Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens

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Foreword

The need to devote more attention to the accountability of the Canadian health care system has been identified by policymakers in *Listening for Direction*, a national-level consultation on research priorities, by all the major health system reviews prepared for the provinces and the federal government from 2001 to 2003, and most viscerally, by citizens in the Citizens’ Dialogue on the Future of Health Care in Canada in 2002. Yet, accountability for health care is not an established area of focus in the Canadian research community, and there are relatively few source documents to start the public discussion rolling.

As a result, CPRN decided in 2001 to fill the gap. This paper is the first in a series of seven papers designed to explore the concept of accountability and how it might apply to health care, to map the statutory accountabilities written into provincial and federal legislation, and to assess four principal approaches to accountability under discussion today: citizen engagement, legal approaches, performance reporting, and citizen governance. The Health Care Accountability Series will close with a synthesis paper to summarize our learnings and make suggestions for next steps.

This paper by Cathy Fooks and Lisa Maslove explores some conceptual issues. How we define accountability generally, how it seems to be applied in health care, and some potential gaps in that application. And, it sets out the framework for the analysis for the following papers.

I wish to thank Cathy Fooks and Lisa Maslove for their clarification of an extraordinarily complex set of accountability relationships, as well as the reviewers and funder. Our hope is that this Series will provide the stimulus for a more sustained discussion of the way in which we hold our governors and providers to account for the public service which is central to our economic and social well-being as Canadians.

Judith Maxwell
March 2004
Executive Summary

One of the many threads in the ongoing debates about Canadian health care is improving accountability. All the provincial and national system reviews over the last number of years have made suggestions to strengthen the accountability of health care systems to citizens. These have taken many forms including public reporting, changing governance structures, providing care guarantees and creating new organizations with a quality mandate. Governments are implementing many of these recommendations in the name of enhancing health care accountability.

This paper reviews general concepts of accountability and how they relate, or don’t relate, to the delivery of health care in Canada. We make the following observations:

- Governments are clearly accountable to citizens but don’t appear to have specific accountabilities to other actors in the health care system.
- The accountability relationship between citizens (as opposed to patients) and health care facilities, regulators and health professions is unclear.
- Financial and managerial accountability are the main types focused upon in Canada.
- Accountability relationships in Canadian health care are uni-directional – there is very little shared accountability for specific goals or outcomes.
- Demonstrating accountability has primarily been undertaken through a commitment to public reporting on indicators of health system performance and population health.

In thinking about the future development of accountability mechanisms, there are at least three gaps that need to be addressed as policy makers move forward. First, there is a definitional gap created by the application of general definitions of accountability to health care delivery. General definitions are based on a traditional notion of government accounting to citizens. The concept of accounting to citizens is now being applied to health care providers, although the nature of the relationship between providers and society isn’t clear. Second, there is a communications gap as the primary route for creating accountability appears to be performance indicators. There is some debate about whether these reporting exercises are useful to citizens and a potential gap between what is reported and what citizens want to know. Third, there is an implementation gap as the generation of information is not directly linked to actors or actions.

Identifying these gaps is not meant to imply that work to date has not been worthwhile. Much good work has been undertaken and governments have pledged to continue health system reform including further development of their accountability mechanisms. The following suggestions are offered to support that continued effort:

- Address the difficulty of using a general accountability definition to fit all aspects of health care relationships by being clearer about roles and responsibilities for specific outcomes. For example, who is responsible for ensuring access to care? Who is
responsible for ensuring quality of care? Who is responsible for improving health outcomes?

- Think about how to create a stronger connection between providers and citizens (rather than patients). What is the societal expectation?
- Think about how to create a stronger professional *group* accountability at the system level for system outcomes.
- Think about how to operationalise and make visible shared accountability relationships.
- Move beyond the reliance on public reporting of performance information as a primary accountability mechanism and start to experiment with other mechanisms such as citizen engagement processes.
- If public reporting is going to continue in the short term as a key citizen accountability mechanism then further refine the kind of information being reported and the way in which it is being reported to making it more useful to citizens. This should involve discussions with citizens.
- Create implementation processes for responding to the published information that explicitly explains to citizens what needs to occur and outlines the consequences of not acting.

Within the next several months, CPRN will be releasing a series of papers with the goal of stimulating more thoughtful discussion about how the health care system and its institutions can respond to the growing pressures from citizens, taxpayers and patients for greater transparency and accountability for a public service which is central to the health and well-being of all Canadians.
Acknowledgements

The authors wish to thank Steven Lewis of Access Consulting, Saskatoon and Sally Thornton of Health Canada for their comments on an earlier draft of this paper. Their insights have resulted in a dramatically different final product.

We would also like to acknowledge the excellent earlier work done in this area by the Queen’s Health Policy Unit, now known as the Centre for Health Services and Policy Research, at Queen’s University. The 1999 inventory and analysis prepared by MacDonald and Shortt has been an invaluable reference point.

Finally, we would like to acknowledge the funding provided for this project from Health Canada. The views expressed herein do not necessarily reflect the views of the Department or the Government of Canada.
Canadians are the shareholders of the public health care system. They own it and are the sole reason the health care system exists. Yet despite this, Canadians are often left out in the cold, expected to blindly accept assertion as fact and told to simply trust governments and providers to do the job. They deserve access to the facts. Canadians no longer accept being told things are or will get better; they want to see the proof. They have a right to know what is happening with wait lists; with health care budgets, hospital beds, doctors and nurses, and whether the gaps in home and community care services are being closed; whether the number of diagnostic machines and tests is adequate; and whether treatment outcomes are improving.

Roy J. Romanow
Commission on the Future of Health Care in Canada
2002

The Canadian literature on accountability is both scant and limited in the range of issues with which it deals...It is difficult to avoid the conclusion that Canadian academics have largely ignored the issue of accountability in health care and that a fertile ground exists for future research.

JK MacDonald et al.
Queen's University
1999
1. Introduction

Canadians are in the process of reshaping their expectations of government, their communities and themselves. A new social contract is emerging based on principles of accountability, shared responsibility and transparency (MacKinnon 2003a; Mendelsohn 2002). No where is this more evident than in the current discussions about the future of health care in Canada.

Recent provincial and federal commissions and task forces asked to review the health care system have highlighted major challenges in the structure, design, funding, management and outcomes of the Canadian health care system.1 Debates have raised issues such as:

- access;
- coverage;
- level and source of funding;
- the quality of, and the evidence base for, care;
- the cost-effectiveness of current investments; and,
- the existing health disparities within and across jurisdictions.

Every system review has offered numerous recommendations for renewal and reform all concluding with a call for greater accountability (Clair 2000; Fyke 2001; Kirby 2002; Mazankowski 2001; Premier’s Health Quality Council 2002; Romanow 2002). While strengthening accountability mechanisms was not seen as a magic bullet for the issues listed above, it was seen as a necessary underpinning to achieve many of the reforms proposed and an important concept in enhancing the link of citizens – as patients and tax payers – to the health system they cherish.

Along with the system reviews, researchers, service providers and managers all agree that accountability in the health care system needs improvement and have proposed ways in which it could be strengthened. (Task Force on Health Policy 2003; Maxwell et al 2002; Public Policy Forum 2002; Canadian Healthcare Association 2001).

Governments, to varying degrees, are currently implementing some of the proposals from the system reviews. Governance structures have changed in the Western provinces and are changing in Quebec. Performance reporting is ongoing and expanding across the country. Care guarantees are being proposed. And, quality councils are springing up. Ensuring these reforms meet public expectations and strengthen accountability within the Canadian health care system requires taking a step back and clarifying what is actually meant by accountability in the context of health care delivery.

