



Approaches to Accountability

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What is accountability?

- Having to be answerable to someone, for something:
 - meeting defined objectives



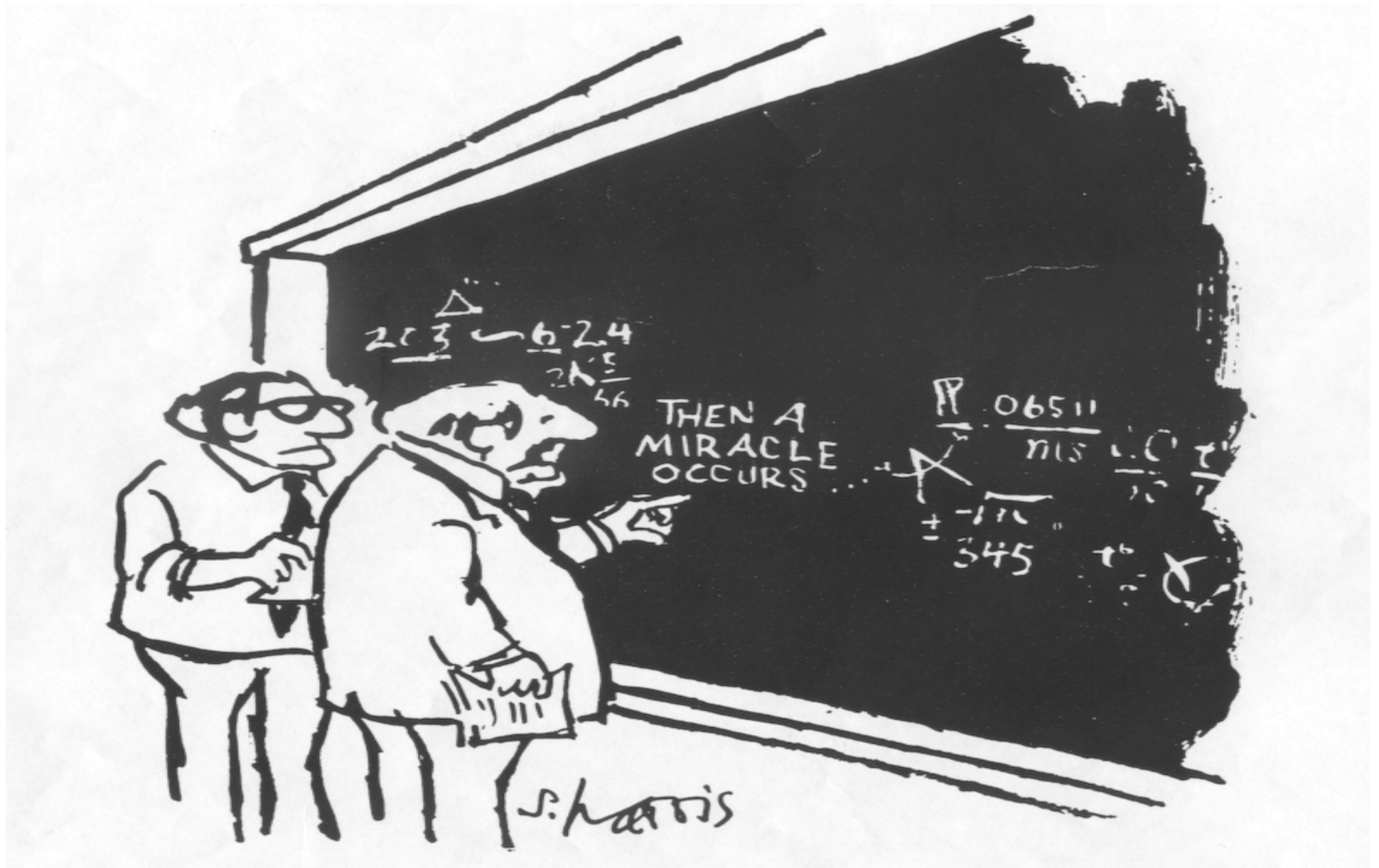
What is the problem?

- Much emphasis on accountability
- Many ways to go about it
- Nagging suspicion that we may not always be using the best approaches
- Done well: may improve performance
- Done poorly: may not only waste time and money, but create perverse incentives



Goal

- Get the 'dial settings' right!
- Learn from experience



“I think you should be more explicit here in step two.”



Can we be more specific?

- Timing?
 - Ex ante or ex post?
- Dimensions?
 - May include:
 - Financial (e.g., fiscal accountability to payers)
 - Performance (e.g., clinical accountability for quality of care)
 - Political/democratic dimensions (e.g., accountability to public)



Who is involved?

