A Qualitative Study of Ontario Cancer System Leaders’ Views on the “Promises of Accountability”

by

Jessica Peace Bytautas

A thesis submitted in conformity with the requirements for the degree of Master of Science
Institute of Health Policy, Management and Evaluation
Dalla Lana School of Public Health
University of Toronto

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Abstract

How Governments compel compliance is a central issue of public policy. The move towards contracting specialized services to agencies is characteristic of a movement that emphasizes a certain set of tools intended to enhance accountability. Critics identify a lack of clarity regarding what accountability is and how it works within and across contexts. Using Dubnick’s “promises of accountability” framework, this study aimed to understand how healthcare leaders’ in Government and a specialized agency make sense of accountability in the context of Ontario’s cancer services system. This study was designed using qualitative description and incorporated key informant interviews, document review of historically relevant texts, and informal observation of advisory council meetings. Findings highlight the need to apply both instrumental and intrinsic tools to foster meaningful inter-personal and inter-organizational relationships. Additionally, while instrumental tools seem to operate sequentially, there is less of a distinction between intrinsic tools.
Acknowledgments

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List of Abbreviations

CCO – Cancer Care Ontario
CPIA – Cancer Program Integration Agreement
CQCO – Cancer Quality Council of Ontario
CSIC – Cancer Services Implementation Committee
CSQI – Cancer Services Quality Index
ID CODES
  #.CCO-AC-CC – Cancer Care Ontario, Advisory Council, Clinical Council
  #.CCO-AC-CQCO – Cancer Care Ontario, Advisory Council, Cancer Quality Council of Ontario
  #.CCO-AC-PLC – Cancer Care Ontario, Advisory Council, Provincial Leadership Council
  #.CCO-BD/ET – Cancer Care Ontario, Board of Directors or Executive Team
  #.MOHLTC – Ministry of Health and Long-Term Care
LHIN – Local Health Integration Network
MOHLTC – Ministry of Health and Long-Term Care, Ontario
MOU – Memorandum of Understanding
NPM – New Public Management
OCP – Ontario Cancer Plan
OCTRF – Ontario Cancer Treatment and Research Foundation
PLC – Provincial Leadership Council
RCP – Regional Cancer Program
RVP – Regional Vice President
Chapter 1. Introduction

1.1 Background

How Governments compel compliance and exert authority is a central issue of public policy generally, and of accountability specifically (Considine 2002). A growing body of public sector theory identifies a shift of responsibility for the direct delivery of services from Government to specialized agencies, alongside a number of contracting, monitoring and reporting functions (Milward 2000). This move toward contracting out services to specialized agencies is characteristic of a public sector paradigm that began to take shape in the 1980s – namely, the New Public Management (NPM) – that involves less “government” and more “governance” (Rhodes 1996). The NPM Paradigm places heavy emphasis on elaborate structures of procedural rules and performance monitoring intended to enhance accountability between Government and agencies and, ultimately, the public (Hood 1995).

Since the “era of accountability and assessment” began in healthcare nearly three decades ago (Relman 1988), “accountability” has reached near mythic proportions.\(^1\) One would be hard pressed to find a health policy

\(^1\) It has been argued that the modern understanding of accountability dates back as far as William I’s Domesday Book and is therefore a uniquely Anglo Saxon concept, making faithful translations of the term challenging if not impossible (Dubnick, MJ. 2002. "Seeking salvation for accountability." in Annual Meeting of the American Policy Science Association. Boston, MA.). However, 20\(^{th}\) century accountability in healthcare arguably finds its roots in Codman’s “end result system”, where systematic data collection served an audit function to evaluate, compare and establish benchmarks for hospital performance (Codman, EA. 1934. "An autobiographical preface." in The Shoulder: Rupture of the Supraspinatus...
document or media release from the past decade or so that did not reference accountability in one way or another. However, despite volumes of policy documents and scholarly publications citing the term, critical observers highlight a lack of clarity and consistency surrounding the concept of accountability and its operationalization.

Accountability has been called a number of names – some more or less friendly than others – from “promiscuous” (Dubnick and Yang 2011), “chameleon-like” (Sinclair 1995) and “a dull buzzword” (Gray 1991), to “symbolic” (Etzioni 1975), “magic” (Pollitt and Hupe 2011) and “delightfully paradoxical” (Jacobs 2004). Scholars have noted the way in which accountability has been used as a catchall term, referring to it as an “umbrella concept” (Wiener 2000) and “a suitcase word” in healthcare (Brown, Porcellato and Barnsley 2006), which is “widely used and often inappropriately applied” (Johnson 1977).