This paper is the first in a series to review concepts of accountability as they relate to Canadian health care and to pose a set of questions about the current state of accountability today. The paper also sets the scene for six other papers in the Health Care Accountability Series as outlined

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1 Health care in Canada is really 13 separate systems at the provincial and territorial level as well as programs run directly by the federal and municipal governments. For the sake of simplicity, the term Canadian health care system is used to include all of these services and programs.
in Appendix A. They will be released in the first half of 2004. One key question guided the series: how is the Canadian health care system accountable to citizens?

The first section of this paper reviews general definitions of accountability, describes the conceptual elements identified in these definitions, outlines the different types of accountability cited in the research literature, describes the broad instruments used to create accountability and lists the supports required to ensure accountability. The second section of the paper briefly reviews the structure and organization of the Canadian health care system. The third section then relates the general accountability concepts to the Canadian health care system. The final section draws some general observations from the analysis and identifies three accountability gaps in the current policy discussions.

Three caveats: first, we are focused on the system’s accountability to citizens. We recognize there is a large question about the reverse relationship but it is not being reviewed here. Second, we are viewing the citizen as an individual but we are also concerned with the citizen at the aggregate level in terms of a societal or public interest. Third, we recognize that factors beyond the traditional health care system contribute to population health but for the purposes of this paper we are focused on services that are funded through federal, provincial and territorial health care budgets.
2. Defining Accountability

The 1979 Royal Commission on Financial Management and Accountability wrote that accountability, like electricity, is difficult to define, but possesses qualities that make its presence in a system immediately detectable (Royal Commission 1979). Historically, much of the work done on defining and describing accountability has been done in the context of governments accounting to citizens. Therefore, it is not surprising that those working in the area focus on the institutional workings of democracy, and the balance of power within, or they focus on with financial issues related to value for money. This legacy – governments accounting to citizens – is important when attempting to apply these concepts to health care.

Accountability has become a common term used in health care reform discussions in Canada. It’s a good word. It conjures up processes in which citizens might come to understand where their tax dollars go, why certain policy decisions are made, or where they can turn if they are dissatisfied with the care they receive. It hints at an environment in which a health care system might take responsibility for improving the health of the population.

However, actual definitions of the word don’t contain any of these ideas. So, what is actually meant when someone promises to “enhance accountability in health care?”

Table 1 outlines a number of definitions of accountability. They are fairly general in nature and, although they are not lengthy, important ideas about accountability are implicitly embedded in them. As the Royal Commission stated, there does appear to be a set of elements that underpin these definitions. We have identified at least six.

**Establishment of a Relationship:** creating accountability requires a relationship between those making decisions and those who are affected by those decisions. The accountability process is based on a connection between the two. (Auditor General of British Columbia 2003; Auditor General of Canada 2002; Brown 1999; Day and Klein 1986; MacDonald 1999; Plumptre 1988).

**Agreed Upon Defined Responsibility:** accountability requires the individual or organization being accountable has a defined responsibility to make decisions that has been agreed to and can carry out an action (Auditor General of Canada 2002; Brown 1999; Macdonald 1999; Plumptre 1988; Kernaghan 1990).

**Delegate or Confer Authority:** accountability requires that those with the authority to take action can delegate or confer it to someone else. This is particularly important for governments who regularly delegate authority for the delivery of social programs (Beaulne 1993; MacDonald 1999; Plumptre 1988; Stenning 1992).

**Answerability:** accountability requires that those who are accountable will answer for decisions made and actions taken. This can be, but is not always, a public accounting (Bjorkman and Altenstetter 1979; Day and Klein 1986; Emanuel and Emanuel 1996; MacDonald 1999; McCandless 1993; Schacter 2000; Sedikides 2002).
Performance: accountability requires that the accounting for action includes an element of judgement about performance (Auditor General of Canada 2002; Brown 1999; MacDonald 1999).

Sanction/correction: accountability requires a process for correction if expectations are not met or performance is deemed to be sub-optimal (Day and Klein 1986; MacDonald 1999; Schacter 2000; Stein 2001).

Table 1
Definitions of Accountability

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditor General of Alberta</td>
<td>2003</td>
<td>Accountability is an obligation to answer for the execution of one’s assigned responsibilities. Accountability is reporting.</td>
</tr>
<tr>
<td>Auditor General of British Columbia</td>
<td>2003</td>
<td>Accountability is a relationship between two parties.</td>
</tr>
<tr>
<td>Auditor General of Canada</td>
<td>2002</td>
<td>Relationship based on obligations to demonstrate, reward and take responsibility for performance, both the results achieved in light of agreed expectations and the means used.</td>
</tr>
<tr>
<td>Bjorkman &amp; Altenstetter</td>
<td>1979</td>
<td>Answering for one’s actions to someone else by means of routinized and agreed upon practices and procedures.</td>
</tr>
<tr>
<td>Brown et al.</td>
<td>1999</td>
<td>Extent to which an organization or individual demonstrates that it is meeting or exceeding its agreed on objectives.</td>
</tr>
<tr>
<td>Day and Klein</td>
<td>1986</td>
<td>Being held answerable for one’s actions and taking direction from and being sanctioned by those to whom one is accountable.</td>
</tr>
<tr>
<td>Emanuel and Emanuel</td>
<td>1996</td>
<td>Accountability is about individuals who are responsible for a set of activities and for explaining or answering their actions.</td>
</tr>
<tr>
<td>Funk and Wagnells</td>
<td>1982</td>
<td>Liable to be called to account; responsible. Capable of being explained.</td>
</tr>
<tr>
<td>Kernaghan</td>
<td>1990</td>
<td>The obligation to answer for the fulfilment of assigned and accepted duties within the framework of the authority and resources provided.</td>
</tr>
<tr>
<td>MacDonald et al.</td>
<td>1999</td>
<td>Set within an implicit ethical context, it is the obligation to answer to an authority which conferred a responsibility, together with the resources and delegated authority to achieve it, with the understanding that inadequate performance will result in corrective intervention.</td>
</tr>
<tr>
<td>McCandless</td>
<td>1993</td>
<td>Obligation to answer publicly for the discharge of responsibilities that affect the public.</td>
</tr>
<tr>
<td>Plumptre</td>
<td>1988</td>
<td>Implies a formal relationship and a prior act of delegation directly from one party to another.</td>
</tr>
<tr>
<td>Schacter</td>
<td>2000</td>
<td>Expect the government to explain and justify publicly the way it uses power and to take prompt corrective action when things go wrong.</td>
</tr>
<tr>
<td>Sedikides</td>
<td>2002</td>
<td>The expectation to explain, justify and defend one’s self-evaluations to another person.</td>
</tr>
<tr>
<td>Stein</td>
<td>2001</td>
<td>Accountability requires transparency, standards, open evaluation, a capacity to learn quickly and to correct deficiencies when they become apparent.</td>
</tr>
</tbody>
</table>


2.1 Describing Accountability Relationships

The assumption of a relationship between the parties (individual to individual, individual to organization, individual to system, organization to system) is really the bedrock upon which the other elements flow. Without a relationship there is no reason to assume an accountability requirement or processes. Notions of accountability are deeply embedded in historical and modern notions of democracy. Groups of citizens agree to be governed and governments then set rules, establish governance structures and distribute resources. The purpose of much of this activity is to provide services – including health care – to citizens. An effective democracy is premised upon accountability as a fundamental right of citizens (Stein 2001) and implies a system that ensures the governors are accountable to the governed (Day and Klein 1986). The governors must answer for their decisions and actions and, in its simplest form, the dissatisfaction of the governed can result in a change of governors. Researchers of democratic theory categorize the relationship between governments and citizens as one of *vertical* accountability (Schedler 1999). Vertical accountability mechanisms would include electoral processes, strong civic organizations and an independent news media (Schacter 2000). These are clearly predicated on the notion of individuals or organizations accounting to citizens for decisions and the existence of effective instruments to hold those individuals or organizations to account.

