

HEALTHCARE

POLICY

Politiques de Santé

*Health Services, Management and Policy Research
Services de santé, gestion et recherche de politique*

Volume 10 ♦ Special Issue

Approaches to Accountability

Démarches de l'obligation de rendre compte

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POLICY

Politiques de Santé

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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision-making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision-makers.

We publish original scholarly and research papers that support health policy development and decision-making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision-makers or researcher–decision-maker collaborations that address knowledge application and exchange.

While *Healthcare Policy/Politiques de Santé* encourages submissions that are theoretically grounded and methodologically innovative, we emphasize applied research rather than theoretical work and methods development. The journal maintains a distinctly Canadian flavour by focusing on Canadian health services and policy issues. We also publish research and analysis involving international comparisons or set in other jurisdictions that are relevant to the Canadian context.

Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

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Accountability in Healthcare Organizations and Systems

ALL DEBATES ABOUT THE WAY TO IMPROVE THE QUALITY AND SAFETY OF CARE, the control of costs or the health of the population, raise the issue of accountability. Behind this notion, there is the idea that healthcare systems have an unexploited margin for improvement if they better align the utilization of resources with what is known about the appropriateness and effectiveness of care (Maynard 2013). The common understanding of accountability is one in which a governing body (e.g., government, regional health authority, healthcare board, professional association) is in a position to mandate providers or organizations to meet certain goals or objectives. Because of the authority or legitimacy of these governing bodies, providers or organizations believe they must account for their achievements in relation to such goals or objectives. The relationship between these two sides of the accountability equation is not necessarily hierarchical – at least in principle (Saltman and Ferroussier-Davis 2000). An accountability relationship can be based on a dialogue where providers or organizations argue with governing bodies about their relative achievement of pre-defined goals. Even the definition of goals and objectives can be made through a collaborative process between governing bodies and concerned providers or organizations. That is, in brief, the notion of accountability does not have to be reduced to the application of formal controls on one's own activities or behaviours.

Despite variations in approaches to accountability, an accountability regime will always be based on three elements: a clear definition of desirable goals or objectives (the object of accountability), the ability to measure and monitor goal achievement and a set of consequences for providers or organizations if achievements regarding goals or objectives are not satisfactory. Defining goals and objectives in healthcare is not easy, and is contested terrain. Quantitative targets for volume of care say nothing about quality of care or patient experience. Targets around the delivery of care may have only tenuous or very indirect linkage with the improvement of the health and well-being of a population. Monitoring the process or the outcomes of care requires proper, adequate and on-time information if the objective is to provide useful feedback to providers of care and services. The consequences of performance failure by providers can be more or less coercive. An organization can face budgetary cutbacks following poor performance, but may also receive support to develop capacities to improve. While accountability is a key element in improving the governance and management of healthcare organizations and systems, an accountability relationship can be developed with a concern for learning and improvement beyond control and sanctions.

Accountability regimes in healthcare systems thus face numerous challenges relating to the definition of a clear mandate in the form of specific goals and objectives, to the attribution of these mandates to skillful providers or organizations and to the design of incentives to support the accountability relationship and improvement. The goals are related to the complex function of production (integration of care, caring for multi-morbidity chronic diseases, improving the health of the population), and they will command a broad set of competencies and knowledge on the part of governing bodies and providers, plus an ability to collaborate for the improvement of care and services.

While accountability is challenging and critical to the improvement of health systems (at least within the context of the Canadian healthcare system), we do not have much systematic research dealing with this issue. In this special issue of *Healthcare Policy/Politiques de Santé*, a research program under the leadership of Professor Raisa B. Deber (University of Toronto) has documented how accountability is structured within various sectors and organizations in the Ontario healthcare system. This collection of papers is very valuable because it is the first one that provides a detailed description of how accountability regimes are developed and structured across the system (e.g., the hospital sector, the long-term care sector and public health). Beyond the richness of the description of the accountability landscape in the Ontario healthcare system, this set of papers raises important issues around the theme of accountability. First, it shows that accountability is still in its infancy – not because providers or organizations do not want to be accountable or that governing bodies do not want to make them accountable, but because identifying the right targets and establishing the right mechanisms to account for the utilization of healthcare resources is a complex task. Second, these papers deal mostly with accountability regimes within the current boundaries of the system with its silos. It says almost nothing about the challenges and promises of developing accountability regimes within the context of networks or programs that transcend current professional or organizational boundaries. Finally, this collection of papers refers only marginally to the question of financial incentives, which seem to be a key lever that governing bodies use to influence the behaviours of healthcare providers and their propensity to take some goals or objectives more seriously.

Having said this, the research team has done a great job based on a single research grant to produce an exhaustive mapping of how the notion of accountability is deployed across the Ontario healthcare system. This is of interest for researchers, but also for any observers of the healthcare scene across Canada, where each system faces the challenge of better aligning the utilization of resources with broad system goals commonly defined now as the Triple Aim: better quality of care, better safety of care and better health outcomes at a minimal cost.

JEAN-LOUIS DENIS, PHD

Guest Editor

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L'obligation de rendre compte dans les organisations et systèmes de santé

TOUT DÉBAT SUR L'AMÉLIORATION DE LA QUALITÉ ET DE LA SÉCURITÉ DES SOINS, SUR LE contrôle des coûts ou sur la santé de la population soulève la question de l'obligation de rendre compte. Derrière cette notion se trouve l'idée qu'il est possible d'améliorer les systèmes de santé si on exploite les ressources en tenant compte des connaissances acquises en matière de pertinence et d'efficacité des soins (Maynard 2013). La notion d'obligation redditionnelle repose habituellement sur l'idée qu'une instance dirigeante (par exemple, le gouvernement, une autorité régionale de la santé, un conseil de la santé ou une association professionnelle) peut imposer certains buts et objectifs à des prestataires de services ou à des organismes de santé. En raison de l'autorité ou de la légitimité de ces instances, les prestataires et organismes se sentent obligés de rendre compte de leurs accomplissements en fonction des buts et objectifs prescrits. La relation entre ces deux éléments de l'équation redditionnelle n'est pas nécessairement hiérarchique, du moins en principe (Saltman et Ferroussier-Davis 2000). La relation redditionnelle peut reposer sur un dialogue dans lequel les prestataires ou organismes discutent avec les instances dirigeantes au sujet d'objectifs prédéfinis. La définition des buts et objectifs peut se faire grâce à un processus collaboratif entre les instances et les prestataires ou organismes visés. C'est-à-dire, en somme, que la notion d'obligation redditionnelle n'est pas réduite à la simple application de contrôles formels sur les activités ou les comportements.

Malgré la variation dans les démarches visant l'obligation de rendre compte, un cadre redditionnel repose toujours sur trois éléments : une définition claire des buts et objectifs souhaités (l'objet de l'obligation redditionnelle), la capacité de mesurer et de surveiller l'atteinte des buts et un ensemble de sanctions pour les prestataires ou organismes qui échouent dans l'atteinte des buts et objectifs. Définir les buts et objectifs n'est pas chose facile dans le contexte des services de santé, et l'exercice est propice aux différends. Les cibles quantitatives pour le volume de soins ne renseignent pas beaucoup sur la qualité des soins ou l'expérience des patients. Les cibles qui touchent à la prestation des soins peuvent n'avoir que quelques liens timides ou indirects avec l'amélioration de la santé et du bien-être d'une population. La surveillance des processus ou des résultats en santé demande une information précise, adéquate et opportune si l'on souhaite offrir une rétroaction utile aux prestataires de soins et de services. Le mauvais rendement de la part d'un prestataire peut donner lieu à des sanctions plus ou moins coercitives. Par exemple, une organisation pourrait devoir faire face à des restrictions budgétaires suite à un faible rendement, mais elle pourrait aussi recevoir le soutien nécessaire pour développer ses capacités d'amélioration. Bien que l'obligation de rendre compte soit un élément clé pour une amélioration de la gouvernance et de la gestion des organismes ou systèmes de santé, on peut développer la relation redditionnelle en misant sur l'apprentissage et sur une amélioration au-delà des contrôles et des sanctions.

Les cadres redditionnels dans les systèmes de santé font donc face à de nombreux défis quant à la définition de mandats clairs étayés par des buts et des objectifs précis, quant à l'attribution de mandats à des prestataires ou organismes compétents et quant à la conception de mesures incitatives pour appuyer la relation redditionnelle et favoriser l'amélioration. Les buts touchent à une fonction de production complexe (intégration des soins, prise en charge de maladies chroniques avec multimorbidité, amélioration de la santé de la population) et demandent un ensemble de compétences et de connaissances de la part des instances dirigeantes comme des prestataires, en plus d'une habileté de collaboration pour l'amélioration des soins et services.

Alors que l'obligation de rendre compte est un élément essentiel pour l'amélioration des systèmes de santé (du moins, dans le contexte canadien), il existe peu de recherche systématique sur le sujet. Dans ce numéro spécial de *Politiques de Santé/Healthcare Policy*, un projet de recherche dirigé par Professeur Raisa B. Deber (Université de Toronto) présente la structure de l'obligation de rendre compte dans divers secteurs et organismes du système de santé en Ontario. Cette série d'articles est très utile puisque c'est la première fois qu'on présente une description détaillée du développement et de la structure des cadres redditionnels dans ce système de santé (notamment, le secteur hospitalier, le secteur des soins de longue durée et la santé publique). Au-delà de la richesse de cette description du panorama redditionnel dans le système de santé ontarien, les articles soulèvent d'importantes questions quant à l'obligation de rendre compte. Premièrement, on y voit que l'obligation de rendre compte en est encore à ses premiers balbutiements – non pas parce que les prestataires et organismes veulent s'y soustraire ou que les instances ne souhaitent pas les rendre responsables, mais bien parce qu'il est extrêmement complexe de définir les bonnes cibles et de mettre en place les mécanismes adéquats pour rendre compte de l'utilisation des ressources en santé. Deuxièmement, la plupart des articles portent sur les cadres redditionnels présents dans les limites actuelles du système, avec les cloisonnements qui s'y trouvent. On y retrouve encore peu de données sur les défis et promesses liés à la mise en place de cadres redditionnels dans le contexte de réseaux ou de programmes qui transcendent les limites professionnelles et organisationnelles actuelles. Finalement, les articles font peu référence à la question des mesures d'incitation financière employées par les instances dirigeantes pour influencer le comportement des prestataires de services de santé ou pour agir sur leur disposition à prendre plus au sérieux certains objectifs.

Cela dit, l'équipe de recherche a effectué un travail formidable, avec cette unique subvention de recherche, en produisant un tableau complet de l'état actuel du concept de l'obligation redditionnelle dans le système de santé ontarien. Cela intéressera les chercheurs, mais aussi tout observateur du milieu des services de santé au Canada, où chaque système fait face au défi d'une meilleure harmonisation entre l'utilisation des ressources et les grands objectifs du système, habituellement désignés comme le triple objectif : une meilleure qualité des soins, une meilleure sécurité des soins et de meilleurs résultats pour la santé à moindre coût.

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Thinking about Accountability

Réflexion sur l'obligation de rendre compte



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Abstract

Accountability is a key component of healthcare reforms, in Canada and internationally, but there is increasing recognition that one size does not fit all. A more nuanced understanding begins with clarifying what is meant by accountability, including specifying for what, by whom, to whom and how.

These papers arise from a Partnership for Health System Improvement (PHSI), funded by the Canadian Institutes of Health Research (CIHR), on approaches to accountability that examined accountability across multiple healthcare subsectors in Ontario. The partnership features collaboration among an interdisciplinary team, working with senior policy makers, to clarify what is known about best practices to achieve accountability under various circumstances. This paper presents our conceptual framework. It examines potential approaches (policy instruments) and postulates that their outcomes may vary by subsector depending upon (a) the policy goals being pursued, (b) governance/ownership structures and relationships and (c) the types of goods and services being delivered, and their production characteristics (e.g., contestability, measurability and complexity).

Résumé

L'obligation de rendre compte est une composante clé des réformes des services de santé au Canada comme à l'étranger, mais on se rend de plus en plus compte que le même moule ne fonctionne pas pour tous. Il est possible d'en avoir une compréhension plus nuancée en clarifiant sa définition et en précisant ce sur quoi elle doit porter, par qui elle doit être faite, envers qui et comment.

Ces articles sont le fruit d'un partenariat pour l'amélioration du système de santé (PASS), financé par les Instituts de recherche en santé du Canada (IRSC), qui examine les mécanismes de l'obligation de rendre compte dans plusieurs sous-secteurs des services de santé en Ontario. Dans le cadre de ce partenariat, une équipe interdisciplinaire travaille avec des responsables de politiques pour mieux comprendre les pratiques exemplaires de l'obligation de rendre compte dans divers contextes. Cet article présente notre cadre conceptuel. On y examine diverses démarches (instruments de politique) et on présuppose que leurs résultats varient selon les sous-secteurs en fonction (a) des objectifs visés par la politique, (b) des structures et relations de gouvernance/appartenance et (c) du type de biens et services fournis, ainsi que des caractéristiques de leur prestation (par exemple, l'optionnalité, la mesurabilité et la complexité).



ACCOUNTABILITY IS A KEY COMPONENT OF MANY CURRENT HEALTHCARE REFORM efforts, both in Canada and internationally (Canadian Healthcare Association 2001; Leo and Canadian Healthcare Association 2006; Marchildon 2013). But there is increasing recognition that one size does not fit all, and that it is important to “unpack” the concept and to clarify both what the term accountability means, and which approaches to achieving it might work where. As Brown and colleagues (2006) have noted, “strengthening accountability is central to the recommendations made in all recent studies on the future of health care.” Yet there is insufficient information about best practices, and a sense that badly designed or implemented approaches may have unintended negative consequences.

This paper presents the conceptual framework that has guided the research reported in this Special Issue of *Healthcare Policy/Politiques de Santé*. The research emerged from a Partnership for Health System Improvement (PHSI), funded by the Canadian Institutes of Health Research (CIHR), on approaches to accountability (see also <http://www.approachestoaccountability.ca>). We use the term “approaches” to refer to the “big picture” that includes such elements as *how* (the instruments, tools or mechanisms being employed), *to whom* these elements apply, and the consequences of success or failure. The full project features collaboration among an interdisciplinary team, working in partnership with senior policy makers across multiple healthcare subsectors, to clarify what is known about best practices to achieve accountability under various circumstances. The research design has employed a series of case studies, using a common data collection template, to allow comparison across subsec-

tors and across jurisdictions, to ascertain the impact of three categories of key independent variables – goals, governance/ownership and services provided – on how accountability is defined and the advantages and disadvantages of the possible approaches.

The Policy Issue

Accountability has multiple definitions (Mulgan 2000). Most simply, it means having to be answerable to someone, for meeting defined objectives (Emanuel and Emanuel 1996). This can be done in a variety of ways, using a variety of policy instruments. In practice, however, accountability has often proven difficult to achieve, and there are lurking suspicions that approaches suitable under certain circumstances may be suboptimal or counterproductive in other settings. Clarification about the best ways to achieve accountability has been identified as a major priority by governments, providers and recipients of healthcare services, both in Canada and internationally.

The literature suggests that accountability has financial, performance and political/democratic dimensions (Brinkerhoff 2004) and can be *ex ante* or *ex post*. Within healthcare, these three dimensions may translate into fiscal accountability to payers, clinical accountability to a variety of actors for quality of care (Dobrow et al. 2008) and accountability to the public. The actors involved may include various combinations of providers (public and private), patients/service recipients, payers (including insurers and the legislative and executive branches of government) and regulators (governmental, professional) who are connected in various ways (Shortt and Macdonald 2002). The ways to establish and enforce accountability are similarly varied. A more nuanced understanding necessarily begins with clarifying what is meant by accountability, including specifying for what, by whom, to whom and how. A related set of concepts are linked to rewards and punishments, including what happens when outcomes are not achieved. Under those circumstances, being answerable may translate into efforts to censure, shame and blame those who are seen as “accountable” for the failure. In these studies, we concentrate on the potential consequences (both intended and unintended) of using various approaches to ensure that goals are met and performance is being improved.

We accordingly constructed an analytical framework drawing from several literatures that have not previously, to our knowledge, been used to analyze the factors affecting the strengths and weaknesses of various approaches to accountability. Rather than focus on “models” that attempt to force an intrinsically variable concept into boxes, we instead focused on dimensions that might affect performance, policy development or both. One dimension of the framework classified potential approaches to accountability in terms of the political science concept often referred to as “policy instruments” or “governing instruments.” We concentrated on four, which were evident in our review of currently used approaches to accountability: financial incentives, regulations, information directed towards patients/payers and professionalism/stewardship – which represented variations on the “expenditure,” “regulation” and “exhortation” governing instruments. Our framework postulated that these approaches would have differing success when applied to various categories of services, and within various subsectors, with the likely

outcomes depending upon three additional dimensions: (a) the policy *goals* being pursued (which affect the question of “accountability for what”); (b) the *governance/ownership* structures and relationships in place, which in turn affect who will be accountable and to whom; and (c) the types of *goods and services* being delivered and their “production characteristics.” To the extent that different subsectors represented different configurations of governance, ownership and service mix, some of these dimensions will not vary within a particular subsector, while others may vary within and between settings. There is also scope for variation depending on the characteristics of those receiving the services, and their ability to monitor performance. The research reported here thus allowed us to compare and contrast across a series of related substudies.

Approaches: Policy Instruments

Political scientists have noted that decision-makers have available to them a series of what are termed “policy instruments” or “governing instruments,” from which they can select to carry out preferred policy directions (Baxter-Moore 1987; Doern and Phidd 1992; Hood 1983; Howlett and Ramesh 1993).

There are a number of different ways of classifying such instruments. Doern and Phidd (1992) stress increasing government involvement/control, ranging from encouraging cooperation to taking over and directly running the activity; they use the terms exhortation, expenditure, regulation, taxation and public ownership. Another formulation, which makes similar points in slightly different language, is Hood’s NATO, which uses the terms nodality (information), authority, treasure and organization (Hood 1983).

These typologies stress that policy instruments vary considerably in how coercive (or intrusive) they are. At the extreme non-intrusive end of the scale, decision-makers may choose not to act at all. Moving slightly up the scale, they can choose symbolic responses to encourage people to act in a particular way. This may involve information/education, symbolic gestures or both. Doern and Phidd (1992) term this approach “exhortation.” Somewhat more intrusively, decision-makers may choose to intervene indirectly by using incentives for action, ranging from attempts to secure voluntary compliance with their objectives without accompanying threats or inducements, through to “expenditures” and/or “taxation” policies. A still more intrusive set of instruments may be termed directives (what Doern and Phidd call “regulation”); these often shift compliance costs from regulators to those being regulated. Although most writing on policy instruments conceptualizes coercion as the extent to which government directly intrudes on private decision-making, this analysis can be extended to examining the potential intrusiveness of one level of decision-makers upon others. The framework also includes the literature on ways of enforcing these agreements, including information, licensure/accreditation, payment and legal sanctions. This literature has been linked to the literature on the new public management (Hood 2000) and pays particular attention to interactions between public and private forces, as well as the implications of the type of policy network for selection of policy instrument (Bressers and O’Toole 1998). Although these

concepts have been applied to the field of environmental regulation, particularly in the European Union (Jordan et al. 2005; Zito et al. 2003) as well as, in a more limited way, to healthcare – e.g., the governance of primary care in Switzerland (Braun and Etienne 2004) and social services, such as child health policy in Australia (Leggat 2004) – we are not aware of any efforts to apply them to accountability.

In these studies, we have focused on the following four major approaches to accountability currently being employed in the health sector in Canada and internationally:

1. *Financial incentives*, which adjust payments to induce providers to behave in a desired manner (Donaldson et al. 2005; Evans 1984; Robinson 2001). These employ the “expenditure” governing instrument (also called “treasure”). One example is the family of pay-for-performance (P4P) experiments for physician services underway in such jurisdictions as the United Kingdom, United States, Australia and Ontario (Devlin et al. 2006; Doran et al. 2006; Epstein 2006; Pink et al. 2006; Rosenthal et al. 2005), which often tie funds to performance of desired activities (Marks et al. 2011). Another involves changes in the financial incentives for hospitals, including moves to activity-based funding (Chalkley and Malcomson 2000; Sutherland 2011; Sutherland et al. 2011). Similar initiatives can be found in other subsectors, including home care.
2. *Regulations*, which by definition employ the “regulation” governing instrument (Walshe 2003), play a major role in healthcare. These require providers to behave (or not behave) in a certain way. Although regulations can be backed up through signing binding agreements, they may also rely on agency theory (Eisenhardt 1989; McGuire 2000) and be enforced using professional regulatory bodies. The literature notes the ongoing tension of balancing market forces and regulation (Chinitz et al. 1998; Saltman et al. 2002) and the implications of regulatory and medico-legal barriers for achieving such goals as interprofessional practice (Lahey and Currie 2005).
3. *Information* directed towards potential users (patients, public and private payers) within a context of allowing market forces to work more effectively by encouraging rational choice of the “best” care (Howells 2005). These are one variant of the “exhortation” governing instrument. This instrument may work both directly and indirectly (e.g., interest groups and media may affect the reputation of various providers, which in turn affects the willingness of patients and payers to purchase their services). Examples of the use of information include ongoing activities in performance measurement and improvement (Barnsley et al. 2005; Hurst and Jee-Hughes 2001; Shaw 2003; Smith 2002; Veillard et al. 2005). Issues in using this approach include who establishes these measures and who enforces them. In healthcare, common examples include the use of report cards (e.g., for hospitals), audit reports, publicly available inspection reports (e.g., for nursing homes) and quality indicators, including adverse events (Baker et al. 2004). The Health Council of Canada and the Canadian Institute for Health Information have been involved in developing, collecting and publicizing various informational mechanisms.

4. *Reliance on professionalism and stewardship* (Saltman and Ferroussier-Davis 2000; Shortell et al. 1998). This approach employs a second variant of the exhortation governing instrument, but directs the information to providers rather than to payers or consumers (Lemieux-Charles and Champagne 2004). It relies on high trust and the expectation that providers – as a group – wish to do the right thing, but may need support in clarifying best practices as well as exposing poor practice. Clinical guidelines and other forms of evidence-based practice often fall within this category if compliance is voluntary; they are currently being used in various subsectors, including hospitals, nursing homes and primary healthcare. Under some circumstances, report cards may also fall into this category of approach, depending upon the indicators used and the dissemination approach adopted. Note that this approach is often backed up by regulatory approaches (e.g., through self-regulation of the professions).

An additional nuance is the extent to which blended models may be used. This is particularly evident in the use of additional policy instruments for enforcement, which may include various combinations of information (e.g., efforts to evaluate and improve the quality of information, citizen engagement to widen the scope of inputs) (Abelson and Guavin 2004), expenditure (e.g., fiscal penalties), taxation (e.g., tax breaks to encourage desired activities) and regulation (e.g., audit, accreditation, professional self-regulation and legal sanctions). Some jurisdictions have established formal appeal mechanisms for patients (e.g., Norway has a Patient's Bill of Rights; Ontario has the various review procedures for getting out-of-province coverage and a public complaints process for nursing homes). Other enforcement mechanisms may rely upon litigation (e.g., malpractice, human rights). Auditor General reports fall within the information category, but may often catalyze additional actions.

What Affects the Impact of Accountability Approaches?

The second component of this framework focuses on three dimensions likely to affect the success of various approaches: goals, governance/ownership and services.

Policy *goals* may encompass both outcomes and processes. Policy goals for healthcare traditionally include combinations of access, quality (including safety), cost control/cost-effectiveness and customer satisfaction. Behn (2001) suggests three objectives for accountability: improved performance, fairness and financial stewardship. Often, policy goals may clash. For example, hospital effectiveness may vary if measured in terms of doing more (increasing the number of admissions, market share, occupancy rate), financial performance (net profit, cash flow), meeting the needs of the community (satisfaction of patients, providers) or delivering high-quality care (better outcomes). Ideally, there should be congruence between the policy goals being pursued and what organizations are being held accountable for, although this is not always the case.

The *governance/ownership* structures in place also vary across jurisdictions and across subsectors; they affect who will be accountable, to whom and for what (Denis 2004; Jordan

et al. 2005; van Kersbergen and van Waarden 2004). One key element is the balance between and rationale for public versus private provision and how such factors affect governance and accountability (Deber 2004; Horwitz 2006; Osborne and Gaebler 1992; Sloan 2000). For example, for-profit organizations also have a fiduciary duty to maximize the return to their investors, which in turn may affect the services they choose to provide and the populations they choose to serve.

As Denis and colleagues (2005) have noted, “governance deals principally with the adaptation of organizations to new contingencies” and deals with “the roles of all regulatory, administrative, professional and clinical authorities in the pursuit of collective goals.” In that connection, structures where actors are accountable to more than one authority can add complexity (Rhodes 1997). An additional complexity is that Canada is what the Organisation for Economic Co-operation and Development (OECD) refers to as a “public-contract model,” in which public payers contract with private healthcare providers (Docteur and Oxley 2003). In turn, this means that many accountability arrangements are between government and the “third sector” (“civil society”), a situation that presents additional complications (Mayne and Wilkins 2005; Schwartz 2001, 2002, 2003).

Ownership presents further issues; one US study found that the effects of the governance/ownership configuration were more pronounced in freestanding and public not-for-profit hospitals compared with system-affiliated and private not-for-profit hospitals. The board structure, including whether corporate-style or philanthropic-style models were used, was also important (Alexander and Lee 2006). Some have suggested that this governance/ownership category of variables may be the most amenable to policy change (Preker and Harding 2003). One potentially useful concept is the “soft governance” approach, in which government “relies less on hierarchy than on information to steer local organizations” (Brandsen et al. 2006). There is literature suggesting a relationship between governance/ownership and the ability to achieve and monitor such goals as quality improvement (Baker et al. 2006; Thomas 2006). A helpful resource is the framework developed by Denis and colleagues (2005) for Accreditation Canada, which identifies three governance models (agency, stakeholder and stewardship).

We also postulate that what economists call the production characteristics of the goods and services being delivered – specifically, what the literature refers to as *contestability*, *measurability* and *complexity* – will affect performance measurement and monitoring (Deber 2004; Jakab et al. 2002; Preker and Harding 2000, 2003; Preker et al. 2000; Rico and Puig-Junoy 2002; Vining and Globerman 1999). Preker and Harding (2000) define them as follows: “Contestable goods are characterized by low barriers to entry and exit from the market, whereas non-contestable goods have high barriers such as sunk cost, monopoly market power, geographic advantages and ‘asset specificity.’” These authors define measurability as relating to “the precision with which inputs, processes, outputs and outcomes of a good or service can be measured.” Monitoring performance is easiest when measurability is high. For example, it is relatively simple to specify the performance desired for conducting a laboratory test or collecting municipal garbage. In contrast, it would be more difficult to specify the activities to be

expected of a general practitioner, and hence more difficult to monitor the physician's performance and ensure quality. Complexity refers not to how complex the particular goods and services are, but to whether the goods and services stand alone or require coordination with other providers. For example, laboratory tests are highly measurable, but gain much of their value by being embedded within a system of care in which providers order tests appropriately and are aided in interpreting and acting upon their results. A related concept that emerged from our research is observability, which we define as the extent to which the activities are easily monitored by others beyond those directly involved in providing or receiving a service. For example, services delivered in a home setting would be less observable than those delivered in a hospital operating room. Additional insights arise from the theory of transaction costs and monitoring costs, which are also addressed in economics theories relating to incomplete contracting (Williamson 1981, 1985, 1999), defined by Williamson (1985) as "the comparative costs of planning, adapting and monitoring task completion under alternative governance structures."

Substudies and Decision-Making Partners

The substudies examined in this Special Issue encompass a variety of subsectors, including hospitals (Kraetschmer et al. 2014; Kromm et al. 2014), cancer (Bytautas et al. 2014), community services (Steele Gray et al. 2014), laboratories (Gamble et al. 2014), public health (Schwartz et al. 2014), primary healthcare (Mukhi et al. 2014), long-term care (Berta et al. 2014; Wyers et al. 2014) and professional regulation (Baumann et al. 2014; Zelisko et al. 2014), and brief commentaries looking at international comparisons (Kirsch 2014; Peckham 2014) and the role of accreditation (Mitchell et al. 2014). These substudies represent different combinations of governance/ownership and services, and should assist in clarifying the advantages and disadvantages of various approaches to accountability. We are extremely fortunate to have the collaboration of such highly qualified decision-making partners and researchers (including graduate students).

The final paper of this Special Issue (Deber 2014) summarizes what we have learned from the substudies.

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Acute Care Hospitals' Accountability to Provincial Funders

Obligation redditionnelle des hôpitaux de courte durée soins actifs auprès des bailleurs de fonds provinciaux



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Abstract

Ontario's acute care hospitals are subject to a number of tools, including legislation and performance measurement for fiscal accountability and accountability for quality. Examination of accountability documents used in Ontario at the government, regional and acute care hospital levels reveals three trends: (a) the number of performance measures being used in the acute

care hospital sector has increased significantly; (b) the focus of the health system has expanded from accountability for funding and service volumes to include accountability for quality and patient safety; and (c) the accountability requirements are misaligned at the different levels. These trends may affect the success of the accountability approach currently being used.

Résumé

En Ontario, les hôpitaux de soins de courte durée sont assujettis à certaines règles, dont les dispositions législatives et les mesures du rendement à des fins de responsabilité financière ainsi que l'obligation de rendre compte en matière de qualité. L'examen des documents portant sur l'obligation redditionnelle aux niveaux gouvernemental, régional et hospitalier révèle trois tendances : (a) le nombre de mesures du rendement utilisé dans les hôpitaux de soins de courte durée s'est accru de façon significative; (b) les efforts du système de santé se sont développés depuis l'obligation de rendre compte des finances et des volumes de services pour inclure l'obligation redditionnelle quant à la qualité et à la sécurité des patients; et (c) les exigences en matière d'obligation redditionnelle ne sont pas uniformisées parmi les divers niveaux administratifs. Ces tendances peuvent avoir des répercussions sur la réussite des démarches actuelles visant l'obligation de rendre compte.

ACUTE CARE HOSPITALS IN THE PROVINCE OF ONTARIO ARE PRIVATE ORGANIZATIONS that receive most of their funding from public sources; traditionally, these funds have come from the Ministry of Health and Long-Term Care (MOHLTC). Although they have long been held accountable to patients, the public and the government for their use of public funds, in 2001 it was recommended that accountability of acute care hospitals to the government be expanded to include a broad range of accountability mechanisms in the area of performance measurement, including hospital report cards. Formal accountability agreements between MOHLTC and acute care hospitals were mandated by the 2004 *Commitment to the Future of Medicare Act* (CFMA) as a condition for funding. As noted in the Introduction to this Special Issue, the agreements included performance measures and targets for financial, service volume and select clinical indicators, and they employ a combination of expenditure, regulatory and information policy mechanisms (Deber 2014).

In 2006, Ontario moved towards a regional model, with provincial funds for selected services (including hospitals) now flowing through 14 geographically based local health integration networks (LHINs). Unlike some other Canadian provinces, Ontario's hospitals retained their independent corporate boards after LHINs were introduced. Each LHIN is a Crown corporation that operates at arm's-length from the government. Accountability for use of these funds employed a series of expenditure policy instruments. The 2006 *Local Health System Integration Act* (LHSIA) that created the LHINs' mandated ministry-LHIN performance agreements (MLPAs) between each LHIN and MOHLTC to establish the flow of funds to,

and set performance targets for, LHINs. The province holds LHINs to account for these targets. In 2007, LHINs were given the responsibility to allocate funds and to sign and monitor hospital service accountability agreements (H-SAAs) with the hospitals in their region, holding hospitals (via their independent corporate boards) accountable for meeting their H-SAA obligations as a requirement for funding. If targets are not met, future funding may be reduced (as outlined in the CFMA and accountability agreements), or in extreme situations, the provincial government may appoint a supervisor to replace the hospital's CEO.

A third piece of legislation, the 2010 *Excellent Care for All Act* (ECFAA), employs the information policy instrument; it requires each acute care hospital to submit an annual Quality Improvement Plan (QIP) to Health Quality Ontario (HQO), an arm's-length government agency created under the CFMA. This policy mechanism assumes that hospitals will want to improve quality of care if they are given the information to do so (Veillard et al. 2005, 2010). Making hospital performance information publicly available has been found to lead to quality improvement (Fung et al. 2008).

Each of these agreements (H-SAAs, MLPAs and QIPs) contains a standard set of required (or recommended, in the case of the QIP) core performance indicators that are used province-wide, but the targets can differ, depending on the LHIN or acute care hospital.

Ontario's use of legislation and performance measurement follows the examples of the UK and the US (Veillard et al. 2012), as well as the Canadian province of British Columbia. Since the early 1980s, performance measures have been used for UK hospitals, initially focusing on activities and costs, then expanding in the 1990s to include clinical aspects of care (Smee 2002). The US also uses performance measurement for hospital quality improvement along with financial incentives and public reporting of performance information (Blumenthal and Jena 2013; Committee on Quality of Health Care in America, Institute of Medicine 2001; Jha et al. 2005; Lindenauer et al. 2007). British Columbia was the first Canadian province to use performance agreements between the government and acute care hospitals (Quigley and Scott 2004).

This paper examines the Ontario government's use of the policy instruments of legislation and performance measurement to hold LHINs and hospitals accountable for the use of public funds, quality of service or both. This examination reveals several issues that challenge hospitals and the success of this approach used for accountability.

Methods

This study focuses on three accountability documents currently used in Ontario's acute care hospital sector: (a) ministry–LHIN performance agreements (MLPAs), (b) hospital service accountability agreements (H-SAAs) and (c) Quality Improvement Plans (QIPs). Links to these documents and specifications of indicator definitions are provided in Appendices A and B to this paper (available online www.longwoods.com/content/23852). For this analysis, we retrieved data on performance indicators from H-SAAs for the years 2005 to the present, MLPAs for the years 2006 to the present and QIPs for 2011 to the present. A performance

indicator is defined as a measure of local health system (or acute care hospital) performance for which a specific target is set and for which each LHIN (or hospital) is held accountable. Table 1 lists performance indicators used in H-SAAs over time, noting indicators that align with those used in the MLPAs. Table 2 shows the indicators used in part B of the QIP, and notes those that are also found in the H-SAAs and MLPAs.

