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# Understanding and Implementing Best Practices in Accountability

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Comparative Health Reform Analysis

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**Abstract**

There has been much emphasis on accountability in health care in all jurisdictions across Canada. Using document analysis and key informant interviews, we assessed the extent to which the findings from our earlier Ontario-based study, *Approaches to Accountability*, applied across Canada. Accountability done well improves performance, improves the patient experience and promotes efficient use of resources. If implemented poorly, it can waste valuable resources, create perverse incentives and encourage gaming in the system. The findings of this study reinforced the earlier findings. Our respondents stressed that it was important to focus on the goals being sought and transition points in the system; they emphasized that resources and stable leadership were key. Although good metrics are essential, they are not always available. Accordingly, what is easily measured tends to be what is reported. Organizations are also reluctant to be held accountable for what they cannot control. They noted that too many organizations are asking for too many indicators in too many forms. Although this is particularly problematic for small organizations, it is not exclusive to them.

Moving forward, it will be important to streamline and prioritize reporting metrics, ensure adequate resources are available to support accountability and educate users as to the value of reporting accountability activities, by showing them that there is something in it for them. In addition, it is important to encourage coordination and sharing among the multiple bodies that request similar information in different forms. Finally, it is important to ensure that that which is difficult to measure is not lost in the shuffle.

*L'on a beaucoup insisté sur la responsabilité dans les soins de santé dans toutes les provinces et territoires du Canada. Par le biais de l'utilisation de l'analyse documentaire et des entretiens avec des informateurs clés, nous avons évalué la mesure dans laquelle les résultats de notre étude antérieure basée en Ontario,* Approches à la responsabilité*, s'appliquaient à travers le Canada. Mise en œuvre de la bonne façon, la responsabilisation peut améliorer la performance, améliorer l'expérience des patients et favoriser une utilisation plus efficace des ressources. Si elle est mal appliquée, elle peut gaspiller des ressources précieuses, créer des effets pervers et encourager le contournement du système. Les résultats de cette étude ont renforcé les conclusions antérieures. Nos répondants ont souligné qu'il était important de se concentrer sur les objectifs recherchés et les points de transition dans le système; ils ont souligné que les ressources et un leadership stable ont été la clé. Bien que les bonnes mesures soient indispensables, elles ne sont pas toujours disponibles; en conséquence, ce qui est facile à mesurer a tendance à être ce qui est rapporté. Les organisations sont également réticents à être tenus responsables pour ce qu'ils ne peuvent pas contrôler. Ils ont noté que trop d'organisations demandent trop d'indicateurs de formes trop nombreuses. Bien que*

*cette situation soit particulièrement problématique pour les petits organisations, le problème ne les affecte pas exclusivement.*

*À l'avenir, il sera important de rationaliser et prioriser les mesures à la base des rapports, d'assurer que les ressources suffisantes soient disponibles pour appuyer la redevabilité et d'éduquer les utilisateurs quant à la valeur des rapports sur les activités de reddition de comptes, en leur montrant qu'ils y trouveront leur compte. En outre, il est important d'encourager la coordination et le partage entre les multiples organisations qui demandent des informations similaires sous différentes formes. Enfin, il est important de veiller à ne pas perdre de vue ce qui difficilement mesurable.*

**Key Messages**

- To analyze accountability, one must consider who is accountable for what, to whom, and how (including penalties or rewards); different approaches may be appropriate under different circumstances.
- The findings of this Pan-Canadian study reinforce the findings of our earlier Ontario-based studies; in particular, organizations are reluctant to be held accountable for what they cannot control and they tend to focus on what is easy to measure.
- Although there is considerable variability across the country, our respondents suggested that there are frequently problems with duplication (with too many organizations asking for too many indicators in too many different forms) of requests for information, in using bad data, and "silly reporting for the appearance of accountability". This is particularly true for small organizations but was also frustrating for large organizations.