On one hand, accountability can be understood to boil down to a simple premise: who is accountable and to whom, for what, and how (Brown, Porcellato and Barnsley 2006). Yet, the literature on accountability in the context of healthcare management points to a multiplicity of ways of thinking about accountability. These definitions contain ideas related to answerability (Brinkerhoff 2004), reward and punishment (Tuohy 2003), responsibility (Emanuel 1996), and trust (O’Neill 2002). Depending on the type of accountability to be achieved – financial, managerial, political/democratic, or

_Tendon and Other Lesions in or about the Subacromial Bursa. Boston, MA: Thomas Todd Company._). Codman’s approach would later be advanced and codified by Donabedian into the now seminal _structure, process and outcome_ framework of quality assessment (Donabedian, A. 1990. "The end results of health care: Ernest Codman’s contribution to quality assessment and beyond." _The Milbank Quarterly_ 67(2):1989.)
professional (Fooks and Maslove 2004) – a variety of mechanisms may be applied in its pursuit. Deber categorizes accountability mechanisms as regulations, financial incentives, information, and professionalism and stewardship (Deber 2014). In addition to pointing out the lack of consistency in defining accountability and its mechanisms, critics contend that the relationship between the application of mechanisms and achieving the goals of accountability is not well understood, and that some mechanisms and/or goals may in fact be in tension with one another (Bovens 2007; Halachmi 2002).

In a recent review of the “magic” concept of accountability in the public management literature, Pollitt and Hupe conclude that, despite its widespread use, there appears to be no consensus on the concept itself or how it is supposed to work (Pollitt and Hupe 2011). Thus, there is a need for more theoretical and empirical research (Dubnick and Frederickson 2011). A vague understanding of accountability – or any other value-laden term, for that matter – allows stakeholders to talk at cross-purposes about different issues without realizing it; it may well be the case that there are a diversity of ways in which accountability is conceptualized and operationalized, but it is important to make these differences explicit in order to better understand the ways these different values fit together (Charles, Lomas and Giacomini 1997; Giacomini et al. 2004).

1.2 "Promises of accountability" framework

Developed principally by Melvin Dubnick, the “promises of accountability” framework aims to capture comprehensively the different ways in which policy makers and managers envision the goals and mechanisms of accountability (Table 1). Dubnick has published on the topic from a public policy
perspective for several decades and is a vocal, self-identified critic of simplistic approaches to the study of accountability. His “promises of accountability” framework offers an attractive framework for study because of its fidelity to the complexity of and uncertainty surrounding the conceptualization and operationalization of accountability. It is worth highlighting the fact that the framework is an evolving tool, as it is presented in slightly different ways in each of its three published iterations to date (Dubnick and Frederickson 2009; Dubnick and Frederickson 2011; Dubnick and Yang 2011).

On the first axis, Dubnick emphasizes the 'stage' at which different functions of an organized activity occur. This simple systems model highlights the input, process and output structure most famously applied by Donabedian in his work on quality assessment (Donabedian 1988). Inputs address the acquisition, maintenance and disposition of resources, processes ensure the appropriate actions are being applied, and outputs refer to expected outcomes.

On the second axis Dubnick emphasizes 'value'. In the three versions of the framework published to date, the characterization of this axis varies. In the first version accountability itself is valued as either means (mechanisms) or ends (virtues) (Dubnick and Frederickson 2009). In the second version accountability mechanisms are valued either instrumentally or intrinsically (Dubnick and Frederickson 2011; Dubnick and Yang 2011).2

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2 In 2012, I had the opportunity to speak with Mel Dubnick by telephone. During this conversation, Dubnick alerted me to a paper he was preparing for an upcoming conference, which presented a very different version of this framework (conference paper accessible at: http://mjdubnick.dubnick.net/papersrw/2012/DubnickVU2012.html). The paper was later published as a chapter in The Oxford Handbook of Public Accountability (2012). As data collection was well underway by the time the latest iteration was published, this thesis was constructed according to the first three published versions of the framework. However, I will return to Dubnick’s new version in the discussion.
Frederickson 2011). Finally, in the third version accountability “solutions” are valued either instrumentally or intrinsically (Dubnick and Yang 2011). For this study, an adapted version is presented that combines all three iterations (Table 1).