Results

Ministry–LHIN performance agreements

MLPAs were first used in 2007 (known then as ministry–LHIN accountability agreements). They outlined performance obligations for LHINs, including financial management; reporting requirements; public accountability; and specific targets for financial, service-level and other performance indicators. Thirteen indicators were used in the 2007 version, and 16 are in the current version, nine of which were carried over. As noted in Table 1, some indicators were dropped and others added over time. The only indicator that holds all LHINs to the same target regardless of their location, size or services delivered by their health service providers is the annual balanced budget requirement, which requires total revenue to be greater than or equal to total expenses. Other indicators that have been retained include percentage of alternate level of care (ALC) days and specific 90th percentile wait time indicators that align with priority areas identified in the federal government’s National Wait Times Initiative (Health Canada 2004). Consistent use of these indicators emphasizes their continued importance and the focus of the health system on financial performance and access.

Hospital-service accountability agreements

The two main categories of performance indicators in the H-SAA are service volumes (including global volumes) and accountability indicators. As with the MLPA, the two financial indicators under the accountability indicators subcategory of organizational health require all acute care hospitals in the province to meet the same performance targets, regardless of their size, location or services provided. The province-wide target for “total margin” (see Appendix B for definition at www.longwoods.com/content/23852) is at least 0%, meaning that each acute care hospital must balance its budget while providing the service levels outlined in its H-SAA. The provinciewide target for “current ratio” (see Appendix B at www.longwoods.com/content/23852) is 0.8 to 2.0. These two financial indicators and seven of the service volume indicators have been consistently used in the H-SAAs.

Quality Improvement Plans

Accountability for quality is emphasized by the use of QIPs, which utilize recommended quality indicators grouped according to five quality dimensions identified by HQO: safety, effectiveness, access, patient-centred and integrated. Hospitals are encouraged to choose at least one recommended indicator in each dimension; this information can then be used for province-wide comparisons. Recommended indicators are used because it is recognized that

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TABLE 1. Indicators used in accountability agreements, 2005–2014

PERFORMANCE INDICATORS (Definitions in Appendix B)	2005– 2007	2007– 2008	2008– 2010	2010– 2011	2011– 2012	2012– 2013	2013– 2014
SERVICE/GLOBAL VOLUMES							
Relative acute length of stay for select case-mix groups	•						
Relative total acute length of stay	•						
Ambulatory care visits (total outpatient minus emergency department visits)	•	•	•	•	•	•	•
Total acute activity (including in-patient and day surgery* weighted cases)	•	•	•	•	•	•	•
Complex continuing care Resource Utilization Group weighted patient days	•	•	•	•	•	•	•
In-patient mental health* weighted patient days	•	•	•	•	•	•	•
Elderly capital assistance program (ELDCAP) in-patient days	•	•	•	•	•	•	•
Rehabilitation* in-patient days (weighted cases)	•	•	•	•	•	•	•
Emergency department visits (weighted cases)	•	•	•	•	•	•	•
ACCOUNTABILITY INDICATORS							
Organizational Health							
Percentage of full-time nurses	•	•	•				
Financial indicators:							
Current ratio	•	•	•	•	•	•	•
Total margin or balanced budget	•	••	••	••	••	••	••
Person Experience							
Percentage of chronic patients with new stage 2 or greater skin ulcers		•	•				
Rate of readmission to own facility for select case-mix groups	•	•	•	X	X	X	X
90th percentile ED length of stay for:							
Admitted patients				X	••	••	••
Non-admitted complex (CTAS I–III) patients				X	••	••	••
Non-admitted minor uncomplicated (CTAS IV–V) patients				X	••	••	••
90th percentile wait times for:*							
Cancer surgery		X	X	X	••	••	••
Cardiac bypass surgery		X	X	X	••	••	••
Cataract surgery		X	X	X	••	••	••
Hip joint replacement surgery		X	X	X	••	••	••
Knee joint replacement surgery		X	X	X	••	••	••
Diagnostic MRI scan		X	X	X	••	••	••
Diagnostic CT scan		X	X	X	••	••	••
Hospital-acquired infections:†							
Cases of ventilator-associated pneumonia (VAP)						•	•
Central line infection rate						•	•
Rates of <i>Clostridium difficile</i>						•	•
Rates of vancomycin-resistant enterococcus						•	•
Rates of methicillin-resistant <i>Staphylococcus aureus</i>						•	•
System Perspective							
Percentage of ALC days		X	X	X	X	••	••

* Not all hospitals provide these services; if not, their targets = 0

• An indicator used in the H-SAA

•• An indicator used in both the H-SAA and MLPA

X An indicator in MLPA but not the H-SAA

not all indicators apply to all hospitals. Some hospitals may not provide care associated with the indicator; or in the case of small community hospitals, the volume of services provided is low, reducing the strength of statistical analyses. Accountability for quality was sought prior to the QIP; MOHLTC had required all acute care hospitals to publicly report information on some quality indicators (e.g., hospital-acquired infections), but the Auditor General of Ontario found that not all hospitals were using the same indicator definitions (Office of the Auditor General of Ontario 2008). The QIP guidance document provides a standard definition for each recommended quality indicator. These standardized definitions are an improvement, making it possible to compare hospitals.

Table 2 shows that all indicators used in the first year of the QIP have been carried over to the present time. The 2012–2013 QIP added two new patient-centred indicators, while the 2013–2014 version added two new safety indicators (including medication reconciliation). Six indicators currently used in the H-SAA, and one in the MLPA, align with indicators used in the QIP.

TABLE 2. Quality dimensions, objectives and indicators used in part B of the QIP

Quality Dimension	Objective	Measure/Indicator (see Appendix B for definitions)	2011–2012	2012–2013	2013–2014
Safety	Reduce <i>C. difficile</i> infections (CDIs) and associated diseases	CDI rate per 1,000 patient days	•	▲	▲
	Reduce incidence of ventilator-associated pneumonia (VAP)	VAP rate per 1,000 ventilator days	•	▲	▲
	Improve provider hand hygiene compliance	Hand hygiene compliance before patient contact	•	•	•
	Reduce rate of central line bloodstream infections	Rate of central line bloodstream infections per 1,000 central line days	•	▲	▲
	Reduce incidence of new pressure ulcers	Pressure ulcers (≥ stage 2)	•	•	•
	Avoid patient falls	% of complex continuing care residents who fell in the last 30 days	•	•	•
	Reduce rates of deaths and complications associated with surgical care	Surgical safety checklist	•	•	•
		Rate of in-hospital mortality following major surgery			•
	Reduce use of physical restraints	Physical restraints	•	•	•
	Medication reconciliation at admission	Medication reconciliation at admission			•
Effectiveness	Reduce unnecessary deaths in hospitals	Hospital standardized mortality ratio	•	•	•
	Improve organizational financial health	Total margin (consolidated)	•	▲	▲
Access	Reduce wait times in the emergency department	90th percentile ED length of stay for admitted patients	▲	▲	▲
Patient-centred	Improve patient satisfaction	"Would you recommend this hospital to your friends and family?"	•	•	•
		"Overall, how would you rate the care and services you received at the hospital?"		•	•
		In-house survey (if available): "Willingness of patients to recommend the hospital to friends or family"		•	•
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days	•	▲	▲
	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to ANY facility	•*	□	□

* Only readmissions to own institution

• Indicator only in QIP

▲ Indicator in both the QIP and H-SAA

□ Indicator in both the QIP and MLPA

Issues in Hospital Accountability

Analysis of indicator data in Tables 1 and 2 reveals three main issues during the evolution of accountability and use of performance measures that can make accountability more difficult to achieve in Ontario's acute care hospital sector: (a) the number of performance measures being used in the acute care hospital sector has increased significantly; (b) the focus of the health system has expanded from accountability for funding and service volumes to include accountability for quality and patient safety; and (c) the indicators are not always clearly aligned under hospital control and may have different targets specified in different agreements. Each of these issues is presented below.

Increased number of indicators

The number of indicators used in all accountability documents has increased over time. The most significant increase is at the acute care hospital level, from 13 in 2005/06 to 25 in the current H-SAA (Table 1). In the past three years, 16 performance indicators have been added to the H-SAA, while no indicators have been removed, increasing the requirements tied to funding. As well, the number of recommended indicators in the QIP has increased from 14 in its first year to 18 in the current year (six of which overlap with the H-SAA for a total incremental increase of 12 recommended indicators). This means 28 new indicators have been introduced for hospitals in the past three years. Hospitals that report on all recommended QIP indicators are now reporting up to 37 indicators for accountability purposes.

Expanding focus of accountability

The government uses the MLPA and H-SAA to monitor fiscal management and health services delivery through the LHINs. Table 1 shows that the H-SAA initially focused on financial performance (balanced budget or total margin of 0%) and service volumes (Reeleder et al. 2008). These areas continue to be focused on but accountability has expanded to include areas related to integration of hospital performance with community-based providers. For example, the MLPA now has indicators for community care access centre (CCAC) in-home services wait times, and repeat unscheduled emergency department visits for mental health conditions and for substance abuse conditions. As well, the H-SAA has added the indicator of percentage of ALC days in 2012/13. The ECFAA continues the expansion into areas of quality of care and patient safety, requiring hospitals to report on effectiveness of care, nosocomial infections, other areas of patient safety and even patient satisfaction (Government of Ontario 2010).

Alignment, controllability and duplication of accountability indicators

The H-SAA states that the Ontario government has recognized the need for alignment between levels of the healthcare system for accountability purposes. Tables 1 and 2 show that alignment has improved over time as indicators aligning with those used in the MLPA have been added to the H-SAA. For example, percentage of ALC days, emergency department length of stay and 90th percentile wait times for priority areas are now included in the

H-SAA. Alignment is important for achieving accountability (Kramer et al. 2009), making increased alignment an improvement. LHINs can now hold acute care hospitals accountable for performance measures aligning with MLPA indicators that are tied to aspects of care provided in an acute care setting or within the control of the acute care hospital.

This increases the controllability of an indicator for LHINs. Controllability is the extent to which a health service provider or LHIN can control its performance on an indicator. Without controllability, organizations may be accountable for performance targets they cannot directly influence, possibly leading to reduced funding as outlined in the CFMA and accountability agreements. The issue of controllability was recognized prior to 2008 by decision-makers when they decided not to include percentage of ALC days as an indicator in the H-SAA. Decision-makers agreed that acute care hospitals would not be held accountable for system issues beyond their control (e.g., lack of suitable discharge locations such as long-term care beds) and because inconsistent definitions of ALC were being used (Ontario Health Quality Council and Ontario Joint Policy and Planning Committee 2008). Standardizing the definition of ALC (see Appendix B at www.longwoods.com/content/23852) and including the indicator in both the MLPA and H-SAA increase controllability.

Duplication of indicators is also shown in Tables 1 and 2; hospitals may need to report on the same indicator to two different agents: HQO and the LHIN. This may seem inconsequential, but can be problematic if indicators have different targets depending on the agent to which the hospital is reporting, as is sometimes the case. (For further discussion of the reporting burdens of hospitals, see Kraetschmer et al. 2014).

Discussion

As defined in the Introduction to this Special Issue (Deber 2014), accountability means having to be answerable to someone for meeting defined objectives. These objectives are often defined in terms of targets for performance measures for financial, clinical and service volumes. Performance measurement for accountability can be beneficial by establishing key dimensions of hospital performance; encouraging the use of best practices through the sharing of information between hospitals on uniform indicators; managing system-wide organizational performance; and aligning organizational strategy with health system strategy (Veillard et al. 2005, 2010).

The present study is limited in its scope by the information contained in the three main accountability documents used in Ontario's acute care hospital sector. Explanations for the increase in the number of performance indicators over time, why the indicators being used were changed and the key drivers, how hospitals react to these changes, and the cost to hospitals of responding to accountability requirements cannot be answered using these documents. These are all areas of future research.

Even so, the three main accountability documents being used for Ontario's acute care hospital sector and their performance measures revealed issues that can make accountability

for the use of public funds more challenging to achieve. However, the situation appears manageable; the significant increase in the number of indicators used for accountability in Ontario's acute care hospital sector is modest when compared to the reporting requirements faced by hospitals in the UK and the US. Even so, the potential of these reporting tools to improve performance would be increased by greater alignment between indicators used at the LHIN and acute care hospital levels (Kramer et al. 2009).

The increased number of indicators also shows an expanding focus of the health system beyond financial and service volumes into important areas such as patient-centred care and quality of care, including integration with community providers. A benefit of this increase and expansion is that hospitals and LHINs are provided with guidance on where to focus their attention and improvement efforts. Even so, it is clear that the expansion and refinement of measures is an evolving process. For example, new measures are introduced for a time, but then discontinued in favour of more commonly used measures such as those for financial performance, access, nosocomial infections and readmissions (Snowdon et al. 2012). Other measures changed over time as their definitions were refined. Changing the measures used, or their definitions, is problematic because inter- or intrahospital comparisons over time become more challenging or not possible.

While a number of accountability measures focus on efforts to coordinate care with community providers, they still fall short of capturing health system coordination and integration in other areas of healthcare provision such as pharmacy services and primary care. As well, continued efforts to increase coordination of care means that controllability is likely to remain an issue, particularly when hospitals are held accountable for performance measures that require collaboration with community-based providers (e.g., readmission rates).

Performance measurement is critical for performance improvement, but a problem arises when hospitals are forced to make trade-offs between measurement activities and attention to improvement. As new measures are developed and added to reporting requirements, hospitals must devote more resources (e.g., finances, time) to performance measurement and reporting. Some organizations may consider these resources better spent on providing more patient care or engaging in improvement activities (not just measurement of activities). Even so, without performance measurement it is not possible to determine whether additional care or improvement initiatives follow best practice guidelines or lead to actual improvements.

Are all performance data valuable and useful for accountability purposes, or is the system moving towards measurement for the sake of measuring what can be measured? Our results support the framework presented in the Introduction (Deber 2014), indicating that measures may be chosen because they capture elements of healthcare that are measurable, or based on their feasibility and the availability of data (Veillard et al. 2010).

Conclusion

This paper has focused on three legislated policies for performance measurement and reporting currently being used in Ontario's acute care hospital sector for accountability and explores

issues that may challenge the effectiveness of these arrangements. The performance indicators used over time for LHINs and acute care hospitals show that some indicators are used consistently, some are abandoned and many others newly introduced. These changes show that the focus of accountability has expanded from financial and service volumes to include access, quality, patient safety and the patient experience, emphasizing the importance of these areas. The expansion of accountability has improved alignment between levels of accountability (LHIN and hospitals), increasing the likelihood that performance targets will be achieved as the system is more aligned. Even so, controllability will likely remain an issue, as the focus on collaborative care between hospitals and community-based providers continues. Expansion of accountability has increased the focus on standardizing definitions but also led to duplication of measures being used. Hospitals are required to report similar data to multiple agents and/or meet more than one target for the same measure; this can negatively affect data quality or lead to confusion in reporting, challenging the ability of accountability policies to improve performance while keeping public spending on healthcare in check. In balance, however, the availability of standardized data may help hospitals improve their performance, at least with respect to the indicators being captured. Standardization provides an additional opportunity for future research to evaluate the effect of accountability on hospital performance.

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Hospitals' Internal Accountability

Obligation interne de rendre compte dans les hôpitaux



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Abstract

This study aimed to enhance understanding of the dimensions of accountability captured and not captured in acute care hospitals in Ontario, Canada. Based on an Ontario-wide survey and follow-up interviews with three acute care hospitals in the Greater Toronto Area, we found that the two dominant dimensions of hospital accountability being reported are financial and quality performance. These two dimensions drove both internal and external reporting. Hospitals' internal reports typically included performance measures that were required or

mandated in external reports. Although respondents saw reporting as a valuable mechanism for hospitals and the health system to monitor and track progress against desired outcomes, multiple challenges with current reporting requirements were communicated, including the following: 58% of survey respondents indicated that performance-reporting resources were insufficient; manual data capture and performance reporting were prevalent, with the majority of hospitals lacking sophisticated tools or technology to effectively capture, analyze and report performance data; hospitals tended to focus on those processes and outcomes with high measurability; and 53% of respondents indicated that valuable cross-system accountability, performance measures or both were not captured by current reporting requirements.

Résumé

Cette étude vise à mieux comprendre les aspects signalés et non signalés de l'obligation de rendre compte dans les hôpitaux de soins de courte durée en Ontario, au Canada. À la lumière d'un sondage dans tout l'Ontario et d'entrevues de suivi dans trois hôpitaux de soins de courte durée de la région du Grand Toronto, nous avons découvert que les deux principaux aspects de l'obligation de rendre compte signalés dans les hôpitaux sont le rendement financier et la qualité. Ces deux aspects mènent à la production de rapports internes et externes. Les rapports internes des hôpitaux comprennent habituellement les mesures du rendement requises ou prescrites pour les rapports externes. Bien que les répondants considèrent que la production de rapports est un mécanisme valable pour les hôpitaux et le système de santé afin de surveiller et de suivre les progrès en fonction des résultats désirés, ils font part de nombreux défis liés aux exigences actuelles dans la production de rapports, notamment les points suivants : 58 % des répondants au sondage indiquent un manque de ressources pour la présentation de rapports sur le rendement; la saisie manuelle pour les données et la présentation de rapports demeure courante et, dans la majorité des hôpitaux, il y a un manque d'outils ou de technologie de pointe pour saisir et analyser les données sur le rendement puis en faire rapport efficacement; il y a une tendance, dans les hôpitaux, à centrer les efforts sur les processus et les résultats qui présentent une grande mesurabilité; 53 % des répondants indiquent que les exigences actuelles en matière de présentation de rapports ne donnent pas lieu à une obligation de rendre compte intersystémique et/ou à des mesures du rendement, ce qui constituerait un atout.

THIS PAPER EXAMINES INTERNAL HOSPITAL ACCOUNTABILITY DIMENSIONS, approaches and requirements and considers the impacts of accountability on performance and reporting in hospitals across Ontario. The focus on performance accountability in healthcare organizations continues to increase, with Ontario hospitals using regulated and mandated performance measurement and reporting systems to improve accountability (Health Council of Canada 2012; Smith et al. 2008; Snowdon et al. 2012;

Veillard et al. 2010). Published evidence suggests that linking strategy to performance measurement to achieve desired outcomes is critical (Jha et al. 2003; Kaplan and Norton 2004, 2005; Porter and Teisberg 2004).

The dominant dimensions of accountability in Ontario hospitals have traditionally been based on financial and quality performance. As noted in the introduction to this issue (Deber 2014), accountability means having to be answerable to someone for meeting defined objectives, and can have financial, performance and political/democratic dimensions. The tools used can vary. Accounting may be linked to financial incentives (e.g., pay for performance) that adjust payments to induce hospitals to behave in desired ways. It may be linked to quality performance, as in Ontario's *Excellent Care for All Act*, 2010 requirements, such as the Quality Improvement Plan (QIP). Not surprisingly, external reporting accountabilities and funding tied to specific performance measures (e.g., wait times) are prioritized over other indicators that do not have incentives or accountability contracts attached.

Externally, selected measures are required to be reported to a variety of bodies, including the Ontario Ministry of Health and Long-Term Care (MOHLTC), local health integration networks (LHINs), Health Quality Ontario (HQO), the Canadian Institute for Health Information (CIHI) and Cancer Care Ontario (CCO). As noted by Kromm and colleagues (2014), these measures are often not fully aligned.

Internally, hospitals report performance to such groups as senior management, clinical teams, boards of directors and board committees. Hospitals select and monitor outcomes that have high measurability, though this approach may not provide the most valuable performance information or drive accountability through cross-system comparisons. Hospitals measure their performance and use internal data analyses to align decision-making with internal goals and external performance expectations. Having a core set of indicators reported across all hospitals encourages benchmarking and has the potential to drive performance in certain domains (Baker and Pink 1995; Veillard et al. 2005).

For the purpose of understanding internal hospital accountability mechanisms, we conducted a case study of approaches and challenges faced by Ontario hospitals.

Ontario Case Study

Ontario hospitals are private, not-for-profit organizations that receive the vast majority of their funding from the provincial government. In 2006, Ontario, like most other Canadian provinces, regionalized elements of its healthcare system. Ontario created 14 regional LHINs to oversee the planning, funding and management of many of Ontario's healthcare services, but allowed hospitals to retain their independent boards.

Ontario has emphasized creating a culture of accountability and has used legislation as a policy tool towards this goal. The province already had in place an extensive and diverse number of hospital legislative compliance requirements intended to drive accountability and performance (including the *Public Hospitals Act* and the *Broader Public Sector Accountability Act*). Hospitals are also covered by provisions for responding to adverse events or complaints

(e.g., the *Drug and Pharmacies Regulation Act*, *Accessibility for Ontarians with Disabilities Act*, *Occupational Health and Safety Act*). The *Commitment to the Future of Medicare Act*, 2004 mandated the use of accountability agreements between the provincial government and each acute care hospital. After the *Local Health System Integration Act*, 2006 created LHINs, these accountability agreements were transferred from the MOHLTC to each LHIN. Hospitals now must sign a hospital-service accountability agreement (H-SAA) with their LHIN in order to obtain funding from the MOHLTC. The H-SAA requires hospitals to measure and report on a core set of indicators (see Kromm et al. 2014). In 2010, the *Excellent Care for All Act* set new standards of accountability for hospitals, outlining a minimum set of core measures with internal and external reporting requirements, a requirement for publicly posted annual QIPs, and requirements for linkage between executive compensation and achievement of improvements in the quality measurements.

In addition, Ontario hospitals participate in a voluntary accreditation process led by Accreditation Canada (www.accreditation.ca), a not-for-profit organization that helps hospitals and other healthcare organizations across Canada drive high-quality care within their organization (see also Mitchell et al. 2014). Hospitals in Ontario voluntarily participate in Accreditation Canada's accreditation programs, which collect data every three to four years, as a way to evaluate their performance against national standards of excellence. Accreditation Canada sets accreditation standards related to governance, risk management, leadership, medication management, prevention and control, and patient safety. As hospitals strive to become accredited, they demonstrate to their employees and the public that the institution provides high-quality healthcare.

Methods

All Ontario acute care hospitals (n=116) were mailed the Acute Care Hospital Strategic Priorities Survey 2011 between September and December 2011. The mailed surveys were addressed to the hospital's chief executive officer. We also interviewed three senior hospital administrators responsible for hospital performance at three different Ontario teaching hospitals located in the Greater Toronto Area in 2011. The interviews allowed us to capture these administrators' perceptions of the advantages and disadvantages of current accountability and performance-reporting arrangements.

Results

The overall survey response rate was 45.7%; 71.4% of teaching hospitals responded, compared to 54.4% of large community hospitals and 26.7% of small community hospitals. For interviews, the response rate was 100%. Based on the analyses of the data from the survey and key informant interviews, we focus on seven themes that emerged. (The precise indicators that are referenced reflect practice at the time of the interviews, and may change over time.)

Theme 1: Internal hospital reporting aligns with external reporting requirements

Key informant interviews suggest that acute care hospitals try to ensure alignment of internal reporting requirements with external reporting requirements, particularly those required by MOHLTC and the LHINs, which collectively control hospital funding. Hospitals internally employ reporting tools such as balanced scorecards, internal reporting dashboards or both to showcase selected organizational goals and specific related measures. These internal performance reports are routinely monitored by management and other internal stakeholders, such as clinical teams and the board. These internal reporting tools reflect performance and financial measures outlined in the H-SAA and annual QIPs, thought to drive improvements in quality of care across Ontario's health system.

Theme 2: Organizational foci aligned with external accountabilities

According to interviewees, hospital focus is driven to a certain extent by external reporting accountabilities and funding (e.g., wait times and alternative level of care) over other indicators that do not have incentive funding (e.g., pay for performance) or accountability contracts attached to them. Interviewees indicated that collecting and reporting data are critical to measuring hospital performance and assisting with making internal decisions. Measures that are most valuable from the perspectives of the organization and senior management include those linked with quality and safety, and efficiency/financial considerations (e.g., cost per weighted volumes, total margin, current ratio, wait times, readmission rate, alternative level of care, patient satisfaction, wait times and employee satisfaction/engagement).

Theme 3: Performance reporting requirement challenges

Fifty-eight per cent of survey respondents indicated their hospital had insufficient resources dedicated to capturing, analyzing and reporting performance data. As the system moves to increased reporting requirements, this resource constraint may become even more of an issue. The key informant interviewees also noted it was challenging for hospitals to track the total resources used to collect and report on mandatory and voluntary indicators. Unless centralized within a department, these costs are spread across the organization and there is no consistent or effective way to capture them for comparative purposes.

Over 73% of survey respondents said that their hospital did not use an automated monitoring and reporting system (e.g., business intelligence system) to manage financial and operational performance (e.g., for reporting and analyzing dashboards and performance scorecards). Being able to capture and report data and provide an integrated view of information at all levels of the organization, in a timely way, could and should enhance decision-making. One interviewee recommended that a centralized, accessible reporting system with one reporting methodology should be used across all hospitals to enhance and standardize data quality, efficiency and collection. As well, there may be inefficiencies and confusion when indicator data collected using different methodologies are compared and benchmarked. Some hospitals have recognized the need to capture data in a consistent and centralized manner within their own

organizations, and have implemented a business intelligence system that supports efficient data collection and reporting, timeliness and information on (internal) trending. These systems are expensive, and many hospitals have neither the access nor the resources to implement them.

Several quotations from respondents illustrate these themes:

Performance and accountability reporting requirements are increasing rapidly without a corresponding increase in budgets to allow for this.

Smaller hospitals have the same reporting requirement as larger community and teaching hospitals, but given our financial means do not have the same infrastructure/manpower to focus on performance and accountability reporting.

Data extrapolation can be arduous – our systems are not fully integrated – organization size impacts analysis and extrapolation of small IS/IT [information system/information technology].

Funding only permits us to capture and report the data; we don't have staff with the needed time and knowledge to analyze the data.

Theme 4: Data should be used to drive quality improvement

Respondents indicated that data should be used to drive quality improvement. Specifically, they suggested that a key set of indicators that can drive quality improvement should be required to be reported publicly, internally to the governing board or both. One interviewee noted that their institution struggles with “old hospital data” being in the public domain when they know there are more recent/real-time data that demonstrate a different picture and are more meaningful internally.

According to interviewees:

Key is not collecting and reporting on indicators but using the information to drive quality improvement.

Funding structures do not necessarily support a systems quality approach/incentive.

Theme 5: Reporting requirements help drive data collection and reporting

Indicators are only as good as the data quality. Reporting requirements help drive improved data collection, quality and reporting. For example, external indicators that have clear definitions and methodologies for data collection and reporting can drive consistency and permit comparisons across hospitals. One interviewee pointed out that it is important to recognize that sudden improvements in performance with respect to certain indicators may not be a

true improvement but just a difference in how the data are collected and reported. Similarly, sudden decreases in performance can be a result of changes to indicator definitions and methodologies.

With the ever-increasing drive towards accountability, it appears that some indicators are susceptible to gaming. Indicators that are difficult to game are pure “counts,” such as the number of hip replacements done by a hospital. However, some other indicators that are attached to funding, including computerized tomography (CT) and magnetic resonance imaging (MRI) hours/volumes and wait times for hip/knee joint replacement surgeries, were seen as being more susceptible to gaming. According to all interviewees, waiting lists for MRIs are sometimes gamed because increased efficiency leads to decreased financial incentives for the hospital. Therefore, hospitals may increase their waiting lists by shutting down MRI operating hours beyond the base funded volumes or hours. If efficiency stays the same with fewer MRI hours, waiting lists will increase, leading to more funding.

Theme 6: Improved coordination with other agents and prioritization of measures

Eighty-five per cent of survey respondents stated that their organization is required to report the same performance measure, often measured slightly differently, to two or more agencies such as MOHLTC, a LHIN, HQO, CCO and CIHI. For example, at the time of this study alternative-level-of-care (ALC) data were being reported to different bodies (e.g., Ontario Hospital Association, LHINs and Wait Time Information System) using different methodologies.

It was suggested by those interviewed that process maps for data collection would be useful in understanding how and where data flowed within the system to determine whether indicators were being reported to multiple organizations and whether efficiencies in reporting processes could be introduced. All interviewees suggested that similar indicators are often reported differently internally than externally. Examples of patient safety indicators that were reported differently internally than externally included internal reporting of rates for nosocomial infections such as *Clostridium difficile* (*C. diff.*) and methicillin-resistant *Staphylococcus aureus* (MRSA), while the external reporting of bacteraemia included only the number of cases of *C. diff.* and MRSA. One reason these indicators may be reported differently within hospitals is that historically, hospitals determined their own reporting requirements for internal reporting, but when this reporting was translated into the system level, different methodologies were often employed, e.g., number of infections versus infection rates. Interviewees also suggested that these indicators may be reported differently because the hospital's focus needs to be on the “vital few” measures rather than the broader reporting that is currently occurring.

According to respondents:

Measurement and reporting is not well coordinated and handled on an organization-wide basis ... needs to be more focused and selective.

Ontario needs to articulate the responsibilities of MOHLTC, CCO, HQO, LHINs in a coherent way ... there is excessive structure and no coherent agenda. A consequence is multiple siloed information requests to hospitals.

Theme 7: Lack of system and physician performance accountability measures

Respondents felt that some current indicators did not capture what is important. A particular omission, mentioned by 53% of survey respondents, was that valuable cross-system accountability or performance measures such as measures of integration across the system are not captured by current requirements. It was also noted that physician accountability indicators (e.g., conservable hospital-stay days, physician performance) were not reported on a system-wide basis, despite the fact that physicians contribute to driving the performance of hospitals. Some hospitals have begun to capture individual physician performance data, but this practice is neither common nor mandatory.

Discussion and Conclusion

In this study, we found that the dominant dimensions of hospital accountability that drive both internal and external reporting were financial and quality performance dimensions. Hospitals' internal reports usually include the performance measures that are also required in reports to external organizations. Our respondents suggested that internal hospital accountability systems are influenced by external hospital reporting requirements, even if these did not provide the optimal data needed for internal purposes.

Reporting is seen as a valuable mechanism for hospitals and the health system to monitor and track progress against desired outcomes. Within hospitals, many different accountabilities and indicators are tracked, and the degree to which hospitals are required to report is seen by some as challenging. The study showed that smaller hospitals in particular struggle with reporting because they do not have the necessary resources, either through a lack of budget, inability to retain staff with the skill sets required or internal resource allocation decisions. Indeed, the low survey response rate (26.7%) from smaller hospitals could have also been a result of these limited resources and gives a fuller picture of the challenges of reporting in rural hospitals. With the increased focus on internal and external reporting, it was interesting to find that most hospitals do not have sophisticated reporting tools to capture and report performance data. Manual reporting is still prevalent and may affect data quality.

There is a tendency for hospitals to monitor performance for those processes and outcomes that have high measurability and controllability. In particular, the desire to have indicators that have high measurability and controllability has resulted in few across-system measures being reported, despite increased stress on improving system integration. There was also a perception among our respondents that organizations report publicly only that information which is required, as there are no incentives or mechanisms to report additional information. With increasing pressures to advance the culture of accountability and quality

improvement, hospitals must focus on increasing the quality of their data and improving the alignment across the various bodies to which these data must be reported so they can utilize it to drive quality improvement.

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Accountability in the Ontario Cancer Services System: A Qualitative Study of System Leaders' Perspectives

Obligation de rendre compte dans le système ontarien des services de cancérologie : étude qualitative sur le point de vue des leaders du système



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Abstract

Cancer Care Ontario (CCO), the provincial cancer agency, operates under a model of accountable governance that has been hailed as exemplary. We explored cancer system leaders' views on the balance and perceived efficacy of approaches to accountability in this context. Semi-structured interviews were conducted with 19 participants (MOHLTC=5, CCO=14).

Adopting a qualitative descriptive approach, we coded data for four policy instruments used in approaches to accountability. Financial incentives are a key lever used by both parties to effect change. Cancer-specific regulations were somewhat weak, but agency-wide directives were a necessary nuisance that had great force. The effect of public reporting on mobilizing consumer sovereignty was questioned; however, transparency for its own sake was highly valued. Professionalism and stewardship, with an emphasis on trust-based partnerships and clinical engagement, were critical to CCO's success. These approaches were seen to work together, but what made each have force was reliance on professionalism and stewardship.

Résumé

Le modèle de gouvernance responsable d'Action Cancer Ontario (ACO), l'organisme provincial de cancérologie, est souvent qualifié d'exemplaire. Nous nous intéressons au point de vue des leaders du système de cancérologie sur l'équilibre et l'efficacité perçue des démarches d'obligation de rendre compte dans ce contexte. Nous avons mené des entrevues semi-dirigées auprès de 19 personnes (MSSLD=5, ACO=14). À l'aide d'une méthode qualitative descriptive, nous avons codifié les données portant sur quatre instruments de politique utilisés dans les démarches liées à l'obligation de rendre compte. Les incitatifs financiers constituent un important levier, utilisé par les deux parties, pour accomplir des changements. Les règlements propres à la cancérologie sont un peu imprécis, mais les directives de l'ensemble de l'organisation constituent un mal nécessaire qui présente une force appréciable. L'effet de la présentation de rapports publics comme facteur de mobilisation pour la primauté du consommateur est remis en question; cependant, la transparence en soi est hautement valorisée. Le professionnalisme et la gérance, avec un accent sur les partenariats et l'engagement clinique fondés sur la confiance, sont essentiels pour le succès d'ACO. Il semble que ces démarches fonctionnent ensemble, mais ce qui fait la force de chacune d'entre elles est la confiance accordée au professionnalisme et à la gérance.

IN ONTARIO, THE CANCER SYSTEM IS OVERSEEN BY CANCER CARE ONTARIO (CCO), a provincial agency and primary adviser on cancer services. CCO's approach has been hailed both at home and abroad for providing insights into how a disease-specific government agency has used various levers to improve quality of care and facilitate partnerships among various stakeholders (Nolte et al. 2008; Ontario Ministry of Finance 2012). We explored system leaders' views on the balance of approaches to accountability at play and their perceived efficacy.

Characteristics of the Sector

In recent years, the Ontario Ministry of Health and Long-Term Care (MOHLTC) has moved from managing regional service delivery towards a stewardship role (Lomas and Brown 2009). Legislated under the *Cancer Act*, CCO is the main adviser to MOHLTC on the cancer

system and plays a brokering role between the ministry and cancer care providers (Thompson and Martin 2004). A memorandum of understanding (MOU) between MOHLTC and CCO defines the terms and expectations of their relationship. A three-year rolling business plan and program-specific accountability agreements provide the basis on which yearly funding is negotiated. These financial contracts reflect the priorities identified by CCO and its partners in their three-year Ontario Cancer Plan, which provides a strategic road map for system improvement.