- Various combinations of:
 - Providers (public and private)
 - Patients
 - Payers (including insurers and the legislative and executive branches of government)
 - Regulators (governmental, professional)



Self-serving interlude

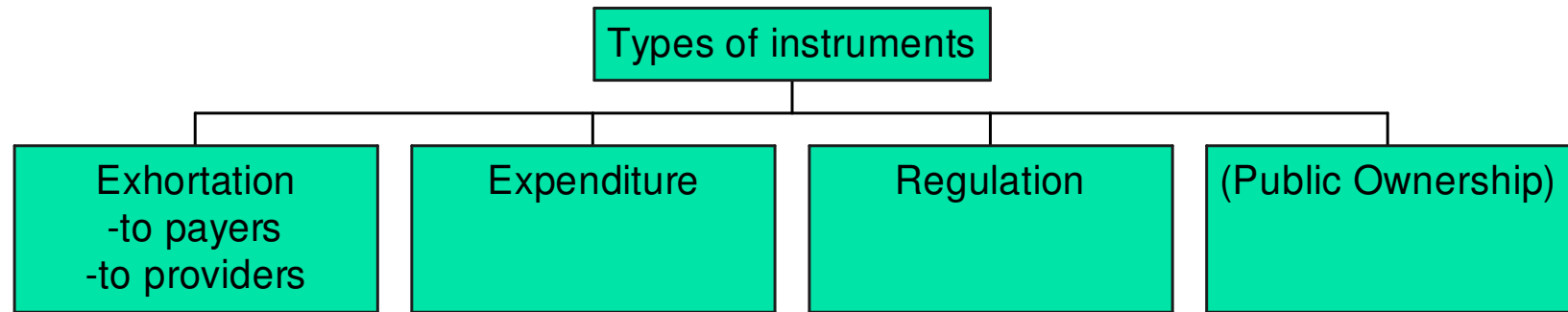
- Our research team is beginning a study about approaches to accountability
- Great team! Great partners!
- Currently: 11 sub-studies



We propose to examine 4 approaches

- Based on the political science concept of policy instruments (aka governing instruments)
- Different ways to implement policy
 - Vary in terms of how 'intrusive' they are

Instruments by increasing coercion/ intrusiveness





We propose to examine 4 approaches

1. Information directed to purchasers/care recipients (e.g., report cards)
2. Information directed to providers (e.g., practice guidelines)
3. Expenditure (e.g., Pay For Performance)
4. Regulation



Another nuance

- There are different ways of enforcing these agreements, including:
 - Information
 - Licensure/accreditation
 - Payment
 - Legal sanctions



What works best?

- It depends
- We propose to examine the impact of:
 - Policy goals
 - Governance (including the public-private mix)
 - “Production characteristics” of the goods and services being provided
- We will compare and contrast across sub-sectors, and across jurisdictions



Goals

- We will concentrate on:
 - Access
 - Cost
 - Quality



Governance - can be linked to dimensions of health systems

- Financing - who pays for what services?
- Delivery - who delivers what services?
- Allocation - how are resources allocated to those delivering services?

We will focus on: public-private mix



Public and Private

- Public can be:
 - Nation
 - Sub-national unit (State/Province)
 - Region
 - Local
 - “Quasi public” (nominally private, but heavily regulated by public sector)



Public and Private

- Private can be:
 - FP/c: Corporate for profit
 - FP/s: Small business
 - NFP: Not-for-profit (volunteers, or paid workers)
 - Individuals and families



Health System Models

	Public Financing	Private Financing
Public Delivery	National Health Service	User fees for publicly delivered services
Private Delivery	Public Insurance	Private Insurance



Production Characteristics

- We will focus on 3 (related to service mix delivered):
 - Contestability
 - Measurability
 - Complexity



Contestability

- Contestable goods are characterized by low barriers to entering and exiting markets
- Non-contestable goods may be characterized by some or all of:
 - monopoly market power
 - geographic advantages
 - high sunk costs, and/or
 - “asset specificity” (a term meaning that it is relatively difficult to transfer assets intended for use in a given transaction to other uses)



What Lowers Contestability?

“Once incumbents have invested in activities that result in expertise or generate trust, they enjoy a significant barrier to entry for other potential suppliers, thereby lowering the degree of contestability.”

Preker and Harding



Measurability

- The precision with which inputs, processes, outputs, and outcomes of a good or service can be measured



Complexity

- Whether the goods and services stand alone, or require coordination with other providers
- (better term – Embeddedness?)