Governments also create formal arms-length public institutions with an explicit accountability mandate which researchers categorize as *horizontal* accountability (Schedler 1999). These institutions act as monitors or watchdogs of government activity and rely upon government to provide the necessary resources and information but they are also accountable to government for their own behaviour by virtue of public funding. Thus, there is more of a two-way relationship. As well, these arms length institutions have a vertical accountability relationship with citizens as they usually report to the public about government activity and must also account to the public for their own actions. Other horizontal accountability mechanisms would include the judiciary, legislatures, auditor generals, public ombudsmen, offices of the privacy commissioner, human rights commissions etc. (Schacter 2000). The adding up of the mutual responsibilities and the multiple directions of accountabilities could be viewed as a first step to creating system level accountability, if the other elements identified in section 2 are in place. These notions of accountability relationships are depicted in Figure 1.

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2 There is some debate about whether the judiciary must report to the public about its own actions. While its decisions and reasons are public information and subject to appeal and legislative override, it is not clear there is a direct expectation of justification to the public.
Many have written about the strengths and weaknesses of these accountability relationships in western democracies, and particularly in a parliamentary system focused on the difference between theory and reality (Phillips and Orsini 2002; Stanbury 2003). Regardless of the perceived effectiveness, these relationships are the starting point for discussions of health care accountability.

2.2 Types of Accountability

Complicating the discussion of accountability is the apparent use of the general term to define different types of accountability. Research literature identities at least four different types:

Financial Accountability: is the responsibility for demonstrating wise use of financial resources (Day and Klein 1986; MacDonald 1999; Thomas 1997). This clearly applies to all those who receive public resources and relates to ensuring that money is spent where it was meant to be spent and that fraud has not occurred. This is accounting for spending and usually takes the form of a vertical relationship. Governments provide resources to providers of service who are expected in a variety of ways to account for their spending.

Managerial Accountability: is slightly broader than financial accountability as the responsibility is for demonstrating effective and efficient management of services or systems (Macdonald 1999). The focus tends to be on performance as well as the use of resources. This is accounting for the how and the why of decisions rather than just the cost. It often takes the form of a vertical relationship but could also apply horizontally at the system level.

Political Accountability: is the responsibility for demonstrating responsiveness to citizens and delivering on commitments – listening and being truthful. This applies mainly to elected representatives in government or elected members of other governance structures. There is a strong element of vertical accountability in these relationships as direct election gives citizens the power to change representatives.

Professional Accountability: is the responsibility for demonstrating the maintenance of professional standards (Day and Klein 1986; MacDonald 1999). This applies primarily to individual professional groups (health professions, law, engineering, accounting etc) and relates
to the quality of service provided. There is clearly a vertical relationship between provider and client but there may also be a system level horizontal relationship in that the professional group may have a public interest obligation to the system.

For the sake of completeness, it should be noted that two other types of accountability were identified in the research literature but have not been included here for the following reasons. Day and Klein argue that participation – the right to participate in and control the outcome of decisions made – is a type of direct accountability (Day and Klein 1986). However, we have viewed this more as a mechanism for achieving accountability and discuss the concept in more detail later on. As well, MacDonald et al identify ethics as a type of accountability in that individuals have an internal conscience to which they "answer" in terms of their own decision making processes (MacDonald 1999). While we agree ethics play an important role in health care, we would argue that the individual calculation of individual ethical behaviour is part of the notion of professionalism. As most professions and professional managers have established codes of ethics to assist individuals in this regard, we do not see ethics as an accountability separate from that of professional accountability.

2.3 Mechanisms of Accountability

There are various mechanisms used to build accountability. MacDonald et al describe 11 instruments: citizen involvement, political activity, constitutional practice, provision of information, delegated activity, review functions, management practices, legal contracts, accreditation and credentialing, complaints procedures and ethics (MacDonald 1999). For the purposes of this discussion, we have grouped them into four broad categories:

A citizen engagement approach: the involvement of citizens in decision making about policy directions (Brown 1999). This goes beyond traditional consultation and “requires governments to share in agenda-setting and to ensure that policy proposals generated jointly will be taken into account in reaching a final decision” (MacKinnon 2003b).

A legal approach: service delivery is predicated on legal authorities and commitments through legislation and regulations, contracts and agreements as well as more informal guarantees and arrangements. To varying degrees, citizens have rights and redress mechanisms within these processes, and sometimes have responsibilities of their own. A number of adjudicative bodies as well as the courts are included in this instrument.

A public reporting approach: the public provision of information to citizens about decisions and actions (Brown 1999). This can include financial information as well as information about service delivery, the effectiveness of programs, client outcomes and policy directions. Facility-based accreditation programs would be included in this category although there are varying degrees of public transparency about the results.

A citizen governance approach: citizens take on a role as governors of institutions, organizations, agencies. In theory this provides direct citizen oversight for accountability purposes and if those individuals are elected, provides a direct vertical accountability relationship between the governor and citizens.
2.4 Requirements for Effective Accountability

Regardless of the type of accountability or the instruments used, the research literature cites a number of requirements that must be in place to ensure effective accountability relationships and processes.

**Clarity of purpose:** agreement on a desired outcome – the purpose of the exercise – increases the likelihood of effective accountability. Without a common view of the overall purpose, compliance will be less likely (MacDonald 1999; Stein 2001).

**Clarity of responsibilities:** it is crucial that responsibilities are explicit and mutually agreed upon. (Auditor General of Alberta 2003; Auditor General of Canada 2002; Brown 1999; Canadian Healthcare Association 2001; Plumpre 1988; Stein 2001). Experts suggest wherever possible, specific objectives or performance targets be delineated to give further clarity to the allocation of responsibilities (CCAF-FCVI 2002; Canadian Healthcare Association 2001; McCandless and Wright 1993).

**Appropriate resources:** organizations can only be accountable for meeting their responsibilities if they are equipped with the necessary resources to do so (MacDonald 1999; Canadian Healthcare Association 2001). Resource capacity is broadly defined here to include funding, the autonomy to make decisions, an information base, skills and experience.

**Evaluation and Feedback:** some assessment must be made as to whether goals are being achieved and feedback provided to the appropriate parties (Auditor General of Alberta 2003).
3. Disentangling Canadian Health Care

Before relating accountability concepts to the delivery of health care in Canada, it is important to understand the structure of Canada’s health care system. Table 2 provides a quick overview of the key actors and responsibilities in health care delivery. Actors include the various levels of government, regional health authorities, health care facilities and individual health professionals, and, health care-specific public institutions such as the regulatory bodies and the agencies mandated to report on system performance and quality. Responsibilities include policy development, service planning, funding, direct service delivery, regulation and redress, and performance and outcome evaluation and reporting.3

As can be seen in the table, responsibilities are shared across the actors.