CCO is responsible for the allocation of approximately \$700 million in funding of cancer services annually (Duvalco et al. 2009). Following restructuring in the early 2000s, CCO moved from being a provider of a limited number of cancer services to overseeing the provision of a broader range of services delivered regionally (Sullivan et al. 2004). (See Cowan 2004 for a detailed history of the integration of cancer services in Ontario.) Currently, performance-based funding agreements exist between CCO and each of its 14 regional cancer programs (Thompson and Martin 2004).

A model of accountability that aligns clinical and administrative approaches to accountability was established, supported by three advisory councils (Dobrow et al. 2008). The Clinical Council consists chiefly of provincial clinical program heads and is responsible for reviewing and making recommendations to the CEO of CCO on all policies, standards, guidelines and clinical care initiatives. The Provincial Leadership Council advises on the planning and coordination of cancer service provision across the province and consists primarily of regional vice presidents. Public accountability is supported by a quasi-independent advisory body, the Cancer Quality Council of Ontario (CQCO), with a mandate to monitor and report publicly on overall cancer system performance, and to make recommendations for improvements to the minister of health through CCO's board of directors (Dobrow et al. 2006). This model of accountability is supported by a comprehensive performance management system that enabled CCO to tie government funding to healthcare delivery and quality (Cheng and Thompson 2006).

Methods

We conducted a qualitative study of Ontario health and cancer system leaders' perspectives on accountability. With ethics approval from the University of Toronto Health Sciences Research Ethics Board, as well as informed consent from participants, we conducted interviews from June to October 2012 with (a) senior civil servants at MOHLTC and (b) board, executive team and advisory council members at CCO. Participants were selected purposively because of their familiarity with and leadership role within the cancer system and, thus, their capacity to provide information-rich descriptions of their experiences (Patton 2001).

Using a semi-structured interview guide, we explored participants' perspectives on (a) how expectations between MOHLTC and CCO are established, (b) the goals of accountability and (c) lessons learned. The guide was developed using the "promises of accountability" framework, which captures the range of meanings that policy makers and managers attribute

to accountability – specifically, the goals of control, integrity, ethical behaviour, legitimacy, performance and justice (Dubnick and Frederickson 2011; Dubnick and Yang 2011). The guide was designed with awareness of existing approaches to accountability at play in the cancer system, but was not used to probe for them specifically, allowing participants to identify what was relevant in their view. Interviews averaged one hour in duration; each was audio-recorded, transcribed verbatim and entered into a web application for the management and analysis of qualitative data (Dedoose version 4.5).

Results

In total, 19 of 24 potential participants completed an interview for the study (five from MOHLTC and 14 from CCO). We review results across the four approaches to accountability: financial incentives, regulations, information, and professionalism and stewardship.

Financial incentives were seen as foundational to the relationship between CCO and MOHLTC. Unlike CCO, which has many levers at its disposal, money was viewed as one of the only tools available to MOHLTC:

... money, I mean, it will keep coming back to money as the biggest lever, right. It's one of the few levers they have. ... [CCO] has a variety of levers. ... But the ministry, when you think about it, they don't have that many levers in the Ontario healthcare system. [29-CCO]

The way in which MOHLTC funds CCO is still not seen to be ideal. A participant from MOHLTC described the desire to move towards more of an outcomes-based funding model:

We eventually want to get to the point where everything is on the cancer outcomes, but in the interim I think we're not there yet. ... we'd like to monitor on those big outcomes, but right now we tend to monitor on activities. [38-MOHLTC]

Similarly, another participant highlighted the desire to move from volume to quality-based funding – and also the challenge of doing so:

Now, what would happen if we didn't achieve a quality metric? Well, it's not clear to me because that's not really the way the ministry works, right. ... what would happen then if somebody saw the right number of patients, but didn't provide the right care? I don't think anybody really knows yet how to handle that, but it's clearly a direction that everybody's moving in. [29-CCO]

Each year, MOHLTC undergoes a reconciliation process with its agencies. However, a participant was unsure what would happen if CCO failed to meet its mandate to improve the system overall:

I don't know if there's something as, you know, formal as a kind of remedy if the results aren't achieved. ... They're not held to account in the way that you would think. [24-MOHLTC]

Although we heard repeatedly that "it's not only money" [46-CCO] that drives the cancer system, funding is leveraged by CCO to encourage participation from the regions:

The way they tend to get their cooperation is they have a little bit of incremental money. ... So they don't have all the money in the cancer centre, but they have sufficient [money] to get people to pay attention. [24-MOHLTC]

Critically, CCO uses money to incentivize participation from clinicians, who are "not going to do things for free." [20-CCO] As this participant described:

... the health professions are pretty slow to change ... it's like a big elephant ... That's a real problem. So how do you do that? Well, you can do it by incentives – financial or otherwise. [42-MOHLTC]

Although CCO has been quite successful in "fund[ing] a lot of doctors to help us" where "the rest of the healthcare system doesn't" [41-CCO], there remains room for improvement:

I think there is a barrier in the way in which resources, financial resources, are used in terms of delivery in the system – hospitals, doctors' compensation, all of those issues are not as well aligned as they could be. [46-CCO]

Two sets of regulations were seen to apply to CCO: those specific to the goals of cancer care and those applicable to all agencies of government.

The *Cancer Act* was not seen by all to be particularly useful, although MOHLTC will sometimes use it as a threat to CCO:

It's not very specific. I mean, you could drive a truck through it. ... Sometimes the ministry will use that as a threat, though. ... It can sometimes be used as a club. ... It doesn't really define the relationship. [42-MOHLTC]

With each iteration, the MOU between CCO and MOHLTC becomes more detailed, creating what this participant called a "tighter leash":

... definitely, the accountability and the structure around accountability has changed significantly in the last number of years. It's almost a significant leap towards more accountability. ... the MOU that we signed in 2009 ... basically provided a tighter

leash from the ministry to CCO. ... So that MOU becomes tighter and tighter as time goes on. [20-CCO]

The directives to which all agencies of government are held had much more force, and were seen by some to make CCO less nimble. Speaking to the effect of these directives, in general, several CCO participants felt the burden:

... the inefficiency of having multiple levels of oversight is, it's pretty obvious to us. ... Like anything, things might have started based on sound problem solving, but they get taken to an extreme that becomes absurd. [29-CCO]

Although these bureaucratic controls were often perceived as a nuisance, they were simultaneously understood to be ultimately necessary:

I think the sad reality is these sorts of mechanisms or processes do serve to remind people of what's right and what's wrong and the importance to stay out of trouble. [30-CCO]

Participants from the ministry were sympathetic and acknowledged that steps were being taken to minimize the burden:

... there might be an overemphasis on some of the control aspects of accountability ... we want to try and make the kind of requirements that we have as not too onerous on them, streamline reporting requirements, et cetera. [38-MOHLTC]

Further, for a MOHLTC participant, these controls are a necessary condition for agency success:

I don't think these controls really have nothing to say about whether they [agencies] are achieving their goals. ... for organizations to be successful, they have to be impeccable in terms of their administrative oversight. ... if organizations want to excel, they have to make sure that their house is in order. [24-MOHLTC]

One of the key ways in which CCO fulfills its "accountability to the public" [20-CCO] is through information, including the work of the CQCO – specifically, the yearly Cancer System Quality Index. As one participant explains, CCO "should be transparent in terms of how we're doing and we should be open to public scrutiny." [46-CCO]

However, there was some discrepancy about who the CQCO really reports to. On the one hand, some participants echoed the council's mandate that "we report to the people of

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Ontario – that's our audience." [27-CCO] However, other participants questioned this view and felt that the real audience is actually the people working in the cancer system:

I don't think the public looks at it, but the people who are in the organizations do. ... it's not the public you're really reporting to. That part is just an illusion. [50-CCO]

To rectify this, some participants recognized the need to modify the council's approach:

We need to start putting the indicators in a different kind of framework so it would be more accessible to the public. ... Then, that really makes it accountable to the public because then everyone is actually able to access the information that's in there. I think we're achieving our mandate right now, which is that we are accountable to the public and we release things publicly. We get things out there but I think we could do more. [21-CCO]

Indeed, another participant took the critique one step further – there is a difference in the way that you report to various "publics," and it is not entirely clear what role public reporting plays in actually changing consumer behaviour:

The way you report to publics versus cancer system people versus the ministry of health versus CCO, very different ways of doing that, and particularly, the distinction between reporting to public versus health system folks. ... The evidence I've seen is that it actually doesn't do a whole lot towards changing behaviour. How would they choose differently? [31-CCO]

Despite this criticism, participants felt that there was great value in simply being transparent, as "the public has a right to know." [42-MOHLTC] Further, this "transparency is real value because that's public confidence and trust." [46-CCO] However, the same participant who questioned the effect of public reporting on consumer behaviour urged caution:

I think you have to be careful about what you're being transparent about. ... You're just putting information out there without any context, and potentially alarming and misinforming. [31-CQCO]

Professionalism and stewardship is a key instrument. Several participants reflected on the legacy of cancer system restructuring. By the early 2000s, wait times had become "a big embarrassment for the ministry" and, in response, a private after-hours radiation clinic was opened, which became "a microcosm of the issues that plagued CCO." [29-CCO] This led to "a lot of animosity" [20-CCO] and "bad blood" [24-CCO] in the system. Rather than terminate CCO, MOHLTC agreed to restructuring. From the perspective of one ministry participant, "that's where I've kind of seen them build back up." [24-MOHLTC]

Participants spoke highly of the current relationship between MOHLTC, CCO and providers. Mutual trust was seen to enable CCO's success:

We have a fixed cancer system. ... because the ministry placed in the organization a trust to do it better. A trust has actually built the environment to allow both organizations to succeed. [38-CCO]

A number of performance monitoring techniques were cited as ways in which both the regions and CCO itself are held accountable. CQCO was seen by many as a key tool for holding CCO accountable for overall system performance:

It's very helpful actually to have that kind of public spotlight scrutiny, because it provides some pressure to move the bar higher. Not only for us but for all our partners. [46-CCO]

The quarterly review process between CCO and its regions was a second key performance monitoring tool. As this participant put it, "If you pay somebody to come and paint your house, you want to make sure you inspect it to make sure they've done a good job." [20-CCO] This "holding people's feet to the fire when you don't get results" has become "a very strong brand" [38-CCO] for CCO.

Quarterly reviews provide valuable face time between the provincial and regional offices, allowing regional vice presidents to voice issues to CCO and advocate for their regional team:

... I take advantage of it to make my points to CCO. I also make my points to the people on my team that I'm advocating for them. ... It's a whole complex dynamic. [50-CCO]

One participant, however, was cynical about the process beyond providing face time between the regions and the provincial office:

I don't think quarterly reviews are useful, but on performance management I think what they do is they give the required face time of their team and our team. So it's a kumbaya, but it's not going to be a region performance-changing event. [38-CCO]

Importantly, the data generated through this process leverage a collective and individual sense of wanting to improve, because "nobody wants to be near the bottom" [50-CCO]:

... one region, one year they were worst at something, then next year they were the best. And that change was made only by showing them the data. Not spending a penny. Because nobody wants to be the worst. [41-CCO]

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Despite the benefits of collecting performance data, many participants expressed concern about the potential for “indicator mania” [41-CCO]:

... we can at times over-measure. Having too many measurements isn't necessarily a good thing. ... I think we need to be very clear that it's clinically relevant and make sure that it's for a good reason that we're measuring it. [45-CCO]

CCO's ability to engage clinicians by providing these data was seen as essential to its work and has created “credibility across the system” [24-MOHLTC]:

... a large part of [CCO's] success formula has been that it's always done it through working with clinician leadership and getting people who are recognized in the field, who are credible onside and working, so it's never been sort of perceived as a bunch of bureaucrats [30-CCO]

Further, CCO “bring[s] the science and the clinical engagement to the table, which are key assets that the government doesn't have.” [35-CCO] Indeed, MOHLTC relies on CCO to “be a bit of a buffer” by “removing decision-making from the political arena and depoliticizing stuff” [30-CCO]:

I think it's very easy for people to say, “What is a bureaucrat going to know about this particular case? It's very easy for them to stand aside and make these black-and-white decisions.” And, so, we need Cancer Care Ontario folks to kind of help advance that discussion a bit. [23-MOHLTC]

However, many participants felt that there was still more to be done to engage the clinical community. The difficulty of engaging more clinicians is exacerbated by the fact that, historically, physicians have had “a sort of carte blanche status” [20-CCO] in the healthcare system and tended to be “treated like different animals” [24-CCO]:

... we're probably still falling short on the clinician side. It is not necessarily because we don't reach out, but it's hard to involve everyone. ... It's still a minority of physicians that are involved, that are interested in trying to make the system better. [45-CCO]

Discussion

CCO's governance model of aligning clinical and administrative accountability, supported by a comprehensive performance management system and commitment to public reporting, employs each of the four approaches to accountability.

Financial incentives are a key lever used by both MOHLTC and CCO to effect change. While money is foundational to both the ministry and CCO, as we heard, these relationships

extend beyond simple funding arrangements. There is a desire on both sides to move towards outcome- and quality-based funding, but challenges persist. Further, barriers exist in the way funding is used to motivate participation throughout the regions down to the level of individual clinicians.

Regulations specific to meeting the goals of cancer care were somewhat weak, whereas agency-wide directives had great force but were felt to be a necessary nuisance. Ministry respondents recognized the potential for burden in meeting agency directives and acknowledged that efforts are being made to streamline reporting requirements. However, on both sides of the relationship, participants recognized that compliance with these types of regulations were not without warrant and ultimately reflected good business practice.

The effect of public reporting on mobilizing consumer sovereignty was questioned by some. There was some discrepancy in terms of which “public” these reports served. As a tool for change, public reporting encourages those working in the system to continuously improve their performance. Transparency for its own sake was regarded as adding value by building confidence and trust.

All these approaches to accountability were seen to work together, but what makes each ultimately have force is reliance on professionalism and stewardship. A variety of performance monitoring tools are used to appeal to administrators’ and clinicians’ individual and collective sense of wanting to improve. However, some cautioned against over-measurement as detracting from this goal. While CCO’s ability to engage and promote regional leadership has generated a sense of its legitimacy across the system, and as an authority the ministry will call on from time to time, there remains room for improvement to further engender a sense of shared responsibility and partnership.

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Home and Community Care Sector Accountability

Obligation de rendre compte dans le secteur des soins à domicile et en milieu communautaire



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Abstract

This paper focuses on accountability for the home and community care (HCC) sector in Ontario. The many different service delivery approaches, funding methods and types of organizations delivering HCC services make this sector highly heterogeneous. Findings from a document analysis and environmental scan suggest that organizations delivering HCC services face multiple accountability requirements from a wide array of stakeholders. Government

stakeholders tend to rely on regulatory and expenditure instruments to hold organizations to account for service delivery. Semi-structured key informant interview respondents reported that the expenditure-based accountability tools being used carried a number of unintended consequences, both positive and negative. These include an increased organizational focus on quality, shifting care time away from clients (particularly problematic for small agencies), dissuading innovation, and reliance on performance indicators that do not adequately support the delivery of high-quality care.

Résumé

Cet article porte sur l'obligation de rendre compte dans le secteur des soins à domicile et en milieu communautaire (SDC) en Ontario. Ce secteur est très hétérogène étant donné les divers types de prestation de services, de méthodes de financement et d'organisations qui offrent de tels services. Les conclusions d'une analyse du secteur font voir que les organisations qui offrent des services de SDC font face à de nombreuses exigences, provenant d'une vaste gamme d'intervenants, quant à l'obligation de rendre compte. Les représentants du gouvernement sont plus enclins à compter sur les instruments réglementaires et de dépenses pour tenir les organisations responsables de la prestation de services. Les personnes interrogées dans le cadre d'entrevues semi-dirigées indiquent que les outils de responsabilisation axés sur les dépenses ont des répercussions non intentionnelles, qu'elles soient positives ou négatives. Cela comprend l'accroissement des efforts visant la qualité, le déplacement du temps consacré aux clients (un effet particulièrement problématique pour les petites organisations), l'entrave à l'innovation et l'utilisation d'indicateurs de rendement qui n'appuient pas adéquatement la prestation de soins de qualité supérieure.

THE HOME AND COMMUNITY CARE (HCC) SECTOR IN ONTARIO HAS CHARACTERISTICS that create a number of challenges to accountability policy. As noted in the introduction to this issue (Deber 2014), the accountability literature suggests that accountability is best understood by three components: accountability “to whom” (the parties involved in the accountability relationship), accountability “for what” (the activities for which parties in the relationship are responsible) and accountability “at what cost” (the sanctions associated with failure to meet responsibilities) (Bergsteiner and Avery 2009; Brinkerhoff 2003; Thomas 1998). Accountability can serve three main purposes: (a) financial accountability (focuses on financial procedural compliance), (b) performance accountability (focuses on outputs and results) and (c) political/democratic accountability (focuses on fulfilling public trust) (Brinkerhoff 2003, 2004).

Using document analysis and key informant interviews, we define the accountability landscape for the HCC sector; this analysis is part of a larger study (Steele Gray 2014).

What Is Home and Community Care?

HCC refers to a basket of support services that can be delivered to clients in their home. The mix of HCC services is provided by both regulated and unregulated care providers. Nursing, physiotherapy, occupational therapy, speech therapy, social work and dietetic services are offered by regulated workers. Unregulated workers, including personal support workers and other community services staff, offer personal care (bathing, dressing and feeding), homemaking, respite services, Meals on Wheels, friendly visitor programs, transportation, security checks, recreation/social programs, lawn and home services, as well as day programs, in community settings. HCC services support a diverse population of clients including seniors, children with complex care needs, those with physical or mental disabilities, and individuals with mental health issues. HCC services have been classified as (a) acute care substitution (supporting individuals who would otherwise have to enter or remain in an acute care facility); (b) long-term care substitution (supporting individuals who would otherwise need to be institutionalized); and (c) maintenance and prevention (helping individuals stay independent in their current living environments (Anderson and Parent 2000; Baranek et al. 2004; Canadian Healthcare Association 2009; Dumont-Lemasson et al. 1999; Hollander and Walker 1998). The types of services and the methods through which they are delivered differ for varying client populations. This study focused on services provided to seniors over the age of 65, including the frail elderly.

As identified in the introduction (Deber 2014), we anticipate that “production characteristics” of a sector may affect accountability. HCC services would be classified as highly contestable, in that there are low barriers to market entry and exit (Preker et al. 2000); as low in observability (i.e., it is not conducive to direct oversight), particularly when delivered in a home setting; and as low in measurability (i.e., it is difficult to measure performance in the sector).

Home and Community Care in Ontario

Both private not-for-profit and private for-profit organizations deliver HCC in Canada. Payers for HCC vary considerably by jurisdiction, type of service and type of client. HCC does not fall under the comprehensiveness requirements of the *Canada Health Act*, which specify full coverage only for medically necessary services provided in hospitals or by physicians; however, provinces and territories are able to go beyond these “floor” requirements (Marchildon 2013). In Ontario, public funds may pay for certain professional services (particularly for clients in the acute care substitution category, where policy makers can defend these services as cost-effective by speeding discharge from hospital), while clients and their families, private insurance and sometimes charities pay for most non-professional services. HCC services are available to clients through a variety of different access points, which may vary in their eligibility requirements and costs, and are funded in a variety of ways (Williams et al. 2009).

The Ontario Ministry of Health and Long-Term Care (MOHLTC) flows its HCC funding through 14 geographically based local health integration networks (LHINs),

Ontario's regional health authorities created in 2006. The LHINs flow these funds to certain local health services including hospitals, long-term care, mental health and addictions services, community health centres, community care access centres (CCACs) and community support services. CCACs, in turn, purchase professional home care services for eligible clients on a competitive basis under capped budgets set by the province. Services are allocated to individuals, but there is a ceiling on the amount or units of services that individuals may receive (Williams et al. 2009). The LHINs also fund some community care services through multi-service accountability agreements (MSAAs), a multi-year agreement for service delivery between LHINs and health service providers (HSPs).¹ The MSAA provides funding for a basket of services to be delivered by the HSP in a particular geographic area. Individuals can also purchase HCC services privately from a wide array of HCC service providers. The Ontario Home Care Association (OHCA) reports that MOHLTC annually purchases 28.6 million visits/hours of home care per year, with another 20 million visits/hours being purchased privately (OHCA 2010).

Accountability Instruments

This study draws on Doern and Phidd's (1992) model of policy instruments to classify and examine the accountability instruments in place for HCC agencies. The model helps to understand why some tools are chosen over others (tools may be chosen based on level of coerciveness, costs of implementation and political acceptability) and the policy trade-offs associated with those choices. Doern and Phidd's model suggests five policy instruments, which can be used as both the means and the ends through which policy goals are pursued. These include self-regulation (private behaviour), exhortation, expenditure, regulation (including taxation) and public ownership. Definitions of these tools are included in the introduction to this Special Issue (Deber 2014).

Methods

This paper presents selected findings gathered through an environmental scan, document analysis and semi-structured interviews. The environmental scan was used to identify accountability requirements imposed on HCC agencies. Documents were gathered primarily from websites including Ontario e-laws, Ontario ministry and agency sites and accreditation sites. In some cases, research partners or key informants who provided insight into accountability demands on HCC organizations in Ontario provided additional documents.

Key informant interviews were conducted with the representatives from one urban and one rural CCAC and LHIN (organizations holding HCCs to account) and with HCC agencies from those two regions as part of a larger study (Steele Gray 2014). Interviews were conducted between September and December 2011. Findings presented here flow from questions regarding challenges and unintended consequences of accountability tools. Purposive criterion sampling (Patton 2001; Teddlie and Yu 2007) was used to identify individuals and organizations to include in the sample, allowing us to target individuals with knowledge required to

answer interview questions. Interviews were conducted with four individuals (one from each LHIN and CCAC) who were involved at the managerial or directorial level in administering the MSAA or CCAC contracts, and 20 individuals representing 13 different community service agencies (CSAs) delivering HCC services in the two regions. Organizations were identified with the help of the LHIN and CCAC interviewees as examples of different types of organizations involved in MSAA and CCAC contracts.

Analysis

Participants were allowed to view their transcripts and provide feedback on whether they felt their views were reflected. Documents relating to the LHIN MSAA and CCAC contract and interview transcripts were thematically coded. Code themes were identified from the literature,² with additional codes being included as new themes emerged in the coding process. A subsample of three documents and four interviews were double-coded by the primary investigator and by a colleague to validate the coding scheme. Once researchers agreed on the set of themes, analytic coding was applied (Cresswell 2003) using NVivo 10 software. Further details regarding the analysis can be found in Steele Gray (2014).

The findings from our document and environmental scan serve to identify the accountability mechanisms in place, while findings from our key informant interviews shed light on implementation issues associated with dominant accountability tools. To preserve anonymity, respondents are identified by number (e.g., CSA 2) in the quotations presented below.

Document and Environmental Scan Findings: Accountability Mechanisms in Place

The environmental scan revealed a wide array of accountability requirements imposed on HCC agencies; they include examples of regulation, expenditure and exhortation policy instruments. Exhortation tools are used primarily by non-governmental stakeholders, such as clients, families, caregivers, shareholders (in the case of for-profit providers) and volunteers (in the case of not-for-profit providers). HCC agencies believe that they are accountable to these groups through their mission and value statements; however, it is not clear how they in fact demonstrate accountability to these non-governmental stakeholders other than through such mechanisms as annual reports or meetings.

Government agencies rely more heavily on regulation and expenditure instruments to hold HCC organizations to account. Regulation instruments include government legislation and regulations that apply broadly to most organizations operating in Ontario (e.g., *Occupational Health and Safety Act*, 1990), social regulations that are imposed on healthcare organizations more specifically (e.g., *Personal Health Information Protection Act*, 2004) and regulations concerning controlled acts performed by healthcare professionals (*Regulated Health Professions Act*, 1991).

Regulation tools are sometimes combined with expenditure tools; for example, HCC organizations that receive government funding for delivering certain services may be bound

by regulations and policies linked to funding for those services (e.g., *Assisted Living Services for High Risk Seniors Policy*, 2011). Expenditure tools commonly rely on performance measurement to hold organizations to account for the funding they receive. Formalized performance reporting systems are particularly important as they enhance the strength of accountability relationships (Bergsteiner and Avery 2009). In Ontario, HCC organizations receiving funding from government agencies are required to report on performance measures on a fixed schedule (which may be quarterly, yearly or both), and missed performance targets can result in reduction or loss of funding. Expenditure tools, in particular LHIN and CCAC funding for HCC services, represent the primary method through which the Ontario government holds HCC agencies to account, and as such are the focus of the remainder of this paper.

Document analysis revealed that the MSAA and CCAC contracts primarily seek to ensure financial and performance accountability. However, production characteristics do appear to play a role. Performance accountability tends to focus on process-level performance (such as access to services, number of services delivered, number of clients), with little attention to potentially important but difficult-to-measure outcomes (such as maintaining a person's independence and capacity to stay at home and delaying functional decline in everyday activities).

Key Informant Interview Findings: Implementation Issues Associated with LHIN MSAA and CCAC Contracts

Key informants were asked about the implementation issues associated with the MSAA and CCAC contract accountability requirements and specifically about any unintended consequences and challenges associated with performance indicators. The following sections summarize the central themes in these two areas identified through analysis of interview findings.

Unintended consequences

The analysis of interview findings suggested that there are both positive and negative unintended consequences associated with the MSAA and CCAC contracts. Participants considered the unintended positive changes in the organization to be the unexpected but welcome effects of the accountability agreements. For example, one positive unintended consequence identified by interview participants was that the MSAA and CCAC contracts increased focus on quality across their organizations:

[The MSAA] focus us probably a little bit more [on quality] like [another interviewee] said and make us more aware of things that we probably could do better or differently. (CSA 2)

I think that the fact that we report on quality indicators quarterly and monthly to the CCAC is known from top to bottom in the organization. They see their team reports. They get competitive between the teams about who is going to perform

better. ... If I was trying to engender that much focus on quality by myself as the director of quality, I think it would probably be a little bit harder. (CSA 8)

Participants also reported negative unintended consequences, and unexpected effects of the accountability agreements that yielded negative changes in the organization. Negative unintended consequences identified included (a) shifting front-line staff time and (b) hindering innovation. Shifting front-line staff time away from client care and towards reporting was amplified for smaller organizations that have fewer resources to devote to reporting requirements. This shift of time away from client care was one of the main reasons for one organization's abandoning its MSAA, returning the funding and deciding not to apply for an MSAA in the future. The participant identified that meeting MSAA requirements as part of reporting for strategic planning or updates took too much time away from clients:

... if I'm wasting 12 hours in a meeting, [and] a drive, it's gone. It's 12 hours that are not being given to my client. (CSA 1)

Participants also pointed to the negative effect of the MSAA on innovation. Some participants identified that they were not comfortable innovating with respect to service delivery, such as adopting new delivery processes or programs that could negatively affect performance targets:

There [are] very few people that are going to take a lot of risk in this kind of environment. ... I don't think we are going to take too many risks. (CSA 10)

The MSAA, they are so criteria-based, you hit the mark, or you didn't. They don't allow that developmental learning to go on. ... And they are very clear to me. If I don't hit my targets, it has implications on [my] receiving the funding again. (CSA 13)

Problems with performance indicators

In addition to unintended consequences, interview participants noted that the performance indicators in the MSAA and CCAC contracts focused heavily on process indicators to the exclusion of outcome measures. While they recognized that health outcomes in community care are difficult to measure, they nonetheless felt that such indicators were important to demonstrate the quality and the funding "worth" of HCC services:

We don't do a lot of outcome measurements. I don't think there are any actually related to client outcomes or achieving the client goals. ... Outcome [indicators], although difficult ... would be very important to ensure that we are using the CCAC dollars appropriately. (CSA 7)

The outcome measures are things like satisfaction with the service. Was the personal care that we are providing, is it increasing the person's independence? Those are harder to measure. (Urban CCAC)

Participants were also concerned that indicators did not take into consideration contextual factors that may affect the meeting of performance targets. Of particular concern to rural organizations is that current indicators merely count the number of home care visits without considering the travel time to get to the visit. Participants also identified that indicators reflected aspects of service delivery that providers cannot control, such as staff turnover rate, which is affected by severe labour shortages that are characteristic of the HCC sector (in large part because this sector pays lower wages than do hospitals or even LTC institutions):

Continuity is definitely something that is important to capture in terms of providing services to the client, but the targets that are established by the CCACs sometimes do not reflect the reality of the service providers in the ability to find staff to meet the targets. Same with the ability to accept referrals. As the service volumes increase and increase from CCACs, when we are experiencing severe human resource challenges there's a bit of a disconnect there. (CSA 4-1)

Participants further reported that some CCAC indicators actually compete against one another, such that meeting a target in one area may well mean sacrificing targets in another. One participant describes how meeting referral targets can affect continuity targets:

... sometimes we don't meet target because targets compete with each other; for instance, sometimes we compromise continuity because we want to take a referral. ... A referral will come in, in the evening because the client has been discharged from hospital stay. We will send the evening nurse ... or somebody that could go [in order to meet the referral request] ... but on an ongoing basis [the] initial evening nurse won't be on [the service team for the client]. (CSA 5)

All respondents, even those from the LHINs and CCACs, reported that the MSAA and CCAC contract performance indicators do not accurately capture their perception of high-quality HCC services.

Discussion

In general, the delivery of HCC services is more tightly controlled when agencies are receiving government funding; otherwise, they are subject only to existing legislation that does not cover many aspects of service delivery, and a variety of voluntary tools that organizations may or may not wish to follow. Expenditure instruments carry a number of advantages, including

encouraging certain activities, permitting flexibility, encouraging innovation and potentially reducing costs. Expenditure instruments also tend to be politically acceptable to policy makers (Howlett and Ramesh 1993).

Despite the number of advantages and the political appeal of expenditure instruments, these tools may be difficult to establish, the associated information costs are high (i.e., requiring information on reporting) and in some instances they may be redundant (i.e., where the activity would have occurred without any funding) (Hood and Margetts 2007; Howlett and Ramesh 1993). By definition, expenditure tools often come with a set of conditions to control how that funding is spent. As previously indicated, performance reporting is considered to strengthen accountability; however, our respondents suggested that this advantage may be offset by the implementation issues identified in our analysis. As such, the problem may not be the expenditure tool, but rather the way in which it is implemented. It is possible that expenditure instruments could be implemented differently in order to support attributes such as innovation, for example, by building in incentives for innovative practice or developing performance indicators related to innovation.

While performance reporting strengthens financial accountability in funding relationships, our findings suggest that the other purposes of accountability (performance and political) are not well supported by the CCAC contracts and MSAAs. A particular concern is the problem with performance indicators, which do not adequately capture the quality aspect of service delivery. Furthermore, we need to recognize that performance may not always be equated with quality. As noted by Thomas (1998: 379): “Not all types of programs are equally amenable to results-based accountability. There are definitional and technical problems with performance measurement, especially when ‘soft’ services are being delivered, and these call into question the validity of such measures.” One encouraging development is a push by government funders for improved quality measurement in the HCC sector (although, like existing measures, these new outcome measures will cover only care providers in Ontario that receive government funding).

Conclusion

Study findings suggest that HCC agencies have a number of accountability requirements, many of which do not cover specifics about HCC service delivery. While expenditure tools more directly hold HCC agencies to account for service delivery, the poor measurability and low observability of the sector means that the accountability frameworks in use focus more heavily on financial performance rather than quality performance, tempered because the high contestability in urban areas may make it easier to replace providers who do not wish to work within these rules. Expenditure tools additionally come with a number of negative unintended consequences that can affect quality service delivery, particularly for small agencies. Careful attention to how these accountability tools are implemented may be able to minimize some of these unintended consequences while retaining the advantages.

Notes

1. See <http://www.lhincollaborative.ca/Page.aspx?id=1968>.
2. Codes for the document analysis were derived from the accountability literature. Key domains included the purpose of accountability, responsibilities of each party, policy instruments used and sanctions for non-compliance. Codes for the interview analysis relevant to this paper pertained to unintended consequences of accountability.

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Accountability through Regulation in Ontario's Medical Laboratory Sector

Réglementation visant l'obligation de rendre compte dans le secteur des laboratoires médicaux en Ontario



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Abstract

Although the use of performance indicators for the analytical (and highly measurable) phase of the medical laboratory process has had a long and successful history, it is now recognized that the value of a laboratory test is embedded in a system of care. This case study, using both documents and interview data, examines the approaches to accountability in the Ontario Medical Laboratory Sector, noting both the challenges and benefits. This sector relies heavily on the regulation instrument, including a requirement that all medical laboratories licensed by the provincial government must follow the guidelines set out by the Quality Management Program – Laboratory Services. We found the greatest challenges exist in the pre-analytical phase (where a large portion of total laboratory errors occur), particularly the interface between the laboratory and other providers.

Résumé

Bien qu'on utilise depuis longtemps les indicateurs du rendement dans la phase analytique (et fortement mesurable) des processus en laboratoire médical, il est maintenant reconnu que la valeur d'un essai en laboratoire est inhérente au système de soins. Cette étude de cas, qui repose sur des données recueillies dans la documentation et par entrevues, examine les démarches visant l'obligation de rendre compte dans le secteur des laboratoires médicaux en Ontario, en soulignant tant les défis que les avantages. Ce secteur est très axé sur la réglementation, notamment avec l'exigence selon laquelle tous les laboratoires médicaux ayant obtenu licence auprès du gouvernement provincial doivent suivre les directives établies par le Quality Management Program – Laboratory Services. Nous avons observé que les principaux défis se situent dans la phase préanalytique (où a lieu une grande partie des erreurs en laboratoire), particulièrement dans le rapport entre le laboratoire et les autres fournisseurs.

MEDICAL LABORATORIES PROVIDE OBJECTIVE DATA ESSENTIAL FOR DIAGNOSIS, monitoring and treatment of patients, as well as playing an important role in disease control and surveillance; the Ontario Auditor General estimated that about 80% of such data came from the Medical Laboratory Sector (MLS) in Ontario (Office of the Auditor General of Ontario 2007).

The laboratory process is highly complex; it begins with the ordering of the test by the healthcare provider and ends with the interpretation of a test result that has a significant impact on patient care (Gamble and Deber 2004; Plebani 2009, 2010). The three phases of laboratory process are identified as pre-analytical (e.g., test ordering, collection and transportation), analytical or technical (e.g., conducting the test) and post-analytical (e.g., interpretation of results and the significance for patient care). It has been reported that the percentage of total errors ranges from 46% to 68.2% in the pre-analytical phase and from 18.5% to 47% in the post-analytical phase (Plebani 2006: 750). As a result, performance measurement for the MLS usually will not involve a single metric but includes a variety of assessments and approaches that require a systems approach to encompass all phases in the laboratory process. Indeed, to measure performance, most jurisdictions, including Ontario, require medical laboratories to continuously develop and implement new performance indicators in response to a number of challenges, including the introduction of new and innovative complex testing procedures (e.g., genetic testing and molecular diagnostics) and technologies (e.g., multi-analytic tests versus single laboratory test, point-of-care testing [POCT]), different delivery models (e.g., rapid response laboratories, core laboratories) and increased volume of testing in response to the increased incidence and prevalence of chronic conditions. The use and type of performance indicators may vary with differences in the type of services delivered, incentive structures in place, technology used and the population being served.

