A qualitative study of Ontario cancer system leaders' views on the "promises of accountability"

Jessica Bytautas
MSc candidate,
Institute of Health Policy, Management and Evaluation
University of Toronto

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Background

- Central issue of public policy and accountability
  - How governments compel compliance?
- Increasingly, governments are contracting out services to specialized agencies
- Characteristic of New Public Management
  - Accountability mechanisms
    - Contracting, monitoring, reporting

Background

- Dawn of “era of accountability and assessment” in healthcare, 1980s
  - Iconic status – ‘suitcase word’, ‘umbrella concept’
    - ‘Symbolic’, ‘magic’, ‘paradoxical’, ‘promiscuous’, ‘chameleon-like’, ‘buzzword’
- Simple premise
  - To whom, by whom, for what, and how?
- Yet nebulous…
  - Goals: Answerability, reward and punishment, responsibility, trust…
  - Types: Financial, managerial, political/ democratic, professional…
  - Mechanisms: Regulations, financial incentives, information, professionalism/ stewardship…
- Lack of consensus

“Promises of accountability”

- Framework developed by Dubnick
- Captures different beliefs held by policy-makers/ managers
- Problem of accountability
  - Assumptions/ mechanisms underlying each promise not well understood

“Promises of accountability”

		Accountability valued…	
		Instrumentally	Intrinsically
Focus on…	Inputs	**Control**	**Integrity**
	Processes	**Appropriate behaviour**	**Legitimacy**
	Outcomes	**Performance**	**Justice or fairness**

Purpose

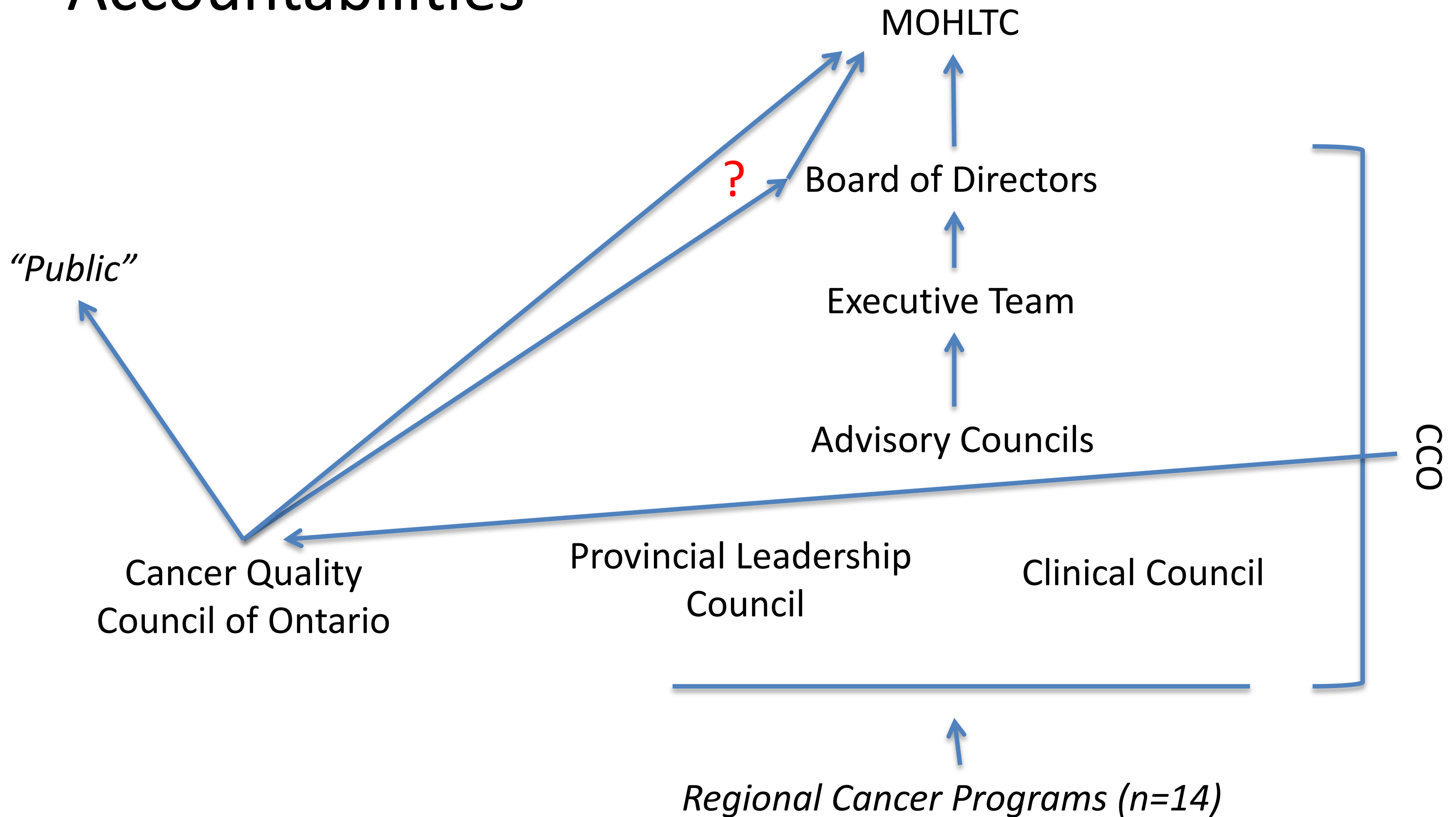
- To explore the perspectives of healthcare leaders in government and a specialized agency of government…
    1. How is accountability valued?
    2. How is accountability operationalized?
- What, if any, are the implications for Dubnick's "promises of accountability" framework?