Concern - From Theory

“Entrepreneurs inevitably seek to segment markets so as to exploit profitable niches, while publicly accountable regulators try to ensure that the entire market is served efficiently and affordably.”

Saltman and Busse



Unprofitable Clients

- May be found in:
 - Certain geographical areas (e.g., poorer communities, which Australia found could not generate enough revenues to support their FP/c hospitals)



Unprofitable Clients

- Particular groups (e.g., those without adequate insurance)
- Particular disease categories (depending upon the reimbursement structures)
- Within disease groups (e.g., if payment is per case, there are incentives to avoid the most expensive cases within that category)



Competition or Cooperation?

- Highly competitive models may also undermine tendencies for cooperation



Contracting Models

- Often rely upon competition
- Requires the ability to verify the activities of those receiving contracts for their services
- Verification assumes high measurability



We Postulate that Contracting Models will be

- Relatively easy for some sub-sectors (e.g., accuracy of laboratory tests; purity of pharmaceuticals)
- But harder for sub-sectors with different production characteristics (e.g., how would one monitor the contents of an office visit to a physician?)



Monitoring Has Transaction Costs

- Monitoring also carries significant transaction costs, particularly if trust is low
- Where measurability is not high, most jurisdictions have therefore chosen to operate in a high trust environment where they can rely more heavily on values and stewardship



Monitoring Has Transaction Costs

- In turn, such high trust models would appear to be a better fit with NFP or FP/s delivery models than with FP/c, because corporate structures have conflicting imperatives to maximize return on investment to their shareholders



Health care is not homogeneous

- Sectors vary considerably in how they are financed and organized
- Public funds can flow to different organizations either directly (e.g., provision of funds to provide a particular service), or indirectly (e.g., purchase by them of goods and services)



The Comprehensiveness Condition

- Based on previous legislation
- Defines insured services in terms of *who* delivers them (doctors) and *where* they are delivered (hospitals)
- Provinces can, but are not forced to, insure care beyond these rules



What happens when we move out of hospitals?

- No longer a requirement to include them within public financing
 - Even though many are undeniably “medically necessary” (e.g., prescription drugs for cancer treatment)



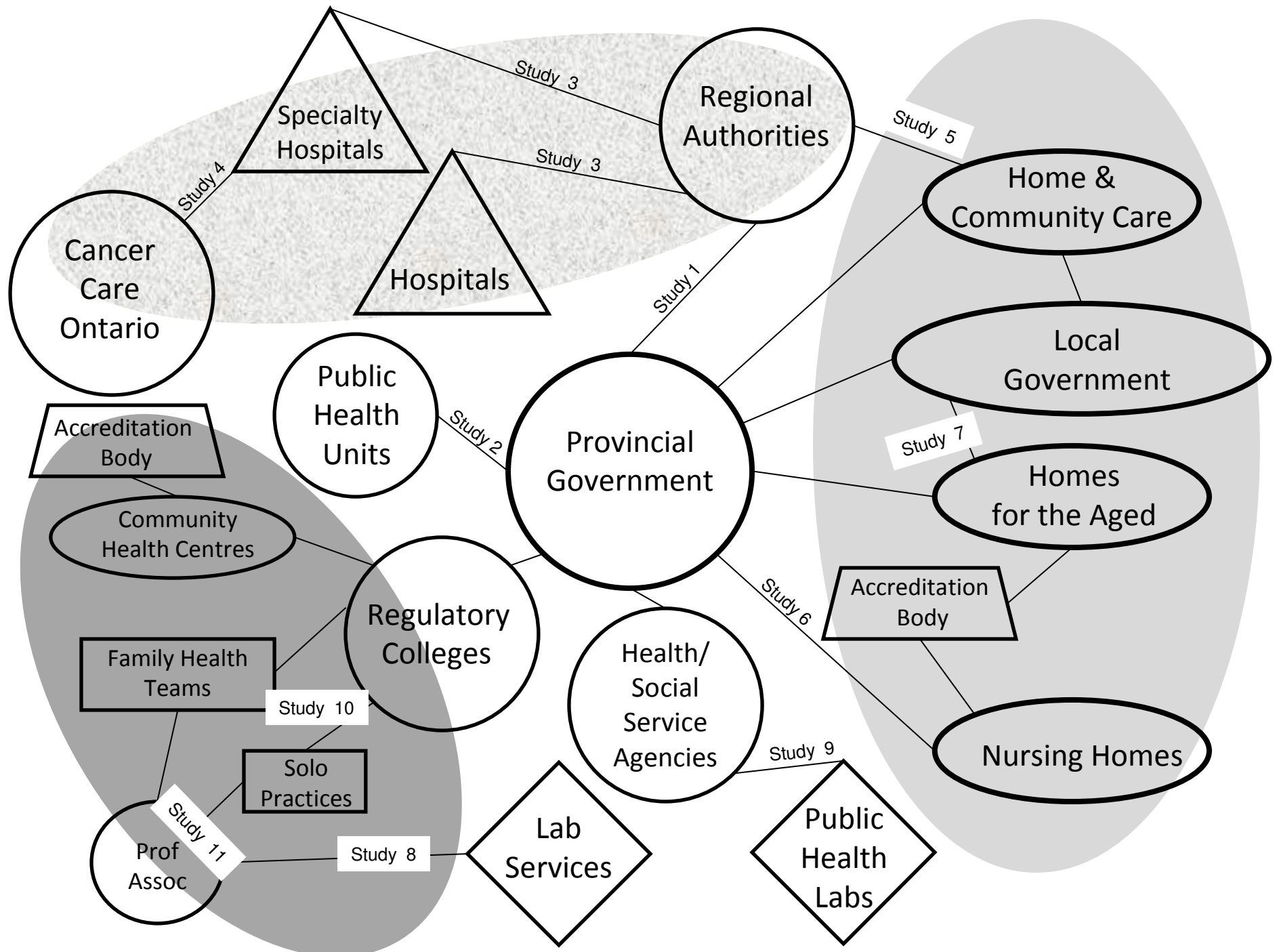
What are we hoping to do?