Performance indicators serve a number of purposes including the documentation of quality, comparisons over time and across settings, assisting in priority setting, supporting accountability, regulation and accreditation and quality improvement (Lohr 1990). Approaches in the past to measure and monitor performance in the MLS have used quality control methods and quality assessments that are focused on the analytical phase of testing (Gamble and Deber 2004; Plebani et al. 2006), but quality assurance in this sector has been expanding to focus across all three phases.

Quality Management of Laboratory Services in Canada

A quality management program for laboratory services, including external quality assessment (EQA) and laboratory accreditation, was first introduced and implemented in Ontario to address many of the concerns listed above. Other provinces across Canada have also implemented the same program, either voluntarily or as a result of regulatory requirements (Ontario Medical Association 2012). This case study sought to identify the approaches to accountability in the Ontario MLS, focusing on Ontario's Quality Management Program – Laboratory Services (QMP-LS), and to determine stakeholder views on the challenges and benefits of the approaches currently in place to aid those seeking to improve the quality of laboratory services in other jurisdictions.

The interpretation and implementation of the requirements of the QMP-LS are left to the responsibility of each individual laboratory. Accordingly, we interviewed individuals responsible for both the interpretation and implementation of the QMP-LS requirements.

Methodology

Using a similar conceptual framework and methodological approach to the other articles in this volume (Deber 2014), we combined a document analysis with a series of 20 semi-structured interviews with key stakeholders from the MLS. Among the websites consulted for the document analysis were the Canadian Society of Medical Laboratory Science (CSMLS), College of Medical Laboratory Technologists of Ontario (CMLTO), IMSM Canada Ltd Ontario (for ISO 17025:2005 Laboratory Competence), Office of the Auditor General of Ontario, Ontario Society of Medical Laboratory Technologists, QMP-LS, Service Ontario E-Law and The Institute for Quality Management in Healthcare. The sample for the interviews included eight laboratory managers, five medical laboratory technologists (MLTs), three educators, two physicians, one participant from a professional organization and one administrator. Seventeen (85%) of the respondents were female and three (15%) were male. Three participants were from private for-profit laboratories, 14 were from the private not-for-profit laboratories, two were from public health laboratories and one was from a private not-for-profit professional organization representing the medical laboratory profession. Data triangulation of information collected from the documents and interviews was used to enhance validity by compensating for the fallibility of either method (Bickman and Rog 1998).

Ontario MLS

The majority of medical laboratory services in Ontario are publicly funded. As a result, medical laboratories are accountable to the government (who pays and regulates this sector), to citizens (who through taxation provide the funds for the delivery of services), to providers (who order the tests) and, ultimately, to patients (who are the recipients of care resulting from the test interpretation). The costs to provide individual laboratory tests are related to factors such as the volume of testing (e.g., high-volume routine testing may gain economies of scales), level of automation (e.g., totally automated laboratory testing system versus POCT) and the extent of the technical expertise (e.g., scientist, pathologist, technician, technologists) needed to conduct and interpret the tests; these cost differences may or may not be reflected in the fees paid.

Like other health services in Ontario, most laboratory services are delivered by the private sector (Marchildon 2013). The Ontario MLS can accordingly be categorized into four sub-sectors, based on their public–private ownership status: hospital-based laboratories (private not-for-profit), community-based laboratories (private for-profit investor-owned), laboratories found in physician offices (private for-profit small businesses) and public health laboratories (public). Although variability exists in terms of ownership and governing structures, costs, testing procedures and types of testing services delivered, all publicly funded medical laboratories in Ontario, with the exception of testing done in physician offices, must comply with the *Ontario Laboratory and Specimen and Collection Centre Licensing Act* (Government of Ontario 1990).

The most recent published estimates reported by the Office of the Auditor General of Ontario (2007) indicate that in the 2005/2006 fiscal year, the Ontario Ministry of Health and Long-Term Care (MOHLTC) spent \$1.4 billion on laboratory services, of which hospital laboratory expenditure was \$824 million, private sector laboratory spending was \$572 million and \$4.4 million were provided to the Ontario Medical Association (OMA) to operate quality assurance programs. It is unclear whether this estimate for private sector laboratories includes laboratory costs for testing conducted in physician offices. However, a 2005 report by the Auditor General of Ontario stated that for the 2003/2004 fiscal year, the Ontario government paid \$30.8 million to more than 750 physicians for laboratory testing (Office of the Auditor General of Ontario 2005).

Hospital-based laboratories are funded through the hospital's global budget, which, as noted, is almost entirely publicly funded. Ontario's community-based laboratories receive public funding based on fee-for-service and bill the Ontario Health Insurance Plan, which covers most physician services. Under the funding model at the time of writing, funding levels for these laboratories were capped. The cap for each community-based laboratory (and its market share) varies (personal communication with an owner from a private for-profit investor-owned laboratory). Community-based laboratories can perform testing above the approved cap, but do not receive any additional funding for this from public sources. Testing performed in physician offices is also reimbursed based on a fee-for-service, but there is no imposed cap for these laboratories. Private sources of funding include payment for services through private insurance

and out-of-pocket payment by individuals (e.g., prostate-specific antigen testing) or employers (e.g., drug testing of truck drivers).

There is widespread agreement in the literature that improvements in the quality of service provided by medical laboratories are desirable, and that not having the proper regulation, controls and quality management system in place has potentially jeopardized the delivery of quality, safe, timely and appropriate care (Chafe et al. 2009; Plebani 2009). This has been highlighted by a series of errors associated with testing, primarily but not exclusively related to pathology laboratories; these have led to provincial inquiries and identified a number of issues associated with laboratory quality. For example, the Cameron Inquiry investigated errors in hormone receptor testing in the Eastern Health region in Newfoundland and Labrador, and determined that there was failure and oversight at all levels, including the medical laboratory. As noted by Justice Cameron "...had proper quality assurance and control policies been put in place and had been followed, the problem with ER/PR (estrogen and progesterone receptors in breast cancer) testing would certainly have been discovered much earlier" (Cameron 2009). Similar problems have been identified in other provinces (British Columbia, Manitoba, Ontario, Quebec and New Brunswick). However, as stated by André Picard, health reporter for *The Globe and Mail*, "there are no national standards, standards vary from province to province and sometimes from one lab to the next." (Picard 2012).

The discussion that follows is based on data collected from documents and interviews relating to public health laboratories, hospital-based laboratories and community-based laboratories.

Role of Laboratory Licensing

The approaches to accountability are mixed, and all four approaches (financial incentives, regulation, information directed to potential users and reliance on professionalism/stewardship) identified by Deber (2014) are used to a varying extent in the MLS. The complexity of the relationship between the different approaches is articulated in this statement from a manager of a regional hospital-based laboratory:

We are accountable fiscally first to our executive vice president for maintaining a balanced budget ... accountability for performance to meet the anticipated customer demands and align ourselves with the strategic plan ... we are accountable through performance indicators which are chosen and monitored to ensure that we are meeting the performance of expectations of our customers and includes things like turnaround time and accuracy ... so from a patient safety point of view we have direct accountability to the medical director and from the operational piece around fiscal management and performance to the VP , we have a dual accountability.

However, regulation plays a major role in determining who is accountable, and for what, in the MLS sector. An educator from a medical laboratory science program noted:

Regulation is what really drives our business. You know we have the Ontario Laboratory Accreditation process and then there are also other regulations just for best practice, people are following and when you are a leading academic institution, you need to follow those, you need to be aligned with your peers.

In terms of “accountable to whom,” there are a number of different legislative structures and stakeholders, both within government and outside government, who play a key role in the regulation of the Ontario MLS. Key stakeholders include but are not limited to the Ontario MOHLTC, the CSMLS, the CMLTO and the OMA. These regulations affect the people who can work in the MLS, as well as the laboratories themselves.

The CSMLS is a national body responsible for the certification of MLTs and medical laboratory assistants/technicians (MLAs) who work in medical laboratories or specimen collection centres. Medical laboratory technology is a regulated profession under the *Ontario Regulated Health Professions Act* and the *Medical Laboratory Technology Act*. The CMLTO is the regulatory college for Ontario’s MLTs. However, MLAs are not regulated in Ontario and work under supervision to assist in a number of pre-analytical activities.

The MOHLTC, under the *Ontario Laboratory and Specimen and Collection Centre Licensing Act*, licenses and regulates Ontario’s medical laboratories (Government of Ontario 1990). This Act sets out the guidelines that are used to own, operate and license a specimen collection centre or a laboratory in Ontario. All public health laboratories, hospital-based laboratories, community-based laboratories and specimen collecting centres must be licensed and renewed annually. The application process involves paying the appropriate fee and providing the MOHLTC with relevant information, which includes details on a laboratory’s staff number, staff qualifications and laboratory equipment. The type of laboratory license determines what kind of tests the laboratory is licensed to perform. Note that under this Act, laboratory testing conducted in physician offices is not regulated.

Quality Management Program – Laboratory Services

In addition, other regulations mandate quality management, which is tied to accreditation. Regulation 682 in the *Laboratory and Specimen and Collection Centre Licensing Act* specifies that the OMA is the agency responsible to carry out a quality management program for the Ontario MLS. This program is called the Quality Management Program – Laboratory Services (QMP-LS) and is funded by the MOHLTC. QMP-LS is responsible for Ontario Laboratory Accreditation (OLA) and for EQA programs.

OLA accreditation is mandatory for all Ontario publicly funded laboratories (with the previously noted exception of laboratory services performed in physicians’ offices). Laboratories in New Brunswick and Newfoundland and Labrador are also required by provincial regulation to participate in OLA. There are 212 OLA-accredited laboratories operating in Ontario (<http://www.qmpls.org/LaboratoryAccreditation/AccreditedLaboratories.aspx>). The QMP-LS, through OLA, examines the quality of laboratory services using a management

process that includes all three analytical phases. The OLA accreditation is a rigorous exercise; laboratories are potentially examined on more than 500 requirements. As reported by the QMP-LS, the requirements are based on the International Organization for Standardization (ISO) standards for quality and competence (ISO 15189:2007), safety (ISO 15189:2007) and POCT (ISO 22870:2006), and on Canadian national standards requirements for safety (CAN/CSA-Z15190-05) and blood and blood components (CSA Z902-10). The standards are cross-referenced with Canadian statutes and regulations, provincial statutes and regulation and Health Canada. Laboratories accredited by OLA demonstrate compliance with international standards for quality and competence.

If areas of non-conformance are cited, the laboratory is expected to take corrective action within 90 days of the visit. A panel then determines if the laboratory meets the criteria for an accreditation certificate. Failure to meet accreditation standards may result in warnings, loss of license and, subsequently, loss of public funding.

The purpose of the EQA program is to assess laboratory test performance and to provide education. Patient/simulated specimen samples and challenge surveys are used to examine the analytical processes of individual laboratories and to measure the effectiveness of different procedures and analytical kits supplied by manufacturers. For example, the identification of unsatisfactory performance by EQA at a single laboratory may indicate that at this laboratory, additional training and/or retraining is required. However, if through EQA unsatisfactory performance is identified at several different laboratories for the same procedure, this may indicate a problem with the method and/or kit being used for testing. Included in the EQA programs are measures to address the pre- and post-analytical stages of testing using patterns-of-practice surveys and questionnaires. Laboratories demonstrating unsatisfactory performance are required to implement corrective action; if the laboratory fails to do so, it may be considered non-proficient and referred to the MOHLTC for further remedial action that may include suspension of its ability to do testing. In addition to the EQA program, laboratories usually perform internal quality assurance and participate in other quality and accreditation programs (e.g., College of American Pathologist Accreditation) offered by organizations other than QMP-LS.

Views on QMP-LS Program

One of the unintended benefits of the QMP-LS program noted by our respondents is that it has raised awareness of the role of the medical laboratory profession. As articulated by a manager of a hospital-based laboratory:

I think what it (OLA) has done is it has raised a different level of awareness for our profession and on some level has put us on the map in terms of a more cutting-edge approach to regulatory standards.

One director of laboratory services spoke about the strengths of the QMP-LS program and made reference to the fact that OLA and EQA are based on international standards:

Everything that we do is measured against a set of standards that are internationally recognized and are based on best available evidence that the international committee through international standardization (ISO) can achieve ... So OLA and EQA themselves are both accountable to a higher authority, which tells us whether or not we are meeting the standards for organizations that do proficiency testing and accrediting bodies. So we too walk the walk of accountability at QMP-LS. There are not many examples to match the degree of accountability that you see in diagnostic laboratory services.

The strengths of OLA and the QMP-LS overall are further illustrated by another hospital-based laboratory manager who has experience as an assessor for OLA:

I think in general it is making everyone rise to a level of quality that is admirable and I really think Ontario is further ahead.

When asked if the accreditation process actually helped their organization accomplish its goals, one director of a community-based laboratory stated:

Yes, for a number of very simple reasons. We are a market-driven, employer-driven institution and that is one of our primary goals and our students could not work without this program being accredited. So it was kind of, we had to be accredited for our students to successfully graduate and enter the workforce.

This statement illustrates that the goals of the MLS sector go beyond producing quality services to include a quality-training environment for students and to maintain a competitive edge in the marketplace.

A community-based laboratory manager stated OLA's strength lies in:

Ease of measurement in terms of faster turnaround time; more cost effective; getting frontline workers to buy into the plan and feedback from physicians and patients.

Another manager from a hospital-based laboratory commented:

One of the strengths was the level of flexibility that was built in the process especially when it came down to interpreting the standards ... and to be able to customize for your organization to meet OLA standards.

However, not all respondents shared this view. In fact, the ability to interpret the standards was seen as challenging especially for those laboratories with smaller fiscal budgets. For example,

Accreditation is very expensive. Our accreditation fees on an annual basis are ten thousand dollars, because it is a very expensive process and we have to support it. It used to come out of our Med Lab budget directly, which you know meant it had a significant impact on our operational costs.

One hospital-based MLT indicated:

I found them (OLA requirements) very, very difficult to interpret. To know exactly the depth and what exactly the documentation was looking for.

A manager of a large regional hospital-based laboratory indicated:

When people have the appreciation of the why, and sometimes when you are dealing with a large number of regulatory requirements, some of them don't always make sense to the people that have to implement ... I struggle with that sometimes with the standards but overall, really at the end of this, the intent is to have a safe system.

Another respondent from a public health laboratory shared a similar view:

I would say that there are probably some grey areas ... their regulations may be a little stringent.

One manager from a hospital-based laboratory voiced the organization's concern with preparation for OLA accreditation:

The Ontario Laboratory Accreditation ... 502 regulations there for effective practice for all the testing that goes on, the reporting right from pre-analytical to post-analytical covers the entire spectrum of what and how, really they don't tell you how, but what you have to do in order to become an accredited facility, and we are beholden with that because without accreditation we don't get our license to perform testing.

One manager from a hospital-based laboratory shared a personal view:

This is my own personal experience and not necessarily in this organization but I have encountered elsewhere where the sole focus has been so much on the regulatory requirement that all the rest of the things are forgotten. So, it [OLA] in some ways does not allow the innovation or the creativity that can happen when people don't have to focus so much on that within their own job roles.

Overall, those interviewed were very supportive of the QMP-LS program and believed that through regulation, the MLS is able to maintain quality and safeguards to identify areas of unsatisfactory performance. Considering the contribution the MLS makes to patient diagnosis, treatment and monitoring, having the appropriate safeguards in place was seen to be important.

While some respondents appreciated the flexibility of the program, which allowed the ease of implementation of the OLA requirements, others were not convinced and experienced difficulties interpreting the standards as applied to their laboratory. This was especially evident when individuals commented on the pre-analytical phase. For example, when referring to OLA, one MLT stated:

I was thinking about how it doesn't really help us with the front end, pre-analytical quality. We are still lacking in the Phlebotomy area with quality and quality assurance as far as our direct patient contact ... do you know where I am going with that? We still need to work on some out-of-the-lab things ... but because it is outside the lab I believe we have a lot more to work on towards that.

A physician from a hospital-based laboratory indicated:

... the accountability of lab tests, part of it depends on the physicians. So, I don't think there was enough physician education to tell them when a test needs more work or what tests need more time, which tests cost more ... they just order them and I feel that really there is no accountability for physicians ordering the tests. They just go down to requisitions and just order whatever they feel like and sometimes they are not what are needed. In the hospital, we can control them a little bit more, but in other labs they just do what tests are ordered and it could be part of our training.

Discussion

Although all four approaches to accountability described in this issue (Deber 2014) are used in the Ontario MLS, the main approach to accountability is regulation. Regardless of ownership structure, all publicly funded medical laboratories (with the exception of laboratories found in physician offices) must comply with regulation as mandated by the Ontario provincial government to maintain an operating license to conduct testing. This approach has been in place for more than 40 years (Gamble and Deber 2004). However, previous quality controls and quality assessments were primarily focused on the analytical phase of the laboratory process. As the conceptual framework would predict, this is related to the high measurability of this phase, which lends itself to the use of both external and internal quality controls and quality assurance programs to measure the reliability, validity and turnaround times of test results.

However, our respondents stressed that this is incomplete; the true value of a laboratory test result is more fully appreciated when it is embedded in a system of care. The complexity

("embeddedness") of the goods and services being produced can also affect performance monitoring. Illustrative of this point is the investigation of the series of events that led to the Walkerton, Ontario water crisis, which resulted in several deaths and illnesses due to contaminated drinking water (O'Connor 2002). The Walkerton Inquiry demonstrated that although the tests themselves were often properly conducted, a series of errors in the pre-analytical and post-analytical stages contributed to the failure of the Walkerton Public Commission to notify Walkerton citizens and the appropriate government officials of the contaminated water.

Key to the QMP-LS is the flexibility of the program to allow individual laboratories to implement the processes to address OLA requirements. This is not surprising, as the type of testing and the automation used for testing vary across the MLS. However, one constant variable stands out – healthcare providers outside of the laboratory are the ones responsible for test ordering and for interpreting the meaning of the test result(s) for the patient. The quality of medical laboratory services directly impacts the patient but also impacts the quality of care provided by other frontline providers, who order the tests for diagnosis, treatment and monitoring. Clearly the interface between the laboratory and other providers is an important aspect of delivering quality laboratory services in the pre-analytical phase, and one which is not always captured in the approaches to accountability being used.

Conclusion

This case study provides an example of a highly measurable service, which seems at first glance to be easily monitored through regulation. However, challenges do exist with implementing laboratory regulation. The laboratory is not a stand-alone entity but is an integral part of the healthcare continuum. As such, ensuring quality in the MLS requires collaboration with other providers outside of the laboratory. Monitoring laboratory performance by solely focusing on the analytical phase is incomplete; it is important to also address and prevent errors in the pre- and post-analytical phases. Further investigation is needed to better understand the interface between the laboratory and healthcare providers outside of the laboratory working in different healthcare sectors (e.g., primary care versus institutional care) in order to develop strategies to inform the implementation of OLA requirements, particularly in the pre-analytical phase. Another emerging issue is the growing reliance on POCT performed by providers outside of the laboratory at the bedside; these are not always captured by existing accountability frameworks.

Questions of who is responsible for monitoring performance and how this will be done need to be addressed. Our results argue that coordination is required between the laboratory and the bedside providers for the monitoring of quality control compliance and operator performance levels. This also presents issues in how to deal with cross-sectoral coordination, particularly when actors in one sector cannot control the behaviour of those in other sectors. Improving quality in the Ontario MLS will ultimately require working with other providers to develop strategies and processes to improve performance measurements and to enhance accountability.

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Hopes and Realities of Public Health Accountability Policies

Espoirs et réalités des politiques de responsabilisation en santé publique



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Abstract

Holding local boards of health accountable presents challenges related to governance and funding arrangements. These challenges result in (a) multiple accountability pressures, (b) population health outcomes whose change is measureable only over long time periods and (c) board of health activity that is often not the key immediate direct contributor to achieving desired outcomes. We examined how well these challenges are addressed in Ontario, Canada at early stages of implementation of a new accountability policy. Findings reveal that senior and middle management are open to being held accountable to the Ministry of Health and Long-Term Care (MOHLTC), but are more oriented to local boards of health and local/regional councils. These managers perceive the MOHLTC system as compliance oriented, and find internal accountability systems most helpful for performance improvement. Like health-care system accountability metrics, performance indicators are largely focused on structures and processes owing to the challenges of attributing population health outcomes to public health unit (PHU) activities. MOHLTC is in the process of responding to these challenges.

Résumé

Tenir responsable les conseils de santé locaux présente des défis quant aux arrangements de gouvernance et de financement. Ces défis donnent lieu à (a) de multiples pressions liées à l'obligation de rendre compte, (b) des changements dans les résultats sur la santé de la population qui ne sont mesurables qu'après de longues périodes de temps et (c) une activité des conseils qui, souvent, ne représente plus une contribution directe et immédiate pour l'atteinte des résultats souhaités. Nous avons examiné comment sont traités ces défis en Ontario, Canada, aux toutes premières étapes de mise en œuvre d'une politique de responsabilisation. Les résultats révèlent que les cadres supérieurs et intermédiaires sont prêts à assumer l'obligation de rendre compte auprès du ministère de la Santé et des Soins de longue durée (MSSLD), mais se sentent plus près des conseils de santé locaux et des conseils régionaux. Ces cadres estiment que le système du MSSLD est axé sur la conformité et trouvent que les mécanismes d'obligation internes sont plus utiles pour une amélioration du rendement. Tout comme les paramètres liés à l'obligation de rendre compte dans le système de santé, les indicateurs du rendement sont très axés sur les structures et les processus en raison des défis liés à l'attribution des résultats sur la santé de la population aux activités des bureaux de santé publique. Le MSSLD a mis en marche un processus pour adresser ces défis.

THIS PAPER PRESENTS FINDINGS FROM A STUDY ON THE STRUCTURES, PROCESSES and perceived implications of accountability in Ontario's public health sector, using the conceptual framework for accountability outlined in the Introduction to this Special Issue (Deber 2014). Several national and provincial crises have inspired the development of new forms and systems for managing and holding local bodies responsible for public

health accountable for their performance (Capacity Review Committee 2005). Yet little is known about the functioning and effects of accountability mechanisms in public health. This study examines opportunities and challenges in existing and emerging accountability systems for Ontario's 36 local boards of health, which provincial legislation has made formally responsible for superintending and ensuring the provision of health programs and services in their geographical region (Government of Ontario 1990).

Accountability in public health presents challenges that set it apart from most other health sectors. Public or population health seeks to ensure and improve the overall health outcomes of populations (Capacity Review Committee 2006). Indicators of population health outcomes can be fairly easily devised and are widely measured. Holding public health organizations to account for maintaining or improving population health outcomes is another matter altogether. A fundamental principle of accountability is that accountability "holdees" be able to effect, through their actions, the results for which they are held accountable (Behn 2001). Yet, "it is often difficult to assess the extent to which variations in health outcome can be attributed to the health system" (Nolte et al. 2009).

Deber and Schwartz (2011) note that there are a number of different ways of describing what public health is, which often intermix services, processes, practices and desired outcomes (Bettcher et al. 1998; Last 1988; Shah 2003). Many, but not all, of public health activities deal with the health of populations. Much, but not all, of the focus is on prevention. Some, but not all, of the activities are carried out by organizations designated as "public health." Such activities include, but are not restricted to, the "health protection and promotion" functions, defined by Kirby and LeBreton (Standing Senate Committee on Social Affairs, Science and Technology 2003) as "disease surveillance, disease and injury prevention, health protection, health emergency preparedness and response, health promotion, and relevant research undertakings."

Yet public health goes beyond even these functions. It can be seen to encompass activities not usually falling within the mandate of public health agencies (e.g., community economic development, education). It may also be heavily involved in provision of services to target populations (sometimes referred to as "indigent" or "vulnerable" persons), usually for populations or services not covered by health insurance systems (a role particularly important in the United States). In Canada, public health is often involved in providing some services to children and new parents, and preventive and clinical dental health services to vulnerable populations. In turn, some public health activities, including immunization, may be offered not only by public health, but also by primary healthcare and occupational health providers, depending on the jurisdiction and the service.

Ontario has a highly decentralized model for funding and delivering public health services. All of its 36 public health units (PHUs) are locally based, and each is governed by a local board of health. These boards are autonomous corporations under the *Health Protection and Promotion Act*, and their membership is largely made up of elected representatives from the local municipal governments. The costs of these services are shared between the local

municipalities and the provincial government. The chief administrative officer, called the medical officer of health, reports to the local board of health, but is also responsible to the provincial Chief Medical Officer of Health.

The province of Ontario has used several approaches in attempts to hold the public health system accountable. Between 1997 and 2009, the Mandatory Health Programs and Services Guidelines was the main accountability platform; it specified expectations of boards of health and accompanying reporting mechanisms. The implementation of this policy intervention was decidedly top-down and widely criticized for: using indicators that did not reflect contributions of public health activities to public health outcomes; inadequate attention to diversity in health needs and capacities of local PHUs; irregularity of reporting; and ineffective use of data to manage public health performance at the provincial level (PHRED 2002).

In 2009, these guidelines were replaced by the Ontario Public Health Standards (OPHS). The OPHS is an evolutionary document with many of the same or similar requirements of the old Mandatory Health Programs and Services Guidelines, made contemporary with the inclusion of foundational standards regarding population health assessment, surveillance, research and knowledge exchange, and program evaluation (MOHLTC 2008). Ontario Public Health Standards are published by the MOHLTC under the authority of section 7 of the *Health Protection and Promotion Act*. There are also 26 program- and topic-specific protocols that are incorporated into these standards. Program standards cover areas such as chronic disease, injury prevention and emergency preparedness, and include general goals, societal outcomes, board of health outcomes and program requirements.

A system of performance management and accountability built around the OPHS constitutes a new accountability system. Components of this system include accountability agreements outlining specific service and performance expectations between MOHLTC and boards of health (MOHLTC 2013). Embedded within the system are performance targets corresponding with 14 indicators that relate to OPHS program requirements (Table 1). Ten of these indicators relate clearly to processes and outputs of PHU activities (e.g., percentage of high-risk food premises inspected), while only four indicators endeavour to measure outcomes (e.g., percentage of youth who have never smoked a whole cigarette). Organizational standards for boards of health, protocols for the delivery of various programs and services, and reporting requirements are main system components. At that time, MOHLTC was responsible for administering the following standards: Foundational; Infectious Diseases; Environmental Health; and Emergency Preparedness, whereas the former Ministry of Health Promotion had responsibility for Chronic Diseases and Injuries and Family Health, and the Ministry of Children and Youth Services for the administration of the Healthy Babies, Healthy Children components of the Family Health standards (MOHLTC 2008). Full implementation of this system, including the first cycle of data collection and reporting, began in 2011. Subsequently, the Ministry of Health Promotion was reabsorbed by MOHLTC.

Hopes and Realities of Public Health Accountability Policies

TABLE 1. Public health accountability indicators, 2011–2013

Indicator # 1	% of high-risk food premises inspected once every 4 months while in operation
Indicator # 2	% of Class A pools inspected while in operation
Indicator # 3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection
Indicator # 4	Time between health unit notification of a case of gonorrhoea and initiation of follow-up
Indicator # 5	Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up
Indicator # 6	DEFERRED: % of known high-risk personal services settings inspected annually
Indicator # 7	% of vaccine wasted by vaccine type that are stored/administered by the PHU
Indicator # 8	DEFERRED: % completion of reports related to vaccine wastage by vaccine type that are stored/administered by other healthcare providers
Indicator # 9	% of school-aged children who have completed immunizations for hepatitis B, HPV and meningococcus
Indicator # 10	% of youth (ages 12–18) who have never smoked a whole cigarette
Indicator # 11	% of tobacco vendors in compliance with youth access legislation at the time of last inspection
Indicator # 12	Fall-related emergency visits in older adults aged 65+
Indicator # 13	% of population (19+) that exceeds the Low-Risk Drinking Guidelines
Indicator # 14	Baby-Friendly Initiative (BFI) status (the BFI indicator monitors PHU performance related to the implementation of a number of activities that promote, support and protect breastfeeding)

Source: MOHLTC et al. 2013.

Methods

Data were collected through four methods:

1. Key informant interviews were conducted with seven individuals from the following organizations: MOHLTC, Ministry of Health Promotion and Sport (MHPS), Ontario Agency for Health Protection and Promotion (OAHPP), PHU medical officers of health and chief executives.
2. A web-based survey of medical officers of health from 27 of the 36 PHUs.
3. Twelve interviews in three PHUs chosen to reflect size, location and level of complexity.
4. A web-based accountability survey of 53 public health unit managers from 12 PHUs.

We corresponded with the medical officers of health in all 36 PHUs and asked permission to recruit public health managers for the web-based survey; 12 agreed to participate. Once consent was granted by medical officers of health, e-mail recruitment letters were sent out (97 valid surveys distributed), and 53 were completed and returned. While the sample is not representative of all public health managers across the 36 PHUs in the province, it is a strong cross-section of the population. The sample reflects affiliation with one-third of the

PHUs in the province. Despite one-third of respondents being from just three PHUs, a varied distribution of rural, mixed rural and urban, and mainly urban environments characterized these sites. Indeed, sample distribution according to these peer groupings is nearly equivalent, with respondents from the urban public health units being slightly underrepresented.

Keysurvey.com was used to develop the online survey and manage recruitment and basic descriptive analysis. Once the survey collection was completed, a data set was exported to SPSS for further analysis. Descriptive analyses as well as some measures of association have been used to generate survey findings. This survey and its findings may not be representative of public health managers in the province and, in most cases, the participating PHUs, owing to the small sample and the clustering of data. The findings herein do, however, provide an initial step in exploring public health accountability in Ontario, which may aid in the development of future research, evaluation and performance management and accountability planning.

Findings

1. To whom, for what: Accountability holders

Ontario PHUs belong to the category of hybrid public sector organizations. As noted above, they are funded by both local and provincial governments and governed by local boards of health; but they also function under the mandate of provincial legislation (*Health Promotion and Protection Act*) and are responsible for promoting and protecting public health in accordance with the provincial Ontario Public Health Standards and associated guidance documents.

Several major national and provincial NGOs, as well as multiple local and grassroots organizations, engage with PHUs for collaboration, advocacy and contracted service provision. Additionally, most PHU employees are members of health professional associations that might be expected to elicit professional accountability relations (Romzek and Dubnick 1987).

This is a seemingly typical situation of multiple accountabilities, often with competing accountability pressures (Hood 1991; Schwartz and Sulitzeanu-Kenan 2004). Interestingly, results from our surveys and interviews consistently indicated that PHU management perceives only three formal accountability holders to be of significant importance – local boards of health, municipal or regional councils and MOHLTC. Survey respondents and interviewees attributed very little importance to accountability relations with NGOs or with professional associations.

Most respondents indicated that both local boards of health and MOHLTC were important accountability holders, partially because both fund PHU activities. Generally, respondents did not feel conflicting accountability pressures from these accountability holders. There was a fairly strong element of accountability ultimately being to the public: “I think that demonstrating accountability has more to do with building public trust than it does in terms of sort of ministry reporting” (senior PHU respondent). Slightly more managers who responded to the survey noted accountability to MOHLTC as being highly important (89%) than accountability to boards of health (77%). However, interviewees suggested some primacy

of accountability to local/regional councils and boards of health that were considered to represent local publics: "I think ultimately I would probably put it down to our council – they represent our public" (medical officer of health respondent). "So we are accountable back to council primarily right now through our budgeting process and our planning processes" (medical officer of health respondent).

In contrast, for some respondents, accountability to MOHLTC was rooted primarily in the funding relationship. In the words of one respondent, "because a significant chunk of our funding comes from the MOHLTC, they are a key player in this..." (senior PHU respondent). Another respondent was somewhat reluctant in agreeing to the legitimacy of accountability to MOHLTC: "So I'm not suggesting that the ministry should just get out of the business of holding people accountable. Clearly they need to also demonstrate that. There are conditions tied to the funding" (senior PHU respondent).

Some respondents noted the importance of internal accountability mechanisms. Several PHUs have internal performance measurement and management systems rooted in strategic plans, planning and budgeting relations with boards of health and accreditation:

We've actually put some mechanisms in place that we feel make us increasingly accountable. So we did a 10-year strategic plan. We identified nine priorities and we are actually following them. The accountability on the strategic directs is that people leading them have to report to the senior team twice a year on the progress. (medical officer of health respondent)

While there was some frustration with effort needed to report differently to different accountability holders, overall respondents did not indicate this as being particularly problematic. There was quite a strong sense of the local public being the ultimate accountability holder and being represented by local/regional councils. There was no parallel sense that the PHU was accountable to the general public of the province through MOHLTC.

2. Using which tools: Accountability mechanisms

There are a reasonably large number of potential mechanisms through which PHUs might be held accountable. These range from financial incentives through legal channels, performance audit, performance reporting and performance management. In the managers' survey we asked a series of questions about perceived issues of abuse of funds, preferential treatment, inefficiency and ineffectiveness. We then asked about the use of various accountability mechanisms to address perceived issues in these areas.

For the most part, respondents did not perceive serious issues in these areas. Only 2% indicated that abuse of funds was common or very common, and 8% perceived preferential treatment of friends, family or close associates to be common or very common. Sixteen per cent perceived inefficiency and 15% ineffectiveness in achieving desired results to be

common or very common. Generally, when asked about the likelihood that issues and threats to accountability are or would be detected, most respondents agreed that they would be. However, a quarter of the sample perceived detection as being unlikely in the areas of preferential treatment, inefficiency and ineffectiveness.

Managers were also asked about their perceptions concerning inspectors, auditors or evaluators checking for various issues and threats to accountability in their PHU. Although a great proportion of the sample perceived these three professional groups as actively checking for accountability issues, this question item elicited much more uncertainty than the previous questions in this section. What seemed most telling was the large number of respondents, ranging from a quarter to nearly half of the sample, reporting that they did not know whether inspectors, auditors or evaluators were purposefully looking for the various accountability issues.