Situating the study

- Ontario cancer services system
  - Ministry of Health and Long-Term Care
  - Cancer Care Ontario
- Restructuring, ~2001-2004
  - Pre: fractured
  - Post: exemplary chronic disease management
- Governance framework
  - Administrative, clinical, public accountability
  - Comprehensive performance management system

Situating the study

- Accountabilities



Methods

- Ethics
  - University of Toronto Health Sciences Research Ethics Board
- Design
  - Qualitative description
  - Key informant interviews
  - Informal: Document review, observation
- Participants
  - Purposive sampling
  - Senior leadership positions – MOHLTC & CCO
- Data collection
  - Semi-structured, open-ended, face-to-face interviews – June to October 2012
  - Interview guide probed promises, but not mechanisms
- Analysis
  - Verbatim transcripts stored and managed using NVivo
  - Predetermined & emergent codes cross tabulated to explore relationships

Results: Overview

- Participants

<table>
<tr><th colspan="2">Organization</th><th>ID</th><th>n</th></tr>
<tr><td colspan="2">MOHLTC</td><td>#-MOHLTC</td><td>5</td></tr>
<tr><td rowspan="2">CCO</td><td>Board of Directors
Executive Team</td><td>#-CCO-BD/ET</td><td>7</td></tr>
<tr><td>Advisory Councils
(PLC & CC)</td><td>#-CCO-AC</td><td>4</td></tr>
<tr><td colspan="2">CQCO</td><td>#-CQCO</td><td>3</td></tr>
<tr><td colspan="2"></td><td>Total</td><td>19</td></tr>
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- "Promises"
  - Inputs
    - Control
    - Integrity
  - Processes
    - Appropriate behaviour
    - Legitimacy
  - Outcomes
    - Performance
    - Justice or fairness

Results: INPUTS – *Control*

- Cancer Act & MOU
  - Foundational, yet ineffective on their own

…their legislation is not particularly good. It's not very specific. I mean, you could drive a truck through it. It's not a particularly instructive document…sometimes the ministry will use that as a threat though. [8-MOHLTC]

Post-restructuring, even in the last three years, it's almost a significant leap toward more accountability…The MOU we signed in December 2009 basically provided a tighter leash from the ministry to CCO. [7-CCO-BD/ET]

Nobody ever sort of pulls these out and lays them in front of each other or anything, but they expect us to live up to our part of the bargain and we expect them to live up to their part of the bargain. [15-CCO-BD/ET]

