

FROM THE BLAME GAME TO ACCOUNTABILITY IN HEALTH CARE

Bruce Harber and Ted Ball

In Canada's \$100 billion health care system, the provinces blame Ottawa for a lack of funding, Ottawa blames the provinces for mismanagement, hospitals and regional health boards blame both, while health practitioners and patients blame them all. We need to move beyond the "blame game" to an adult culture of accountability and best practices in delivering high quality health care, suggest Bruce Harber and Ted Ball. Acknowledging that this requires moving to a new mind set, they propose six principles for a new system of accountability and a transformation of corporate governance in health care. They sound a note of urgency, suggesting that the current health care system is "a burning platform" that threatens the quality of life of hard pressed front-line workers.

Dans le secteur de la santé, qui dispose d'un budget de 100 milliards de dollars, les provinces accusent Ottawa de les sous-financer, Ottawa accuse les provinces de mal gérer leurs fonds, les hôpitaux et conseils de santé régionaux accusent à la fois Ottawa et les provinces, alors que patients et praticiens accusent en bloc tout ceux qui précèdent. Il faut en finir avec cette ronde d'accusations pour adopter une culture de responsabilisation axée sur des pratiques assurant des soins de qualité, affirment Bruce Harber et Ted Ball. Ce qui exige un tout nouvel état d'esprit, conviennent-ils. Ils définissent donc six principes en appui à un nouveau système de responsabilisation et à la transformation subséquente de la gestion des soins de santé. Et le temps presse, jugent-ils, étant donné le climat délétère dans lequel travaille le personnel de première ligne, soumis à des pressions qui menacent sa qualité de vie.



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

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

Our first ministers chose to make Roy Romanow's recommendations to improve accountability within the health system mean: "Who is in charge?" Within the traditional

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

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

Within the health care delivery system, our existing culture of blame generates fear and destroys trust. When we blame, we attempt to prove that others must have had bad intentions or lack ability. The qualities of blame are "judgment, anger, fear, punishment and self-righteousness," according to Marilyn Paul a scholar in the field of organizational accountability.

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

It was 15 years ago when the health care system flirted with techniques and processes for Total Quality Management and Continuous Quality Improvement (TQM/CQI). We learned back then about Edward Deming's "93 percent vs. 7 percent" rule. Deming taught us the wisdom of 60 years of his experience working with organizations that were seeking to improve their performance.

Deming said that 93 percent of the time, problems in the organizations and systems that he dealt with could be traced back to the design of the systems, structures and processes. He said that only 7 percent of the time were the problems caused by people, and in half of those cases where there was a "people problem" the root cause was actually inadequate training or skills.

So, if we already know that most of our problems flow from design flaws in our existing systems and processes, why do we continue to insist on clinging to our ingrained habit of "blaming people" in our accountability processes? It may be too late for the premiers and the health ministers to shift from their traditional political strategy of blaming the federal government, but it is not too late to shift course when it comes to defining the word "accountability," with respect to the relationships between provincial ministries of health and the agencies and institutions that they fund in each province; the relationship between boards and their CEOs; and between the CEO and their managers. Experts like Marilyn Paul, advise us that "a focus on accountability recognizes that everyone may make mistakes or fall short of commitments. Becoming aware

of our own errors or shortfalls, and viewing them as opportunities for learning and growth, enables us to be more successful in the future."

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

Paul says that "accountability creates conditions for ongoing construc-

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tive conversations in which our awareness of current reality is sharpened, and in which we work to seek root causes, understand the system better, and identify new actions." She lists the true qualities of accountability as: "respect, trust, inquiry, moderation, curiosity and mutuality."

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

Are we now ready for such a mindset shift?

The truth is that our health system is still addicted to the mental blinder that Peter Senge calls "the illusion of control." Having an "illusion of control" does not mean we actually have

any real control over the results we are producing. In British Columbia, reducing the number of health authorities from 52 to 6 does not mean that the BC Ministry of Health actually has better "control" over the quality and effectiveness of health care delivery in that province.

Across the country, public servants — few of whom have any practical operating experience in complex service delivery organizations — are being assigned the task of drafting or redrafting "performance agreements" that in many cases seek to "micromanage" and "control" health care agencies and institutions in a belief that a centralized approach will make health care provider organizations "more accountable."

Our intentionally provocative question is this: Are we doomed to continue to repeat the mistakes of the past, or are we ready to fundamentally rethink how accountability is actually designed into our systems and processes? Are provincial politicians and their public servants prepared to give up the "illusion of control"; and are local Boards and CEOs ready to accept their accountability for achieving measurable and agreed-upon high-level outcomes?

From the available research, and from our own reflections and experience, we suggest six key principles that we think should be embedded in a new accountability system.