Table 2

<table>
<thead>
<tr>
<th>Key Responsibilities in Canadian Health Care Delivery</th>
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<tbody>
<tr>
<td><strong>Federal Government</strong></td>
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<td></td>
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<tr>
<td><strong>Provincial/ Territorial Governments</strong></td>
</tr>
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<td><strong>Regional Health Authorities</strong></td>
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<tr>
<td><strong>Health Care Facilities</strong></td>
</tr>
<tr>
<td><strong>Health Professionals</strong></td>
</tr>
<tr>
<td><strong>Regulators</strong></td>
</tr>
<tr>
<td><strong>Quality Agencies</strong></td>
</tr>
</tbody>
</table>

3 A more detailed paper is being prepared describing the legal authorities for these functions at the national and provincial/territorial level. See Appendix A.
3.1 The Federal Role

The federal role has been explored extensively by the Commission on the Future of Health Care in Canada and by the Standing Senate Committee on Social Affairs, Science and Technology (Kirby 2002; Romanow 2002). Most constitutional experts agree that health care is largely a provincial responsibility but that the federal government has a legitimate constitutional right to be a major player in the area (Leeson 2002).

The federal government sets and administers national standards through the *Canada Health Act* (CHA). It assists in financing health care services through transfers to the provinces and territories and it provides health care services directly to veterans, native Canadians and people living on reserves, military personnel and the RCMP, and inmates in federal penitentiaries. As well, the federal government has general responsibility for other health-related functions such as health protection, disease prevention and health promotion.

Currently, the CHA is the key piece of federal legislation that establishes the conditions for publicly funded services provided by hospitals, physicians or dental surgeons. Through the Canada Health Transfer, the federal government provides funding to the provinces and territories to ensure that all Canadians have reasonable access to medically necessary insured services without a direct charge. Insured hospital services include ward accommodation, nursing services, diagnostic procedures such as blood tests or x-rays, drugs administered in the hospital, dental-surgical and medical procedures on an in-patient or out-patient basis. Physician services are defined as "medically required services rendered by medical practitioners." The Act does not define medically required, leaving its determination to individual physicians on a case-by-case basis.

There are five criteria which govern the receipt of the federal funds. They are often referred to as the principles or the standards of the Act. They are:

- **Public administration**: the health insurance plan must be operated on a non-profit basis by a public authority and responsible to government;
- **Comprehensiveness**: the health insurance plan must insure all services listed above;
- **Universality**: the health insurance plan must cover 100% of eligible residents;
- **Portability**: the health insurance plan must cover the citizen if he or she is temporarily in another province at the home province rate;
- **Accessibility**: the health insurance plan must provide "reasonable access" to insured services unencumbered by user fees or extra-billing.

It is within this section of the CHA that a number of analysts have suggested adding the concept of accountability either as a sixth principle or specifically contained within the existing five (Flood and Choudhry 2002; Romanow 2002; Task Force on Health Policy 2003).

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4 The Canadian Government has announced its intention to enact a new *Canada Health Protection Act* to strengthen its capacity in these areas.
There is a range of services not covered by the CHA such as prescription drugs, home care, or services provided by non-medical personnel such as chiropractic or dental services. Provinces may choose to fund these services but in doing so they do not have to meet the principles of CHA. Some services that are provided by physicians are not considered medically necessary are also not covered by the Act such as cosmetic surgery, third party medical exams, or the provision of medical certificates for work or insurance purposes.

**Federal/Provincial/Territorial Discussions**

Along with the CHA, there are other important agreements that shape health care delivery in Canada and also outline accountability expectations. First, in February 1999, the Government of Canada and the Governments of the Provinces and Territories agreed to a framework to improve the social union for Canadians which became known as SUFA (the Social Union Framework Agreement). SUFA established a number of important principles for the delivery of social programs to Canadians including public accountability and transparency (Government of Canada 1999). The framework clearly viewed accountability as public reporting activity by agreeing to reporting regularly on the outcomes of social programs, sharing information across governments and with citizens. The involvement of Canadians in developing program priorities and assessing outcomes was referenced as well as improving appeal mechanisms for citizens. Finally, recognizing the roles and contributions of various levels of government in public communication was also noted.

Subsequently, a First Ministers’ Meeting in September 2000 resulted in a Communique on Health that reiterated a number of the SUFA points in further detail (Canadian Intergovernmental Conference Secretariat 2000). Governments committed to regular reporting on a series of health and health care indicators with third party validation. Interestingly, the references to appropriate recognition of the roles of governments and the involvement of citizens in actual priority-setting were not repeated in this document.

SUFA was evaluated at the three-year mark by the Federal/Provincial/Territorial Ministerial Council on Social Policy Renewal, comprised of the individuals tasked with implementing the agreement (Ministerial Council 2003). They reached generally positive conclusions all round. Three specific sections are of relevance here:

**Health Reporting:** they concluded that the agreement had been met as a set of common reporting indicators had been developed and released in September 2002. No further recommendations were made.

**Accountability Framework:** they concluded the accountability framework needed to be strengthened and made a number of recommendations focused on: improving the process and communication for the public reporting; publicly and appropriately recognizing and explaining the respective roles and contributions of government; building on mechanisms for the public to participate in developing social priorities and reviewing outcomes; and, working together to ensure the application of federal policy on accountability for federal transfers takes into account the extensive accountability mechanisms that provinces and territories have in place.
Dispute Resolution: they concluded that dispute resolution processes needed improvement and encouraged sector Ministers to refer to the dispute avoidance and resolution process for the CHA principles.

The primary complaint about SUFA with respect to health issues during this period was focused on the nature of the federal transfer and the lack of specific conditions attached to health programs. Because it is difficult to trace the federal contribution, an accountability problem arises. The federal financial contribution is not visible either to the auditor or to the public (Sullivan 2004).

While this work was underway, the Prime Minister also appointed a Royal Commission on the Future of Health Care in Canada chaired by former Saskatchewan Premier Roy Romanow. Following the release of the final report from the Commission, a First Ministers Accord on Health Care Renewal was released in February 2003. Although there was some confusion after the fact about which provinces had actually signed the Accord and which had not, the Accord did and is still guiding subsequent federal/provincial/territorial work. With respect to accountability, the Accord set up a number of reporting requirements through the provinces focused on the policy domains listed in the Accord as well as the performance indicators previously developed.5

Finally, a key accountability item was the commitment to establish a Health Council to monitor and report on the implementation of the Accord, particularly its accountability and transparency provisions (Government of Canada 2003). A second national level organization was also agreed to through implementing the recommendations of the National Steering Committee on Patient Safety to create an independent Patient Safety Institute.

3.2 The Provincial/Territorial Role

Provinces have primary responsibility to design and implement policy directions for their health care systems and to plan service delivery directly or through working with regional structures. They transfer funds to a variety of service providers to deliver health care directly to citizens and they fund a number of health care-specific public institutions for accountability purposes. As well as referenced above, they have taken on the primary responsibility for public reporting on system performance and population health outcomes.

Intergovernmental Relations

Roles and responsibilities between the federal and provincial/territorial levels of government have been a contentious issue for a number of policy domains for many years recently culminating in the creation of the Council of the Federation, comprised of the provincial and territorial leaders. Its self-declared mandate includes “exercising leadership on national issues of importance to provinces and territories” and analysing “actions or measures of the federal government that in the opinion of the members have a major impact on provinces and territories” (Council of the Federation 2003). Health care has been at the center of these disputes and the

5 The indicator reports are to include the earlier 2002 indicators as well as new indicators to be developed on quality, access, system efficiency and effectiveness.
accountability for spending and policy-making has been a focal point of conflict. In January 2002, the premiers launched a Premiers’ Council on Canadian Health Awareness “to improve Canadians access to information and enhance public awareness of the challenges of and solutions for the future of health care” (PCCHA 2002).