Performance measurement and reporting is the most prominent accountability mechanism mentioned by respondents (22 mentions each). Financial incentives were rarely mentioned, and legal accountability was not mentioned at all. Accountability agreements were noted by 12 respondents and accreditation by 11. Some respondents viewed accreditation as continuous quality improvement (CQI) rather than accountability:

I'm just kind of looking at what I sort of do here for the accountability piece of accreditation. Because this is a voluntary piece and because we look at this as CQI, ... the only consequences that would be there is if we are not identifying the gaps and working towards continuously improving the program delivery; then there could be gaps in getting that information out to our community. I know with some of the programs there are things you definitely have to do, you have to meet this.

A common theme across several PHUs is the importance of internal accountability mechanisms. These internal mechanisms – generally performance measurement and management systems – include long-term strategic planning, the evidence review process, performance management, stand-alone evaluations and priority setting. For example, in one PHU internal reporting mechanisms occur among senior management on a bi-weekly basis and also culminate in a year-end report:

There is also reporting to our executive committee, and what happens there is [that] every two weeks they gather the senior management team and they meet. They review what's happening there and it gets reported back to the division heads that way. That's all documented through meeting minutes, things like that. Then the other reporting piece is when we do our mid-year, year-end review as a management team across the department and report back on what we are doing at the program level.

Internal accountability was seen almost exclusively as oriented towards learning and performance improvement:

Our goal is to make better mistakes. We don't expect "perfect" from us. I don't expect "perfect" from our staff. I'd like our mistakes to get – I don't mean more spectacular, I do mean that they are more refined, that the mistakes we make are mistakes that come from processes that got better because of the mistakes we made before those. That everything just improves over time. That we are learning. That we are taking those lessons learned and implementing them and then just getting better. That is what I think we are really trying to do. Do things better for the public.

3. How well is it working? Accountability to MOHLTC

Our data collection took place during the months in which the new accountability system was in initial stages of implementation. Accountability agreements between MOHLTC and PHUs were being signed and the first round of performance data was being collected. Findings therefore reflect early impressions of the new accountability system. Many respondents appreciated the efforts made to improve on the previous system and expressed some optimism that the new system might indeed be used to help improve performance: "I fully support the accountability agreements – what gets measured gets done – we need the data to be able to tell our story and explain how the funds are being spent and our impact."

At the same time, there was considerable skepticism and some frustration with the new accountability system. Some of this stemmed from the objective difficulty of identifying meaningful indicators when, as one respondent noted, "this is particularly difficult in public health, where outcomes are truly occurring far into the future." The indicators that were chosen were criticized as "not indicative of the effectiveness of our services," "lacking relevancy to us," "number counting" and being "beyond our control." Importantly, MOHLTC has responded to dissatisfaction with the indicator set and convened working groups to identify an improved set of indicators.

Beyond concerns with specific indicators, there is concern with the accountability system more broadly. Overall, many respondents viewed the accountability system as aiming more to ensure bureaucratic compliance with the Ontario Public Health Standards than to generate learning to improve performance and the health of the local population. Ten of the 27 (37%) medical officers of health who completed our web survey anticipated that the accountability agreements would not contribute at all or would contribute only to a small extent to the performance of their PHUs. Thirteen respondents (48%) anticipated a moderate contribution, and only four (15%) anticipated a large contribution to performance. Eighty-four per cent of PHU manager respondents felt that the system had the intent of capturing compliance with public health performance expectations. While most agreed that there was also a focus on learning, one-third (33.3%) disagreed that the system would primarily focus on learning about and improving performance.

Some respondents felt that the system did not include adjudication of performance information provided or imposing consequences in light of the results of such adjudication. Several respondents noted that there is no tie between expected performance and funding, indicating that poor results may be caused by inadequate funding but that increased funding was not being offered to improve those results. While almost all PHU managers were moderately or greatly familiar with accountability agreements, performance targets and performance indicators, half of them (46%) indicated little or no familiarity with potential sanctions or remedial actions resulting from poor performance.

Discussion

Findings confirm the expectation that holding PHUs to account presents considerable challenges. Expected challenges emerge from the fact that PHUs draw authority and funding from both provincial and regional/local mandates and provide a diverse range of services, many in collaboration with governmental, third-sector and sometimes for-profit organizations. Four accountability holders emerge as playing key roles in the eyes of medical officers of health and PHU managers: boards of health/regional–local councils; MOHLTC; the local/regional public; and senior management through internal accountability channels. Overall, PHUs are more attuned to local accountability holders than to MOHLTC. They see more learning and performance improvement coming from internal systems and from relationships with boards of health/regional–local councils than from the new (and certainly the previous) accountability system with MOHLTC. While agreeing with the premise of accountability to the ministry and open to its being used for performance improvement, respondents see the new accountability system, at this time, as more oriented towards compliance than performance improvement.

An additional major challenge stems from the nature of much of the work conducted in PHUs. Attributing population outcomes to activities of PHUs is fraught with issues. Change in population-level outcomes can be slow and hard to detect, especially over short periods of time. These outcomes are often influenced by environmental and ecological factors more powerful (by far) than the potential contribution of anything that the PHU itself can do through its activities. Performance measurement systems that recognize this issue tend to end up with structure and process measures that resemble bean counting and compliance auditing. Ontario's new public health accountability system is struggling with this issue and looking to improve on its first round of performance indicators at this time.

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Accountability and Primary Healthcare

Obligation de rendre compte et soins de santé primaires



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Abstract

This paper examines the accountability structures within primary healthcare (PHC) in Ontario; in particular, who is accountable for what and to whom, and the policy tools being used. Ontario has implemented a series of incremental reforms, using expenditure policy instruments, enforced through contractual agreements to provide a defined set of publicly financed services that are privately delivered, most often by family physicians. The findings indicate that reporting, funding, evaluation and governance accountability requirements vary across service provider models. Accountability to the funder and patients is most common. Agreements, incentives and compensation tools have been used but may be insufficient to ensure parties are being held responsible for their activities related to stated goals. Clear definitions of various governance structures, a cohesive approach to monitoring critical performance indicators and associated improvement strategies are important elements in operationalizing accountability and determining whether goals are being met.

Résumé

Cet article se penche sur les structures de l'obligation de rendre compte dans les services de soins de santé primaires (SSP) en Ontario, en particulier pour savoir qui est responsable de quoi auprès de qui et pour connaître les mécanismes utilisés. L'Ontario a mis en œuvre une série de réformes progressives, au moyen d'instruments de politiques des dépenses, renforcées par des ententes contractuelles qui visent à définir un ensemble de services financés par les deniers publics et offerts par le secteur privé, le plus souvent par des médecins de famille. Les résultats indiquent que les exigences de responsabilité dans la production de rapports, le financement, l'évaluation et la gouvernance varient selon les modèles de prestation de services. L'obligation de rendre compte auprès des bailleurs de fonds et des patients est plus courante. Des ententes, des mesures incitatives et des outils de compensation ont été employés, mais ils pourraient être insuffisants pour assurer que les intervenants soient tenus responsables des activités liées aux objectifs définis. Une définition claire des diverses structures de gouvernance, une démarche cohérente pour le suivi des indicateurs de rendement et des stratégies d'amélioration constituent des éléments importants pour la mise en œuvre de l'obligation de rendre compte et pour déterminer si les objectifs ont été atteints.

P RIMARY HEALTHCARE (PHC) IS, FOR MOST PEOPLE, THE FIRST POINT OF CONTACT with the healthcare system, usually through a family physician. It is where short-term health issues are resolved, where the majority of chronic health conditions are managed, where health promotion and education efforts are undertaken and where patients in need of more specialized services are connected with care. A strong PHC system is characterized by accessible, person-focused, comprehensive care, effectively delivered and coordinated by an interdisciplinary team across the health sector continuum using efficient technology and anchored in the principles of continuity of care (Starfield 1998).

Medically required PHC services delivered by physicians fall within the requirements of the *Canada Health Act* and as such, must be fully covered by the publicly funded provincial health insurance plans. They are privately delivered, under a variety of organizational models. In recent years, most Canadian provinces have sought to reform PHC to improve access, quality, equity, system integration and accountability (Hutchison 2008; Hutchison et al. 2011). Ontario has implemented a series of incremental reforms, largely using expenditure policy instruments to encourage transformation from a solo, fee-for-service (FFS) model to models that encourage patient enrolment, with interdisciplinary teams offering a comprehensive range of PHC services. These mechanisms include the introduction of an array of alternative organizational service delivery models, with reimbursement models using blends of capitation FFS and salary and performance-based incentives, depending on the model and the jurisdiction (Hutchison 2008). One consequence has been an increase in payments for PHC, as well as

considerable pressure to demonstrate the impact of these reforms, including a critical report from the Auditor General of Ontario (Office of the Auditor General of Ontario 2011).

This paper examines the approaches being used to ensure accountability within PHC in Ontario; it focuses on who is accountable for what and to whom, the policy tools being used and perceptions of the disadvantages and opportunities, including the intended and unintended consequences.

Method

An extensive literature review was conducted (see Appendix at www.longwoods.com/content/23849). Relevant policy literature was also examined to determine approaches to accountability in PHC, including how it is defined, the types of governing mechanisms that have been used and the key enablers and barriers. Nine key informants from Ontario were interviewed via telephone, using open-ended questions to gather data about aspects of accountability such as for what, by whom, to whom and how. The key informants came from five provincial-level agencies, plus two physician-led and two community-based interdisciplinary teams. Ethics approval was obtained from the University of Toronto.

PHC in Ontario

Ontario has implemented an “alphabet soup” of PHC models since 2000 (Hutchison 2008). These include three new funding models – family health groups (FHGs), family health networks (FHNs) and family health organizations (FHOs) – and one service delivery model with interdisciplinary teams, family health teams (FHTs). FHGs are based on blended FFS, while FHNs and FHOs have slightly different service packages funded through blended capitation. An expenditure policy instrument, enforced through contractual agreements, provides a defined set of services.

In Ontario, primary care physicians in these models sign four-year physician services agreements (PSAs) whose terms reflect agreements negotiated between the Ontario Ministry of Health and Long-Term Care (MOHLTC) and the provincial Ontario Medical Association; these PSAs include financial incentives. FHTs have yearly funding agreements with MOHLTC. Another model, community health centres (CHCs), were initiated over 40 years ago. They are situated in geographic areas with identified underserved or high-needs populations. Staff, including physicians, are salaried. CHCs sign agreements with the regional Local Health Integration Networks (LHINs), which are delegated responsibility (and funding) from MOHLTC for a series of other provider organizations, including hospitals, long-term care institutions and home care agencies. These different agreements vary in their scope of accountability requirements for (a) services, (b) performance measurement and reporting, (c) governance, (d) goals and (e) duration of term (see Appendix at www.longwoods.com/content/23849).

Findings and Discussion

Accountability mechanisms: Who is accountable for what and to whom?

SERVICE REQUIREMENTS

The PSA incorporates financial incentives, including premiums and bonuses, to encourage specific types of physician behaviours. For example, the agreement includes incentives to enrol patients with a specified primary physician. One major requirement is for access to after-hours PHC services for enrolled patients, either by phone or clinic. Enrolled patients are free to seek care elsewhere, but if they do, the primary physician will lose a portion of a bonus payment. The agreements also include incentive payments to encourage physicians to provide specified preventive care services. Reporting requirements for physicians are voluntary and are limited to performance tied to FFS and incentivized tasks. The limited scope of performance measures may offer insufficient insight on improvement in health status and PHC system performance (Starfield and Mangin 2010) and may overlook patients with multiple chronic conditions, who account for a substantial proportion of government health expenditures.

ORGANIZATION AND GOVERNANCE REQUIREMENTS

Separate from funding provided to individual physicians through the PSA, FHTs receive funding to hire interdisciplinary healthcare professionals (IHPs), other than physicians, to deliver comprehensive and coordinated care for enrolled patients as well as for non-enrolled (unattached) patients. Separate agreements oversee the provision of IHP resources and mandatory reporting requirements for specific performance metrics (such as enrolled and unattached patient counts, chronic disease prevalence, IHP resource distribution to support chronic-condition patients and IHP vacancies or turnover), budgetary assessments and governance.

FHTs are required to establish one of three governance structures: community-based, provider-based or a mix of community- and provider-based. The PHC practice key informant interviews for this study represented a provider-based governance model in an urban setting and a mixed community- and provider-based governance model in a rural setting. In these governance models, accountability for operational activities (e.g., the governance structure of the team, balanced budget, IHP resources, privacy of records management and management of emerging risks) falls to the organization's board of directors (BOD) and the funder. The IHPs, as regulated health professionals, are accountable to their self-regulatory body. However, the scope and terms of multidirectional accountability within an interdisciplinary setting are not explicitly described in the funding agreement or other official documents.

The agreement for salary-based CHCs contains mandatory requirements for indicator reporting (e.g., preventive care activities, vacancy rates of physicians and nurse practitioners, service cost per unit, number of individuals served, variance forecast to actual expenditure and units of service), as well as for such things as community engagement, BODs' responsibilities and comprehensive service coverage. In this model, physicians and IHPs are equally responsible

for delivering a broad scope of care activities, including primary care, illness prevention, health promotion, community capacity building and service integration. The community-based BODs ensure that community needs are solicited through engagement and incorporated into strategic and program operational planning.

Accountability domains

The current agreements are largely bi-directional between a single funder (i.e., MOHLTC or the LHIN) and a physician provider or provider organization. Implicit assumptions are made throughout the agreements that providers will observe their professional and legal forms of accountability and act in the best interest of patients. The most common form of accountability involves PHC providers' interaction with patients. The second common form of accountability is provider accountability to the funder. Accountability solely based on funding poses challenges for measuring PHC system performance and whether contractual obligations are being met both by physicians as well as IHPs.

Policy Instruments

To drive the policy agenda – improve access, quality, equity and system integration – the policy making and implementation processes have addressed accountability gaps by embedding performance measurement requirements in the contractual agreements, engaging policy subsystem actors and passing a regulation to facilitate the involvement of the PHC sector with other parts of the broader health system.

Expenditure policy tool: Contracts

WHAT IS BEING MEASURED? VS. WHAT SHOULD BE MEASURED?

Key informant interviews, the agreements and other literature indicate that the PHC Performance Measurement Systems (PMSs), in general, are predominantly based on volume counts of services, focused on a small set of problems in PHC and on factors that can be measured (Saltman et al. 2006; Starfield and Mangin 2010; Working Group to the Primary Healthcare Planning Group 2011). Quality outcomes measures are absent in the PMSs. The lack of focus on the measures that may be required to evaluate PHC system performance makes it difficult to discern whether the intended PHC service delivery goals and objectives are being met and to determine opportunities to make PHC a stronger system.

The following quotations from key informant interviews offer insight into the present state of the PMSs:

Usually they tend to be fairly straightforward operational indicators, volumes, prices, cost, averages in terms of performance.

The scope of our accountability measures ... has been very narrow. It's the service, the output, it's one point in time, it's within one practice, and I think we realize that while these things are important, many of the outcomes we are really looking to improve in the health system come from integration and coordination of care across sectors, and they are much broader in scope than those measures we currently have.

But what PHC models and service providers are still not accountable for is those sorts of quality measures or outcomes that you can see downstream from primary care. For example, emergency department visits, inappropriate hospitalization for chronic conditions, or readmission.

Moving more into the quality judgments around outcomes, certainly in clinical areas I would say less likely because (a) they are harder to measure and (b) oftentimes the information systems to collect and report the information aren't available.

Patient surveys, 30-day readmission rates and emergency department (ED) use, chronic care outcomes and total cost of chronic care for chronically ill patients are examples of critical PMS indicators (Guterman et al. 2011); these are absent from the reporting requirement in Ontario. To fully engage PHC practices in the collection of PHC data, quality improvement initiatives, system integration and policy governance structures (with clinician representation), reliance on expenditure policy tools has been recommended (Saltman et al. 2006; Working Group to the Primary Healthcare Planning Group 2011).

UNINTENDED CONSEQUENCES

Volume-based measures provide an incomplete view of the PHC system and act as a barrier to measure and identify ways to advance towards the characteristics of a strong PHC system. There appears to be no cohesive approach to measure how the PHC system is performing relative to the goals for which it is supposed to be held accountable. Where service volume monitoring and random auditing do show non-compliance with contractual obligations, the only corrective action currently available is contract termination. The remediation process to allow both parties to consider corrective action is absent.

Compensation models have produced some change but they also have produced some perverse effects, including overutilization of services for which incentives are offered, shift of resources from one clinical area to another, concentration on improving quality for one or a small number of diseases or patient populations, and treating all patients uniformly rather than being able to respond to differences in clinical needs (Hurley et al. 2011; Kiran et al. 2012; Primary Healthcare Planning Group 2011; Starfield and Mangin 2010). Some differential effects on care quality measures have been observed across models, but these appear to be related more to organizational characteristics (e.g., presence of electronic medical records

(EMRs), human resource composition and smaller patient panel sizes) than to the impact of funding schemes (Dahrouge et al. 2012; Kiran et al. 2012). New PHC models appear to have increased patient enrolment without improving access, particularly with regard to after-hours care (Office of the Auditor General of Ontario 2011). Because patient feedback was absent in the approach to PHC accountability, the Ontario Working Group has recommended adding this dimension (CIHI 2013b).

Key informants and PHC researchers noted that agreements, various incentives and premiums, compensation models and infrastructure funding appear to be insufficient to ensure that parties are held responsible for their activities. Ongoing monitoring and measuring of the critical PMS indicators and corrective strategies were mentioned as key to achieving accountability targets.

Information and exhortation policy tool: Indirect governing

Indirect governing mechanisms are used to coordinate a dialogue among subsystem actors and solicit input on ways to advance PHC system policy goals and inform the strategic directions for accountability levers and incentives to meet patient and health system needs and to drive performance (Primary Healthcare Planning Group 2011). In 2012, Health Quality Ontario (HQO) and the Canadian Institute for Health Information (CIHI) teamed up to launch a new initiative called the Ontario Primary Care Performance Measurement Steering Committee, which developed a series of 10 measurement priority areas to guide PHC system planning and management (CIHI 2013a).

Key informant interviews drew attention to several issues concerning the PHC PMSs:

Defining what are the relevant indicators of accountability, meaningful. They can't always be meaningful to governments and politicians. Keeping them happy is part, but that's not going to improve the healthcare system.

Ofentimes the accountability pieces are limited by the infrastructure of an agent. If there isn't the infrastructure, then the reporting back of more complicated accountability measures is limited.

What's such a big barrier in the sector is the lack of infrastructure. For example, the whole access to information piece. So easy for you and I to say we should incent the outcome, but the EMRs aren't that functional; we don't have data management support.

When we do try to put [the CIHI Voluntary Reporting System] in place, the quality of data that comes out isn't great because there isn't standardization going in and the EMRs aren't designed for this kind of data. And admin data is not helpful ...

There are a number of barriers to achieving accountability – for example, absence of a cohesive PMS strategy, information infrastructure and monitoring systems, and standard approaches to governance to manage information sharing, communication and relationships within organizations and across organizations. Some of these barriers contribute to the limited scope of PMSs in Ontario, which is based on factors that are easy to measure and on what data are available.

Regulation

The *Excellent Care for All Act* is an example of a policy lever used to advance the quality and system integration agenda by facilitating formal participation of PHC providers in health system planning and integration initiatives across the continuum of care. PHC participation is perceived to be of strategic importance in steering system coordination because of the evidence to date on its moderating effect on healthcare spending and its role in serving as a gatekeeper of the system. However, to date, funding and reporting requirements have not been revised and the governance structure remains self-directed, premised on trust and mutual interdependence.

Conclusion

Accountability relationships in PHC are multidirectional within and between organizations. The current state of the contracts presents a number of gaps and points to the need to define governance structures to support partnership, data management, monitoring and reporting requirements to align with the goals, roles and responsibilities of service delivery organization, providers and funders. Some jurisdictions are moving in the direction of defining governance structure to support infrastructures for IHP teams, but are far away from defining public reporting requirements involving the medical profession. It has been suggested that the multi-directional relationship in PHC needs to be reflected explicitly in the agreements, and a mechanism is needed to capture the range of relationships that exist within the PHC system in order to assess accountability by role, for what and for whom, across the circle of care providers and institutions.

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Accountability in the City of Toronto's 10 Long-Term Care Homes

L'obligation de rendre compte dans les 10 foyers de soins de longue durée de la cité de Toronto



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Abstract

Long-term care (LTC) residential homes provide a supportive environment for residents requiring nursing care and assistance with daily living activities. The LTC sector is highly regulated. We examine the approaches taken to ensure the delivery of quality and safe care in 10 LTC homes owned and operated by the City of Toronto, Ontario, focusing on mandatory accountability agreements with the Local Health Integration Networks (LHINs). Results are based on document review and seven interviews with LTC managers responsible for the management and operation of the 10 LTC homes. One issue identified was the challenges associated with implementing new legislative and regulatory requirements to multiple bodies with differing requirements, particularly when boundaries do not coincide (e.g., the City of Toronto's Long-Term Care Homes and Services Division must establish 10 different accountability agreements with the five LHINs that span into the City of Toronto's geographic area).

Résumé

Les foyers de soins de longue durée (SLD) offrent un ensemble de soutien aux résidents qui nécessitent des services infirmiers et de l'aide pour mener à bien leurs activités quotidiennes. Le secteur des SLD est très réglementé. Nous examinons les démarches prises pour assurer la prestation de soins sécuritaires de qualité dans 10 foyers de SLD administrés par la cité de Toronto, en Ontario, en mettant l'accent sur les ententes d'obligation redditionnelle conclues avec les réseaux locaux d'intégration des services de santé (RLISS). Les résultats se fondent sur une revue de la documentation et sur sept entrevues menées auprès de gestionnaires responsable de la gestion et de l'exploitation dans les 10 foyers de SLD. Un des enjeux repérés a trait aux défis liés à la mise en œuvre des exigences légales et réglementaires dans plusieurs organismes dont les besoins diffèrent, particulièrement quand les territoires ne coïncident pas (par exemple, la Division pour les services et foyers de soins de longue durée de la cité de Toronto doit conclure 10 ententes quant à l'obligation de rendre compte, et ce, avec les cinq RLISS qui couvrent l'aire géographique de la ville).

LIKE OTHER COUNTRIES, CANADA'S POPULATION IS AGING. BY 2026, IT IS ESTIMATED that one in five Canadians will have reached the age of 65 years (Health Canada and Interdepartmental Committee on Aging and Seniors Issues 2002). Supporting this aging population will require efforts directed at implementing strategies for healthy aging. This includes the provision of supportive environments within communities for seniors and sustainable government programs (Health Canada and Interdepartmental Committee on Aging and Seniors Issues 2002).

Residential long-term care (LTC) homes provide a supportive environment and 24-hour nursing care for the small but vulnerable proportion of seniors and other individuals who are unable to live on their own due to cognitive/physical impairment, challenges with daily living activities and/or the lack of informal support. Although the number of LTC beds across Canada per 1,000 seniors has remained stable, the level of care has become more intense due to more complex conditions and health needs. Overall, the majority of residents in LTC homes in Canada are female, single, over the age of 85 years old, and cognitively impaired (CIHI 2011).

The provision of safe, quality and efficient residential LTC for this vulnerable population is a high priority for residents, families, governments and providers. LTC homes are not required to be a publicly insured service under the terms of the *Canada Health Act* (Madore 2005). Nonetheless, most jurisdictions cover a proportion of the costs for certain populations (Berta et al. 2006). A number of different funding models exist that rely on a mix of public (e.g., provincial/territorial and municipal governments) and private (e.g., private insurance, co-payments paid by residents) sources. Variation also exists across Canada in terms of ownership status of the homes (Berta et al. 2006). Although there are many unregulated LTC

homes (often called “retirement homes”), the formal LTC sector in Ontario is highly regulated and must respond to a variety of legislative/regulatory measures and policy decisions made by different levels of government.

Currently in Ontario, there are approximately 77,605 residents in 628 regulated LTC homes (Ontario Association of Non-Profit Homes and Services for Seniors 2013). Recent media reports have foregrounded the need to address abuse and neglect in Ontario's LTC home sector. The Long-Term Care Task Force on Resident Care and Safety in Ontario was established in 2011 in response to these reports highlighting the need to recognize the rights of residents to receive quality care in a safe, respectful environment free of abuse; it has issued progress reports (Long-Term Care Task Force on Resident Care and Safety 2013). Providing quality and safe care for LTC residents is also a high priority for Ontario's Ministry of Health and Long-Term Care (MOHLTC). In a January 2013 press release, the Minister of the MOHLTC stated: “My ministry has been working closely with task force members, and I am proud of the actions and recent investments the ministry has made to further support long-term care homes, and staff to improve the care and safety of residents” (<http://www.newswire.ca/en/story/1106837/working-together-to-provide-safe-care-to-residents-in-long-term-care>).

Purpose

Ontario's LTC homes can be categorized into three sub-sectors, based on their public–private ownership status: private not-for-profit (e.g., religious or lay groups), private for-profit (e.g., individual, private organizations or corporations) and public (e.g., City of Toronto's LTC homes) (Berta et al. 2006). This study focuses on the 10 public LTC homes owned by the City of Toronto, Ontario; a companion paper in this volume deals with other private LTC homes in Ontario (Berta et al. 2014). Responsibility for both the operation and management of these 10 homes rests with the City of Toronto's Long-Term Care Homes and Services Division (the Division). The Division is responsible for providing a variety of long-term healthcare services in the City of Toronto. A number of different factors influence the quality and care delivered to residents, including management structure and process (Wodchis et al. 2014). The Division's mission statement is to “...provide a continuum of high quality long-term care services to eligible adults in both long-term care homes and the community.” The Division is guided by a set of core values: Compassion, Accountability, Respect and Excellence (CARE). The CARE values are intended to be shared by all stakeholders, drive culture and priorities and provide a framework in which all decisions are based. A general manager, three directors and 10 administrators, along with a number of other senior staff, provide overall leadership to the Division using a participatory style of management that involves shared decision-making and shared responsibility for the Division's performance.

City of Toronto's 10 LTC Homes

Each of the 10 LTC homes has an administrator whose primary focus is on the operations of that particular home. A variety of healthcare, social care and administrative staff provide “nurs-

ing and personal care, medical, recreational, rehabilitation, nutritional, spiritual, social work, housekeeping, laundry and administrative services.” Volunteers also play an important role providing assistance, visitations, programs and activities for the residents.

The City’s LTC homes have 2,641 approved beds (17.3% of the regulated LTC beds in Toronto) and provide permanent, convalescent and short-stay accommodations to a diverse population (mainly seniors) from more than 50 countries of origin and speaking 38 languages. The Division’s decision-making framework for providing support and activities for the 10 LTC homes takes into account the cultural, religious and sexual diversity of their residents, as well as diverse abilities such as the level of cognitive ability. The majority of permanent residents have some form of cognitive impairment and require nursing care and assistance with daily living activities.

In 2006, the Ontario government implemented the regionalization of healthcare services with the introduction of 14 Local Health Integration Networks (LHINs). Each LHIN is responsible for the planning, integration and funding of specified health services in its region, including hospitals and community care, as well as LTC services. To ensure the responsible use of healthcare resources, accountability agreements between healthcare providers and LHINs and between LHINs and government have been established. The LHIN boundaries are not necessarily co-terminus with those of the local government. Toronto falls into five different LHINs, some of which also encompass areas outside the city boundaries. Accordingly, the 10 public LTC homes operated by the Division are situated in five different LHINs, and this has resulted in the establishment of 10 different accountability agreements with five different LHINs. We examine the approaches taken to ensure the delivery of quality and safe care in LTC homes owned by the City of Toronto by focusing on the challenges and/or benefits resulting from these accountability agreements.

Methodology

Data collection for this case study used data triangulation from more than one type of data source to give more insight into the sub-sector and to identify more easily any inconsistencies found between the data (Bickman and Rog 1998). We used a combination of document review and in-depth interviews with seven LTC managers from the City of Toronto’s Long-Term Care Homes and Services Division who are responsible for implementing the accountability requirements within this sub-sector. Participants were each given a unique identifier, e.g., M1, M2, etc. Participants provided informed consent prior to data collection, and the Research Ethics Boards at University of Ontario Institute of Technology and the City of Toronto Long-Term Care Homes and Services Division provided ethics approval. One-hour semi-structured interviews were conducted via telephone or in person.

Documents reviewed included peer-reviewed literature, grey literature (e.g., professional association websites) and provincial legislation and regulations. The City of Toronto Long-Term Care Homes and Services Division provided strategic directions documents, report cards, efficiency review documents, annual reports and long-term care home service

accountability agreements (L-SAAs). Following identification of the relevant documents, each was summarized and reviewed by at least two members of the research team (which included at least one expert from the LTC sub-sector) to ensure consensus. Similar procedures were used for the coding of the key informant interviews to validate the themes identified.

Results

Approaches to Accountability

In terms of “to whom,” our respondents noted multiple layers. They noted that providing quality and safe care to the residents was the first and most important priority and that they believed that the Division was accordingly primarily:

...accountable to the residents and their families, who in some cases provide a co-payment for their accommodations ... and by extension we are accountable to the local citizens. (M1)

However, management is not only accountable to the residents and their families but also to other stakeholders. As articulated by one respondent:

The Division receives funding and therefore is financially accountable to the Province of Ontario, Central East LHIN, Toronto Central LHIN, Central LHIN, Central West LHIN and Mississauga/Halton LHIN and the City of Toronto Council. (M2)

While respondents agreed, “there are many layers” (M3) of accountability, they agreed that primary governance and oversight lies with Toronto’s City Council:

even though the majority of the funding is from the province, they [City Council] have governance over the operations. (M1)

In terms of how, accountability in this sub-sector uses a combination of all four mechanisms of accountability (financial incentives, regulation, information directed to potential users and reliance on professionalism) identified in the conceptual framework (Deber 2014). These do not entirely derive from the government. For example, the Long-Term Care Task Force on Resident Care and Safety in Ontario released an 18-item action plan in 2012 to improve safety in Ontario’s LTC homes (Long-Term Care Task Force Ontario 2012). A subsequent report provided educational/training strategies for staff (i.e., professionalism) and support tools for staff and families (i.e., information directed to potential users), as well as earmarking resources (i.e., financial incentives) for the recruitment of qualified clinical, support and administrative staff (Long-Term Care Task Force on Resident Care and Safety 2013).

Role of Regulation

Regulation plays a significant role in ensuring accountability in the LTC home sector in Ontario. In the opinion of one respondent: “After nuclear power plants, long-term care homes are the most regulated sector. (M4)”

In respect to whether the Division or LTC homes have any influence over these regulations, one respondent commented:

We have an opportunity to influence policy ... or influence the direction of various legislation or regulations, and certainly provide evidence to the direction in which change needs to be made. (M1)

All regulated LTC homes in Ontario are licensed and approved by the MOHLTC. Regardless of the ownership status (private not-for-profit, private for-profit and public), LTC homes are governed by the *Long-Term Care Homes Act* (LTCH) of 2007 and Ontario Regulation 79/10 (Legislative Assembly of Ontario 2007). In addition, a variety of other legislation and regulations apply to this sector, as noted by two respondents from the senior management team:

They [regulations] are all specified from the Ministry standpoint, long-term care home acts, including homemakers and nurses’ services, health and safety, privacy (MFIPPA [the *Municipal Freedom of Information and Protection of Privacy Act*] and PHIPA [the *Personal Health Information Protection Act*]), and so many others ... even the AODA ... the fire code, lots [of others] as well. (M5)

The Act ... public health requirements, Ministry of Labour, Health Quality Ontario ... there are many, many layers. (M6)

The LTCH Act and Regulation 79/10 are considered the foundation of the Ontario government’s commitment to reforming the accountability of LTC homes. LTC homes are accountable for providing safe, respectful, quality health and social care services, as well as safeguarding residents’ rights. The Long-Term Care Homes’ Quality Inspection Program was initiated to ensure that LTC homes comply with legislation and regulations. Health Quality Ontario (HQO) makes the data available to the public on the Ontario MOHLTC website.

Accreditation processes are overseen by Accreditation Canada or the Commission on Accreditation of Rehabilitation Facilities and are encouraged by MOHLTC through financial incentives to accredited LTC homes. Two of the LHINs to which the Division must report (Central East and Central West LHINs where three LTC homes are located) go beyond this and require accreditation by a recognized Canadian accreditation program as a performance requirement. In 2012, the City of Toronto’s Long-Term Care Homes and Services was awarded

Accreditation with Exemplary Standing by Accreditation Canada, their highest level of performance recognition in meeting the requirements of the Qmentum accreditation program (Mitchell et al. 2014).

Long-Term Care Home Service Accountability Agreements

With the enactment of the *Local Health System Integration Act* (LHSIA) in 2006, the LHINs began the negotiation of service accountability agreements (SAAs) between the LHINs and health service providers (HSPs) funded by the LHINs in accordance with the timetable set out in LHSIA, O.Reg. 279. LHINs were originally expected to enter into SAAs with LTC homes by March 31, 2010; however, the L-SAA was developed within the context of the LTCH Act. The L-SAAs are for a period of three years. Accordingly, LTC homes signed their first L-SAA on July 1, 2010, concomitant with the date of proclamation of the LTCH Act, and were effective until March 31, 2013.

The LHINs have an accountability framework that supports their legislative requirements with respect to the LTC sector, but this framework acts only as a guideline. The planning and accountability cycle within the LHIN and HSPs began in the fall of the final year of the agreement. The beginning of this cycle is the Long-Term Care Home Accountability Planning Submission (LAPS). The LAPS informs discussion with the LHIN in regards to the L-SAA. It provides a tool for homes to describe their services, and is composed of two parts: (a) an overview of the LTC home that includes general identifying information, bed types and numbers offered within the home, structural classification and listing of additional services provided to residents; and (b) the Service Plan narrative, which will allow the LTC home to provide information that describes services that the home operates or plans to operate within each year of the agreement. There are strict instructions on how this is to be completed. The LAPS documents facilitate discussions with the LHIN and become appendices to the L-SAA.

Commenting on the accountability process and who had final say on the contents of the L-SAA, one respondent indicated:

We had input and some opportunity with respect to the development of service accountability agreements, but they are accountability agreements and not contracts, so you don't necessarily negotiate them, you discuss, you provide feedback but in the end they [LHIN] can prescribe, and in some respects it had been prescribed. (M3)

There was consensus from the respondents that there was oversight provided from the Division at the provincial L-SAA Steering Committee (in the formulation of the agreements).

While there is guidance from the provincial steering committee to align the processes and to provide guidance to the LHINs, each LHIN ultimately has flexibility on how it carries out the L-SAA process. One result is that timelines may vary for each LHIN, and not be consist-

ent with the Division approval process. One requirement of the LAPS and L-SAA is having the submission and agreement endorsed by the governing body and executed by two signing authorities that can bind the organizations. For the Division, this means having City Council approval, which requires time for management to review and obtain the necessary approvals, and often this process does not coincide with the LHINs' timelines.