You can't be accountable for anything over which you have no control. A best-practice accountability agreement must be a "fair business bargain." It is a personal promise to achieve measurable results. But a person can't keep their promise if circumstances beyond their control change. That makes sense, doesn't it? If a CEO is being held accountable for improving staff/physician morale, and their provincial government is engaged in highly emotional disputes with unions and physician organiza-



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Just another day at the office — doctors and nurses, the front-line workers of Canada's health care system, in action at a Montreal ER.

tions, how can the CEO be held accountable for the results that such an atmosphere will produce?

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

If a manager is being held accountable for an outcome that can only be achieved if a certain barrier is removed — like the lack of a skills development program, or the lack of

equipment or technology — and nobody removes the barrier, why should they be expected to be accountable? How can they possibly deliver on their promise if they are not given the support they require to succeed?

Best practice accountability agreements list the "supports required" to achieve the outcomes for which a person is willingly accountable. If they don't get the support they need, they can't be held accountable. It's that simple. That's where this concept of mutual accountabilities comes into play.

At the operating level, a manager with an accountability agreement

must be able to hold his or her boss accountable for providing the supports they mutually agree are required to successfully achieve their outcomes.

An accountability agreement is therefore a tool for people to mobilize the support they need to make them successful. It's a manager's best friend, not their worst enemy! Between the provincial governments and the agencies and institutions they fund, there also needs to be an explicit and "fair business bargain."

Accountability for outcomes means that activities/efforts and processes

are not enough. Think of the mindset shift required here. Our health care system is characterized by a complex set of rigid bureaucratic processes designed in separate silos holding different assumptions. Unfortunately, bureaucratic processes create jobs with turf boundaries to protect at the operating level of the system and between the public servants and the organizations that receive funding.

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

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

Not only must everyone under-

stand what is expected of them and why, they must also have the necessary resources, conditions and skills to achieve the outcomes for which they are being held accountable. Is

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that not a reasonable and “fair business bargain?” In a best practice accountability process, no one is given points for “following the process.” The only thing that counts is getting the results.

If the process design does not produce the results required, we need to change the process. Better yet, we need to design processes that are focused on achieving the results that are required — right from the start! So let’s start now, by honestly reflecting on the unintended consequences of the way we currently define and practise accountability in the health care system — and in the public sector generally.

We urge public servants who are currently designing “performance agreements” or “business planning process” for the health agencies and institutions that receive public funding to re-examine some of the core assumptions behind the design of such agreements. Is the accountability process really designed to achieve the outcomes that we all want to achieve, or are the processes designed to exert “control” by the public service, and to ensure that blame can be placed elsewhere?

There is another wicked question: Is there a danger that such “agreements” become the CEO’s real boss, rendering the board to play the role of observer and interim monitor? The fundamental policy question is this: Is there really a system for independent community governance, or, is the public service in our provincial capitals in charge — and therefore

accountable — for the outcomes or results achieved at the service delivery level of the system?

At the operating level of our health care system, we need to ask our-

selves: what are we in management and governance going to do to provide the practical supports required to make our people successful?

The leadership of the Canadian health care system has argued very publicly over the past ten years that our sector’s root problem was “a lack of funds.” Now that we have an additional \$49 billion in federal funding, will we achieve better outcomes through a redesigned system, or, will we sink the new money into the exact same system and start another campaign to complain that we still don’t have enough money?

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

Accountability for results requires real empowerment and room for personal discretion and judgment. This principle would require another paradigm shift for the health sector: the principle is about the reality of balancing empowerment and accountability. Not the empty rhetoric that has contributed to the growing cynicism of our front-line health care providers, but real empowerment. While the health care sector is clearly part of the knowledge economy, many of us continue to live with industrial-age assumptions about the “need for command and control.”

The assumption in other modern knowledge-based industries that rely on skilled professionals is that the

Six Principles for Accountability Design

1. You can’t be accountable for anything over which you have no control.
2. “Accountability for outcomes” means that activities/efforts/processes are not enough.
3. Accountability for results requires real empowerment and room for personal discretion and judgment.
4. Accountability must be dynamic: outcomes and targets change as circumstances change.
5. Accountability and stewardship for the organization belongs to every employee.
6. Accountability is meaningless without fair and appropriate consequences.

solutions to their most complex and perplexing problems are within the hearts and minds of the people who work in the system.

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

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

Accountability must be dynamic: outcomes and targets change as circumstances change. While most people would agree that this seems perfectly reasonable, the existing rigid bureaucratic culture of health care — from the premiers on down to the front-line nurse — is about inflexibility. In the existing system, we are given every incentive to focus on the process, rather than the outcomes.

