reforming the federal public service was tabled in Parliament in February. It observes that "when the accountability framework tells managers that 'keeping the Minister out of hot water' is more important than delivering results to citizens and taxpayers, we've got a serious problem."

The report deals openly and honestly with the mindset that has evolved in the public sector where "any public servants who are entrepreneurial and bottom-line oriented are viewed as loose cannons in the eyes of the system – even when they produce results."

Control processes, rather than a results-orientation, are what are important from the traditional bureaucratic perspective.

We urge public servants who are currently designing "Performance Agreements" for the health agencies and institutions that receive public funding to re-examine some of the core assumptions behind the design of such agreements.

Is the accountability process really designed to achieve the outcomes that we all want to achieve? Or, are the processes designed to exert "control" by the public service, and to ensure that blame can be placed elsewhere?

Are the folks who are designing these agreements designing an instrument and a process that assumes all institutions, agencies and communities are the same? Are they really the same?

And here is the important policy question: Do the Performance Agreements now being developed within the centralized bureaucracies in each province actually replace the role of community governance – the essential function of which is to reflect the unique needs of the population that they serve?

Another wicked question: Is there a danger that such “agreements” become the CEO’s real boss – leaving the Board to play the role of observer and interim monitor?

The fundamental policy question is: Is there really a system for independent community governance, or is the public service in our provincial capitals in charge? “Accountable to Bureaucrat x14,” as Ontario’s former Health Minister, Tony Clement, described such a regime by faceless bureaucrats.

At the operating level of our healthcare system, we need to ask ourselves: What are we in management and governance going to do to provide the practical supports required to make our people successful? Are our existing internally designed systems, structures and processes for accountability a major part of the problem? And if they are, are we going to redesign them now – before we begin spending all the new money?

In the last round of macro healthcare politics in Canada, our system “won” \$22 billion in net new federal funding – which we are still absorbing without achieving any significant improvements to the system!

How about this next cash infusion of an additional \$27 billion? How will we focus this time on achieving measurable improvements for the net new funding we receive? Or, are we about to repeat the same patterns? And will we keep repeating the pattern until our health systems consume 100% of the provincial budgets?

The leadership of the Canadian healthcare system has argued very publicly over the past 10 years that our sector’s root problem was “a lack of funds.”

Now that we have an additional \$49 billion in federal funding, will we achieve better outcomes through a redesigned system, or will we sink the new money into the exact same system and start another campaign to complain that we still don’t have enough money?

In our view, a system that is focused on “accountability for outcomes” would have the best chance of finally shifting our traditional pattern of spending more and more resources to produce poorer results.

The third principle:

3. Accountability for results requires real empowerment and room for personal discretion and judgment.

This principle would require another paradigm shift for the health sector: the principle is about the reality of balancing empowerment and accountability. Not the empty rhetoric that has contributed to the growing cynicism of our front-line healthcare providers, but real empowerment.

While the healthcare sector is clearly part of the knowledge economy, many of us continue to live with industrial-age assumptions about the “need for command and control.” The assumption in other modern knowledge-based industries that rely on skilled professionals is that the solutions to their most complex and perplexing problems are within the hearts and minds of the people who work in the system.

Smart organizations that are thriving in the knowledge economy invest between 1% and 5% of their payroll budgets on developing the skills of their people to work in high-performance teams solving organizational problems and dilemmas by tapping into the collective intelligence of the people in their system.

Is our healthcare system now prepared to invest in its own IQ? Could we even get to investing 1% of our budgets on developing the internal capacity of our people in management and on the front line to work synergistically together to achieve the outcomes that we all ought to be accountable for achieving?

Are we prepared – at the governmental, Board and managerial levels – to replace the rhetoric about being “learning organizations” with the reality of learning organizations – by having a real balance of empowerment and accountability, and by investing in the skills of our people?