- These are the confirmed potential partners and research leads
- 11 sub-studies with confirmed partners
- Sub-sectors vary in terms of goals, governance, service mix



Research team

- Researchers and partners:
 - Raisa Deber, Ross Baker, Jan Barnsley, Andrea Baumann, Whitney Berta, Adalsteinn Brown, Judy Burns, Roger Chafe, Mark Dobrow, Brenda Gamble, Audrey Laporte, Janet Lum, Heather Manson, Carol Sawka, Robert Schwartz, Michael Sherar, Terrence Sullivan, A. Paul Williams, Walter Wodchis
- Partners and Collaborators
 - Tom Closson, Anne Coghlan, Tony Culyer, Gregory Flynn, Gilbert Heffern, Louise Lemieux-Charles, Eric Nauenberg, Sandra Pitters, Linda Rabeneck, Gilbert Sharpe, Tina Smith, Anne Wojtak





1. Provincial governments- Regional authorities

- Leads: Deber, Baker
- Decision making partners:
 - Ontario Ministry of Health and Long-Term Care:
 - Adalsteinn Brown, Assistant Deputy Minister, Health Strategy Branch – nominated decision making partner
 - Vasanthi Srinivasan, Director, Health System Planning and Research Branch
 - Corrine Berinstein
 - Sahba Eftekhary
 - Eric Nauenberg
 - Richard Prial, Director, Strategic Alignment Local health integration networks
 - Bill MacLeod, CEO Mississauga Halton LHIN
 - Matthew Anderson, CEO Toronto Central LHIN



2. Provincial governments- Public Health Units

- Leads: Schwartz, Deber
- Decision making partners:
 - Ontario Ministry of Health and Long-Term Care
 - Monika Turner, Director, Public Health Standards Branch
 - Ontario Agency for Health Protection and Promotion
 - Decision making partner: Dr. Heather Manson, Senior Medical Advisor to the President
 - Region of Peel
 - David Mowat, Medical Officer of Health
 - Ontario Ministry of Health Promotion
 - Pegeen Walsh, Director, Director , Chronic Disease Prevention and Health Promotion Branch



3. Regional authorities- Hospitals

- Leads: Baker, Deber, Smith
- Decision making partners:
 - Ontario Hospital Association
 - Tom Closson, President and CEO
 - Anthony Dale, Vice-President, Policy and Public Affairs
 - Lou Reidel, Director, Health Finance and Research
 - Elizabeth Carlton, Director, Policy, Legislative and Legal Affairs Council of Academic Hospitals of Ontario
 - Mary Catherine Lindberg, Executive Director
 - Sanober Motiwala, Director of Policy & Research
 - Canadian Healthcare Association
 - Pamela C. Fralick, President
 - Denise Desautels, Director, Policy and Communications
 - Local health integration networks (same as sub-study 1)