Results: INPUTS – *Control*

- Funding
  - Money is MOHLTC main resource for change
  - Money ties it all together

Their [MOHLTC] biggest lever in terms of making sure that things are going in the direction they want is money… We don't have [market share] system in Ontario. We don't have unused capacity sitting there waiting. It doesn't leave the ministry very many other options. [1-CCO-BD/ET]

It's a bit of a back and forth, very organic sort of working relationship…we work quite closely with them. But the actual accountability is the MOU, the legislation, and the funding letter each year. [15-CCO-BD/ET]

Results: INPUTS – *Control*

- Agency-wide bureaucratic controls
  - Necessary nuisance

We are subject to all of the directives of agencies…things might have started based on sound problem solving, but they get taken to an extreme that can become absurd…Nobody objects to having these policies in place, everyone wants to adhere…but the inefficiency of having multiple levels of oversight is pretty obvious to us. [1-CCO-BD/ET]

In the current environment, for organizations to be successful, they have to be impeccable in terms of their administrative oversight and controllership…if organizations want to excel, they have to make sure that their house is in order. [16-MOHLTC]

Results: INPUTS – *Integrity*

- Trust
  - Healthy working relationship between MOHLTC and CCO enables success
  - Filters down to the grassroots

If I compare the system today to that of ten years ago, I think what the ministry and the government expects agencies to do and how they expect them to behave and what they're holding them accountable for is much clearer…everybody has a heightened sense of the code under which we operate…there's good trust now on both sides. [1-CCO-BD/ET]

This has been a good partnership. The ministry has benefitted enormously. We have a fixed cancer system…because the ministry placed a trust in CCO to do it better. I think that trust has actually built the environment to allow both organizations to succeed…and that goes right down to the grassroots. [3-CCO-AC]

Results: INPUTS – *Integrity*

- Nature of healthcare and cancer care
  - Draws individuals with integrity
  - Bureaucratic controls promote integrity

By and large, the people in healthcare delivery have very, very high integrity. The processions in the health system draw people who have that sense of integrity…It's very rooted in interpersonal relationships. You can't screw around with people and expect to survive. [8-MOHLTC]

There's an incredibly good, conscientious, well-meaning, ethically responsible group of people working in CCO and the cancer system. I do think those institutional structures in place promote integrity…you're almost looking at a subset of people who have a really strong clock of being accountable and wanting to make a difference and wanting to do good. [18-CQCO]

Results: PROCESSES – *Appropriate behaviour*

- Agency-wide and internal codes of conduct
  - Helpful reminders

I think the sad reality is these sorts of mechanisms do serve – and that's why we put them in place – to remind people of what's right and what's wrong and the importance to stay out of trouble. [14-CCO-BD/ET]

Results: PROCESSES – *Appropriate behaviour*

- Elaborated structures around due process
  - Deliberative processes
  - Principle-driven

At many levels there are deliberative processes, whether it's at CCO with the PLC and Clinical Council, or within my region…It's hard for any one faction to overrun, dominate or steal the resources at the expense of others. It's complex, it's matrixed in many ways. And I think it leads to pretty good decisions. [13-CCO-AC]

We establish the principles before we even look at the data, and we've done it transparently…Everyone's essentially embraced those principles…so there's a perception that this is a principle and data driven process. [3-CCO-AC]

Results: PROCESSES – *Legitimacy*

- CCO's credibility across the system
  - MOHLTC reliance on CCO

CCO probably prides itself on being able to make the tough decisions…if the evidence says this is how it has to be done, this is how it has to be done….it's a culture that they feel it's their job…they probably have credibility across the system. [16-MOHLTC]

We can be a bit of a buffer quite frankly because we bring the clinical authority to bear on those things and can kind of allow the minister to distance themselves from the decision making…a big piece of CCO is depoliticizing stuff…making sure that we're doing things for the right clinical reasons as opposed to what might play on Main Street. [14-CCO-BD/ET]

Results: PROCESSES – *Legitimacy*

- Clinician engagement
  - Feeds and is fed by CCO's credibility

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 perceived as a bunch of bureaucrats that are driving the agenda, even though there is some of that involved. [14-CCO-BD/ET]