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**Messages-clé**

- *Pour analyser la responsabilité, il faut déterminer qui est responsable de quoi, envers qui et comment (y compris en tenant compte de pénalités ou de récompenses) ; différentes approches peuvent être utilisées de manières appropriées dans des circonstances différentes.*

- *Les résultats de cette étude pancanadienne renforcent les résultats de nos études antérieures réalisées en Ontario; en particulier, les organisations sont réticentes à être tenues responsables de ce qu'elles ne peuvent pas contrôler et ont tendance à se concentrer sur ce qui est facile à mesurer.*
- *Bien qu'il y ait une grande différence à l'échelle du pays, nos répondants ont laissé entendre qu'il y a souvent des problèmes de répétition (trop d'organisations demandant trop d'indicateurs sous de trop nombreuses formes) de demandes d'information, d'utilisation de mauvaises données et de " résultats inappropriés uniquement retenus pour être comptabilisés dans le cadre de la responsabilité ". Ceci est particulièrement vrai pour les petites organisations mais a également été remarqué au sein des grandes organisations et ceci peut être particulièrement frustrant.*

# 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

There has been much emphasis on accountability in health care in Canada and internationally. This is happening across multiple jurisdictions and subsectors across the country, leaving scope for clarifying and learning from best practices.

In an earlier CIHR-funded Partnership for Health System Improvement (PHSI) on Approaches to Accountability (Deber 2014a), a series of sub-studies were conducted, using a variety of research methods, which examined accountability across multiple health care subsectors in Ontario, with particular attention to the impact of governance models (at the provincial, regional or local level) for resource allocation, and service planning and delivery, and their relationship to the performance and accountability of health care professionals and the health care system. The results were published in a special issue of *Healthcare Policy* in 2014 (Baumann *et al.* 2014; Berta, Laporte and Wodchis 2014; Bytautas *et al.* 2014; Deber 2014a, 2014b; Denis 2014; Gamble, Bourne and Deber 2014; Kirsch 2014; Kraetschmer *et al.* 2014; Kromm *et al.* 2014; Mitchell, Nicklin and MacDonald 2014; Mukhi, Barnsley and Deber 2014; Peckham 2014; Schwartz *et al.* 2014; Steele Gray *et al.* 2014a; Wyers, Gamble and Deber 2014; Zelisko *et al.* 2014). Other related studies focused on home and community care (Steele Gray *et al.* 2017; Steele Gray *et al.* 2014b) and public health (Schwartz and Deber 2016).

A Healthcare Renewal Policy Analysis initiative grant from the Canadian Institutes of Health Research (CIHR) built upon these findings, using a systematic review of the literature (including the grey literature) and interviews with key informants to understand: *1*) how accountability was being managed in various subsectors of health care and in multiple jurisdictions across Canada (including all provinces/territories) and *2*) the implications of various approaches to accountability, with particular focus on their strengths and weaknesses (for more detail on the search strategies employed see Appendix A).

The questions that we sought to answer included:

- What activities are underway (and in what subsectors) in Canada?
- Are the findings from our first study of *Approaches to Accountability in Ontario*, applicable in other jurisdictions, primarily provinces and territories in Canada?
- What policy goals were being pursued?
- What approaches to accountability were being used?
- What were the consequences of success and failure, including unintended consequences?
- What were the strengths and weaknesses of the various approaches to accountability?
- Where was accountability seen to be working well?

A main objective of this research was to see if what we had found in the earlier study was applicable across the country. The resounding answer was yes.

A number of key stakeholders were involved in this research. Our initial partner was the

Health Council of Canada. After it was disbanded in 2014, individual members of the Health Council continued to work with us, helping to identify what activities in their jurisdictions we should include in our review, recommending documents (and links to relevant web pages), and suggesting which people we should speak with to ensure that we understood what was/was not working and how this related to identifying best practices. The work was supplemented by key informant interviews with one or more decision makers in many Canadian jurisdictions. As specified in the ethics approval from the University of Toronto, the key informants are not identified by name. Accreditation Canada also worked with us to assist in dissemination, including placing this project on the agenda for several of their national meetings, held by teleconference. Participants in the roundtable discussions found the research to be illuminating, as they were all struggling with the questions that we were tackling. These findings thus represent insights from the document review, key informant interviews, and insights from participants in the roundtables.

## 2 HISTORY AND CONTEXT

Accountability is defined as being answerable to someone for meeting defined objectives (Emanuel and Emanuel 1996). It can be subdivided into accountability by whom, to whom, for what (which relates to the policy goals being pursued), and how. Behn suggests three objectives for accountability: improved performance, fairness, and stewardship (Behn 2001). The "Goals of the Reform" section briefly describes our findings in terms of "for what", "to whom", and "by whom", while the "How the Accountability Reforms were Achieved" section assesses "how" with a focus on the policy instruments used.