3.3 Health Care Providers

Health care providers are the men, women and organizations who deliver health care services to Canadians and they are a very powerful force in the public and political dynamic of service delivery. They comprise the majority of expenditures (public and private) and they often have a delegated legal authority from government to establish their own governance structures, provide services and spend public money. Health care providers include:

- Regional health authorities (RHAs);
- Municipal public health units;
- Public and private health care organizations: hospitals, long term care facilities, home care agencies or community-based primary care groups;
- Individual health professionals (physicians, nurses, physiotherapists, dentists, chiropractors, midwives etc).

3.4 Health Care-specific Public Institutions

Health care-specific public institutions are also an important, and proliferating, component of the Canadian health care landscape. Like the more general institutions such as the courts or auditors general, these institutions have an accountability role specific to the delivery of health care. There serve a variety of functions including:

- **Monitoring and evaluation**: the analysis and reporting on the performance and outcomes of service provision. Recent examples include the Health Council of Canada, the Quality Council in Saskatchewan, the Health Services and Outcomes Commission in Alberta or the Health Quality Council in Ontario;
- **Professional regulation**: self regulatory health professionals have the authority to establish professional colleges with a responsibility to set professional standards, register health professionals, and deal with patient complaints. Redress mechanisms include quality assurance programs and disciplinary action such as the suspension or revocation of an individual’s registration. While the colleges are generally not funded directly by government, they are established by government with a clear mandate to govern themselves and their professions in the public interest (HPRAC 2001).
- **Oversight and adjudication**: the appeal and review boards dealing with patient complaints related to health insurance coverage, hospital services, and the health regulatory colleges.
4. Accountability in the Health Care Context

4.1 Health Care-specific Definitions

A health-care specific definition of accountability was not identified in this review. Instead, governments and researchers appear to rely on the general definitions cited in section one (Alberta Ministry of Health and Wellness 2001; Canadian Healthcare Association 2001; Manitoba Health 1999). This is not to say that a health-care specific definition is necessarily required but what are the implications of using the more general definitions? As referenced earlier, the historical connotation is one of governments accounting to citizens in a global fashion for their actions. How does this apply when service providers, both institutional and individual, and regional structures are added to the mix? What are the accountability relationships for these intermediaries who actually deliver health care? Do we assume they too are accountable to citizens in a similar fashion to governments? Or, are they more accountable to governments who in turn account to citizens? What are the accountability relationships between the service providers and health care-specific public institutions and the regional structures? How will citizens know whom to hold to account for what?

4.2 Accountability Relationships

The traditional relationships as identified in Figure One exist within health care delivery but there are additional relationships created by the presence of health care providers and health care-specific public institutions. Providers and institutions work within a context created by government and are thus expected in varying degrees to account to government for their actions and/or use of public resources. They are also sometimes subject to the authority of other public institutions such as the courts or provincial auditors. It would appear they also have some form of a vertical accountability relationship with citizens at least through minimal annual reporting on activities at an organizational level (e.g., hospitals or regional health authorities), and the availability of complaints-based processes at the patient level.6

Figure 2 presents these new actors. Health care providers have been divided into three groups: regional health authorities, health care facilities and health professionals as each have slightly different relationships with the other actors in the system. Health care specific public institutions have been divided into those with a regulatory mandate and those with a quality or evaluation mandate as the regulatory mandate is legislated with relatively clear responsibilities whereas the quality mandate is largely an oversight one based on moral suasion and influence. As well, patients have been added to the diagram as their perspectives and accountability avenues are distinct from those of citizens in general. The lines connecting the boxes are based on an assessment of accountability relationships documented in legislation, funding agreements or performance contracts. Readers may disagree with the direction of the arrows – and they may be right – but the main message here is that adding the providers into the traditional accountability relationship between government and citizens changes, perhaps even distorts, the picture.

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6 We are not referring here to the accountabilities inherent in individual patient-provider relationships but rather the accountabilities at the societal level.
It is possible to locate much of the recent public debate about health reform and the need for greater accountability within the boxes in the middle. Canadians are asking for greater vertical accountability from their governments but also from their health care providers. And Canadians are asking for greater horizontal accountability between governments and health care providers in the form of a public watchdog or oversight body dedicated specifically to health care issues (Flood and Choudhry 2002; Kirby 2002; Maxwell et al 2002; Romanow 2002). But as they make these requests, what type of accountability are they asking for? What do they need to know and what is the best way to provide that information? This takes us back to the four mechanisms of accountability referenced in section 2.3.

**Figure 2**
Health Care Accountability Relationships

4.3 Accountability Types and Mechanisms

Citizens are demanding more accountability in their health care system and these demands are finding their way into both the mechanisms recommended by the expert reviews and the
initiatives undertaken by government. It would appear that several types of accountabilities are contained within these more general recommendations and demands. Table 3 summarizes the accountability mechanisms proposed in the system reviews and we can see reflected therein a desire to know more about money and performance (financial and managerial accountability), an increased capacity to codify rights (political accountability) and an increased desire to involve citizens more actively in policy reforms (political accountability). It is striking how many of the system reviews proposed a health care-specific public institution as a way of increasing accountability. What is driving the perception that citizens need an arms length, third party agency as a way of holding governments and providers to account?

It is worth noting that the effectiveness of these mechanisms isn’t entirely clear and is the reason behind the other papers in our series. Some research has been undertaken on the effectiveness of governance approaches and public reporting of performance information as citizen accountability mechanisms. Little work has been done yet on legal approaches or the use of citizen engagement techniques.

Table 3
Accountability Mechanisms Proposed by System Reviews

<table>
<thead>
<tr>
<th>Citizen Engagement</th>
<th>Legal</th>
<th>Public Reporting</th>
<th>Citizen Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta (Mazankowski Report)</td>
<td>* Access to treatment 90 days from diagnosis for selected services</td>
<td>* Benchmarks on quality and outcomes</td>
<td>* Expert Panel on Coverage</td>
</tr>
<tr>
<td>New Brunswick (Health Quality Council)</td>
<td>* Charter of Rights and Responsibilities (no specific service guarantees)</td>
<td>* Health System performance indicators to be reported by the Regional Health Authorities</td>
<td>* Outcomes Commission</td>
</tr>
<tr>
<td>Quebec (Clair Commission)</td>
<td>* Citizens’ Forum for Regional Boards to give advice.</td>
<td>* Annual report on costs.</td>
<td>* Governance Task Force</td>
</tr>
<tr>
<td>Saskatchewan (Fyke Commission)</td>
<td></td>
<td>* Goals, outcomes and performance indicators</td>
<td>* National Health Council</td>
</tr>
<tr>
<td>Senate Committee (Kirby Committee)</td>
<td>* Health Care Guarantee (with specific service guarantees)</td>
<td>* Performance indicators and outcomes</td>
<td>* National Health Care Commissioner and Council</td>
</tr>
</tbody>
</table>

| * National Coordinating Committee on HHR |
A Citizen Engagement Approach

A relatively new potential accountability mechanism on the Canadian landscape is focused on new ways to engage citizens in decision making about policy and system issues (Romanow 2002). The OECD has defined citizen engagement in policy processes in the following terms (MacKinnon 2003b):

Active participation recognizes the capacity of citizens to discuss and generate policy options independently. It requires governments to share in agenda-setting and to ensure that policy proposals generated jointly will be taken into account in reaching a final decision.

This is not about consulting the public on health reform but rather building permanent engagement processes into public policy development and creating a direct accountability between citizens and policy makers to enable a reflection of Canadian values in public policy choices. Proponents are clear that it is not an approach that can be used for all issues and questions. Rather, it is useful when there is room to discuss and influence the design and direction taken or there is a need to determine a consensus (MacKinnon 2003b). These methods are expensive and issues of representativeness will need to be addressed if they become built into broad based policy development.