Performance Indicators

Another portion of the L-SAA agreement that varies by LHIN is the performance indicators used to measure the HSPs' performance and tools used for demonstrating accountability. The L-SAA Indicators Working Group is responsible for developing recommendations for consideration by the L-SAA Steering Committee regarding L-SAA performance indicators. The Working Group is composed of LTC sector representatives, MOHLTC, HQO and LHIN staff, and is chaired by an LHIN Senior Director of the Health System Indicator Initiative Steering Committee. For the 2013–2016 L-SAA, the working group created the following sets of indicators to reflect the Pan-LHIN "Ontario" systems imperative: Enhancing Coordination and Transitions of Care; Maintaining Achievements in Access, Accountability and Safety; and Ensuring Sustainable Organizational Health. Within these categories, there were four indicators that were in every L-SAA. Each indicator has a performance target, performance corridor and a performance standard. Because the Division has LTC homes situated in five different LHINs, it must thus comply with five different processes. This has implications for the Division's financial and human resources. Even within one LHIN, there are differences for performance targets for the same indicator across different sub-sectors.

In addition to the four Pan-LHIN indicators, the Division reports on 17 separate performance indicators that were identified by the five different LHINs. Reporting on all the indicators requires resources and systems in place in order to meet the reporting requirements laid out in the L-SAA. One respondent commented that while reporting on the indicators is achievable, it was time-consuming:

It's not difficult for us to achieve them [indicators], it is difficult for us when we are reporting to the five LHINs ... the five LHINs don't even use the same template, for their reporting systems ... we find the workload really difficult. (M2)

Concern was also raised regarding the ability to get the work done in a timely manner:

...it is not that the work doesn't get done, it doesn't get done in a timely fashion because of the different reporting systems that we need to meet. (M3)

Resourcing Accountability

Whether an increase in regulation, accountability requirements or performance indicators, in most instances, respondents said that meeting their accountability requirements was getting

increasingly challenging. The proportion of funding was decreasing, while the expectations and requirements were increasing. Our respondents believed that insufficient funding was provided to implement new legislative and regulatory requirements. For example, although the Division attempts to be sensitive to the cultural needs of their residents and their families, including incorporating ongoing review and revision of policies, prioritizing could be affected by legal requirements. One respondent expressed frustration with the lack of additional funds to meet the requirements of the *Accessibility for Ontarians with Disabilities Act*:

... one of the residents was demanding an interpreter; this is a very expensive proposition to have an interpreter available constantly for an individual resident, but there is an act that requires that you do so. (M2)

Quality is a major concern for the Division, especially when cuts are made to an already limited budget. One respondent commented on the struggles on being a municipal home:

... you are limited on how far back you can cut without having an adverse effect on your residents, while still providing quality of care. (M7)

As noted previously, the Toronto City Council provides funds to and oversight of the Division. Recognizing that the Division is one of the many responsibilities of the City Council, delivering care in an efficient matter is an important part of the Division's accountability to the City of Toronto:

we [the Division] subject ourselves to higher levels of accountability, so there is the value for money. (M1)

Discussion and Conclusion

Our respondents stressed that delivering quality and safe care to the residents of the City of Toronto's 10 LTC homes is a top priority. Demonstrating accountability to funders is also required to ensure the 10 LTC homes have the resources needed to deliver care to this vulnerable population. The necessity of establishing 10 different accountability agreements with five different LHINs for its 10 LTC homes has brought to the foreground implementation challenges in terms of both time and human resources for the Division. Each LHIN is given some latitude to define performance indicators to better respond to the needs of the population that it serves. As a result, each home has autonomy and the potential to negotiate performance indicators that are meaningful to the home (Ontario Local Health Integration Network 2012). As well, there are different funding opportunities for each home depending on what LHIN it resides in, including behavioural support units and process improvement initiatives (e.g., through the Health System Improvement Pre-Proposal). Although this can present

difficulties in responding to the various requirements, the ability to respond to local health needs is seen as one of the benefits of regionalization. Considering the diversity between the 10 LTC homes, accountability agreements with the different LHINs strengthen each home's ability to meet the needs of its clients.

Funding for the 10 LTC homes is transferred from the LHINs to each individual LTC home, and funding may vary depending on LHIN-funded priorities; however, the Toronto City Council allocates funds to the Division based on a global budget. This adds another layer of complexity that can potentially lead to resource planning challenges. For example, Toronto's City Council implemented a 10% funding cut in 2011, which affected all Divisions, including the Long-Term Care Homes and Services Division.

Results of this study have brought to the foreground the challenges service providers face when implementing new legislative and regulatory requirements. This is increasingly challenging when negotiating accountability agreements with multiple organizations (in this case, LHINs) that can use funding tools to force compliance. This experience is not unique to Toronto's Long-Term Care Homes and Services Division (which deliver not only residential care but also community services and supportive housing services), but is also experienced by community agencies that receive public funding and provide services to specific populations located in different LHINs. Accountability through performance indicators can be highly measurable. However, the implementation of measures to demonstrate quality and value for money must take into consideration the governance structure of service providers and the relationship between the funders and providers.

As in other healthcare sectors and within the LTC sector, providers are not only responsible to the recipients of care (in this case, residents and their families) but also to other stakeholders who provide funding and are responsible for ensuring regulatory requirements are met to demonstrate accountability. The creation and implementation of accountability agreements in the City of Toronto's 10 LTC homes requires flexibility to accommodate and respond to the needs of the residents and their families, as well as the budget requirements of the City of Toronto. This does not come without its challenges for the Division responsible for the operation of the LTC homes. However, the Division recognizes these challenges and endeavours to ensure the regulatory structures are adhered to while maintaining balanced budgets, but more importantly ensuring quality and safe care for their residents.

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Ensuring Accountability through Health Professional Regulatory Bodies: The Case of Conflict of Interest

Assurer l'obligation de rendre compte par l'entremise
des organismes de réglementation des professionnels
de la santé : le cas du conflit d'intérêts



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Abstract

How do self-regulated health professions' regulatory bodies address financial conflict of interest (COI) and ensure accountability to the public? Using document analysis, we examined how four Ontario regulatory colleges (physicians, nurses, physiotherapists, audiologists/speech-language pathologists) defined COI and the education, guidance and enforcement they provided for COI-related issues. These colleges are upholding the mandates to define, identify and address financial COI by providing regulations or standards and guidelines to their membership; they differed in the amount of educational materials provided to their registrants and in the possible COI scenarios they presented. Although there were few disciplinary hearings pertaining to financial COI, findings for the hearings that did occur were documented and posted on the college public registers (the listing of all registered college members along with all relevant practice information), informing the public of any limitations or restrictions placed on a member as a result of the hearing.

Résumé

Comment les organismes de réglementation des professionnels de la santé, qui sont autoréglémentés, peuvent-ils faire face aux situations de conflits d'intérêts d'ordre financier tout en assurant l'obligation de rendre compte auprès de la population? À l'aide de la documentation, nous avons analysé la définition du conflit d'intérêts donnée par quatre organismes de réglementation (médecins, infirmières, physiothérapeutes, audiologistes/orthophonistes) et nous avons analysé la formation, les directives et les mesures coercitives qui touchent aux situations de conflit d'intérêts. Ces organismes sont responsables de définir le conflit d'intérêts, de déceler les situations de conflit et d'y faire face en fournissant à leurs membres la réglementation, les normes et les directives nécessaires; on note des différences dans la quantité de matériel de formation fourni aux nouveaux membres et dans les divers scénarios de conflit présentés. Bien qu'il y ait peu d'enquêtes disciplinaires en relation avec un conflit d'intérêts d'ordre financier, les résultats de ces enquêtes sont consignés et affichés sur les registres publics des organismes (la liste de tous les membres inscrits comprenant des renseignements pertinents sur leur pratique), informant ainsi la population de toute restriction qui pourrait toucher un des membres suite à une enquête.

SELF-REGULATION IS AN AUTHORITY-BASED APPROACH TO POLICY IMPLEMENTATION that may be used by the government during the implementation of health policy (Doern and Phidd 1992; Howlett et al. 2009). As clarified in the Introduction to this Special Issue (Deber 2014), self-regulation as a policy instrument allows the government to delegate responsibility for managing the creation, administration and renewal of standards governing the activities of certain groups to non-governmental regulatory bodies. It relies heavily on the concept of professionalism, which includes such factors as the existence of a

specialized body of knowledge, the recognition that good/bad practice is difficult to evaluate by those who do not have that body of knowledge, and an “agency” relationship where the professionals act on behalf of their clients, plus the potential for harm if the activities are not carried out well (Bayles 1986; Freidson 1994, 2001). Professionalism assumes that the expertise and experiences of healthcare professionals are best evaluated by similarly trained individuals who can evaluate the quality of work done and ensure that high-quality service is regarded as more important than financial gain, supporting the maintenance of professionalism in practice (Freidson 1994, 2001).

In Ontario, the *Regulated Health Professions Act* (RHPA) grants self-regulation to 26 healthcare professions (Government of Ontario 1991). Each healthcare profession has a governing regulatory body (usually called a College) that is responsible for ensuring all aspects of the RHPA are upheld. The Health Professions Procedural Code (HPPC) of the RHPA outlines the duty and objects of the colleges as well as the complaint handling process and the disciplinary process. The RHPA stipulates that in carrying out the objects, the colleges have a responsibility to “serve and protect the public interest” (p. 30). Conflict of interest (COI) is not specifically noted in the objects; however, the fifth object in the RHPA does direct the colleges to “develop, establish and maintain standards of professional ethics for the members” (p. 30).

A COI occurs when conditions exist that may unduly influence an individual’s behaviour or ability to carry out the obligations of his or her office or position (Carson 1994; Thompson 1993). These conditions are related to opportunities to advance self-interest and are often financial. COI may interfere with patient care, erode patient trust and, if not well managed, undermine the effectiveness of self-regulation (Haines and Olver 2008; Tonelli 2007). COI is influenced by how providers are paid; different payment models may incentivize undertreatment or overtreatment (Deber et al. 2008).

Another potential source of COI may arise when the pharmaceutical or medical device industry attempts to align professional interests with that of the industry instead of the patient (Brennan et al. 2006; Thompson 1993; Tonelli 2007). Influence may be exerted through gifts, continuing education sponsorship and support, guideline development or consultancy roles (Coyle 2002; Guyatt et al. 2010; Marco et al. 2006).

Various approaches can be used to address financial COI, including provincial oversight, self-regulation, policy development and full disclosure to the consumer. The RHPA specifies that the self-regulatory bodies governing the healthcare professions falling under the Act are responsible for developing, establishing and maintaining standards pertaining to ethics and conduct (Government of Ontario 1991). As part of maintaining the standards of professional ethics and conduct under the HPPC, the colleges are mandated to have an Inquiries, Complaints and Reports Committee (ICRC) and a Discipline Committee. The ICRC is mandated to investigate all complaints or reports brought forward and render a decision, which may include requiring the member to appear before a panel of the ICRC to be cautioned, refer the member to a panel of the ICRC for incapacity proceedings, or refer a specified allegation of the member’s professional misconduct to the Discipline Committee (RHPA 1991, c. 18,

sched. 2, s. 26). If the ICRC refers a case to the Discipline Committee, a panel is formed to review the evidence and determine whether an act of professional misconduct has been committed.

Disciplinary hearings are open to the public unless circumstances exist, such as issues of public security, which are outlined in the HPPC, indicating that the public should be excluded. At the disciplinary hearing, the evidence is presented to a panel of the Discipline Committee. The discipline panel is a subset of the Discipline Committee and must include at least two public members and one professional member who is also a member on the college council (RHPA 1991, c. 18, sched. 2, s. 38[2]). Public members are non-professional members of the college's council that are appointed to the council by the province's lieutenant governor. In the event that a member is found culpable, the panel can issue orders that direct the registrar to suspend or revoke the member's certificate of registration or impose specific terms, conditions and limitations on the member's certificate. Members may also be reprimanded by the panel and issued a fine not exceeding \$35,000, payable to the Minister of Finance.

The purpose of this study was to examine how financial COI was addressed by four regulatory bodies in Ontario: the College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the College of Physiotherapists of Ontario (CPO) and the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO).

Professionalism and Self-Regulation

Professional self-regulation is an approach to accountability that places the responsibility on the professional regulatory bodies to set and enforce standards of behaviour. Owing to the nature of work performed or type of work environment within which a provider practises, standards of behaviour may be difficult to measure, and in theory may be best addressed by appealing to professionalism. For example, physicians clearly qualify as health professionals and provide a variety of services that may endanger their patients if not performed well. One complicating factor is that the complexity of the work performed, and the observability (i.e., extent to which this work is directly observed by other professionals who can judge the quality of work performed), may vary significantly across work settings. For example, physicians working in a solo practice environment, compared to those working in a hospital operating room, vary in how likely other professionals will be present and observing or collaborating on the work performed.

Methodology and Research Questions

The methodology used included a descriptive document analysis to compare each of the colleges, the results of which are reported here. CPSO, CNO, CPO and CASLPO were selected to maximize the variability among professional colleges based on number of registrants, registrants' scope of practice, types of workplace settings and the number of controlled acts bestowed upon the members of these colleges. The four colleges selected varied considerably in the number of registrants, scope of practice and authorization to perform a controlled act.

The most recent annual reports published at the time of this study indicated that CASLPO had the smallest number of registrants with 3,595 members while CPO had 7,524 registrants, CPSO had 30,227 registrants and CNO had the largest number of registrants, with 153,073 members. All the professions governed by these colleges had title protection and defined scope of practice under the RHPA. Title protection refers to restrictions that the specific health profession's act imposes in the use of the title to those who are members of the college. For example, only members of CPO can use the titles physiotherapist or physical therapist (*Physiotherapy Act*, SO 1991, c. 18, s. 8[1]). The scopes of practice are the areas that the profession's acts outline as entailing the profession's practice. For example, the *Nursing Act* outlines the following scope of practice for nursing: "The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function" (SO 1991, c. 32, s. 3).

Controlled acts are specified in the RHPA as activities that may be performed only by authorized regulated health professionals as outlined in the legislation (SO 1991, c. 18, s. 27[1]). There are 14 controlled acts outlined in the RHPA (SO 1991, c. 18, s. 27 [2]). Each of the colleges had registrants who were authorized to perform at least one controlled act. The speech-language pathology registrants at CASLPO were not authorized to perform any controlled acts, but the audiology registrants were authorized to perform one controlled act. Registrants at CPO were authorized to perform up to seven controlled acts; CNO registrants (who included nurse practitioners) were authorized to perform between five and nine controlled acts, and CPSO registrants were authorized to perform up to 13 controlled acts. A higher number of controlled acts would suggest greater autonomy and, based on the rationale behind controlled acts, greater risk of harm to the patient during the course of treatment.

Three questions guided the study:

1. How did each college define COI?
2. What steps did each college take to address potential financial COI?
3. How did each college enforce the legislation or address issues where allegations of financial COI occurred?

The documents reviewed were obtained from governing provincial legislation and regulations, including the RHPA and each profession-specific governing legislation, and college by-laws, practice standards and guidelines, policies, records, reports, training documents/modules and disciplinary outcomes. Documents were initially classified according to the type of document or publication, including government legislation, by-laws, standards, guidelines, policies, official records pertaining to disciplinary findings for the reporting year 2012, and registrant communication materials, which included newsletters, postings, educational videos and webinars. After classification, document analysis for each college examined how COI was defined; whether the college published regulations, position statements or guidelines pertaining to

financial COI; whether other educational materials were published; how COI was managed (explicit directives to the membership); and whether any disciplinary hearings conducted in the past reporting year pertained to allegations of professional misconduct related to financial COI. Evidence pertaining to the research questions was charted and the materials were compared across the four colleges. The materials consulted are listed in the supplementary Appendix (see Appendix at www.longwoods.com/content/23850).

Results and Analysis

Defining and setting standards for conflict of interest

In terms of determining how COI was defined, document analysis focused on discovering what each college had in place with respect to a code of ethics, professional misconduct regulations, COI regulations and practice standards or guidelines. Three of the four colleges, CNO, CPO and CASLPO, had a published code of ethics. CPSO did not have its own code of ethics but deferred to the national professional association, with a reference to the Canadian Medical Association's code of ethics on its website. Neither CPO nor CNO explicitly addressed COI in their codes of ethics. Only CASLPO had COI specifically noted in its code. By-law 2011-08 addressed COI in broad terms, stating in section 4.2.6 that members "shall avoid activities that could be construed as involving a conflict of interest." Professional misconduct was an important component to examine, as the regulation is used in both the definition and the enforcement of practice standards. Each college had a professional misconduct regulation in place as part of its mandated profession-specific regulations. All these regulations, as outlined in the profession-specific legislation, indicated that practising while in a COI, or in the case of CPSO, having a COI, constituted professional misconduct. However, a definition of COI was not outlined in these regulations.

The next component of the document analysis focused on COI-specific regulations and how the colleges defined COI. CPSO's COI regulation, as outlined in the *Medicine Act*, included a detailed definition of COI, including various benefits or advantages a professional might be exposed to that could lead to a COI. CASLPO had a proposed regulation for COI that was drafted in 1996, while CPO defined COI in multiple practice standards and CNO provided a definition in its Professional Conduct: Professional Misconduct reference document, which also indicated there was a proposed COI regulation for nursing, although this was not available at time of writing. All four colleges had similar definitions of COI and explicitly stated that members should take the necessary steps to avoid practising while having a COI. Each of the four colleges included additional disclosure steps. CPSO required disclosure to the patient and written notification to the college. CPO, CNO and CASLPO required disclosure to the patient in the event that COI was unavoidable. CASLPO also required members to provide patients with a list of alternative practitioners in order to offer them choices in the event of a COI.

Educational materials

A document analysis of the materials available to educate registrants of their obligations revealed similarities and differences in the types of learning materials supplied by each college (for references see Appendix at www.longwoods.com/content/23850). As noted earlier, all the colleges provided explicit definitions or directives regarding COI for registrants. CPO and CNO provided practice scenarios, self-reflection exercises or learning examples of when and why COI might occur. For example, CPO's "Guide to Advertising, Fees & Billing and Conflict of Interest" (2008) listed a number of learning scenarios, including referring patients for non-physiotherapy services at a practice where the physiotherapist would financially benefit, payment for referrals and also selling products for profit in addition to providing services. The guide included two tools to assist CPO's membership in assessing their practice scenario. The first tool included questions for professionals to ask themselves to determine whether a potential COI existed, while the second tool provided steps to follow when COI could not be avoided. CPO also had three ethics e-learning modules that included self-reflection questions and guidance.

CNO tended to focus more on maintaining professional boundaries and, in its Therapeutic Nurse–Client Relationship Practice Standard (2006), provided a decision tree to determine whether such boundaries were being maintained. In its e-learning module on maintaining boundaries, CNO suggested specific scenarios involving taking money as a gift from a patient. It also had an "Ask Practice" section of its website that provided guidance and answers to practice scenarios. The COI scenario presented was that of a nurse selling products privately and the conditions under which this might be acceptable. Both CNO and CASLPO had similar e-learning modules on social media awareness, "Pause Before You Post," which had a section pertaining to COI in the CASLPO version.

CASLPO provided specific expectations regarding the sale of products in the proposed COI regulation that involves full disclosure to the patient along with providing the patient with alternative options. CPO and CNO also provided specific expectations in their practice standards on the sale of products and included the mandate to provide patients with recommendations based on standards of the profession, along with options. All three colleges indicated that products should be sold at cost.

CPSO did not provide any practice scenarios or learning modules pertaining to COI. It did provide a summary of the COI regulation that it published in its quarterly magazine, *Dialogue* (2006), along with an electronic disclosure form. The college also provided a link to the "Good Medical Practice" learning modules of the General Medical Council, which included a module on financial COI.

Enforcement and disciplinary hearings

The colleges shared the same responsibilities under the RHPA in relation to duties and objects and addressing professional misconduct. Each college conducted mandatory investiga-

tions when necessary and had an ICRC and a Discipline Committee. Results for the colleges' most recently published annual reports summarized each college's ICRC decisions and included the number of referrals to its Discipline Committee. Referrals included any cases where allegations of COI constituting professional misconduct might exist. CASLPO's 2012 annual report stated that three of the 25 matters decided by its ICRC for that year were referred to the Discipline Committee, and were all for the same member. No disciplinary hearings were held in 2012 (see Appendix).

CPSO's 2012 annual report noted that 67 of its 2,676 ICRC decisions were referred to the Discipline Committee. These proceedings resulted in a total of 38 members being referred to the Discipline Committee, as some had multiple ICRC referrals (see Appendix). The ICRC also reported on the types of matters that were investigated that included COI. Of the 37 hearings conducted in 2012, 13 involved allegations of disgraceful, dishonourable or unprofessional conduct, but the annual report did not elaborate on the nature of the allegations or the factual details. A review of CPSO's website postings on discipline decisions for 2012 indicated that up to four of them related to COI, although the allegations specified only professional misconduct. One case involved a member borrowing money from patients; another involved a member requiring patients to pay a "membership fee" to the member's private business in order to receive publicly funded services; and two cases involved members being reimbursed for authorizing prescription medications based on reviewing information for patients submitted online. For all these cases, the members' orders included public reprimands, a temporary suspension of registration, and terms, conditions and limitations placed on their registration. The two cases involving authorization of prescriptions included fines from other jurisdictions.

CNO reported that for 2012 its ICRC rendered decisions on 317 complaints, four of which were referred to the Discipline Committee (see Appendix). The annual report indicated there had been 41 discipline outcomes, with six revocations of registration and 35 reprimands, temporary suspensions, and terms, conditions or limitations imposed (see Appendix). The nature of the allegations and the findings were not detailed in the annual report, but were posted by member names on CNO's website. A review of the discipline decisions posted for 2012 indicated that five involved an element that might be construed as COI, as the allegations pertained to professional misconduct. One case involved a member accepting gifts from a patient; two other cases involved members taking money, gifts or credit cards from their patients or patients' families; and another case involved the member borrowing a patient's credit card to pay registration dues and also suggesting that the patient move in with the nurse. The final case involved a member borrowing money from a patient; in this case, the member resigned from the profession. In the remaining cases, all members were ordered a public reprimand, a temporary suspension of registration, and terms, conditions and limitations placed on their registration.

CPO's annual report for 2012/13 indicated that 69 decisions were rendered by its ICRC and of these, four were referred to the Discipline Committee (see Appendix). Three disciplinary hearings were completed during this reporting period, and the summaries were noted

in the report. One of the three cases involved a member submitting false claims to and being reimbursed by insurance companies for various healthcare services and products supposedly provided to her, although these products and services were never actually provided. This situation might be considered a COI because of the failure to put responsibilities as a healthcare professional ahead of personal interests, although the term COI was not used in the summary or the agreed-upon statement of facts (CPO 2013). The member was ordered a penalty that included a reprimand, a six-month suspension that could be shortened to three months upon completion of an ethics program, and practice monitoring for three years (CPO 2013).

As part of their disciplinary process, the colleges published discipline matters and outcomes and included the names of the registrants involved for the public record. CNO, CPSO and CPO summarized disciplinary outcomes on their websites. The public register of members, which each college is required by the HPPC to post, noted for each of the members the reprimands, suspensions, and terms, conditions or limitations ordered through any hearings. As previously noted, there were no discipline hearing outcomes for CASLPO, although pending hearings were noted on the website, as was the case for CPSO.

Discussion

The purpose of this study was to examine how financial COI was addressed by CASLPO, CNO, CPSO and CPO. All four colleges had the mandated committees and processes in place to meet the RHPA requirements. All four colleges had a regulation, a proposed regulation or a standard in place that addressed COI. Although all had references to COI in the profession-specific professional misconduct legislation, the colleges took different approaches in addressing COI. CPSO's COI regulation gave a detailed definition of benefit and what constituted conflict of interest. CASLPO had a proposed COI regulation posted on its website that also provided a definition of COI. Both CNO and CPO addressed COI in detailed practice standards.

All four colleges provided materials to their membership pertaining to COI, although these varied across the colleges in scope and detail. CNO and CPO provided decision tools and scenarios pertaining to possible COI, along with standards and guidelines as part of their approach. CNO and CASLPO both had online learning modules on social media that contained a section on COI, and CNO had an e-learning module that involved financial COI. CASLPO provided directives in the proposed COI regulation pertaining to the sale of products. CPO and CNO offered directives in their standards. CNO gave details on the therapeutic patient–client relationship and how crossing professional boundaries might lead to COI. CPSO had a self-reporting requirement that its membership submit notice when they were practising in circumstances where COI might be unavoidable.

The findings from the last available annual reporting period indicated that these regulatory colleges had few disciplinary hearings pertaining to allegations of professional misconduct related to COI. Specifically, four (11%) of the CPSO disciplinary hearings, five (12%) of the CNO hearings and one (33%) of the CPO hearings had elements of COI, although the term

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COI was not used in the allegations. The orders made as part of the decisions in these hearings included public reprimands, temporary suspensions of registration, and terms, conditions and limitations, all of which were posted on the public register for the college. These decisions and orders provided evidence that the ICRCs and the Discipline Committees were enforcing and upholding the HPPC mandate of ensuring accountability to the public.

What is not clear from the document analysis is how all facets of professional practice are addressed in the practice standards and educational materials in order to ensure accountability. How services are paid for, the work environment and the nature of the work being performed are practice variables that are not all specifically addressed. For example, as the payment of services and devices becomes more privatized and professionals either charge for products and services through their employer or move into an independent practice model where both services and products are sold to the public, COI may be unavoidable. As a result, these practice models may render the regulatory requirement to refrain from practising in COI situations unrealistic. Only one of these colleges required self-reporting, and only two provided learning modules outlining and addressing practice scenarios in which COI might occur. The cases that were referred to Discipline Committees that involved COI had scenarios that differed slightly by college. For example, cases unique to each college for 2012 included CPSO's cases involving member reimbursement for authorizing prescriptions through a review of online patient information, while CPO had a case involving false insurance claims and CNO had cases involving receipt of gifts. These differences may be related to the types of practice scenarios under which particular professionals may work, including type of work, work environment and how they are paid. The colleges that did provide scenarios and associated guidelines had varied scenarios, indicating that there may be differences according to a profession's practice variables.

In order to clarify how work environment, work performed and means of remuneration affect how regulatory colleges deal with COI, key informant interviews will be held in the near future with staff from each of the colleges. It is expected that the information gathered in these interviews will further inform the processes that the colleges undertake to ensure accountability to the public.

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Accountability: The Challenge for Medical and Nursing Regulators

Obligation de rendre compte : le défi pour les organismes de réglementation médicaux et infirmiers



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Abstract

Little has been written about how regulatory bodies define and demonstrate accountability. This paper describes a substudy of a research project on accountability in healthcare. The aim was to increase understanding of how regulatory bodies perceive and demonstrate accountability to their stakeholders. Twenty-two semi-structured interviews were conducted with provincial/territorial CEOs from the two largest health professional regulatory bodies in Canada: medicine and nursing. The regulators indicated that accountability was essential to their mandates and provided the foundation for regulatory frameworks. However, they did not offer a common definition of accountability. They agreed that they were accountable to three constituencies: the public, government and their members. Regulators noted that protecting the public and meeting the demands of the government and their members creates tension. They were also concerned about maintaining independence in the regulatory role.

Résumé

Il existe peu de textes sur la façon dont les organismes de réglementation définissent et démontrent l'obligation de rendre compte. Cet article décrit une étude sur un projet de recherche portant sur l'obligation de rendre compte dans les services de santé. L'objectif était de mieux comprendre la façon dont les organismes de réglementation perçoivent et démontrent l'obligation de rendre compte auprès de leurs intervenants. Vingt-deux entrevues semi-dirigées ont été menées auprès de tous les DG provinciaux et territoriaux des deux plus grands organismes de réglementation professionnelle de la santé au Canada : la médecine et les services infirmiers. Ces personnes ont indiqué que l'obligation de rendre compte était un aspect fondamental de leur mandat et fournissait la base du cadre de réglementation. Cependant, elles n'ont pas donné une définition commune de l'obligation de rendre compte. Elles ont convenu devoir rendre compte auprès de trois entités : la population, le gouvernement et les membres de leurs ordres. Les personnes chargées de la réglementation notent que la protection de la population et la réponse aux demandes du gouvernement et des membres crée des tensions. Ils se disent également préoccupés par le maintien de l'indépendance dans le rôle de la réglementation.

ACCOUNTABILITY IS DEFINED IN MANY WAYS (DEBER 2014). IN THE FIELD OF governance, for example, it is often used synonymously with such terms as responsibility, fairness and transparency and associated with the expectation of account-giving (Brown et al. 2006). Citing Chandler and Plano, Koppell (2005: 94) noted that accountability in public administration is “a condition in which individuals who exercise power are constrained by external means and by internal norms.” Emanuel and Emanuel (1996: 229) observed, “Accountability has become a major issue in health care.” However, little has been written about how health professional regulatory bodies define and demonstrate accountability, even though regulation is considered an important policy instrument to enforce it. The study

upon which this paper is based focused on professional self-regulation and examined how regulators in Canada perceived and operationalized accountability when interacting with their stakeholders.

Background

Under Canada's constitution, healthcare, education and health human resources are provincial/territorial responsibilities (Marchildon 2013). The operational details for regulating health professions have been delegated to the provincially/territorially based regulatory bodies (usually referred to as colleges). However, there are differences in how (and which) professions are regulated in each jurisdiction.

The key role of regulatory colleges is to ensure the health and safety of the public (Federation of Health Regulatory Colleges of Ontario 2014). Individuals who want to work in a regulated health profession cannot practise unless they are registered with the self-governing body in their province/territory. Self-regulation implies that the professions develop and monitor their respective professional codes of conduct and licensing requirements and set standards of practice (College of Licensed Practical Nurses of Alberta 2014; Government of Saskatchewan 2014).

The federal government of Canada provides some legislation that eases the mandates of provincial/territorial regulatory bodies. For example, the Agreement on Internal Trade (AIT) allows regulated health professionals to apply for certification in another province/territory without having to undergo significant additional training, examination or assessment (Labour Mobility Coordinating Group 2014).

Depending on the province/territory, healthcare professions are regulated by varying combinations of overarching acts such as Ontario's *Regulated Health Professions Act*, Manitoba's *Regulated Health Professions Act*, or profession-specific acts such as Nova Scotia's *Registered Nurses Act*. In all cases, these regulatory bodies are self-funded through membership dues and do not receive government funding.

Method

This exploratory descriptive study is one component of a larger study designed to connect the complex concepts of accountability in Canadian healthcare. In 2012, interviews were conducted with provincial/territorial CEOs from the two largest health professional regulatory bodies in Canada. Twenty-five were invited to participate and 22 accepted the invitation to participate in semi-structured interviews. The data were supplemented by an electronic review of annual reports and other public documents, such as vision and mission statements and professional standards of practice. Eleven nursing regulators and 11 medical regulators participated in individual targeted 30-minute semi-structured interviews conducted in person or by telephone. The interview schedule was pretested for clarity. Participants provided informed consent prior to data collection.

The Research Ethics Board at McMaster University granted approval. The interviews were audiotaped and transcribed verbatim. Transcripts were anonymized to preserve confidentiality. Interview data were analyzed using NVivo10 (QSR International Pty Ltd., Doncaster, Victoria, Australia). Texts were interpreted through thematic analysis (Boyatzis 1998). Preliminary coding was completed by three members of the research team, who coded several texts independently for comparison. Inter-rater reliability of the coding was determined. Team members then collaborated to develop a refined scheme to code the transcripts.

Results

Our key findings were categorized under the following major themes, which arose from the analysis.

Regulatory organizational structures

With regard to nomenclature, all 10 provincial medicine regulatory bodies are called College of Physicians and Surgeons, while the three territorial medicine regulatory bodies are called departments or councils. Five of the provincial nursing regulatory bodies are referred to as colleges; four are associations, and one is a combination of a college and an association. In the territories, one nursing regulatory body governs both the Northwest Territories and Nunavut, and the other governs the Yukon; both are titled associations.

Perceptions of accountability

The regulators indicated they had no common definition of accountability. However, one said, “We certainly use the term a great deal.” Some offered definitions that described accountability in relation to such concepts as responsibility, answerability, fairness and transparency. One regulator noted, “For me, regulatory accountability is about fair, transparent, legally defensible processes that support the accountability to the public.”

In terms of whom, there was consensus among regulators that they were accountable to the public, the government and regulatory body members. They agreed that legislative requirements make them answerable to the public first:

We are accountable more broadly to the public ... that’s our primary owner. ... Our legislation clearly states that we regulate in the public interest.

In terms of means, the regulators indicated they demonstrate accountability to the public through transparency:

When we talk about accountability, we talk about ensuring that we are transparent in our processes, that we are evidence-informed and that when we make decisions based on evidence, we clearly articulate what that evidence was that led us to the decision that we made.

However, in practice, limits were placed on what information would be made accessible, to whom and how:

There are some things that won't go on the [regulatory body] website. Our rule is that everything should be transparent and open unless there is a very good reason legally or otherwise not to put it there.

Regulatory body membership varied. All had members of the profession, but many jurisdictions also had public representation on their boards, and some had government appointees. The number of public seats varied across the provinces. One regulator noted that the role of public representatives "is not to go and then report back to somebody. They are there to represent the public interest." Most regulatory bodies have board meetings that are open to the public.

Accountability to government

Health professional regulatory frameworks vary across provinces. Consequently, regulators varied in their freedom to interpret legislation and their perception of accountability to government. There was consensus that accountability was influenced by legislated requirements, including financial reports, registration numbers, types and categories of registration relative to complaints, and discipline hearings. However, legislation often left room for interpretation:

Our ... profession's Act is pretty [vague] in terminology ... we have a lot of latitude as to how we interpret things.

We have to have a complaints mechanism in place, but [the Act] doesn't ... dictate in great detail what it looks like, which is fortunate for us because it allows us some flexibility.

Some regulators were concerned that growing government prescriptiveness was restricting this flexibility.

Regulators varied in their perceptions of accountability to government. Some saw providing information as a moral obligation:

I feel a sense of accountability to government because I have this job, basically, as a result of the courtesy of the government.

Other regulators emphasized their autonomy:

Our only role with government is our annual reports, our activity. I don't perceive us to be accountable to government.

The regulators stressed governmental collaboration, categorizing their relations with the government as “formal or informal.” Formal relations included submission of an annual report and financial accounts demonstrating the fulfillment of the regulator’s mandate. Informal collaboration included “regular meetings with the ... directorate.”