The template of getting strong clinical involvement…where it's not really just driven by ministry or administration, but by clinical leadership is a really good approach. 15 years ago it just felt like, as a provider, it wasn't my system. But we've taken steps in the right direction so that providers really feel part of the system and can have an impact. I get the feeling that this is unusual. I don't see it with my colleagues doing cardiology for example. I think it's because we hve this system approach to thinks. [5-CCO-AC]

Results: OUTCOMES – *Performance*

- MOHLTC and CCO
  - CCO considered to be ahead of the curve on performance management
  - Uncertainty what would happen if CCO failed to meet its mandate

We have accountability agreements with CCO. There's clearly indicators and results. And then a kind of audit and evaluation and working together. I don't know if there's something as formal as a kind of remedy if the results aren't achieved. [16-MOHLTC]

Results: OUTCOMES – *Performance*

- CCO and the RCPs
  - Quarterly reviews ensure oversight
  - Some disagreement about the direct impact of quarterly reviews

You get the rose coloured glasses version…the review that really happens for me is a week before when I talk to each of the clinical leads. You're not going to get change by embarrassing someone in front of their peers…They do give the required face time between their team and ours. It's a kumbaya. [3-CCO-AC]

I take advantage of it to make my points to CCO. And I also make my points to the people on my own team that I'm advocating for them or identifying issues that CCO should be helping us with. There's a whole complex dynamic. [13-CCO-AC]

Results: OUTCOMES – *Performance*

- Public reporting
  - Important for providing transparency
  - Some complicate the idea of public reporting

It's part of accountability to publish and be transparent…If you're trying to create the best cancer system in the world, you have to be transparent. [7-CCO-BD/ET]

Transparency is real value because that's public confidence and trust. [2-CCO-BD/ET]

The way you report to publics versus cancer system people…very different ways of doing that…not to mention that public reporting has not been shown to be particularly effective…I think you have to be careful what you're being transparent about…without context and potentially alarming, misinforming… [18-CQCO]

Results: OUTCOMES – *Justice or fairness*

- Outcomes data
  - Appeals to healthy sense of competition
  - Among administrators and clinicians alike

One year a region was the worst at something, the next year they were the best. That change was made only by showing them the data not spending a penny, because nobody wants to be the worst. You create this healthy competition through display of information. [15-CCO-BD/ET]

The catalyst is funding. We got their attention. The data is actually the driver because people want to do better. Most people want their region to do better. They want their hospital to do better. They want their patients to do better. [3-CCO-AC]

Results: OUTCOMES – *Justice or fairness*

- Outcomes data
  - Avoiding over-measurement, gaming
  - Ensuring measures and ranking are fair

You can sort of get exhausted by the amount that we're asking people to measure. So we need to be very clear that it's clinically relevant [5-CCO-BD/ET]

…everybody games the indicators….what is important in any system is to know the difference between gaming and what you really produce. [17-CCO-AC]

Every indicator is given the same weight as every other, which isn't necessarily fair….there's an element of nimbleness, there's new versus old, academic versus community based. Just to be homogenized as overall the same I've objected to it. [13-CCO-AC]

Results: OUTCOMES – *Justice or fairness*

- Closing the loop
  - Demonstrable outcomes achieved through due process feeds back to inputs

As long as you're demonstrating you're moving towards your targets, you're concordant with the guidelines, they're inclined to give you more money. [13-CCO-AC]