Deming told us: “first, drive out fear.” Yet fear and anxiety are the dominant emotions that are driving our health care system today. Best practice accountability agreements are flexible. When circumstances change, accountabilities change. The focus is on what needs to be done to ensure that a person is successful.

Accountability and stewardship for the organization belongs to every employee. Management guru Tom Peters has said that health care systems, structures and processes are the most complex organizational designs ever conceived by humans. But most of our core design assumptions are

rooted in the old industrial model. Systems thinking, chaos theory and quantum physics have all contributed greatly to our emerging understanding of the health care sector as a complex adaptive system.

Each part of the system impacts on the performance of the other parts of the system. We know that. When there are insufficient home care services within a community, elderly people get trapped in acute care beds, and then we get back-ups in our emergency departments.

When that happens, the resulting headlines seem to compel many of our politicians to invest even more money in emergency services, rather than on

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the root cause of the key system design problem: an underinvestment in community care. Despite the fact that all parts of the health care system are interconnected, we've organized ourselves into rigid silos and departments that we attempt to “manage” through traditional bureaucrat control mechanisms, where we solve issues within each silo, often without any apparent concern about its impact on the other parts of the system.

The recent SARS crisis certainly demonstrated the truth about the extent to which system fragmentation contributes to system dysfunction.

Best practice accountability processes include integrating the agreements cross-functionally — across the organization and across the system. That way people truly understand how their actions impact on others and why we need to ensure that we are working

synergistically together within our organizations and with all parts of the system.

Accountability is meaningless without fair and appropriate consequences. For all the fear and anxiety that our existing hierarchical, command-and-control accountability processes produce in people, the truth is that there really isn't much of a focus on the consequences — but just the “threat” that maybe something bad could happen.

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

In a best practice accountability development process, managers throughout an organization think through the outcomes in their organization's balanced scorecard that they should be accountable for; the supports they need to be successful; and what the consequences will be on their organization, their unit and themselves if they fail — or if they surpass the targets agreed to.

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

At the top of our health care system hierarchy, there is very little understanding of the “lessons” we have already learned over the past 10 years of downsizing, mergers, restructuring and reengineering — the lifespan of ministers of health, and their deputies is about 18 to 24 months in many provinces. So there is little or no historical memory.

Today, at the system delivery level, we have confused board members — uncertain what their role is or how they are supposed to hold their CEO and chief-of-staff accountable for the outcomes/results that the board wants to achieve on behalf of their community and in the broader public interest.

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If our health care system is to improve, managers need to have some clarity on what is expected from the system funders and from their direct boss: their board. At the managerial level, we often have blame-avoidance behaviour in a constantly changing, chaotic environment paradoxically charged with copious amounts of absolute certainty and complete ambiguity. Is it any wonder that all this is a bit "crazy-making"?

At the front-line of the health care delivery system we have created working conditions that are, by any measure, intolerable — and yet we must continue to coax our front-line people for every ounce of compassion, care, commitment and love that they have left. We need to think about how we are going to finally start providing some "care" to our care-givers. This is our real burning platform: the collapsing quality-of-work life of our front-line workers.

Clearly we cannot stay on this burning platform any longer, which means that status quo on accountability cannot survive if we intend to be successful.

So how are we going to change the way in which we define and practise "accountability?"

Here are our suggestions:

First, ministers of health need to reflect upon how we currently practice accountability and acknowledge that their officials are in no position to

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"assume control" by holding senior managers of health care organizations accountable to them.

It would make much more sense to develop high level outcomes for each sector — hospitals, home care services, public health departments, etc — and hold the governing boards accountable.

Second, governing boards need to think deeply about the needs of their communities — and the broader public interest — and work in partnership with their CEOs and their senior managers on the vision for the organization within their local system and the outcomes they are seeking to achieve within their local health care delivery system.

Boards need to understand how they can hold their CEO and chief-of-staff accountable for agreed-upon outcomes — with policy governance monitoring processes that enable them to add value.

Third, CEOs and their senior management teams need to spend at least a year with their middle managers and supervisors getting aligned on their strategy. From our experience of leading and facilitating several balanced scorecard strategy development processes in Ontario, British Columbia and the United States, we recommend this best practice approach to getting an organization aligned and focused on their strategy.

Fourth, senior management teams and their CEOs also need to think about how they currently define and practise "accountability" in their organizations.

Health care managers need to learn how to tap into the collective intelligence of their organization so that they benefit from the knowledge and commitment of front-line workers.

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

We all need to keep in mind the burning platform we are on. Let's ask ourselves: if we absorb another \$27 billion in federal funding over the next few years, will the new money put the fire out or make it hotter? We believe that it will be hotter if we don't redefine "accountability" and design ourselves to be successful.

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