Regulators indicated that recent legislative changes, such as the federal AIT, the *Regulated Health Professions Act* (RHPA) and the *Fair Registration Practices Act* (FRPA) created challenges for demonstrating accountability. As noted above, the AIT attempts to give regulated professionals the freedom to move among provinces, but they must still become registered by the applicable provincial/territorial regulatory body. In general, regulators spoke favourably of the AIT, particularly as an impetus to cross-provincial collaboration in setting standards:

The good thing from the regulatory perspective is that we have defined Canadian standards for admission – full certificate of registration.

However, one regulator noted that provinces with lower standards might find harmonization difficult. Furthermore, harmonization might cause local shortages in some regions by facilitating mobility to other areas in Canada.

The provincial/territorial regulatory Acts are intended to create overarching statutes that provide uniform standards and practices that apply to all professions governed by the legislation. Some participants favoured the Act in their province/territory:

It gave us better bylaw-making authority ... [and] set out explicit requirements for quality assurance programs The minister of health can ... set benchmarks or targets or expectations on the colleges. ... I think that our legislation over the last five years has improved.

Others feared that the Acts would lead to greater accountability requirements that could undermine the autonomy of the professions:

[If] the RHPA ... in essence says that if it’s in the public interest, the Ministry of Health can impose all kinds of things on a college and create new standards of practice, or change things and replace a council, or can appoint an administrator to assume any role or the functions.

At the present time the RHPA exists in four provinces to ensure that regulated professions are governed by transparent, objective, impartial and procedurally fair registration practices. Regulators commented:

[The Act] maintains self-regulation of each health profession while enabling collaboration.

It's an enabling legislation and not top-down government oversight legislation.

Other regulators suggested that the Acts increased their need for vigilance because provinces could be fined if regulations prevented health professionals from moving between provinces/territories. One regulator suggested that an independent arm's-length body should review decisions of the college with respect to registration practices and complaints in order to increase transparency, accountability and fairness.

Accountability to regulatory body members

Regulators acknowledged their responsibility to registrants, who pay licensing fees with the understanding that these fees will be used to regulate the profession:

Accountability to the members would be that we provide a reasonable service in terms of licensing registration to ensure public safety ... in a cost-effective manner.

Regulators used their websites as well as annual meetings and other official occasions to demonstrate both the fulfillment of their mandate and fiscal accountability to their members:

We see our members as customers of our services. They receive the annual report and there's an annual meeting. ... We communicate changes, regulatory changes, that might impact on the employers, [and] send [the information to] ... the union as well.

Regulators indicated that they educated their members about qualifications, standards of practice and complaints investigation.

Metrics supporting accountability

Metrics are an important aspect of demonstrating accountability. In some jurisdictions, legislation specifies the statistics that regulators must provide:

The content of the report is included in the bylaw under the Code of Professions. It is decided by the minister of justice, the Office of Professions and the Order of Professions.

Other provinces have fewer legal requirements. Minimally, statistics reported included such information on registrants as licence renewal, professional examinations, disciplinary matters and financial data.

The extent to which self-reported information was collected or audited varied. Small jurisdictions with few financial resources and few members used no metrics beyond basic

statistics that described their membership. Larger jurisdictions used metrics to improve their performance by monitoring the efficiency of registration or complaints processes, or measuring stakeholder satisfaction.

Some jurisdictions used or planned to use metrics to support strategic planning. Larger jurisdictions envisaged creating sophisticated measurement tools. One regulator had developed a 10-year plan for improving data collection and tracing. Another noted that his organization had established goals, strategies, targets and measurements and provided both progress and financial reports to its council.

Several jurisdictions were interested in trending and tracking complaints and their outcomes to demonstrate public accountability and stimulate improvement. However, even regulators with larger memberships indicated it was hard to identify whether the figures represented random variation or actual trends. Regulatory bodies in small jurisdictions received too few complaints to identify trends.

Accountability Challenges

Stakeholder understanding

To be accountable, regulatory bodies sometimes had to instruct members and the public about their role. Participants noted this was a challenge:

You are constantly trying to help ... the public understand who you are.

[Members] sometimes think that [we] ... just take their money and do policing kind of work, but a lot of what we do is to support members.

In some provinces, nursing organizations have the dual mandate of protecting the public and representing their members. Since these mandates can be conflicting, there has been a trend towards establishing separate organizations, a process that requires educating members about the parameters of the regulatory role:

We were an association that regulated and then we transitioned out of that role into the role of sole regulator. The association sort of advocacy role was lost. ... I think as a result ... nurses are confused about the purpose of the college, why it doesn't represent the voice of nursing anymore.

Both medicine and nursing regulators indicated that younger registrants and internationally educated healthcare professionals do not understand the distinct roles of the association and the college. New registrants believe the former acts as an advocate while the latter appears to be "the dark side." Members need to understand that the regulators "support them in their practice and make their practice better":

I think we find that the biggest challenge is helping them to understand and realize what profession-led regulation means.

One regulator felt that education would help new members and the established membership gain a clearer appreciation of their professional responsibilities and was “looking very closely at introducing education on jurisprudence for a licensee.”

Transparency and privacy

The regulators acknowledged that the reconciliation of transparency with privacy was a challenge:

Although we are responsible to the public, we provide our members with whatever degree of privacy and personal protection we possibly can.

A regulator noted that regulations such as the RHPA mean that “all terms and conditions for all practitioners will be public unless they are related to the [practitioner’s health].” Competing pressures to be open and to protect privacy were influenced by provincial policies and legal or regulatory structures, and regulators had to make decisions about how to deal with them.

Use of social media

All regulators discussed inappropriate use of social media by members and stated that they either had or intended to develop guidelines on social media use. Many senior members of the regulatory organizations did not personally use social media, but they felt under pressure to adopt such communication to inform or demonstrate accountability to their members and the public. They found the prospect daunting and were concerned about the potential spread of misinformation; they also cited lack of resources, time and expertise to implement social media infrastructure. Most regulators perceived Twitter as too informal a communication tool. However, they believed social media were the answer to the apparent invisibility of regulators to the public, and that such media were helpful in small jurisdictions in which membership was scattered over a large area.

Organizational costs

The regulators indicated that changes to legislation caused financial strain and generated competing priorities. Increases in regulatory costs are borne by members. In particular, smaller colleges have similar obligations as larger colleges, but they have fewer resources. Because producing accountability data consumes resources, regulators stressed the need to ensure that data supported solutions:

I think we ask for too much information ... [that] we cannot properly interpret ... and for which there is no real follow-up.

Several regulators suspected that government-mandated data was not always utilized:

...we are required to collect data we didn't previously collect. That increases complexity of work [and] increases cost. ... some of the data they want us to collect, we have no clue what they are going to do with, and they don't either. That's very frustrating.

Regulators indicated that data are expensive to produce and that their use should be carefully assessed.

Discussion

Although variously perceived and defined, accountability is a key concept in regulation. How it is demonstrated depends on the size of the province/territory, government relations and transaction costs inherent in regulatory processes. The regulators in this study did not provide a common definition of accountability, but they agreed on a triad of accountability constituencies (the public, government and their members) and saw their responsibility to report to them similarly. However, despite their efforts to the contrary, the regulators felt the public had little awareness of the regulatory presence and function, and that their members had a mixed understanding of the regulatory role.

As noted by Benton and colleagues (2013), lack of a "common set of indicators" makes measuring accountability a challenge. Regulators cited pressure to provide more metrics and expressed reservations about increasing fees to pay for additional accountability measures. All the provinces/territories had Acts and regulations that addressed the fulfillment of accountability in the interest of better serving the public. There was consensus among the regulators that legislation was important, and they valued the privilege of self-regulation. They noted that competing priorities, such as privacy versus transparency, depended on context. They also identified tension between self-regulation and government oversight.

Limitations

The current study was a substudy with a limited sample of healthcare regulators from one country. Therefore, the findings may not necessarily apply to regulators in other sectors and other jurisdictions.

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Approaches to Accountability in Long-Term Care

Démarche de l'obligation de rendre compte dans les soins de longue durée



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Abstract

This paper discusses the array of approaches to accountability in Ontario long-term care (LTC) homes. A focus group involving key informants from the LTC industry, including both for-profit and not-for-profit nursing home owners/operators, was used to identify stakeholders involved in formulating and implementing LTC accountability approaches and the relevant regulations, policies and initiatives relating to accountability in the LTC sector. These documents were then systematically reviewed. We found that the dominant mechanisms have been financial incentives and oversight, regulations and information; professionalism has played a minor role. More recently, measurement for accountability in LTC has grown to encompass an array of fiscal, clinical and public accountability measurement mechanisms. The goals of improved quality and accountability are likely more achievable using these historical regulatory approaches, but the recent rapid increase in data and measurability could also enable judicious application of market-based approaches.

Résumé

Cet article porte sur l'organisation des démarches de l'obligation de rendre compte dans les résidences de soins de longue durée (SLD) en Ontario. Un groupe de discussion formé d'informateurs clés du secteur – des propriétaires ou gestionnaires de centres d'hébergement et de soins à but lucratif ou non – a été réuni pour déterminer qui sont les intervenants impliqués dans la définition et la mise en œuvre des démarches d'obligation de rendre compte ainsi que de la réglementation, des politiques et des initiatives connexes dans le secteur des SLD. Ces documents ont été examinés systématiquement. Nous avons observé que les principaux mécanismes sont les mesures incitatives ainsi que le contrôle financier, la réglementation et l'information; le professionnalisme y a joué un rôle secondaire. Plus récemment, l'évaluation de l'obligation de rendre compte dans les SLD s'est accrue pour inclure une gamme de mécanismes de mesures concernant l'obligation fiscale, clinique et publique. Il serait plus facile d'atteindre les objectifs d'amélioration de la qualité et d'obligation de rendre compte en utilisant ces démarches de réglementation traditionnelles, mais l'accroissement rapide des données et de la mesurabilité pourrait permettre une application judicieuse de démarches propres aux marchés commerciaux.



IN CANADA, LONG-TERM CARE (LTC) PROGRAMS ARE GENERALLY DELIVERED VIA TWO distinct channels: communities and facilities. This paper focuses on regulated facility-based LTC services in Ontario, referred to as LTC homes (LTCHs). LTCHs generally provide a lower level of care than that offered in hospitals; however, some overlap exists. Individuals residing in LTCHs in Canada are those in need of high levels of daily personal care; this may entail supervision or assistance with activities of daily living, 24/7 nursing care or supervision or provision of a secure environment (Williams et al. 2009). Because LTCHs do not fall under the terms of the *Canada Health Act*, there is no requirement for them to be publicly funded. As is the case for all healthcare services, provincial governments have jurisdiction over which (if any) policies will be applied to these facilities; for example, there is also an extensive, largely unregulated subsector providing “residential care” to privately paying seniors, an activity deemed to fall outside the LTC system, and outside the scope of this paper. As a consequence, the nature, level and availability of institutional LTC varies from jurisdiction to jurisdiction (Berta et al. 2006). Most provinces, including Ontario, have delegated much of the responsibility to regional health authorities.

In Ontario, the provincial government pays for a portion of the costs of institutional LTC, and regional community care access centres (CCACs) have been given responsibility for managing resident admissions and placement to publicly subsidized LTCHs. The governance and ownership of LTCHs is an important feature of this sector. As of April 2012, 57% of Ontario's 630 LTCHs were for-profit, with a mix of private ownership and board oversight

among publicly traded, investor-owned companies. Another 26% were not-for-profit (principally charitable) homes with varying governance structures; the remaining 17% were municipally owned homes (see also Wyers et al. 2014).

Accountability in Healthcare

Accountability refers to the imperative to answer to someone (e.g., a stakeholder, shareholder or overseer) and to demonstrate doing so by meeting the objectives set by them (see Deber 2014, this issue; Emanuel and Emanuel 1996; Fooks and Maslove 2004). Accountability can be complicated by the need to be accountable to multiple parties who may have divergent interests. Accountability is multidimensional; Brinkerhoff (2003, 2004) refers to three dimensions. Financial accountability refers to a focus on complying to explicit financial reporting procedures; in healthcare, health service providers are fiscally accountable to payers, which for some services may include the government. Performance accountability refers to a focus on achieving defined or prescribed, measureable outputs; in healthcare, this is generally articulated as clinical accountability and clinical measures/outcomes. The political/democratic accountability dimension refers to fulfilling public trust, and in healthcare equates to public accountability. Specific approaches to accountability – how accountability is exercised – vary. The series of substudies in this Special Issue focused on four main approaches (“policy instruments”) that dominate in healthcare (recognizing that these are not mutually exclusive): regulations, the use of financial incentives/expenditures, the provision of performance information to payers and the public and professionalism/stewardship (Deber 2014). We hypothesized that the mix of these approaches would vary by sector, and that the “success” with which they were applied would vary, in turn, as a function of the clarity and feasibility of the policy goals that are set, the fit between these goals and the governance/ownership structures of provider organizations, and the types of goods and services being delivered and their production characteristics.

Accountability Dynamism in Ontario’s Long-Term Care Sector

In most jurisdictions, LTC is stringently regulated (Grunier and Mor 2008; Hollander 1994), and a vital aspect of LTCHs’ operations is to ensure adherence to the standards set by government regulators; failure to do so may incur loss of provincial funding or of licensure. In Ontario, the Ministry of Health and Long-Term Care (MOHLTC) regulates and inspects all nursing homes that fall under the terms of the 2007 *Long-Term Care Homes Act* (LTCHA), and it is responsible for the granting of nursing home licences.

The past several years have been transformational for Ontario’s LTC industry. Changes have been wrought that not only affect how Ontario’s 630 LTCHs are accountable, but to whom, and the goals of accountability approaches have been expanded from a historical focus on the operational to the aspirational, including support for continuous quality improvement initiatives. Throughout this evolution, the provincial government has maintained a strong oversight of LTCHs in Ontario through legislation and regulatory oversight.

In 2006, Ontario set up 14 regional local health integration networks (LHINs) with responsibility for managing the flow of provincial funds for specified healthcare services in their regions; these services include hospitals and community care access centres (CCACs). CCACs also commission certain home care professional services (see Steele Gray et al. 2014), and have some responsibility for helping to manage admissions to publicly subsidized LTCH placements. Accordingly, some of the operational aspects of accountability, historically the purview of MOHLTC, were delegated to the LHINs. In particular, the LHINs have been given responsibility for managing accountability agreements with many of the regional bodies (including hospitals) who receive provincial money (see also Kromm et al. 2014).

Methods

Focus group

In Fall 2012, we held a focus group discussion with eight key informants from the LTC industry, including representatives of the for-profit (n=2) and not-for-profit (n=2) nursing home subsectors, and health services researchers with experience in examining policy (n=2), performance (n=1) and economic issues (n=1) in Ontario's, and Canada's, LTC industry. Focus group participants were asked to identify all stakeholders involved in the formulation and implementation/execution of accountability approaches; to identify the regulations, accountability policies, programs and initiatives of relevance to Ontario's institutional LTC sector; and to elaborate on their experiences – direct and observed – with the application of these accountability mechanisms. Focus group participants were selected purposively (Patton 2001) in the interests of identifying key informants with adequate knowledge and experience to address our questions. Since the purpose of the focus group was to inform the document review, we do not report on results of the focus group separately in this paper.

Document review

We then reviewed all current regulations of relevance to the LTC sector, and the documented information relating to accountability policies, programs and initiatives identified by our participants. These are publicly available documents, where regulations are accessible on the government website, and information about current long-term care service accountability agreements (L-SAAs) are posted on several websites.¹

We also consulted a series of draft L-SAA templates from previous years, some of which can be found on the Ontario Long Term Care Association's website² and on individual LHIN websites.

The numerous acronyms associated with the materials included in our review are summarized in the Appendix (see Appendix at www.longwoods.com/content/23851).

Results

Of the four approaches to accountability that are prominent in healthcare generally, the three of particular prominence in the LTC sector are regulation, the use of financial incentives and the provision of performance information to payers and the public; there was far less emphasis on mechanisms related to professionalism/stewardship, in part because LTC relies heavily on personal support workers and other providers who are not regulated (see Baumann et al. 2014). Control is dispersed; regulations are standardized by MOHLTC, but LHINs are responsible for the payments to LTCHs, and financial accountability and accountability for inspection findings are included within three-year service-agreement contracts (L-SAAs).³ Two other accountability mechanisms are aligned with the exhortation governing instrument; these include information included in public reporting of LTCH quality of care on a public website maintained by Health Quality Ontario (HQO) and accreditation. While all Ontario nursing homes must be licensed, most are also accredited by Accreditation Canada,⁴ a non-governmental entity that evaluates nursing homes as well as other healthcare providers (see Mitchell et al. 2014) and by the Commission on Accreditation of Rehabilitation Facilities (CARF).⁵ Public reporting at HQO began as a voluntary exercise in 2009 but became mandatory in 2013. Accreditation is voluntary.

Regulatory approaches to accountability in LTC

THE LONG-TERM CARE HOMES ACT, 2007 (LTCHA)

Effective July 2010, the LTCHA replaced the three discrete acts that had governed Ontario's different models of LTCHs: the *Nursing Homes Act* (for-profit homes), the *Charitable Institutions Act* (not-for-profit homes) and *Homes for the Aged and Rest Homes Act* (municipal homes). In addition to reinforcing the notion that LTCHs must be places where residents feel safe, secure and comfortable and receive care that meets their needs, the LTCHA enforces building codes and operational procedures more stringently than these previous Acts. Under the LTCHA, the Resident's Bill of Rights has been extended such that every home must have a Residents' Council, a Family Council and a mission statement developed in collaboration with these councils. Every resident must have a plan of care covering all aspects of care, with clearly defined goals and direction to staff on how they will be achieved, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care, which must be reviewed and revised at least every six months. Significantly, the LTCHA requires that assessment instruments are applied in five clinical areas that have long been linked to the quality of resident care (Richardson et al. 2001): falls, skin and wound care, continence care and bowel management, responsive behaviours (a term referring to challenging behaviours exhibited by residents with dementia) and pain management.

Approaches to Accountability in Long-Term Care

REVISING COMPLIANCE INITIATIVES AS PER THE LTCHA AND NEW QUALITY IMPROVEMENT AIMS

In April 2008, MOHLTC's LTCH Compliance Management Program was redesigned to align with the LTCHA. The program ensures that LTCHs are meeting the standards and criteria set out in MOHLTC policy and licensing agreements, and the L-SAA. The new compliance system also responds to public and sector interest in improving residents' safety, and their quality of care and life, through continuous quality improvement. Compliance inspections are more collaborative and consultative, and now include a Resident Quality Inspection (RQI) that engages residents, families and staff in structured interviews regarding their care experiences.

Unannounced random inspections have been implemented; they use mandatory inspection protocols that are based on the most problematic areas as reflected in complaints (these include admission processes, dining, infection prevention and control, medication management and charges to residents). As a result of Ontario's legislative changes and the new Compliance Management Program, all issues of non-compliance are identified and documented in an inspection report. In the event of non-compliance, a more in-depth inspection process is undertaken that targets the areas of care quality described in the LTCHA and regulations. Past history of compliance, and the severity and the scope of the non-compliance, are used to determine actions; these may range from requiring a response plan, to fines, to closure of the facility to new admissions or, in extreme cases, closure of the LTCH.

With the LTCHA, the provincial government has maintained a high degree of regulatory oversight with the policy goal of ensuring the safety of residents in LTCHs. This regulation is classified as a high-coercion policy instrument; compliance is required for licence renewal. MOHLTC also continues to determine funding levels, licensing and approval of LTC beds, and approves changes of ownership, sales and amalgamations for purposes of licensing, as well as the selection of a third-party management company in the event of a bankruptcy.

Financial accountability approaches in LTC

DEVOLUTION OF FISCAL ACCOUNTABILITY TO LOCAL HEALTH INTEGRATION NETWORKS (LHINs)

While the precise powers of LHINs are still contentious, on paper they have a mandate to plan, fund and integrate healthcare services for more efficient and effective care in their regions. LTCH funding is provided through four funding envelopes paid by the province but managed by the LHINs: (a) nursing and personal care (NPC), from which the majority of LTCH staff are paid, including nursing and personal care staffing, and medical/nursing supplies and equipment; (b) program and support services (PSS), from which certain recreation staff and expenditures are covered, as well as therapeutic services, pastoral care, staff training and volunteers; (c) raw food; and (d) other accommodations, from which room and board costs are expensed, including housekeeping, laundry, dietary services, administration and building/property operations and maintenance, mortgage payments and taxes. Residents pay a

co-payment as a portion of the full funding levels, the amount of which is set by the province and is dependent upon the type of room (e.g., private) and the resident's ability to pay. The NPC, PSS and raw food envelopes are "reconcilable," meaning that MOHLTC's Financial Management Branch compares actual spending to allowable spending in these envelopes. Unspent funds must be returned to the LHIN, although overexpenditures in these envelopes can be balanced with surpluses from the other accommodation envelope (which is non-reconcilable, meaning that excess revenues in this envelope can be retained by the LTCH). The Financial Management Branch retains responsibility for reviewing the audited annual report (AAR) and Revenue/Occupancy Report, and administering the subsidy calculation worksheet, on behalf of the LHINs. This very tight management of financing provides a strong incentive to manage budgets closely but does not incentivize rewarding quality or performance.

L-SAAs encapsulate the terms of the service agreements between the LHINs and the LTCHs. While largely operational in nature with a focus on financial reconciliation and adherence to compliance inspection standards, the next generation of L-SAAs is expected to focus more on performance management and achieving performance goals. While LHINs do not have the authority to establish LTCH resident care standards (this responsibility still remains within the domain of MOHLTC), LHINs may set performance targets for LTCH indicators in the L-SAA.

Beyond administering the L-SAAs, LHINs are also responsible for reviewing and monitoring LTCH occupancy rates, as well as placement refusal trends, transfer request trends and wait list profiles. LHINs further monitor bed utilization, performance and expenditures, and recover and reallocate operating funds through an annual reconciliation process facilitated through the Revenue/Occupancy Report.

ALIGNING PERFORMANCE MEASUREMENT SYSTEMS WITH NEW FISCAL ACCOUNTABILITY IMPERATIVES

Advances in both clinical and fiscal accountability in Ontario's LTC sector are being supported by the introduction of two initiatives that enhance the measurability of financial performance and resident clinical outcomes: the full-scale implementation of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) and the introduction of the Long-Term Care Homes Ontario Healthcare Reporting Standards/Management Information Systems.

Full-scale implementation of the RAI-MDS in Ontario's LTCHs began in 2010. RAI-MDS provides a comprehensive functional and clinical assessment of residents, and is intended for use in resident care planning and evidence-based decision-making. RAI-MDS data are used to provide evidence-based indicators for compliance inspection purposes and are also used by HQO to publicly report quality care indicators at the home level. RAI-MDS data are also used to calculate LTCHs' case mix index (CMI) based on the Resource Utilization Groups (RUGs) case mix grouping system.⁶

The second major initiative relating to performance measurement is the Ontario Healthcare Reporting Standards/Management Information System (OHRS/MIS), which provides LTCHs with a standardized financial and statistical framework for data collection processes; benchmarks with peers based on indicator tools and provincial comparative reports; the ability to track trends; improvements to transparency and performance accountability; and the means by which to demonstrate service efficiency and effectiveness. The OHRS/MIS complies with the Canadian Institute for Chartered Accountants (CICA) and Generally Accepted Accounting Principles (GAAP). Following a pilot phase in 2009, all LTCHs have implemented OHRS reporting.

Public accountability approaches in LTC

GOVERNMENT ACCOUNTABILITY TO THE PUBLIC

MOHLTC leads or supports a number of initiatives intended to ensure accountability to the public. The Ministry's Reports on Long-Term Care website⁷ provides basic information on every LTCH operating in Ontario (ownership, management, size, accreditation status) and the results of compliance inspection reports including critical incidents, complaints and other inspection outcomes. Concurrent with the introduction of the LTCHA and the public reporting initiative, MOHLTC has improved the process for complaints reporting through a toll-free Long-Term Care ACTION Line (complaints may also be made in writing or by e-mail).

PUBLIC PERFORMANCE REPORTING

In addition to the public reporting website supported by MOHLTC, HQO provides an annual report on the health system and includes indicators related to nine areas of health system performance, assessing healthcare organizations on the basis of whether they are accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on the population. In its annual report, HQO currently tracks LTCH indicators associated with six of these domains (see Table 1). In addition to the QMonitor, HQO maintains its own LTC public reporting website⁸ and offers performance data for each LTCH in Ontario relative to provincial averages for falls, incontinence, pressure ulcers and restraint use.

TABLE 1. Areas of performance in HQO's QMonitor Annual Report on Ontario's healthcare system

Area of Performance		Indicator
Accessible	Wait Times	Median number of days to long-term care home placement
Effective	Incontinence*	% of residents with worsening bladder control
	Activities of Daily Living (ADLs)	% of residents with increasing difficulty carrying out normal everyday tasks
	Cognitive Function	% of residents whose language, memory and thinking abilities have recently decreased
	Pain	% of residents with pain that got worse recently
	Emergency Department Visits	# of emergency department visits due to an ambulatory care-sensitive condition per 100 LTC residents per year
Safe	Falls*	% of residents who had a recent fall
	Pressure Ulcers*	% of residents who had a pressure ulcer that recently got worse
	Restraints*	% of residents who were physically restrained
	Medication Safety	% of residents aged 65 years or older prescribed a drug that should never be used among the elderly per 100,000 residents aged 65 years or older per year
Appropriately Resourced	Health Human Resources	# of injuries per 100 LTC workers per year
Focused on Population Health	Infections	% of long-stay residents with new infections

* Also reported on the public reporting website.

ACCREDITATION

While all Ontario LTCHs must be licensed through MOHLTC, most also voluntarily seek accreditation through Accreditation Canada, a non-governmental entity that evaluates nursing homes and assists them in meeting regulations and compliance (see also Mitchell et al. 2014).

In 2008, Accreditation Canada introduced a new program, Qmentum, which emphasizes health system performance, risk prevention planning, client safety, performance measurement and governance. Extensive feedback is synthesized from a LTCH's clients, surveyors, board members and staff to produce tailored required organizational practices (ROPs) to help them meet their performance goals. Qmentum surveyors debrief administrators and staff members on their findings, and provide evaluation results via a client organization portal supported by Accreditation Canada. One key feature of this portal is the quality performance roadmap (QPR), which displays the organization's progress. The QPR is intended to be used as a quality improvement tool. It allows organizations to submit evidence of action to Accreditation Canada.

Discussion

Approaches to accountability in Ontario's LTC sector

The three dominant approaches to accountability being used in Ontario's LTC sectors are regulation, financial incentives and the provision of performance information to payers and public.

Regulations are enacted by MOHLTC and enforced through compliance and unannounced inspections, and through another layer of oversight, the regional health authorities (LHINs). The stringency of regulatory oversight is likely associated with the perceived vulnerability of LTC residents who are commonly medically, physically or cognitively impaired and less able to reliably use formal approaches to raise concerns about the quality of care provided in LTCHs. The high degree of regulatory stringency suggests that policy makers do not believe that other mechanisms, such as information and professionalism, are sufficient to achieve the policy goal of the sector.

Financial incentives and oversight in LTC have historically focused on cost containment and case mix adjusted standardized payment for residents, with the strong emphasis on financial oversight perhaps due in part to the dominance of for-profit providers in the sector. The devolution of more focused objectives regarding resident safety through the 2007 LTCHA reflects to some degree the view that oversight should occur as closely as possible to the location of care delivery. Nevertheless, the focused objectives still tend to be highly weighted towards financial measures, albeit with increased emphasis on performance assessment.

The extent and sophistication of information directed towards patients and providers is evolving and is accessible online, facilitated by inspection reports made available from MOHLTC and public reporting by HQO. Information availability and use is still fairly limited, however, and we see this as one of the most promising areas for improved accountability and performance in LTC. The recent greater involvement of patients and their families and the development of a complaints accountability infrastructure appear to be mechanisms that have been employed within the LTC sector to increase the flow of information about the quality of care being provided at facilities across the province.

Recently, there has been an effort to align these approaches. For example, with the articulation of policy goals that focus on residents' quality of life and outcomes, cemented in the *Long-Term Care Homes Act, 2007*, regulatory approaches are augmented by performance improvement mechanisms such as the RAI-MDS. The RAI-MDS, for example, has facilitated a shift from case mix payments based on age and sex adjustment to payments based on more detailed health indicators (e.g., cognitive and functional limitations) that better reflect the care needs of the aged. By tying funding resources more closely to patient needs, the disincentives that existed for assuming the care of highly complex patients in the LTC sector are markedly diminished. This specific example illustrates an important synergy between "old" financial accountability approaches, new policy goals articulated through new regulation, and the operationalization of these goals using new performance accountability approaches.

The role of professionalism is far less emphasized in the LTC sector compared to others. This finding is likely attributable in large part to the relatively low involvement of professional staff in care delivery in LTC homes. There is minimal physician oversight, with managerial and clinical roles carried out predominantly by registered nurses (RNs) and registered practical nurses (RPNs). Most of the direct resident care (~80%) is delivered by unregulated workers – healthcare aides (HCAs) and personal support workers (PSWs). While professionalism as traditionally constructed may play less of a role in LTC, there may be a future for unions to play a role in ensuring standards of care. The Canadian Union of Public Employees (CUPE) represents 24,000 workers, and the Canadian Auto Workers Union (CAW) represents 16,000 workers in Ontario's LTC sectors.

Appropriateness of accountability approaches in Ontario's LTC sector

In terms of production characteristics, publicly subsidized LTC services in Ontario have limited contestability (that is, market entry is highly restricted) as a consequence of licence requirements and the limits imposed by the Province on the number of LTC "spaces" it will pay for. Measurability is somewhat problematic (particularly for "softer" outcomes) but has been enhanced with the comprehensive clinical information and public reporting based on the RAI-MDS data that include not only adverse clinical outcomes as currently measured but also health-related quality-of-life measures (including cognitive and physical function, engagement and participation in activities, pain and emotional health). Such public reporting of a larger set of quality indicators and a star-rating system for consumers based on RAI-MDS quality indicators and state inspection results is being used in the US to improve market functioning. Complexity is difficult to assess, although most services must be delivered within the LTCH.

The largest of these issues is contestability, with greater allowance for market entry and exit, suggesting that a less stringent regulatory approach might be successful. The governance of LTC is highly varied and includes a large proportion of for-profit enterprises and corporations with some cottage industry solo private operators, and may require strengthening to enable the success of a less regulatory approach. This extensive variety of governance and ownership models in the LTC sector suggests that the application of policy instruments will likely have non-uniform effects across the models. The appearance of low trust in the LTC sector is potentially affected by the high vulnerability of the population, as well as media reports of poor quality and occasional avoidable deaths in LTCHs.

Conclusion

In sum, our assessment of accountability mechanisms in the LTC sector suggests that improving quality and accountability is likely more responsive to regulatory approaches, but could also be enabled through judicious market-based approaches. For the latter approach to succeed, expanded and strengthened public reporting of quality, including clinical quality and

quality-of-life or resident experience information, would be necessary to improve the capacity of individuals to make informed choices about their selection of LTCH. Success of the market-based approach would clearly depend on the complexity of cases, and may be less feasible because an emphasis on care in the community means that those admitted to such homes are increasingly frail.

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Notes

1. See, in particular, www.lhincollaborative.ca/Page.aspx?id=1968, www.lhincollaborative.ca/lsaa/lsaahome.aspx and www.health.gov.on.ca/en/public/programs/ltc/lsaa_policies.aspx.
2. See <http://oltca.com/funding-policy-bulletin-archives>.
3. See www.lhincollaborative.ca/lsaa/lsaahome.aspx.
4. See www accreditation.ca/en.
5. See www.carf.org/Programs/AS.
6. See www.cihi.ca.
7. See www.health.gov.on.ca/en/public/programs/ltc/26_reporting.aspx.
8. See www.hqontario.ca/public-reporting/long-term-care.

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How Do the Approaches to Accountability Compare for Charities Working in International Development?

À quel point les mécanismes de l'obligation de rendre compte dans les organismes de bienfaisance qui œuvrent au développement international sont-ils comparables?



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Abstract

Approaches to accountability vary between charities working to reduce under-five mortality in underdeveloped countries, and healthcare workers and facilities in Canada. Comparison reveals key differences, similarities and trade-offs. For example, while health professionals are governed by legislation and healthcare facilities have a de facto obligation to be accredited, charities and other international organizations are not subject to mandatory international laws or guidelines or to de facto international standards. Charities have policy goals similar to those found in the Canadian sub-studies, including access, quality, cost control, cost-effectiveness and customer satisfaction. However, the relative absence of external policy tools means that these goals may not be realized. Accountability can be beneficial, but too much or the wrong kind of accountability can divert resources and diminish returns.

Résumé

Les mécanismes de l'obligation de rendre compte varient entre, d'un côté, les organismes de bienfaisance qui travaillent pour réduire la mortalité des enfants de moins de cinq ans dans les pays sous-développés et, de l'autre, les travailleurs et les établissements de services de santé au Canada. Une comparaison révèle d'importantes différences, similitudes et mécanismes de

substitutions. Par exemple, alors que les professionnels de la santé sont gouvernés par des lois et que les établissements de santé ont l'obligation de facto d'obtenir leur agrément, les organismes de bienfaisance et autres organisations internationales ne sont pas assujettis à des lois ou directives internationales obligatoires, ou à d'autres normes internationales de facto. Les organismes de bienfaisance ont des objectifs semblables à ceux des établissements canadiens qui ont fait l'objet de l'étude, notamment, l'accès, la qualité, le contrôle des coûts, le rapport coût-efficacité et la satisfaction des clients. Cependant, l'absence relative d'outils de politique externes met en péril l'atteinte de ces objectifs. L'obligation de rendre compte peut être avantageuse, mais une obligation trop exigeante ou erronée peut dévier les ressources et en diminuer les retombées.

HOW APPLICABLE ARE THE FINDINGS OF THIS STUDY TO OTHER SETTINGS? My work examining accountability in various charities working to reduce under-five mortality in developing countries (Kirsch 2013) suggests that there are key differences and similarities that highlight the importance of the existing structures and how they influence the ability to use various policy instruments. Like this study, my work considered the “for what, to whom and why” of accountability, and also looked at the effects of accountability and variations based on size and other organizational characteristics.

One key difference relates to the differences between who is delivering care and how care is funded. Although reductions in under-five mortality rates are one of the United Nations' Millennium Development Goals (MDGs), the vehicle for accomplishing this is usually through non-governmental organizations (NGOs), defined as formal, self-governing organizations that are separate from governments and hence have no ability to direct societies or require support from them, and also are not in the business of making or distributing profits (Gordenker and Weiss 1996). For tax purposes, Canadian NGOs are incorporated as charities, and the terms NGO and charity are used interchangeably in this commentary.