The fourth best practice principle of accountability design is:

4. Accountability must be dynamic: outcomes and targets change as circumstances change.

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While most people would agree that this principle seems perfectly reasonable, the existing rigid bureaucratic culture of healthcare – from the Premiers on down to the front-line nurse – is about inflexibility.

In the existing system, we are given every incentive to focus on the process, rather than the outcomes. We tell our people that we should “learn from our best mistakes,” and then maintain the same old systems, structures and process that account for 93% of the reasons why our results are sub-optimal!

Deming told us: “First, drive out fear.” Yet fear and anxiety are the dominant emotions that drive our healthcare system today.

Best practice Accountability Agreements are flexible. When circumstances change, accountabilities change. The focus is on what needs to be done to ensure that a person is successful.

That is how learning organizations function. The bosses are “in service to” rather than “in control of” those who work for them. As circumstances change, sometimes it is possible to achieve gains that are double the original target. Sometimes the circumstances that emerge require downsizing the target, or even shifting the goal altogether.

The fifth key principle for accountability system design is:

5. Accountability and stewardship for the organization belongs to every employee.

Management guru Tom Peters has said healthcare systems, structures and processes are the most complex organizational designs ever conceived by humans. But most of our core design assumptions are rooted in the old industrial model.

Systems thinking, chaos theory and quantum physics have all contributed greatly to our emerging understanding of the healthcare sector as a complex adaptive system. Each part of the system has an impact on the performance of the other parts of the system. We know that.

When there are insufficient home care services within a community, elderly people get trapped in acute care beds – and then we get back-ups in our emergency departments. When that happens, the resulting headlines seem to compel many politicians to invest even more money in emergency services, rather than in the root cause of the key system design problem: an underinvestment in community care.

Despite the fact that all parts of the healthcare system are interconnected, we've organized ourselves into rigid silos and departments that we attempt to “manage” through traditional bureaucratic control mechanisms – by which we solve issues within each silo – often without any apparent concern about its impact on the other parts of the system.

Best practice accountability processes include integrating the agreements cross-functionally – across the organization, and across the system. That way, people truly understand how their actions affect others, and why we need to ensure that we are working synergistically within our organizations and with all parts of the system.

The sixth and final principle that we propose for designing accountability systems is:

6. Accountability is meaningless without fair and appropriate consequences.

For all the fear and anxiety that our existing hierarchical, command-and-control accountability processes produce in people, the truth is that there really isn't much of a focus on the consequences – just the “threat” that maybe something bad could happen.

A province could theoretically face a tiny reduction in its federal transfer payment; a provincial Ministry of Health might experience a few days of bad press; the members of a Community Board of Governors might have some discomfort explaining to their neighbours how a decision they made in the interests of their silo resulted in harm to the rest of the community; or a manager at the service delivery level might experience some embarrassment over the results that were produced.

In their book, *Accountability: Getting a Grip on Results*, authors Klatt, Murphy and Irvine state: “Accountability is not about assigning after-the-fact blame. Rather, it's about providing before-the-fact incentive for success, and room for decision-making, risk-taking and growth.” They further state that “consequences may be positive or negative, but either way they need to be fair. They are not punishing or underhanded. Finding out what went wrong in a situation is essential for preventing the recurrence of problems.”

But for the most part, there are not many real “consequences.” That's why in the past we could go off to our annual Board and staff retreats and generate our mission, vision, values and strategic directions – and then promptly forget all about them.

Let's be open and honest about this: the annual events that generated these types of “lists” did not affect what we did every day. Our focus is mostly on managing the crisis “du jour.” And we keep repeating the same old patterns – exhausting the system and never learning from our best mistakes.

In a best practice accountability development process, managers throughout an organization think through the outcomes in their organization's Balanced Scorecard that they should be accountable for; the supports they need to be successful; and the consequences for their organization, their unit and themselves should they fail – or surpass the agreed-upon targets.