## 3 GOALS OF THE REFORM

Defining what is meant by accountability in health care is an ongoing issue. Across Canada and in all jurisdictions, governments and stakeholders are wrestling with how to incorporate best practices in accountability into their health care systems and health care practices.

Policy goals for health care have traditionally included combinations of access, quality (including safety), cost control / cost effectiveness, and customer satisfaction. Often policy goals may clash. For example, assessment of hospital effectiveness may vary depending on whether it is measured in terms of doing more (increasing the number of admissions / market share / occupancy rate), financial performance (net profit / cash flow), meeting the needs of the community (satisfaction of patients, providers), and/or delivering high quality of care (better outcomes). Ideally, there should be congruence between the policy goals being pursued and what the organizations are being held accountable for. Our respondents suggested that this is not always the case.

### 3.1 Accountability for what

Provincial governments, in their role as funders of the major proportion of health care, have placed a heavy emphasis on cost control in their implementation of accountability. Other major goals of accountability include quality improvement and patient safety, at the level of the individual hospital or provider, and sometimes it is linked to accreditation. Accountability is becoming increasingly linked to patient and public engagement. We found that different provinces and even different jurisdictions within provinces place varying emphasis on accountability. Given changes in governments and government priorities, this emphasis is highly subject to change over time. Accordingly, our findings may not necessarily describe current activities in all provinces/territories. However, our respondents suggested that the key messages were generally applicable.

### 3.2 Accountability by whom

Although some of the literature on accountability in government relates to delegation or sharing of power and the resultant requirement to answer back for the use of that delegation, this model does not apply well to health care in Canada. Canada uses what the Organisation for Economic Co-operation and Development (OECD) refers to as a public contract model, in which care is delivered by private (albeit often not-for-profit) organizations that receive public money to provide insured services to insured persons (Docteur and Oxley 2003). As noted below, the resulting accountability arrangements thus depend upon the goals (for what) and the parties to whom the organizations/providers are accountable.

### 3.3 Accountability to whom

In terms of "to whom", all provinces incorporate responsibility for reporting to the provincial government (as payer) on how their money is spent. However, a number of different approaches were used to assess accountability for quality of care.

One striking element was the use of independent arm's length bodies (often linked to quality assurance) in some provinces to assess and report on performance. Such bodies were set up in Alberta, New Brunswick, Ontario, Québec, and Saskatchewan. British Columbia and Manitoba have a patient safety body with a mandate for patient safety and quality improvement in the province. Some provinces have set up bodies for accountability within their regional health authorities; these include British Columbia and Prince Edward Island. Nova Scotia had not yet set up formal bodies, although this has been discussed. In addition, mechanisms were in place for reporting to Accreditation Canada. Members of particular professions are accountable to their provincial regulatory bodies for meeting standards of professional practice; these were not included in this study, although the earlier sub-studies had analyzed the regulatory bodies for medicine and nursing (Baumann *et al.* 2014).

One consequence of this de-centralized model is that there is variability across jurisdictions in who sets the targets that are going to be measured and reported. For example, in

Ontario, hospitals set their own target measures but they must send the reported measures to Health Quality Ontario for review and evaluation. New Brunswick had developed a joint collaboration between the New Brunswick Health Council and the province's regional health authorities (RHAs) to develop, standardize and report on quality improvement. As noted below, Québec had placed a heavy emphasis on public reporting and citizen engagement.

# 4 HOW WERE ACCOUNTABILITY REFORMS ACHIEVED?

## 4.1 Policy instruments

This study used the analytical framework developed by Deber *et al.* (Deber 2014a) to analyze the strengths and weaknesses of the various approaches to accountability. The potential approaches we identified employed four major policy instruments which were variations on three of the governing instruments identified by Doern and Phidd (1992). "Exhortation" involves the least amount of coercion; the two approaches falling into this category were information directed towards patients/payers, often in the form of public reporting, and reliance on professionalism/stewardship. "Expenditures" often took the form of financial incentives. Examples of "regulation" (in the form of laws and/or regulations) are also described. Our study hypothesized that these different approaches to accountability would have differing success when applied in organizations, be it government, hospitals, regional bodies and community settings, depending on the policy goals being pursued; the governance/ownership structures and relationships in place; and the types of goods and services being delivered. The main tools we found being used in the Canadian provinces examined were public reporting, financial incentives and penalties, and legislation/regulations.