A Legal Approach

Increasingly, individual Canadians and provincial governments are looking to legal approaches to "enforce" accountability in Canadian health care. This takes the form of a number of different legal and administrative instruments and includes proposals such as a care guarantee for minimum wait times for procedures (Clair 2000; Kirby 2001; Mazankowski 2001) or a Patient Charter of Rights (Kirby 2001; Kirby 2002; Premier’s Health Quality Council 2002). Although instituted in other jurisdictions, they have yet to be fully implemented in Canada. Citizens like the idea of being given a specific expectation around wait times and having certain rights when dealing with health care providers. What is not clear, and has yet to be tested, is what happens when the wait times are not met? Indeed, it was this specific question that led Commission Romanow to stay away from a guarantee and to propose instead a health care covenant spelling out rights and responsibilities (See Appendix B). Interestingly, no one has adopted the covenant yet.

Embedded in these concepts is the notion that rights need to be spelled out in more detail, that citizens need redress mechanisms if they are dissatisfied, and that there needs to be an appeal process if citizens are not satisfied with the redress mechanism either through independent tribunals or the courts.

Canadian courts have begun to hear cases about health care entitlements but it is not entirely clear how the courts will balance individual needs with broader social policy goals (Ries and Caulfield, forthcoming).
A Public Reporting Approach

Accounting for decisions and actions through public reporting requires a systematic and ongoing measurement of agreed-to indicators and regular public reporting of such. Much activity has been devoted to this work in Canada in recent years led by the Canadian Institute for Health Information, Statistics Canada and various levels of government. Standardized indicators were agreed to by the federal/provincial/territorial governments for regular public reporting in 2000 with a first round of information being quietly placed on government web sites in the September 2002. Each jurisdiction produced their own report and despite a consistent template, the reports ranged in length from 35 pages (federal government) to 286 (Saskatchewan government). Citizens were left to draw their own conclusions as no overview or comparative report was produced.

Recent health reform reviews suggested public reporting of a combination of population health status, financial, clinical outcomes and service volume and performance data (Clair 2000; Fyke 2001; Kirby 2001; Kirby 2002; Mazankowski 2001; National Forum 1997; Premier’s Health Quality Council 2002) and the 2003 Accord committed to further indicator development and regular public reports. The next round of information is expected to be released in 2004. Along with the standardized indicator reports being produced by governments, other health care report cards have become ubiquitous on the Canadian scene reporting on institutional outcomes (Ontario hospitals), disease outcomes (cardiac, cancer), and population outcomes (children, women).

It is not entirely clear what citizens make of all this activity. Canadians report in public opinion polls that they want the information to be collected and published (Ipsos-Reid 2002) but whether they actually pay attention to these reports or use them in any way to make decisions about their own health or the health care services they receive is debatable (Hibbard 2002; Schneider 1998). Increasing evidence from Canada, the US and the UK is leading experts to question whether report cards and comparative indicators are really a citizen accountability mechanism or perhaps more suited to clinical and system managers (CHSRF 2003a). An alternative school of thought is focused more around creating better knowledge translation and communication methods and processes so that the information is rendered sensible for citizens to digest and use.

A by-product of the public reporting approach in Canada seems to be the need for a reporting body that is somewhat independent of government or service providers thus several “independent” councils have been created. The provinces of Saskatchewan, Ontario and Alberta have established Health Quality Councils: Saskatchewan’s being fully operational, Ontario’s in the proposal stage, and Alberta’s an expanded version of the previous Health Services Utilization and Outcomes Commission. And, there is the recently established national Health Council of Canada (HCC) minus the participation of Quebec and Alberta. Quebec has committed to collaborating with the HCC and there is space reserved for Alberta if the provincial government wishes to participate at some future point.
A Citizen Governance Approach

In theory, placing citizens in governance roles in health care structures (i.e. as Board Directors) provides a direct accountability to citizens. In practice, this is the most commonly used and oldest accountability mechanism present in Canadian health care and encouragingly, a recent national dialogue with Canadians highlighted that they see themselves as more active participants in governance than has historically been the case (MacKinnon 2003a).

Provincial governments in all provinces but Ontario have created governance structures at the regional level to manage health care services. Regional health authorities have existed in varying forms in Quebec since the 1970s, in Western Canada for the last 5-10 years and more recently have been instituted in Eastern Canada. Different models of direct election and government appointment to the boards have been tried in a number of provinces but regardless of the process, all models have been based on citizen governors.

Originally these citizen governors were created as a mechanism for community involvement and public oversight for health care decisions and spending as well as an integrative mechanism for services at the local level (Frankish 2002). As they have evolved and been reorganized into larger units, their function has become more of a system manager with a legal responsibility to administer a budget envelope to cover an agreed upon set of services.

Citizen governance is one of the few policy innovations since the inception of Canadian medicare yet it would appear there is still much work to be done to sort through appropriate accountability relationships. A recent survey of members of regional health authorities and provincial governments found that accountabilities were still not clear. The RHAs reported that they did not have enough legal authority to deal with the issues of the day. The provincial governments reported that, contrary to the perceptions of the Boards, government did not hamper the ability of boards to make decisions and that the boards were captured by vested interests (Kouri 2002).

Citizen governors also sit as members on the boards of specific health care provider organizations such as hospitals, and on the councils of the regulatory health professions’ colleges. Hospital trustees have been surveyed from time to time generally focusing on information needs, the evidence base for their decisions, and their opinions on health reform issues (Brunelle 1998). Citizen members of the health professions’ regulatory councils have not been studied at all and little is known about their views of their accountabilities.

Citizen governors are also part of the quality councils to some degree. The councils have experts and health care providers and usually have some “citizen” representatives. As previously stated, the relationships of these organizations with citizens beyond a public reporting function is unclear.

Table 4 summarizes these four approaches.

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7 However, Ontario does have regionalized program structures for services such as mental health or home care programs.
Table 4
Summarizing Current Approaches

<table>
<thead>
<tr>
<th>Approach</th>
<th>Issues Around Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen Engagement</td>
<td>Methods are still in their infancy in terms of broad based processes.</td>
</tr>
<tr>
<td></td>
<td>Not clear how to balance these views with professional expertise.</td>
</tr>
<tr>
<td></td>
<td>Expensive to undertake.</td>
</tr>
<tr>
<td>Legal</td>
<td>Not clear how the courts view individual entitlements balanced against social policy context.</td>
</tr>
<tr>
<td></td>
<td>Expensive to undertake.</td>
</tr>
<tr>
<td></td>
<td>Experience with charters or bills of rights in their infancy.</td>
</tr>
<tr>
<td></td>
<td>Not clear yet if care guarantees make a difference in wait times.</td>
</tr>
<tr>
<td></td>
<td>Not clear is general commitments in charters or covenants are enforceable.</td>
</tr>
<tr>
<td>Public Reporting</td>
<td>Not clear if citizens understand or use the information.</td>
</tr>
<tr>
<td></td>
<td>Not clear if current processes are providing the information citizens want.</td>
</tr>
<tr>
<td></td>
<td>Not clear what the relationship is between citizens and third party reporting agencies.</td>
</tr>
<tr>
<td>Citizen Governance</td>
<td>Not clear to whom citizen governors are accountable.</td>
</tr>
<tr>
<td></td>
<td>Clear there is confusion amongst RHA members and provincial governments around accountability and roles.</td>
</tr>
</tbody>
</table>
5. Discussion

Table 5 summarizes the various accountability concepts discussed thus far in relation to Canadian health care.