4. Cancer Care Ontario- Hospitals

- Lead: Dobrow
- Decision making partners:
 - Cancer Care Ontario
 - Dr. Terrence Sullivan, President and CEO
 - Dr. Michael Sherar, Vice-President, Planning and Regional Programs
 - Judy Burns, Director, Regional Programs and Performance Management
 - Dr. Carol Sawka, Vice-President, Clinical Programs and Quality Initiatives
 - Dr. Linda Rabeneck, Regional VP and Chief, Odette Cancer Centre



5. Regional authorities-Comm. support services/ Home care

- Leads: Lum, Williams, Deber
- Decision making partners:
 - Toronto Central Community Care Access Centre
 - Anne Wojtak, Senior Director, Performance Management and Accountability
 - Canadian Home Care Association
 - Nadine Henningsen, Executive Director
 - Victorian Order of Nurses
 - Judith Shamian, CEO



6. Provincial governments- Nursing homes

- Leads: Wodchis, Berta, Laporte
- Decision making partners:
 - Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS)
 - Donna Rubin, CEO
 - Ontario Long Term Care Association
 - Paula Neves, Director of Health Planning and Research



7. Local governments-Homes for the aged

- Leads: Gamble, Laporte
- Decision making partners:
 - City of Toronto Homes for the Aged (Pitter)
 - Ontario Long Term Care Association (see sub-study 6, above)



8. Provincial governments- Laboratory services

- Lead: Gamble
- Decision making partners:
 - Quality Management Program - Laboratory Services, Ontario Medical Association
 - Dr. Gregory Flynn, Managing Director
 - University of Ontario Institute of Technology, Faculty of Health Sciences
 - Dr. Carolyn Byrne, Dean, Faculty of Health Sciences



9. Public health agency- Public health labs

- Leads: Gamble, Schwartz
- Decision making partners:
 - the Ontario Agency for Health Protection and Promotion (see sub-study 2 above)
 - University of Ontario Institute of Technology, Faculty of Health Sciences (see sub-study 8 above)



10. Primary care (including community health centres):

- Lead: Barnsley
- Decision making partners:
 - The Ontario College of Family Physicians
 - M. Janet Kasperski, CEO
 - Eilyn Rodriguez, Assistant Executive Director, Research and Educational Services
 - College of Family Physicians of Canada
 - Dr. John Maxted, Associate Executive Director, Health & Public Policy



11. Health Professionals- Professional regulatory bodies

- Leads. Gamble, Baumann, Laporte
- Decision making partners:
 - Canadian Medical Association
 - Owen Adams, Assistant Secretary General, Research, Policy & Ethics
 - College of Family Physicians of Canada (see sub-study 10 above)
 - The Ontario College of Family Physicians (see sub-study 10, above)
 - College of Nurses of Ontario
 - Anne Coghlan, Executive Director



Proposed data collection template

1. Describe the organization:
public/NFP/FPs/FPc; Governance,
payment, cost structure, who provides
(professionals?), accreditation?



Proposed data collection template

2. Describe the mix of goods/services they deliver:
 - production characteristics (measurability, contestability, complexity)
 - availability of administrative data regarding activities?



Proposed data collection template

3. Describe the accountability approaches used.
 - Policy instruments
 - Indicators/measures
 - Stage (proposed, under negotiation, implemented, abandoned)
 - To whom. For what. goals. Enforcement tools.



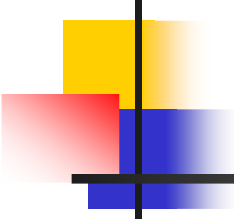
Proposed data collection template

4. Analyze perceptions and/or data regarding:
 - strengths and weaknesses
 - transaction costs
 - what is/is not being captured (and differences between activities and indicators)
 - room for improvement



Proposed data collection template

5. Additional questions germane to sub-study (as identified by researchers and decision-making partners)



My Policy Assumption: There is No Quick Fix

- Policy choices are often about trade-offs
- As Wildavsky noted:
 - One rarely solves complex policy issues
 - One usually replaces one set of problems with another set
 - The mark of success is whether you prefer the new problems to the old ones



Environmental scan

- What approaches are being used in your sector?
- How well are they working?
 - Advantages and disadvantages



Future steps?

- Potential partners?
- Interested in working with us to share information?



Right now

- Suggest we now divide into three groups:
 - Hospitals/regional authorities (Seija Kromm facilitating)
 - LTC (Brenda Gamble facilitating)
 - Community/other (Tina Smith facilitating)
- Raisa Deber – listener/rover