### 4.1.1 Policy instrument: public reporting

Public reporting is becoming increasingly important across jurisdictions in hopes that this will allow for flexibility and transparency while encouraging improvement and benchmarking. At the national level, several organizations are involved, including the Canadian Institute for Health Information (CIHI) and Accreditation Canada. The former Health Council of Canada also produced a number of reviews on indicators and accountability.

Public reporting was explicitly incorporated into the accountability frameworks reviewed for Saskatchewan, Ontario, Québec, New Brunswick, Prince Edward Island, and Newfoundland and Labrador. For example, New Brunswick's health plan included accountability into its goals and emphasized the need to start with the needs of the population, while recognizing that such needs may differ from other jurisdictions due to the province's relatively slow population growth coupled with a high proportion of elderly and a high proportion of the population with chronic diseases (New Brunswick 2013). At the time of the key informant

interviews, Québec also placed heavy emphasis on public reporting, requiring annual reporting to the Legislative Assembly by the Minister of Health and Social Services, involvement of citizens in the accountability process, and reporting of information on websites.

### 4.1.2 Policy instrument: financial incentives and penalties

Accountability is often tied to money. Depending on the model, different rewards and penalties may be attached to performance. Approaches include service agreements whereby providers are paid based on the number of procedures that they perform (which would also require them to report on what they have done), and requiring balanced budgets.

One issue noted by our respondents concerns the type of consequences attached to a failure to meet targets, and whether there should be penalties associated with this. One respondent suggested "if you have the authority to make it happen, you should get less because you didn't do it. If what you are being held accountable for is beyond your control, you are only going to cripple the system by taking money away from an organization that didn't have the authority to make it happen." In some cases, organizations argued that they did not meet targets because of a lack of resources; accepting this argument might justify rewarding failure by increasing budgets. Clearly, the potential for unintended consequences and perverse incentives is high. Accordingly, most of the jurisdictions we examined are moving towards metrics/indicators but were not attaching rewards/penalties to meeting these targets. British Columbia did experiment with pay for performance with some success, but we were told that this evoked anger among participants and was more complicated than first thought.

As one respondent noted, "there's a realization that we weren't able to buy change just by putting money into the system."

### 4.1.3 Policy instrument: legislation/regulation

Although at present, there has been little effort to entrench accountability measures into legislation, some examples were found. New Brunswick's *Regional Health Authorities Act* specifies roles and responsibilities of certain players, including the department of health and the regional authorities. They also have an accountability structure within the provincial government, in which every government department is required to have a strategy map and a balanced scorecard along with a list of initiatives. They must also report back to the executive council office on their progress. The province of Québec also had legislated a program; Appraising Performance of Québec's Health and Social Services System, led by the Health and Welfare Commissioner. Prince Edward Island has an accountability framework detailed in the provincial *Health Services Act*.

At the time of the key informant interviews, Quebéc was placing great emphasis on accountability. In 2006, it had established an independent Office of the Health and Welfare Commissioner, which had a legislated mandate to report regularly to the National

Assembly. To enhance transparency, the reports were posted on their website (http://www.csbe.gouv.qc.ca/en/home.html). The Commissioner's advisory board included citizens as 50% of the members. The Commissioner was given considerable independence, including deciding what would be reported on each year. The Commissioner submitted his report annually to the Minister of Health and Social Services; the Minister was obliged by law to table the report within one month to the National Assembly. The legislation also stipulated that the Minister of Health and Social Services could make a written request to the Commissioner if there was a topic that the Minister wanted reported on. Subsequently, the province abolished the commission in their March 2016 provincial budget and handed over responsibility to two existing organizations, the Institut national d'excellence en santé et en services sociaux (INESSS) which focuses on technology assessment, and the Institut national de santé publique du Québec (INSPQ) which provides expertise largely focused on public health. This move has been opposed by various bodies, including the Québec Medical Association and provincial nurses' union, which have said that this will make it more difficult to evaluate the performance of the health system in Québec. At the time of writing, the Commissioner's website was still available, but its future is unclear (Laframboise 2016).