Table 5
Health Care Accountability

<table>
<thead>
<tr>
<th>Actor</th>
<th>Primary Accountability</th>
<th>Type of Accountability</th>
<th>Direction of Accountability</th>
<th>Accountability Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>Citizens</td>
<td>Financial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Political</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td>Regulators</td>
<td>Government</td>
<td>Financial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td>Quality Agencies</td>
<td>Government</td>
<td>Financial</td>
<td>Horizontal</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Horizontal</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td>RHAs</td>
<td>Government</td>
<td>Financial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td>Health Care Facilities</td>
<td>Government</td>
<td>Financial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients</td>
<td>Vertical</td>
<td>Citizen Governance Public Reporting</td>
</tr>
<tr>
<td>Health Professionals</td>
<td>Patients</td>
<td>Professional</td>
<td>Vertical</td>
<td>Legal</td>
</tr>
<tr>
<td></td>
<td>Facilities (if employees)</td>
<td>Financial</td>
<td>Vertical</td>
<td>Legal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managerial</td>
<td>Vertical</td>
<td>Legal</td>
</tr>
<tr>
<td></td>
<td>Regulators</td>
<td>Professional</td>
<td>Vertical</td>
<td>Legal</td>
</tr>
</tbody>
</table>

* RHAs in some provinces have begun to engage their communities in needs assessments or some form of community consultation about priorities.

A number of observations can be drawn from this table. First, governance and public reporting are the primary mechanisms used although legal redress is clearly relied upon for dealing with specific patient issues. Second, governments are clearly accountable to citizens but don’t appear
to have specific accountabilities to anyone else in the system. Third, there is no obvious accountability relationship between citizens and the regulators, health care facilities or individual health professions. It is true that regulators and health care facilities are often required to provide public information about their activities; however, does this public reporting actually create an accountability relationship? Fourth, financial and managerial accountabilities are primarily the types focused upon in Canada. This leaves a large question about professional accountability in relation to the delivery of health care and clinical decision making. Fifth, almost all the relationships are uni-directional. The one exception is the accountability relationship between government and the quality agencies. Both organizations actually do account to the other.

In attempting to assess whether all these relationships add up to an accountability framework, we need to return to the definitional elements of accountability (establishing a relationship; agreed-upon defined responsibility; authority; answerability; performance; sanction). It is clear that some of them are in place. There is a relationship between providers and governments through funding and performance contracts. There is a relationship between providers and individual patients. Whether there is a relationship between providers and society is less clear. Some responsibilities are defined in legislation, funding agreements, professional codes, organization policy and government clearly has the authority to delegate decision making. Canada is certainly in the process of increasing performance measurement and evaluation activities, although primarily focused on indicator reporting. This leaves the question of answerability and this is where the application of the general accountability definitions to the provision of health care becomes difficult. If the relationship between providers and citizens (as a group) isn’t entirely clear, how can answerability be identified – to whom and for what? If for example, evidence demonstrates differences in intervention rates, wait times, or health outcomes that are not related to differences in population health or available resources, where is the accountability for change and how would we identify who is responsible for what? If evidence demonstrates existing clinical practice has no known therapeutic benefit yet it continues to be practiced, who is responsible for changing it? What are the sanctions if it isn’t changed? It is precisely the nature of the shared roles as identified in Table Two and Figure Two that makes this question so difficult to answer in the Canadian context. It is everyone and no one simultaneously.

Three gaps can be identified in the current health care accountability discussion in Canada.

1) **Definitional Gap**

A definitional gap has been created by relying on general definitions of accountability to convey a desired picture of health care accountability. Something is missing. Canadians are attempting to apply a general definition of accountability based on the historic relationship between governments and citizens to health care – a service delivery system based on another set of historical relationships between individual health care facilities and health professionals dealing with individual patients. It may be that in this attempt to take a societal expectation about government and overlay it on a system of somewhat independent providers, we have taken a big leap. Further thought may be required to define who is accountable for what and to whom before we can have clarity about system-level accountabilities.
2) Communication Gap

There is gap between the language being used to describe accountability efforts and the actual efforts being undertaken. Policy makers promise to “hold the system accountable” and to “enhance system accountability” but behind the sentences is essentially a commitment to public reporting of performance measurements and outcomes. The reporting of this information is important but if it is to be a citizen accountability mechanism it may need to be in a format citizens can readily use to identify responsibilities or assess accountability processes.

There may also be a gap between what is being provided and what citizens actually want. It isn’t at all clear that the information currently being generated is what citizens would really like to know about their health care system and more in-depth discussion with citizens about public reporting might be advisable.

3) Implementation Gap

There is a gap between the desired and actual effect of reporting the information. Public reporting of this information is an essential first step in creating a true accountability relationship but the reporting process itself does not create the relationship nor ensure effective accountability. Implementation plans are needed to deal with the implications of the information. Citizens will need to understand what the information actually says about system performance, who is responsible for changing it individually or collectively, and what can be done at the local, regional, provincial and national level. As well, the reporting processes need to be tied to some evaluation and correction process identifying who has not made the necessary improvements.
6. Conclusions

Governments are currently attempting to implement many of the recommendations made by various health system reviews, including those aimed at improving system accountability. They are to be applauded for undertaking the work and the following suggestions are made to support their efforts:

- Address the difficulty of using a general accountability definition to fit all aspects of health care relationships by being clearer about roles and responsibilities for specific outcomes. Who is responsible for ensuring access to care? Who is responsible for ensuring quality of care? Who is responsible for improving health outcomes.
- Think about how to create a stronger connection between providers and citizens (rather than patients). What is the societal expectation?
- Think about how to create a stronger professional group accountability at the system level for system outcomes.
- Think about how to operationalize and make more visible horizontal or shared accountability relationships.
- Move beyond the reliance on public reporting of performance information as a primary accountability mechanism and start to experiment with other mechanisms such as citizen engagement processes.
- If public reporting is going to continue in the short term as a key citizen accountability mechanism then further refine the kind of information being reported and the way in which it is being reported to making it more useful to citizens. This should involve discussions with citizens.
- Create implementation processes for responding to the published information that explicitly explains to citizens what needs to happen and outlines the consequences of not acting.

To be clear – accountability does exist in the Canadian health care system at some levels between some groups; however, there are gaps. These gaps needed to be addressed so that the multiple accountability relationships add up to a coherent accountability system for citizens. This will depend upon all the actors in the system accepting responsibility at an individual and group level for their contributions to specific system outcomes. Without that acceptance, true accountability will not be achieved.

The purpose of this paper has been to ask questions in a systematic fashion to set the frame for the other papers in the series. Within the next several months, CPRN will be releasing all of these papers with the goal of stimulating more thoughtful discussion about how the health care system and its institutions can respond to the growing pressures from citizens, taxpayers and patients for greater transparency and accountability for a public service which is central to the health and well-being of all Canadians.
7. References

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Appendix A – Papers in the CPRN Health Care Accountability Series

No|1 – *Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens*, by Cathy Fooks and Lisa Maslove

A recent scan of research literature indicates that general definitions of public accountability do exist – that is, being accountable publicly for actions. However, notions of accountability to citizens within health care are not well developed. Furthermore, the Canadian focus to date has been largely on the public release of comparative health indicators and the establishment of citizen governance structures at the regional level. Little attention has been given to other potential accountability mechanisms such as legal avenues or citizen engagement approaches for policy development. This first project will review concepts summarizing research on current definitions of accountability to citizens.