When these processes are truly designed with a learning and continuous improvement focus, they work. They don't work in anti-learning environments.

The Burning Platform

At the top of our healthcare system's hierarchy there is very little understanding of the “lessons” we have already learned over the past 10 years of downsizing, mergers, restructuring and reengineering. The lifespan of Ministers of Health and their Deputies is about 18 to 24 months in many provinces. So there is little or no historical memory!

Today, at the system delivery level, we have confused Board Members – uncertain of their role or how they are supposed to “hold their CEO and Chief of Staff” accountable for the outcomes/results that the Board wants to achieve on behalf of the community and in the broader public interest.

Among the questions: Is it the role of the Board simply to monitor what someone in the provincial capital has decided is important? How do we integrate the high-level outcomes required by the provincial government with the outcomes that reflect the Board's understanding of the unique needs of its community?

If our healthcare system is to improve, managers must have some clarity on the expectations of the system funders and of their direct boss, their Board.

At the managerial level, we often have blame-avoidance behaviours in a constantly changing, chaotic environment – paradoxically charged with copious amounts of absolute certainty and complete ambiguity. Is it any wonder that all this is a bit “crazy-making”?

At the front line of the healthcare delivery system, we have created working conditions that are, by any measure, intolerable. And yet we must continue to coax every last remaining ounce of compassion, care, commitment and love from our front-line people.

We need to think about how we are finally going to provide some “care” to our caregivers. This is our real burning platform: the collapsing quality-of-worklife of

our front-line workers! But we cannot continue on this burning platform any longer – which means that the status quo on accountability cannot survive, if we intend to succeed.

Prescription for Change

So how are we going to change the way in which we define and practise “accountability”? Here are our suggestions:

1. Ministers of Health need to reflect upon how we currently practise accountability and acknowledge that their officials are in no position to “assume control” by holding senior managers of healthcare organizations accountable to them. It would make much more sense to develop high-level outcomes for each sector – hospitals, home care services, public health departments, etc. – and hold the Governing Boards accountable.

2. Governing Boards need to think deeply about the needs of their communities – and the broader public interest – and work in partnership with their CEOs and their senior managers on the vision for the organization within their local system, and the outcomes they are seeking to achieve within their local healthcare delivery system. Boards need to understand how they can hold their CEO and Chief of Staff accountable for agreed-upon outcomes – with policy governance monitoring processes that enable them to add value.

3. CEOs and their Senior Management Teams need to spend at least a year with their middle managers and supervisors in aligning their strategy. From our experience of leading and facilitating several Balanced Scorecard strategy development processes in Ontario, British Columbia and the United States, we recommend this best practice approach to getting an organization aligned and focused on its strategy. But this means giving CEOs and their management teams some “space” to think and reflect on how they are going to achieve their goals – something they don’t normally have time for when they spend enormous amounts of time responding to the crisis “du jour” – often created

by well-meaning provincial civil servants and their ministers who regularly hijack entire management teams.

4. Senior Management Teams and their CEOs also need to think about how they currently define and practise “accountability” in their organizations.

We need to ask ourselves: Do we really balance empowerment and accountability? Do we really focus our efforts on ensuring that people have the supports they need to be successful? Or, is what we are currently doing really a “hierarchy of blame” that is contributing to the environment of fear and anxiety? Healthcare managers need to learn how to tap into the collective intelligence of their organization – so that they benefit from the knowledge and commitment of front-line workers.

5. Health System leaders in government, management and local governance need to be much more open to learning, and much better prepared to be innovative and more collaborative. Because every organization is different, healthcare leaders must resist simply adopting a model or template. We must be prepared to innovate and customize.

In closing, we urge that we all remember the burning platform we are standing on. Let’s ask ourselves: If we absorb another \$27 billion in federal funding over the next few years, will the new money put the fire out, or make it hotter?

We believe that it will be hotter – if we don’t redefine “accountability” and design ourselves to be successful.

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