Alberta took a centralized approach; responsibility for service delivery in Alberta lies with Alberta Health Services. Heavy emphasis has been placed on improving performance measurement. An independent body, the Health Quality Council of Alberta, was mandated to promote and improve patient safety and health service quality for the province. This model placed a number of policy levers within government control. The *Alberta Health Act* was modified as of 2014 to add provisions for adopting a Health Charter and establishing an Office of the Alberta Health Advocate (Government of Alberta 2010).

British Columbia has left considerable flexibility to individual health authorities. Our respondents felt that the City of Vancouver had been quite successful, but that other jurisdictions in the province had less success in implementing approaches to accountability and had left out smaller hospitals entirely on the grounds that they did not have the resources to complete accountability tasks.

## 4.2 Conditions for successful implementation: intended and unintended consequences

### 4.2.1 What facilitates accountability?

One of our key informants argued that there were at least three conditions he felt were absolutely essential for accountability to exist: *1*) objective metrics of performance, *2*) clearly indicated targets on which both parties (the party being held accountable and the one holding them accountable) can agree, and *3*) the person being held accountable for the organization having the authority to make it happen. In the hospital sector, for example, managers may be responsible for minimizing wait times. However, if the hospital beds are full of Alternate Level of Care (ALC) patients, and the manager does not have the authority

to move patients to a more appropriate setting, it may prove difficult to meet the wait time targets.

Another key need for successful implementation was clarity of roles. As one informant noted: "If you are doing things that others are responsible for, you are not doing them right or doing the right things. There is a document that describes roles and responsibilities and this is important to understand." Another told us: "You cannot be accountable for what you cannot control and measure."

Our respondents stressed the importance of taking a system perspective, rather than trying to manage within a series of silos.

One key informant noted that formal agreements had good intentions but some were more effective than others. Another key respondent noted that in the regional authority in his province that achieved some success, this was because management believed in accountability, money flowed directly to the organization (the hospital in this case), and there was a high degree of transparency with minimal interference from any regional bodies.

### 4.2.2 What are the barriers to accountability?

One point noted by several key informants was that, even if there were formal agreements, it was often difficult for the provincial minister of health to enforce them due to political realities. There was also a tendency for crises to dominate decisions to the extent that "leadership has been overwhelmed with crisis management." This leads to the question, noted above in the example of ALC beds, of whether failure should be rewarded by getting more resources, often without getting to the root cause of the problem.

One theme that emerged over and over again was the importance of good metrics. Measurement presents challenges for accountability. Finding the right measures was not always possible. Respondents confirmed that there was a strong focus on things that are easy to measure and that they had data on. However, as noted by Bevan and Hood (2006), what is measured is not always what matters. One respondent said "So metrics is the number one thing to start off an accountability journey and you have got to applaud that. But getting the right metrics, not metrics that are there because you can measure them. It needs to be really looked at." There was the persistent problem of focusing on what is easily measured and on things that can be controlled. As an example, public health was reluctant to be held accountable for smoking rates in their jurisdiction because they had no control over this. Another persistent problem was the tendency to focus on process and in some cases outputs, rather than outcomes. One respondent noted that a good place to start was to have a clear sense of the outcomes that were sought. "This may sound very simplistic or quite obvious but I'll tell you in the quality improvement area... when people start talking about analyzing scorecards and so on and so forth, we tend to spend a whole lot of time looking at outputs, volumes, and so on... not that much as really clarifying the required outcome." As another one of our key informants noted: "Access is a feature of accountability but not patient safety and effectiveness."

Many respondents noted the challenges faced by smaller organizations in reporting accountability performance indicators. Small organizations, including hospitals, did not have the resources to report as do larger hospitals. In one jurisdiction, the small hospitals were left out of the accountability exercise entirely.

All respondents noted the requirement to report slightly different metrics to multiple bodies, in slightly different forms. This again proved to be a challenge for smaller organizations, but larger organizations found this to be a problem as well. It was suggested that the entire field of measurement and evaluation needs a lot of work to avoid perverse incentives and gaming.