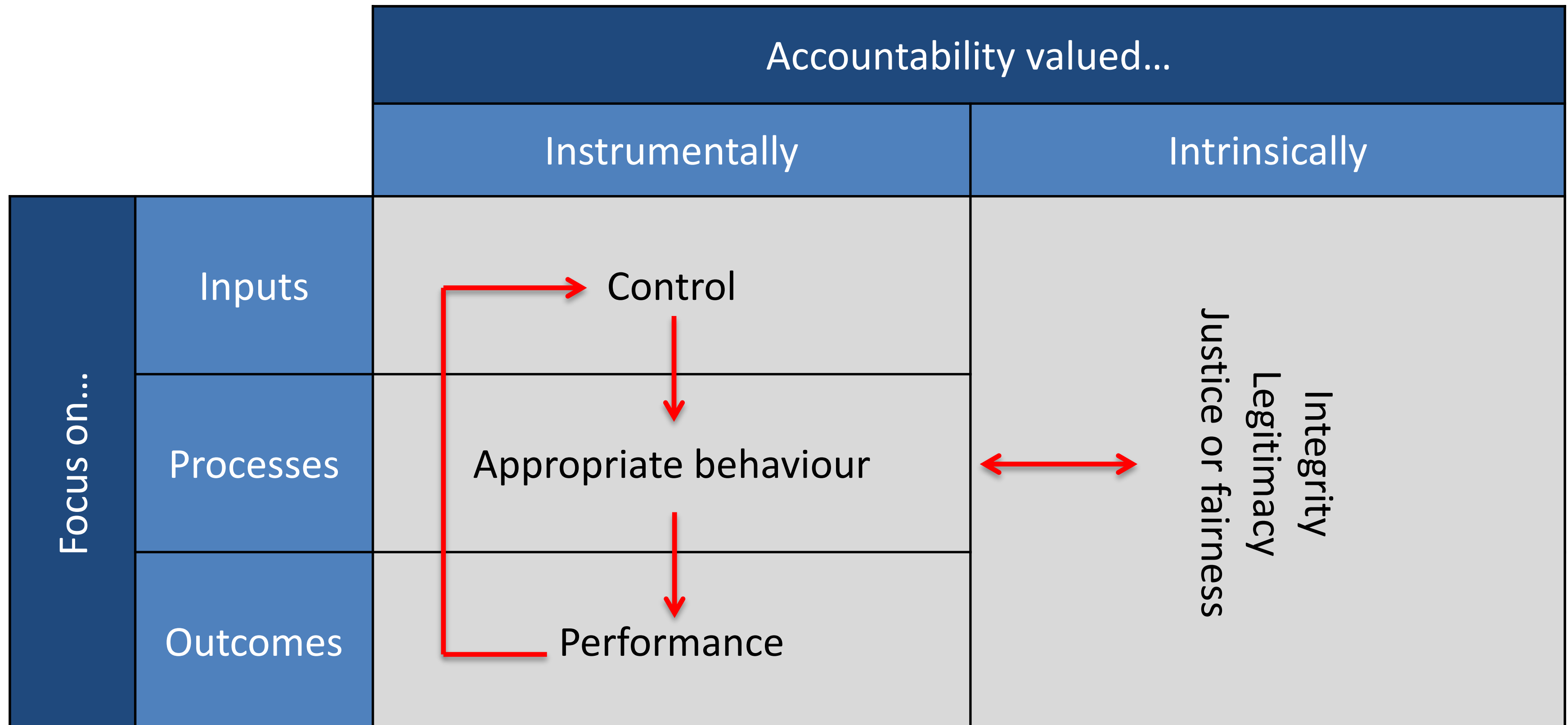
We've had the luxury of being able to apply a coordinated set of levers for cancer because we had clinical leadership, programmatic infrastructure, we're able to collect data, and we have funding. We can tie those together through accountability for implementing change in the regions. [1-CCO-BD/ET]

Discussion

1. How is accountability valued?
   - Both instrumental and intrinsic promises are highly valued
   - Instrumental promises seen as unique yet interrelated
   - Intrinsic promises ultimately similar constructs
2. How is accountability operationalized?
   - Instrumental promises achieved through formalized mechanisms, yet ineffectual on their own
   - However, intrinsic promises cannot be achieved without the instrumental in place
   - Chicken and egg…

Discussion

3. What are the implications for the "promises of accountability" framework?



Conclusion

- First application of “promises of accountability” framework in healthcare context
  - Highlights complexity of accountability
  - Instrumental and intrinsic accountability are inextricably linked
- Implications for government-agency relationships
  - Aligned understanding of values
  - Coordinated set of mechanisms
  - Sustained conversations

Thank you!

Questions or comments?jessica.bytautas@mail.utoronto.ca