No|2 – *Mapping Legal Accountabilities*, by Susan Zimmerman

Responsibility for designing, delivering, funding and evaluating health care in Canada is confusing. Before assessing potential improvements, mapping out current responsibilities and accountabilities is required and will be the focus of this second project. We will pose a series of who does what questions for various aspects of Canadian health care examining where decisions are made within the current legislative, regulatory and health policy environments. It will include an examination of the responsibility of governments, regional health authorities, the regulatory bodies, non-profit and for-profit health care providers (individuals and organizations), professional associations, educational institutions, patient organizations, and corporations. An accountability matrix will be created for the federal and provincial/territorial level health care responsibilities.

No|3 – *Engaging Citizens to Strengthen Citizen-Government Accountability*, by Julia Abelson and François-Pierre Gauvin

An engagement approach focuses on new ways to engage citizens in decision making about policy and system issues, going beyond traditional public consultation and focus group methodologies. This paper will assess the possibilities for increasing the use of engagement approaches in Canadian health care.

No|4 – *The Effectiveness of Performance Reporting as a Citizen Accountability Mechanism*, by Kathleen Morris and Jennifer Zelmer

Canada has begun work in this area with a common federal/provincial/territorial reporting framework being established in 2001 and further refined in 2003. Accreditation of institutions and individual providers is another approach that is closely tied to performance measurement.
This paper will review the evidence on the effectiveness of these reporting processes for citizen accountability and will describe the scope and nature of current performance reporting exercises.

No|5 – Accountability in Health Care and Legal Approaches, by Nola Ries and Tim Caulfield

Proposals such as a service guarantee outlining items such as minimum wait times for procedures, or a Patient Charter of Rights, are being proposed in the Canadian health policy community. They are in the development stage at present with one province proposing specific language (New Brunswick), one province committed to a service guarantee 90 days after diagnosis (Alberta), and one province committed to a process to establish clinically appropriate wait times (Ontario). As well, Canadians are heading to court to assert specific entitlements to specific health care services. This paper will review the effectiveness of these proposals as citizen accountability mechanisms.

No|6 – The Effectiveness of Governance Approaches as a Citizen Accountability Mechanism, by Steven Lewis

Regional health authorities with citizen governors are in operation in all provinces except Ontario and a number of provinces are establishing provincial-level organizations such as quality councils. A national level health council has also been established as a citizen accountability mechanism. This paper will review the evidence on the roles of citizens as governors in health care.

No|7 – Policy Synthesis and Action Plan

Once the six papers are completed, CPRN will host a national solutions symposium to bring together researchers, policy makers, stakeholders and citizen representatives to review and comment on early findings. As well, the round table will test specific proposals to strengthen accountability mechanisms. From there, CPRN will develop a final report summarizing the information gathered throughout the project and make specific recommendations about next steps for Canada’s health care system.
Appendix B – Health Covenant for Canada
Commission on the Future of Health Care in Canada

Canada was founded on the basis of co-operation, perseverance and mutual respect. Canadians continue to be recognized through the world for these qualities. Building from this solid foundation, as Canadians, we agree to apply and be bound by the following in shaping our health care system:

**Mutual Responsibility**: The success of our health care system requires a balance between our personal responsibility for our own health and our mutual responsibility for our health care system. All Canadians share the responsibility for maintaining this system through their actions and tax dollars, and all should contribute to it within their means.

**A Public Resource**: Our health care system is a public resource and a precious national asset.

**Patient-centred Care**: The direction of our health care system must be shaped around health needs of individual patients, their families and communities.

**Equity**: All Canadians are equally entitled to access our health system based on health needs, not ability to pay.

**A Universal, Accessible and Portable System**: Public health insurance must be accessible to all Canadians on uniform terms and conditions, regardless of where they live in the country. But the provision of care should be sensitive to the race, colour, gender, sexual orientation, ability, disability, ethnic origin, language, place of residence, social or economic status and religion of those using the system.

**A Respectful, Ethical System**: Our health care system must be based on the highest ethical standards, and must recognize the worth and dignity of the whole person including biological, emotional, physical, psychological, social and spiritual needs.

**Transparency and Accountability**: The decision governments and providers make in operating our health care system should be clear and transparent. Canadians are entitled to regular reports on the status, quality and performance of our health care system.

**Public Input**: Public participation is important to ensuring a viable, responsive and effective health care system.

**Quality, Efficiency and Effectiveness**: The resources needed to support our health care system are limited and the system must be run as efficiently as possible. Care should be integrated, multidisciplinary, timely and convenient and services should be designed around the health of the population, with emphasis on the physical, social, economic and environmental determinants of health. Wellness, public health and prevention must be a major focus of the system. Decisions at all levels of the system must be based on the best available information and we must foster innovation and sharing of best practices.
Responsibilities and Entitlements of Individuals Canadians

Canadians:
- Have a responsibility to observe good health practices, and to promote and support the well-being of their families and communities.
- Have a responsibility to use the system prudently, and to support the system through their actions and tax dollars.
- Are entitled to health services based on health needs, not ability to pay.
- Are entitled to timely, high quality care.
- Are entitled to make informed decisions regarding their personal care, and to receive all information and medical documentation related to them, while respecting the judgment and expertise of health providers.
- Are entitled to have appropriate input into, as well as to be informed of relevant policies and laws, including procedures to complaints, and all Canadians are entitled to utilize appeals/complaints mechanisms relating to the system.
- Are entitled to be treated in a courteous, respectful and dignified manner, and consistent with relevant legislation, should have their right to privacy respected.

Responsibilities and Entitlements of Health Care Providers

Health care providers:
- Have a responsibility to ensure that the health care system places the highest priority on the concerns and health needs of patients.
- Have a responsibility to work with governments, the public and each other to continuously improve the quality of services and maximize patient safety.
- Have a responsibility to respect the confidentiality and privacy of individual patients.
- Have a responsibility to provide information to patients on treatments, related services, and available alternatives, while taking into account the preferences of their patients.
- Have a responsibility to exercise prudent management and careful stewardship of resources in support of our health care system, as these resources are finite.
- Have a responsibility to uphold all professional standards.
- Are entitled to professional recognition, the ability to exercise clinical judgment, and reasonable compensation.
- Are entitled to be treated with dignity and respect in the performance of their duties.
- Are entitled to a meaningful role in making decisions related to the operation of the system.

Responsibilities and Entitlements of Governments

Governments:
- Have a responsibility to develop and administer the health care system for the common good of all and in a manner that provides equitable access and treatment for all Canadians.
- Have a responsibility to dedicate adequate, stable and predictable funding for our health care system in a manner transparent to Canadians.
• Have a responsibility to work collaboratively with each other and with the public and health care providers, as appropriate, to foster innovation and ensure the system remains responsive and sustainable.

• Have a responsibility to regularly review the performance and operation of the health care system and report to the public so that Canadians can make informed decisions and contribute to the system in an informed way.

• Have a responsibility to ensure that decisions regarding the future direction of our health care system are made with transparency and accountability to all: this means establishing goals, targets, and benchmarks for the system, tracking performance and reporting to the public.

• Have a responsibility to ensure that health services are delivered in a way that ensures the flexibility necessary to reflect local needs and circumstances.

• Have a responsibility to establish appropriate mechanisms that allow the public and health care providers meaningful input into decisions on the future of our health care system.

• Have a responsibility to develop healthy public policies that are designed and implemented in a manner consistent with promoting the health of the population.

• Are entitled to have their jurisdictional roles and responsibilities recognized and respected in charting new directions for the health care system of the future.
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