Perverse incentives were a problem identified by many respondents. One example pointed to was a hospital that was trying to reduce the number of admissions in their emergency department by using GEM (geriatric emergency management) nurses to help to place patients over age 75 who did not have acute problems in alternate care locations. However, in keeping such patients waiting in the emergency room while the GEM nurse tries to find a more appropriate place for them to be managed, the emergency room wait time metric "goes way up" because these patients were not being admitted to the hospital. In turn, this created pressure to admit them in order to meet those accountability targets, even if that was not the most appropriate way of caring for them. This then made it harder to reduce excess capacity by reducing the number of hospital beds. Our informants noted that such issues could be dealt with—a number of experiments were under way to break down silos, and work with community agencies to treat complex patients (e.g., Ontario's Health Links), but it was essential to ensure that the accountability and funding models encouraged that.

Clear, committed and stable leadership was identified as a key to enabling accountability. It became clear in our investigations that accountability is adversely affected by changes in leadership. As one key informant observed, "imagine trying to bring improvements like these in private corporations if you are rotating the CEO role every two years", adding that such rotation is a natural occurrence with deputy ministers and even with the CEOs of regional authorities.

Transparency is critical to accountability. Lack of transparency led to organizations picking and choosing what they wanted to measure. One consequence of the lack of transparency is that it encourages gaming the system, which decreases the likelihood that improvements will be encouraged. Indeed, some managers felt that if they waited long enough, the emphasis on performance measurement would just go away.

Another challenge that was identified by many respondents was the duplication in reporting of metrics. One respondent noted that "there is a huge amount of waste in duplicated reporting analytics, using bad data, silly reporting for the appearance of accountability, as opposed to measurement for the purpose of improvement."

A common observation was that there were many silos, which it is difficult to coordinate across. This was seen as a major issue. It was noted by one key informant that discussions tended to be focused on silos, rather than on systems of care. "People are so focused on

their own little islands and not on the bigger picture and how all the little elements feed into the bigger picture". A particular area of concern was the interface between hospital and home/community. One respondent noted "[c]ertainly nobody seems to be accountable for what I will describe as care pathways, following the care from end to end of a patient's journey. There are accountable pieces." One respondent noted, "we have got to stop calling it a system until it starts behaving like one."

# 5 EVALUATION

After reviewing all the literature, including grey literature, completing our key informant interviews and reviewing the data, the following themes emerged:

- When accountability is done well, the goal is often to improve performance, improve the patient experience and ensure efficient use of resources. However, when it is implemented poorly, it cannot only be a waste of valuable resources, but also can create perverse incentives and produce gaming in the system.
- It is important to recognize that there are multiple goals of a well-functioning health care system. Those frequently mentioned by our key informants were quality improvement, cost control, cutting waste in the system, focusing on care at transition points in the system and improving care at these points ("breaking down the silos"). These policy goals may clash. In addition, our respondents stressed that you cannot be accountable for what you do not control.
- For accountability to be effective, you need good metrics, you need targets and you need someone with the authority to make it happen. However, what is easy to measure tends to be what is reported, and this is not always what matters. Our study found that there is duplication in reporting to multiple bodies, using bad data, and what some called "silly reporting for the appearance of accountability." Our respondents suggested that the whole field of measurement and evaluation needs a lot of work to avoid perverse incentives, avoid neglect of key outcomes, and to avoid gaming.
- Moving from single organizations to larger organizations (e.g., merged structures serving a larger region) can affect accountability approaches. On the one hand, it may undermine responsiveness to local communities. On the other, it is harder for smaller organizations to find the resources needed to gather data.
- Timeliness can also be a problem. Acting on information is more difficult if there are long lapses in time between the collection of the data and reporting to the body one is accountable to.
- Public reporting *per se* does not seem to cause much change in behaviour. However, public reporting and transparency are seen as valuable.
- Leadership is seen as key. Rotating leadership is a barrier to accountability.
- The findings of this study reinforce the findings of our earlier study that organizations are reluctant to be held accountable for what they cannot control. Duplication is a

problem with too many organizations asking for too many indicators in too many different forms. This is particularly true for small organizations but equally frustrating for large organizations. Resources are required to achieve accountability and stable leadership is vital to the success of accountability.