The Government of Canada (GOC) does not work directly to reduce under-five mortality in developing countries, but rather provides funding to organizations, such as the Canadian International Development Agency (CIDA), which in turn directs funding to NGOs. The GOC also provides tax incentives for taxpayers who donate funds to charities. Given this chain of delegation, the “to whom” element can be complex; NGOs may be expected to be accountable to various combinations of those who fund charities (both governments and private donors), those whom they help, those who are interested in or indirectly affected by what they do and those with whom they work (Christensen and Ebrahim 2006). With few exceptions, accountability for charities is not strongly regulated within Canada; depending on the country, charities frequently have few legal requirements to be accountable in the countries where they work. Depending on the sources of funding, however, charities may have strict contractual obligations to provide predefined accountability reports to major funders.

The substudies described in this Special Issue concentrated on four policy instruments: financial incentives, regulations, information directed towards patients/payers and professionalism/stewardship. The enforcement mechanisms thus can include provision of information, licensure/accreditation, payment, legal sanctions or some combination of these. In contrast to the Canadian examples, whereby healthcare professionals are governed by legislation and healthcare facilities have a de facto obligation to be accredited, charities and other organizations that work internationally are not subject to mandatory international laws or guidelines, or de facto international standards. Although these policy instruments are not always available in international charitable settings, organizations such as the Red Cross, Humanitarian Accountability Partnership and the Philippine Council for NGO Certification have developed standards for conduct, accountability and accreditation. However, these organizations do not have any legislative power to force charities to join their organizations, or to stop the charities or their staff from conducting programs or providing services, even if they do not meet these standards; at most, they can stop the charities from using the association's logo. To further complicate the situation, a staff member who is terminated with cause from one charity can go to work at another charity: privacy laws may even restrict a charity from providing a bad reference. Similarly, health professionals from Ontario and other jurisdictions who work overseas for NGOs are not subject to the same scrutiny overseas as they are in their own jurisdictions.

NGOs have similar policy goals to those found in the Canadian substudies, including access, quality, cost control, cost-effectiveness and customer satisfaction. However, there is a relative absence of external policy tools to ensure that these goals are realized. The key tool appeared to be information/exhortation. In order to ensure a donation stream, charities have traditionally provided information about their good works and high-level information about their programs and administrative costs. In lieu of extensive accountability reporting, the literature suggests that the public has evaluated charities based on mission statements, annual fundraising and administrative expenses, and the perceived quality of the brand. People generally give because they believe in the vision and trust or hope that the charities will eventually succeed (Aldashev and Verdier 2010; Waters 2008). Governments also subsidize these private donations to charities, to the extent that taxpayers can use tax donation receipts to reduce their taxable income. Although administrative costs are not applied consistently across the sector (Wenar 2006), the ratio of money spent on administrative costs to money raised is often used as a proxy for effectiveness (Walsh and Lenihan 2006). Sargeant (1999) notes that, while people do not necessarily believe the ratios, they often continue to support the charities.

NGOs can also be funded by corporations, development banks, governments, high-net-worth individuals and others in a position to demand accountability through evaluations and other means. However, the literature contains mixed reviews of evaluations (Doucouliagos and Paldam 2006), and some literature suggests that rather than enhancing accountability and improving effectiveness, evaluations have created incentives for deception (Bornstein 2006; Hager 2005). Fortunately, stewardship and professionalism play an important role in ensuring that many NGOs do not yield to these temptations. Although many of those working for

NGOs are volunteers, they (and the paid staff) typically have strong beliefs in the vision and mission of their organizations and wish to act in a professional manner. These internal, external and financial pressures can be beneficial, especially when they encourage learning.

However, should that trust be seen as unwarranted, NGOs may see a reduction in their donation/funding stream due to lack of trust or violations of their funding agreements with major funders. In practice, larger charities do tend to follow the standards of various standards groups and work together to improve accountability in the sector. As in this study, answerability may lead to attempts to censure, shame and blame those who are deemed to be accountable, but these tactics are limited to the confines of the individual charities.

My study found that with strong regulation, accountability can lead to better care, better efficiency in use of resources and improved outcomes. It noted that if accountability was poorly implemented, it could result in excessive expenditure of resources and potential loss of support. The charities were asked for the reasons driving their accountability; they said that they were most likely to be accountable because accountability was perceived to be a good management practice that improved program effectiveness while reducing risk, and least likely to be accountable because it was a standards body, legal or accreditation requirement. Charities were also accountable because of the contractual obligations of funders. In the absence of strong regulation, my study further found that charities are most accountable to their boards of directors, staff and management teams and least accountable to peers, community groups, the general public and beneficiaries.

Charities can be accountable because of external or internal pressures. We found that being accountable because of external pressures often equates to being accountable in order to comply with an external requirement, while being accountable because of internal pressures can equate to either complying or learning, depending on the policies established by the charities' management. The accountability information that funders demand certainly fits as a compliance requirement while, depending on the details, the information may also provide a learning opportunity for charities.

One positive unintended consequence is that, as accountability information becomes more readily available internally, it becomes easier to share externally. My study found that the amount and type of information that charities are willing to share varied by accountability mechanism and, to a lesser extent, by the size of the charity. In general, the survey data showed that charities were more willing to be accountable for learning from successes than they are for their failures. Keohane (2003) notes that successes lead to improved reputation, which gives charities the incentive to report on their successes. Another similarity to the results in the Canadian substudies is that size matters; among the NGOs studied, the existence of accountability mechanisms within charities tended to increase with charity size and there was a much greater difference in their use between small and medium charities than there was between medium and large charities (size was categorized based on annual budgets).

Increased accountability to peers, a group that was very low on the accountability lists of all charities, could help charities learn from the mistakes of the past and ensure that they are not repeated in the future, especially when such reports are published for all to review.

How Do the Approaches to Accountability Differ for Charities Working in International Development?

This concept is embodied in the requirements of various standards bodies and international initiatives, but reality must be aligned with the rhetoric for any positive effects to be realized. As noted, there are fewer consequences for NGOs than for the organizations studied in the Canadian examples reported in this special issue.

Although financial consequences did play a role in all of these studies, they also operate somewhat differently among NGOs. In particular, the desire to maintain trust means that accountability information is directed to donors/major funders but not necessarily to beneficiaries, who typically have less power to demand accountability. Devising mechanisms to involve beneficiaries in the process would still seem advisable, however, because other research has found that this leads to better quality of services and improved outcomes (Wenar 2006).

In conclusion, it is striking that similar trade-offs/balances were found in both studies. Accountability can be beneficial, but too much or the wrong kind of accountability can divert resources and diminish returns. However, the absence of consequences can also leave meeting goals to the good will of the NGOs, which may or may not be sufficient.

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The Accreditation Canada Program: A Complementary Tool to Promote Accountability in Canadian Healthcare

Le programme d'Agrément Canada :
outil complémentaire pour la promotion de l'obligation
de rendre compte dans les services de santé canadiens



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Abstract

Across Canada and internationally, the public and governments at all levels have increasing expectations for quality of care, value for healthcare dollars and accountability. Within this reality, there is increasing recognition of the value of accreditation as a barometer of quality and as a tool to assess and improve accountability and efficiency in healthcare delivery. In this commentary, we show how three key attributes of the Accreditation Canada Qmentum accreditation program – measurement, scalability and currency – promote accountability in healthcare.

Résumé

Au Canada et à l'étranger, la population et tous les paliers de gouvernement ont des attentes de plus en plus grandes pour ce qui est de la qualité des soins, du rendement de chaque dollar dépensé pour la santé et de l'obligation de rendre compte. Dans ce contexte, on reconnaît de plus en plus la valeur de l'agrément à titre de baromètre de la qualité et comme outil pour

évaluer et améliorer l'obligation de rendre compte et l'efficacité dans la prestation des services de santé. Dans ce commentaire, nous montrons comment trois caractéristiques clés du Programme d'agrément Qmentum d'Agrément Canada – évaluation, adaptabilité et fiabilité – favorisent l'obligation de rendre compte dans les services de santé.

WORLDWIDE, HEALTH SERVICES ACCREDITATION IS VIEWED AS EXTERNAL evaluation, an external third-party review aimed at validating the achievement of healthcare standards (Accreditation Canada 2014). Accreditation Canada is a not-for-profit independent organization that provides national and international health services organizations with quality-focused, comprehensive accreditation services. Accredited by the International Society for Quality in Health Care, Accreditation Canada has supported organizations in improving healthcare quality since 1958. Accreditation is voluntary in some sectors and jurisdictions and mandatory in others. Within this reality, in total over 1,200 organizations (located on over 6,000 sites) throughout the continuum of care participate in Accreditation Canada programs. In 2008, Accreditation Canada launched the Qmentum accreditation program, a major refocusing of the preceding program.

Tailored Measurement for Individual Healthcare Organizations within a National Context

The Qmentum program provides a framework to guide measurement, known as the Accreditation Canada Quality Framework. Eight dimensions are used to define quality and guide the focus of the standards: population focus, accessibility, safety, work life, client-centred services, continuity of services, effectiveness and efficiency. The Accreditation Canada program promotes accountability through measurement by providing benchmarking – across teams in an organization, across time and in comparison to other peer comparators within the appropriate jurisdiction or sector of care. Performance in each quality dimension is reported back to each organization. Leaders at all levels of an organization can use this dimension benchmarking to diagnose strengths and opportunities for improvement (Mitchell et al. 2012).

During the on-site survey, surveyors – senior healthcare professionals from Canadian healthcare organizations accredited by Accreditation Canada – observe and evaluate the extent to which the standards are met. Surveyors interact directly with a wide variety of staff, clients and stakeholders in their work environments to gather evidence about the quality and safety of care and services provided. The independent on-site peer review and the standards criteria rated by surveyors serve as an accountability tool by enabling the staff of healthcare organizations to identify strengths and opportunities for improvement.

Surveyors assess what is evident and presented to them; what is not evident or presented cannot be assessed. The interaction of direct care providers with surveyors enhances the information obtained during the on-site survey. In the Qmentum program, information is also

collected through survey instruments that complement the on-site survey. These questionnaires – focusing on work life, patient safety culture and governance – provide data across the organization, different groups of staff/service providers and programs. The survey instruments are applied, at minimum, once per accreditation cycle; however, they can be utilized as often as the organization chooses.

Accreditation Canada produces organization-specific, sector-specific, national and jurisdictional reports, as well as joint reports with other national healthcare organizations on emerging trends, quality and safety risks, and best practices (Accreditation Canada 2013; Accreditation Canada et al. 2012). This analysis of accreditation data/results promotes accountability in organizations by allowing for the comparison of organization-specific results to sector, jurisdictional and national results and by sharing quality improvement practices across Canada.

Scalability: Customizing the Accreditation Program to Individual Organizations' Needs

The size and structure of healthcare organizations across Canada varies, with regional health systems in the western and eastern provinces and health networks in the central provinces. Consequently, the healthcare organizations that participate in the Accreditation Canada program differ greatly in size, scope and context. An organization participating in accreditation may be an entire provincial health system, made up of many sites providing a wide range of services, or a single-site independent organization providing a narrower scope of services, such as a primary care practice. In addition, Accreditation Canada accredits several healthcare delivery systems under the jurisdiction of the federal government – Aboriginal Health Services, Corrections and the Canadian Forces.

In many jurisdictions, Accreditation Canada accredits organizations as an entire system, further promoting accountability and integration across an entire organization as opposed to accrediting particular program areas. Close to one hundred different standard sets have been developed by Accreditation Canada to cover the continuum of care that a patient/client experiences; these standards are developed to be sensitive to variances in sectors of care and cultures (e.g., First Nations and Inuit health). In consultation with Accreditation Canada, each client organization selects those standards sets that reflect the care and services that the organization provides to its clients.

Maintaining Currency and Looking Forward

What are some of the key findings from the Canadian healthcare organizations surveyed over the past years? Processes for the standardization and storage of medications and the implementation of policies for infection control continue to be identified as strengths (Accreditation Canada 2012, 2013). (See the Canadian Health Accreditation Reports at www.accreditation.ca for additional information.) While the accreditation program has primarily focused on structure and process measures of performance, outcome-focused

The Accreditation Canada Program: A Complementary Tool to Promote Accountability in Canadian Healthcare

content will continue to be added to the program in order to obtain a more comprehensive view of organizational performance. In identifying outcome measures, key quality and safety elements will be examined such as patient flow, access to services and patient experience.

Accreditation Canada continues to work in partnership to shift the focus away from data reporting requirements to supporting healthcare organizations in using their own data for quality improvement. Data that organizations are already using for quality improvement purposes can be used for their accreditation process. For example, results of patient, client, and resident experience surveys and the action plans that are developed and applied place the emphasis on quality improvement rather than simply reporting data and results to Accreditation Canada.

How is the information in the accreditation program kept current? The Accreditation Canada database is updated continually owing to the ongoing accreditation surveys across the country, ensuring that data are current and relevant. Feedback from client organizations, surveyors and stakeholders, as well as research and best practice, are used to update the content of the program. The standards and other key components of the program are adjusted to ensure their relevance and value and therefore provide access to a wealth of information for users' knowledge and practice to "keep pace." Accreditation Canada continues to partner with researchers, academics, medical and policy experts as well as ministries and organizations across Canada and internationally to understand the emerging area of risks to quality and safety and to develop tools to guard against these risks.

The pace of change within the healthcare environment is rapid. Within this reality, accreditation represents a valuable "neutral" yet complementary accountability mechanism to assess and improve the quality of healthcare and healthcare delivery through ongoing surveys, the timely reporting of results and data reporting.

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Accountability in the UK Healthcare System: An Overview

Obligation de rendre compte dans le système de santé du Royaume-Uni : un aperçu



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Abstract

Recent changes in the English National Health Service (NHS) have introduced new complexities into the accountability arrangements for healthcare services. This commentary describes how the new organizational structures have challenged the traditional centralized accountability structures by creating a more dispersed system of governance for local healthcare commissioners. It sets the context of discussions about accountability in the UK NHS and then describes the key changes in England following the implementation of the NHS reforms in April 2013. The commentary concludes that while there is increased complexity of accountability within a more decentralized and fragmented healthcare system, the government's goal of achieving increased local autonomy and greater control by general practitioners (GPs) will probably not be realized. In particular, the system will continue to have strongly centralized aspects, with increased regulation and central political responsibility.

Résumé

De récents changements dans le système de santé NHS, au Royaume-Uni, ont ajouté un niveau de complexité dans les arrangements de l'obligation de rendre compte pour les services de santé. Ce commentaire décrit comment les nouvelles structures organisationnelles mettent au défi les structures centralisées traditionnelles de l'obligation de rendre compte, et ce, en

créant un système de gouvernance plus dispersé pour les commissaires locaux des services de santé. Il présente le contexte des discussions sur l'obligation de rendre compte dans le NHS et décrit les principaux changements en Angleterre, qui ont suivi la mise en œuvre des réformes du NHS, en avril 2013. En guise de conclusion, le commentaire indique que bien qu'il y ait une hausse du niveau de complexité pour l'obligation de rendre compte, au sein d'un système de santé plus fragmenté et décentralisé, l'objectif du gouvernement visant à atteindre une plus grande autonomie au niveau local et un plus grand contrôle des médecins ne se réalisera probablement jamais. En particulier, il continuera d'y avoir de forts aspects centralisateurs ainsi qu'un accroissement de la réglementation et des responsabilités politiques centrales.

THE NATIONAL HEALTH SERVICE (NHS) OF THE UK IS GENERALLY DESCRIBED as a “command and control” system that provides the context for accountability within the NHS. Budgets and strategic policy are set centrally by the government and Department of Health (DoH) and administered locally by NHS organizations with delegated powers, but with direct lines of accountability to the DoH, albeit mediated through central and regional administrative structures. The situation is more complex, however, than the “command and control” model would suggest. Since 1948 the balance between central and local control and autonomy has fluctuated with successive governments, and now also includes diversity between devolved governments in Northern Ireland, Scotland and Wales (Exworthy et al. 1999; Peckham et al. 2008). The NHS also embodies both diversity between devolved political systems and uniformity across the United Kingdom. At the time of writing, the NHS in Wales, Scotland and Northern Ireland is under the control of the devolved authorities overseen by the territorial parliaments of Wales and Scotland and the Northern Ireland Assembly. However, the national (UK) character of the health service is reinforced by centralized funding and an emphasis on shared values such as equitable access, universality, free access and comprehensiveness, as well as by professional conformity and common standards or conditions of service. An additional complexity is that the NHS is formed of a series of local health services (Powell 1998) responding to local needs and conditions and working in partnership with other local organizations (Exworthy and Peckham 1998). There is, therefore, a tension between the requirement for central accountability for the NHS and the need for local accountability to reflect local contextual issues. There has also been a shift in the way accountability within the NHS is developing, from a centralized bureaucratic governance structure to one where there is greater decentralization of control over inputs and processes but an increasing centralization of outcome measures through performance targets and regulation (Peckham et al. 2005, 2008).

Some aspects of healthcare demonstrate both centralist and decentralist approaches – such as utilizing national frameworks to develop local innovative solutions and supporting changes in the workforce. While the UK retains significant elements of a centrally coordinated

system, political devolution and changes in the organization of health services, in England in particular, have resulted in an increasingly complex framework for the accountability of UK health services. These are described in more detail in this commentary.

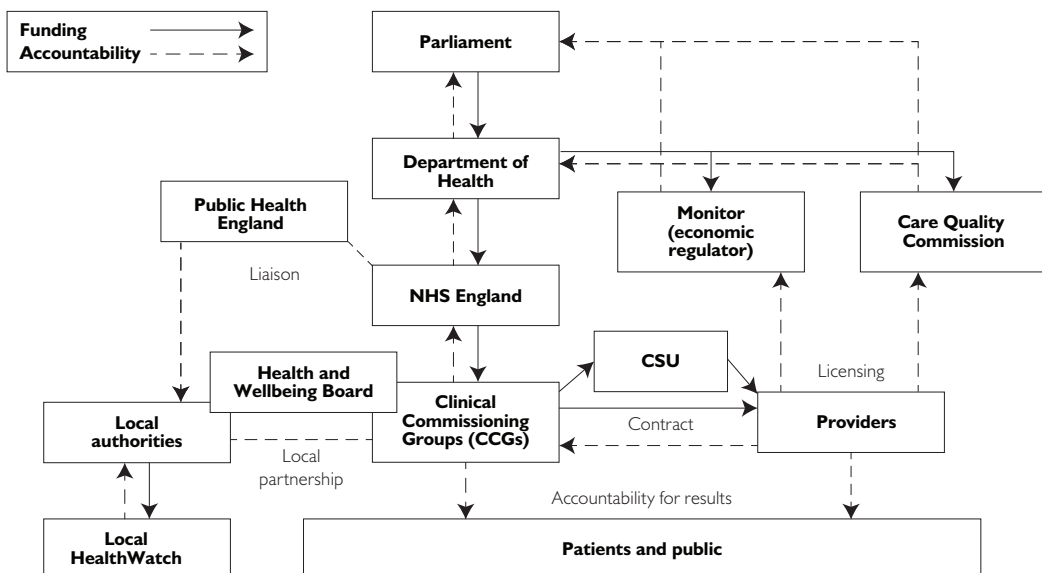
Changing Contexts of Accountability in the NHS: The New English System

On coming to power in 2010, the coalition government of Conservatives and Liberal Democrats embarked on a major reorganization of the English NHS system, despite having initially promised “no more top-down reorganisations of the NHS” (Government of England 2010):

The Government’s reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP [general practitioner] practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver. (Department of Health 2010: para. 4.1)

The new English system shown in Figure 1 represents a substantial and radical overhaul of the NHS in England that affected almost every level of the service and was decidedly “top down.”

FIGURE 1. The NHS in England from April 2013



Prior to April 2013, primary care trusts (PCTs) held delegated responsibility for 85% of the NHS budget; they commissioned and contracted the majority of primary and secondary care for a defined geographical population and had responsibility for public health. PCTs had boards constituted of executive and non-executive directors and were held to account by a regional authority. Since April, no single organization holds budgets for all healthcare sectors and public health. The principle of geographic populations has been retained, but clinical commissioning groups (CCGs) do not contract general medical services (GMS contracts are now commissioned by NHS England) or some specialist services and do not commission public health services (where responsibility lies with Public Health England and local government). CCGs are held to account by NHS England but also have to respond to their co-located local authority. The new structure has created a complex web of relationships.

The changes in the English NHS, introduced in 2010 and enacted in 2012/13, had three main goals:

- to stimulate a self-sustaining set of incentives that foster continuous organizational reform driven by clinicians;
- to allow greater autonomy, but on a selective basis and dependent on central assessment of performance against centrally set criteria;
- to create a pluralist model of local provision. (Department of Health 2010)

The changes themselves were extensive in scope, involving the removal of overall responsibility for running the NHS from the DoH and handing it to a new arm's-length body, NHS England (NHSE), which is also responsible for commissioning 40% of English health services (e.g., general practice, dental services, specialist services and some public health programs). Central accountability of the NHS to the government flows from the NHS mandate – a contract between the DoH and NHSE that sets out the government's requirements (see Box 1).

The mandate sets out the contractual obligation of NHSE to deliver healthcare and the areas that it will be accountable for to the DoH. It incorporates a mixture of specific government policy objectives and a framework within which national and local NHSs are expected to operate. The secretary of state for health has specific duties set out in the *Health and Social Care Act, 2012*, including the promotion of a comprehensive health service, reducing inequalities and having regard for the NHS Constitution. The secretary is accountable to Parliament. Responsibility (and accountability) for operational aspects of the English NHS have been delegated from the DoH to NHSE, which then holds local NHS organizations to account through the outcomes framework or through direct contractual mechanisms (e.g., for general practice or locally delivered specialist services). The NHS Constitution sets out a principle for the government to ensure that “there is always a clear and up-to-date statement of NHS accountability” and a transparent process of accountability that is clear to the public, patients and staff (Department of Health 2013).

BOX 1. The NHS mandate

The Mandate – at a glance

The mandate is structured around five key areas, which align with the NHS Outcomes Framework, as well as including additional direction on topics such as finance. (This is only a summary – see the Mandate for details.)

1. Preventing people from dying prematurely

We want England to become among the best in Europe at preventing ill-health, and providing better early diagnosis and treatment of conditions, such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age. Objectives include:

- Supporting the earlier diagnosis of illness;
- Ensuring people have access to the right treatment when they need it;
- Reducing unjustified variation between hospitals in avoidable deaths;
- Using every contact with NHS staff as an opportunity to help people stay in good health.

2. Enhancing quality of life for people with long-term conditions

We want the NHS to be among the best in Europe in supporting people to manage ongoing physical and mental health conditions, such as diabetes and depression, so that people can experience a better quality of life, and so that care feels much more joined up. Objectives include:

- Involving people in their own care and treatment;
- The use of technology (e.g., ordering repeat prescriptions online);
- Better integration of care across different services;
- Better diagnosis and care of those with dementia.

3. Helping people to recover from episodes of ill health or following injury

The Board is being asked to highlight the differences in quality and results between services across the country in order to share best (practice) and improve services.

- Ensuring greater equality between access to mental and physical health services;
- Improving transparency through publication of data and involving local people in decision-making about services.

4. Ensuring that people have a positive experience of care

The Board is being asked to make sure we experience better care, not just better treatment, particularly for older people and at the end of people's lives. Objectives include:

- Measuring and understanding how people feel about their care ("the friends and family test");
- Ensuring vulnerable people receive safe, appropriate, high quality care;
- Improving the standards of care and experience for women during pregnancy;
- Supporting children and young people with specific health and care needs;
- Providing good quality care seven days of the week;
- Improve access and waiting times for all mental health services, including IAPT.

5. Treating and caring for people in a safe environment and protecting them from avoidable harm

The Board is being asked to continue to reduce the number of incidents of avoidable harm and make progress towards embedding a culture of patient safety through improved reporting of incidents.

6. Freeing the NHS to innovate

We want to get the best health outcomes for patients through objectives that include:

- Strengthening autonomy at the local level;
- Promoting research and innovation;
- Controlling incentives, such as introducing the quality premium for CCGs;
- Leading the continued drive for efficiency savings, while maintaining quality, through QUIPP.

7. The broader role of the NHS in society

We want the Board to promote and support participation by NHS organizations and NHS patients in research, to improve patient outcomes and to contribute to economic growth. The Board must also seek to make partnership working a success.

8. Finance

The Board's revenue budget for 2013-14 is £95.6 billion. Its objective is to ensure good financial management and improvements in value for money across the NHS.

The statement emphasizes the importance of accountability to patients and the public more generally, as well as outlining arrangements for organizational responsibility and accountability within the English health system. The actual degree of autonomy from the DoH that NHSE will enjoy is debatable. There is both formal oversight and a blurred distinction as to whether NHSE is answerable only to its board or whether it also responds to political pressure from the public or from the DoH and Parliament.

Alongside the creation of NHS England there has been some concentration of regulatory structures at a national level, with wider powers for the Care Quality Commission and Monitor as key regulators of NHS and healthcare providers in England. The National Institute for Health Care Excellence has also seen its guidance role significantly developed.

It is responsible for the development of outcomes measures for the Quality and Outcomes Framework and also the Commissioning Outcomes Framework (Department of Health 2012). The new NHS system has substantially increased the level of centralization, shifting powers and functions previously held by PCTs and regional strategic health authorities to enhanced national agencies.

Responsibility for commissioning the majority of services for a defined geographical population lies with the CCGs, which involve primary care physicians (GPs) working together with other local clinicians, managers and lay representatives. However, while emphasizing CCGs' local freedom and accountability, the government has created a highly centralized accountability structure within which CCGs operate. CCGs had to go through a formal authorization process managed by NHS England to assess their fitness to be autonomous statutory organizations and sanction formal appointment processes for key board members. Standard constitutions have been developed by NHSE and the DoH, and CCGs are monitored by NHSE through a new outcomes framework. Regulation is also provided by Monitor, an arm's-length government body that was set up to regulate NHS Foundation Trusts and now has an expanded role as economic regulator of the new NHS system. Monitor's responsibilities include preventing anticompetitive behaviour, promoting integration, setting prices within the system and ensuring service continuity. This framework constitutes a fairly strong national accountability.

Similarly, the actual degree of autonomy of CCGs is also open to question. While policy highlights the "liberation" of professionals to make commissioning decisions, it is clear that "CCGs (unlike all previous manifestations of clinically led commissioning) will be statutory bodies with associated accountability and governance responsibilities. This will act to limit GPs' ability to act quickly and autonomously" (Checkland et al. 2012: 120). CCGs are subject to a complex web of accountability relationships. The strongest form of accountability is likely to be their accountability to NHSE, as this is backed by sanctions and subject to annual assessment. Furthermore, the currency of this accountability is clearly established, encompassing fiscal accountability and program accountability for the CCG outcomes indicator set. The accountability to other external bodies is, by contrast, much weaker and less clearly defined, with CCGs simply required to "give an account" of how they have responded to the locally developed joint strategic plan but where there are no associated sanctions. Accountability to Monitor, as the national financial regulator, may be more formal because Monitor is apparently being empowered to enforce competition law, but how this principle will be applied remains unclear. More interestingly, other non-health regulators are now intervening within the healthcare sector, including the Office for Fair Trading and the Competition Commission – both of which have ruled on recent health service organizational changes. Accountability to the public is focused upon the relatively weak notion of "transparency," with no associated sanctions. In addition, there are further layers of professional accountability to the local medical committee (the local manifestation of the UK General Medical Committee, which regulates professional medical practice).

Internal accountability relationships are similarly complex. Locally, CCGs are accountable to their board, which consists of elected GP members, certain centrally authorized posts (including the chair and an accountable officer) and other appointed members, including two lay members. The CCG governing body is elected by and answerable to GP members. This status as a “membership” organization is highlighted as a key new and desirable feature of CCGs. However, it remains to be seen whether, for example, in the future, GP practices might try to act together to dismiss a governing body that was not performing as they would like. Furthermore, should the wishes of the CCG membership clash with the requirements of NHS England (as is entirely possible), it will be interesting to see how a governing body might resolve the ensuing conflict.

However, there is also oversight through new local authority subcommittees known as health and wellbeing boards (HWBs). Government policy places key importance on the role of the HWB as part of its aim to increase democratic legitimacy and accountability. HWBs are part of the local council’s statutory arrangements and provide strategic direction and promote health and social care integration (Department of Health 2010: para. 4.17). However, their accountability role is also seen as important:

The joint local leadership of CCGs and local authorities through the health and wellbeing board will be at the heart of this new health and social care system. ... They will enable greater local democratic legitimacy of commissioning decisions, and provide an opportunity for challenge, discussion and the involvement of local representatives. (Department of Health 2011: 15)

CCGs have a representative on the HWB and are expected to set their own priorities in response to the strategic direction set by their local HWB. It is not clear how this relationship will evolve or what influence local authorities will have over local health services planning despite this statutory strategic role, as this is a new area of responsibility. CCGs are also required to be responsive to local populations, with responsibilities for consulting with patients and the public. Despite the rhetoric of increased localness and decentralized decision-making, accountability is, as suggested earlier, dispersed between central and local accountability and between formal and less formal accountabilities (Checkland et al. 2013).

Tensions between Central and Local Accountability in the New English NHS

Despite government policy promoting a more decentralized NHS structure and commissioning, it is hard to see how a system funded from central taxation can successfully be entirely removed from the overview of the central political system. While it is possible to argue the theoretical distinctions between developing policy (a political responsibility) and delivering healthcare (a management responsibility), distinctions between policy formation and policy implementation are, in reality, hard to make (Hill and Hupe 2002). There has also been a

shift towards a decentralization of responsibility for processes and service delivery, but within very clear, centrally defined goals and outcomes to be achieved (Osborne and Gaebler 1992; Peckham et al. 2008). In addition, any local change of NHS services can potentially raise national political concerns because of the nature of the UK parliamentary system and the fact that funding comes from general taxation, an issue firmly in the jurisdiction of Parliament. Current debates about the national payment-by-results (PBR) tariffs are an example of how the concerns and decisions at a local level are constrained by nationally set tariffs (Jones 2012). Questions are also being asked about the role of resource allocation models used within the NHS (Buck and Dixon 2013).

Responsibility for quality of care is another contentious area within this more fragmented governance system. Recent national concerns about accident and emergency (A&E) attendances, poor performance in hospitals and even individual patient care issues can easily become national political concerns (Francis 2013). These national issues highlight the varying responsibilities of, and relationships among, national policy makers, regulators and local CCGs and providers.

The introduction of NHSE and CCGs was aimed at increasing the autonomy of the NHS and GPs' leverage over the system. Instead, it has created a more fragmented and complex commissioning and service delivery system – introducing complexities to accountability structures and new forms of organizational accountability that operate alongside existing funding and professional accountability structures. While aspects of the NHS have been decentralized, there are continuing central accountability structures that, in a more diversified and fragmented system, create a context that ultimately favours stronger centralized accountability. Alongside these tensions are increasing tensions between a move towards more competition and market approaches to service provision and policies that stress greater integration and a desire in many local areas to develop and manage services. Traditionally within the NHS, central accountability has remained predominant; as yet, there is little to suggest that this situation will change in the future.

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What Have We Learned from the Substudies?

Leçons retenues des études

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THE FINDINGS SUGGEST THAT ACCOUNTABILITY IS INCREASINGLY SEEN AS important. This scrutiny has both positive and negative implications. It forces providers to be aware of what they are doing, and to strive to improve their performance. Many of our respondents told us that there is an increased focus on quality. Accountability has moved beyond its traditional focus on financial dimensions (and ensuring that resources are not misappropriated) to add a major focus on performance. These are all positive outcomes.

Yet our findings also suggest some warnings that should be heeded to ensure these benefits are realized while minimizing adverse unintended consequences.

One clear signal arises from the examination of accountability “to whom.” Across many subsectors, but particularly within hospitals and the community, multiple bodies ask for similar information, but in different forms. The resulting costs and confusion can be considerable. A number of the papers in this Special Issue note that informants are concerned that their efforts are being diverted to reporting at the expense of front-line care.

A related issue is accountability “by whom.” Complying with accountability requests appears more difficult for smaller organizations, which may not have the resources to respond to increasing requests for information. Respondents begin to see some of these requests as make-work, particularly when they must duplicate efforts for few perceived additional benefits. To the extent that multiple parties are seeking accountability, it would seem advisable for them to coordinate their efforts.

As noted in the introduction (Deber 2014), there are a variety of policy goals that can be pursued, among them access, quality (including safety), cost control/cost-effectiveness and customer satisfaction. The accountability models and tools used may focus on various combinations of these. The substudies suggest the importance of clarifying what should

be done when conflicts arise among the demands, with different parties stressing different factors. Who should get priority and according to what criteria? Who will resolve conflicts? Do all these demanders of accountability have equal legitimacy? If not, how are they, or should they, be ranked? One clear example arose for professional self-regulation, where demands for transparency may conflict with demands to protect privacy. Another arises from the extent to which goals should be tailored to fit local circumstances. The UK example notes the tension between responding to local and national authorities. Similar tensions were evident in many of the substudies.

Another clear finding comes from examining accountability “for what.” The findings from almost all of these substudies suggest the accuracy of our hypothesis, stated in the introduction, that the “production characteristics” of the goods and services being provided indeed have a major impact on accountability. In particular, measurability and controllability appear critical. This finding differs considerably by subsector. The quality of laboratory services, for example, is relatively simple to measure. In contrast, the quality of community-based care is much more difficult to capture in simple metrics, and the accountability metrics used incline heavily towards process measures. A major concern is that factors that are less easy to measure may be ignored, even if they are essential to success.

A related concern is that organizations are reluctant to be held accountable for factors they cannot control. Public health units cannot control whether their population smokes, so may attempt to have such indicators removed from the metrics for which they will be held accountable. Cross-system issues showed up as a persistent omission; although ensuring smooth transitions among systems of care is a high priority, it did not turn up in most of the accountability measurement systems that were examined.

A particular concern is that respondents in many of the substudies indicated the systems of accountability that had been set up often ignored many aspects they thought were important. This did not mean, however, that respondents thought accountability should be ignored.

The bottom line is mixed. Accountability is important; taking steps towards it can help to ensure better-quality care and, ideally, both save resources and improve outcomes. Yet, poorly done, it can divert resources from crucial activities, erode support for what may seem like poorly conducted activities and miss the forest for the trees.

We hope that these substudies can be helpful in highlighting strengths and avoiding potential weaknesses.

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