### 5.1 Moving forward: what can be done

The study suggested a number of things that could help improve accountability:

- Streamline and prioritize reporting of metrics: One theme that emerged over and over was the requirement to report to multiple bodies, with slightly different information. One of our key informants referred to this as "metric and indicator chaos." Another suggested "that the field of measurement and evaluation needs a lot of work to avoid the perverse incentives and gaming." Other key informants stated that "this is a huge problem, and something that our academic community should be much more focused on" and "we should be trying to develop harmonized approaches to measurement and evaluation with some better metrics that are not perverse."
- Examine resources required for accountability and ensure they are adequate by adjusting requirements and/or resources available. Encourage coordination so that multiple bodies do not request similar information in different forms.
- Educate users to see the value of reporting, to see that there is something in it for them. Our key informants stated that accountability was much more effective, with much less gaming if those involved saw that they would ultimately gain from the exercise.
- Move towards accountability in care pathways rather than just in silos.
- Ensure that important outcomes that may not be easy to measure are not lost in the shuffle.

## 6 CONCLUSION

Accountability in the health care system is seen as important across all jurisdictions in Canada. Although we found that those involved in attempting to bring more accountability to the health care system in Canada appear to be doing an admirable job within the constraints placed upon them, attention to the findings of this review may help ensure that approaches to accountability make things better, rather than lead to perverse consequences.

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# A NOTES ON SEARCH STRATEGIES EMPLOYED IN THE LITERATURE REVIEW

The literature review was conducted by performing searches using the following three queries: "accountability, health"; "accountability, health, Canada"; and "accountability, health, [Province name]" for all provinces using Google Scholar, PubMed, Ovid®, CINAHL®, and Web of Science™. A research associate screened titles and abstracts for inclusion and exported relevant articles into EndNote. References citing and cited by each of the key articles were also examined (i.e., "snowballing") to locate potentially relevant articles beyond the database search. The PI also reviewed all captured articles to further assess relevance to the research questions.

To locate key provincial documents, we also conducted a series of Google searches using the terms "Accountability" + "health" + "[Province name]". The table below shows the results of this search. The search yields two messages—the approximate number of hits (displayed in the "about # results" column), and the "most relevant results" (as reported by Google with the preamble "In order to show you the most relevant results, we have omitted some entries very similar to the NUMBER already displayed.") Although initially we did not record this value, we subsequently did. (For the provinces where we did not initially do this, we conducted a new search on 15 April 2015 and recorded the value produced; those are indicated by an * in Table 1.)

Table 1: Approximate number of hits by date and province

| Province | Date | about # results | # "most relevant" |
|---|---|---|---|
| Alberta | 2014-Sept-18 | 2,320,000 | 208 |
| BC | 2014-Sept-19 | 1,940,000 | 250 |
| Manitoba | 2014-Sept-15 | 447,000 | 179 |
| New Brunswick | 2014-Aug-29 | 477,000 | 265* |
| Newfoundland | 2014-Nov-26 | 7,590,000 | 240 |
| Nova Scotia | 2014-Aug-28 | 435,000 | 121* |
| Ontario | 2015-Apr-15 | 13,300,000* | 314* |
| PEI | 2014-Aug-28 | 408,000 | 192 |
| Quebec | 2015-Apr-15 | 17,300,000* | 446* |
| Saskatchewan | 2014-Sept-29 | 556,000 | 253 |

Note that there was considerable variation over time in the number of hits, even when the searches were done in close proximity. By way of example, a search of "accountability health New Brunswick" on 25 June 2015 yielded about 628,000 results. The same search on August 28th yielded about 636,000 results, and on August 29th yielded about 477,000. However, the vast majority of hits were not germane to the project, covering a variety of topics, including help wanted advertisements, accountability for election costing, etc. We

accordingly were selective in which material was reviewed. We used a mixed methods approach, combining the key results from this search, information from government websites, and material recommended by our key informants (who were extremely helpful).

In total, as of 4 May 2015, we had identified 1,701 references with the keyword project-accountability. Of these, upon further examination, 42 were explicitly coded as not germane to the study (e.g., dealt with the ethical framework "accountability for reasonableness", dealt with clinical matters, etc.)