At the intersection of ‘stage’ and ‘value’, Dubnick’s “promises of accountability” emerge: control, appropriate behaviour, performance, integrity, legitimacy, and justice or fairness. The promises of accountability represent the belief that it is possible to achieve certain goals sought from the governance process, but exactly which mechanisms ought to be applied in a particular context remains an open question. As Dubnick explains: “These promises of accountability help determine the design of organizations and strategies of implementing policies and programs, and they energize reorganization and reform efforts” (Dubnick and Frederickson 2011).
Table 1. “Promises of accountability” framework adapted from Dubnick and Frederickson (2009, 2011) and Dubnick and Yang (2011)

<table>
<thead>
<tr>
<th>Stage of Accountability</th>
<th>Accountability valued...</th>
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<tr>
<td>Inputs</td>
<td>Instrumentally</td>
</tr>
<tr>
<td><strong>CONTROL</strong></td>
<td>Assumes hierarchy, standardized procedures and orders will result in greater accountability. Mechanisms determine directly the acquisition, use and disposition of material and human resources.</td>
</tr>
<tr>
<td>Processes</td>
<td>APPROPRIATE BEHAVIOUR</td>
</tr>
<tr>
<td>Outcomes</td>
<td>PERFORMANCE</td>
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1.3 Research questions

While the “promises” help us see the different ways public policy makers and managers regard the goals of accountability, the actual usage of accountability in particular settings is not well understood. Further, empirical study of how those in leadership positions make sense of and deal with competing interpretations of accountability is lacking. To address this gap, this study aims to apply an empirical approach to examine a conceptually-derived framework about accountability.
Broadly, the objective of this study is to explore the ways in which accountability is valued and operationalized among healthcare leaders in a public sector management context – specifically, healthcare leaders in Government and a specialized agency of Government. Within this overarching objective, there are three central research questions:

1) How is accountability valued?

   *What do healthcare leaders think accountability can achieve? What is its purpose?*

2) How is accountability operationalized?

   *How do healthcare leaders think the goals of accountability are achieved? What are their mechanisms?*

3) What, if any, are the implications for Dubnick’s “promises of accountability” framework?

### 1.4 Overview of chapters

This study is presented according to a traditional thesis structure. Following this introduction, Chapter 2 provides a brief overview of the public sector management context in which this study is conducted – namely, Ontario’s cancer services system and the relationship between Government and a specialized agency of Government. Chapter 3 outlines the methods used, including justification of study design, sampling, and the process of data collection and analysis. Chapter 4 presents and elaborates upon study results in two parts. Findings from a review of documentary sources are described.
narratively to provide important historical context for the study of accountability, followed by results from key informant interviews. Chapter 5 provides a discussion of findings. Interpretation of results, policy implications and limitations are considered, followed by the conclusion.
Chapter 2. Situating the study

This study focuses on the system-level accountability relationship between the Ontario Ministry of Health and Long-Term Care (MOHLTC) and its cancer agency, Cancer Care Ontario (CCO). While this study takes place within a particular context – namely, the cancer services system in Ontario – the goal of this research is not to generalize to all similar contexts. Rather, by situating the study in this context, this study aims to put Dubnick’s framework to an empirical test.

The cancer system in Ontario has come to be regarded as one of the most effective examples of chronic disease management in the world. Cancer Care Ontario has been hailed for providing insights into how a specialized agency of Government uses a model of aligning administrative and clinical accountability, supported by a comprehensive performance management system, to improve patient care and facilitate partnerships among various stakeholders (Commission on the Reform of Ontario’s Public Services 2012; Nolte, Knai and McKee 2008).

2.1 Ontario Ministry of Health and Long-Term Care and Cancer Care Ontario

In recent years, the MOHLTC has shifted its focus from the delivery of health services towards more of a stewardship role. For fiscal year 2012-2013, the MOHLTC oversaw a $47 billion budget (Ministry of Finance 2014). In this capacity, the main functions of the MOHLTC are setting priorities, establishing policy, and ensuring accountability to provincial priorities by administrators and providers (Lomas and Brown 2009). The day-to-day operations are overseen by
the Deputy Minister of Health and Long-Term Care. Under the Deputy, a varying number of Associate and Assistant Deputy Ministers, Directors and Managers in their respective divisions carry out the various responsibilities of the MOHTLC.

Cancer Care Ontario is a provincial agency and the chief advisor to the Ontario Government on cancer control across Ontario. CCO plays a big role in developing cancer policy to improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services (Memorandum of Understanding 2009). CCO directs and oversees more than $1.5 billion in funding, of which a large proportion is for hospitals and other cancer care providers (Cancer Care Ontario 2014). A three-year rolling business plan between the MOHLTC and CCO defines funding, and is negotiated on a yearly basis. In addition to this document, a number of “Accountability Agreements” exist for funding specific initiatives.

Following restructuring of regionalized cancer services in 2004, which set out a new accountability context that emphasized performance, quality, and fiscal control (Sullivan et al. 2004), funding agreements were established between CCO and its 14 Regional Cancer Programs (RCP). (See Appendix 1 for an Ontario cancer system map.) These regional networks deliver cancer services

3 In recent years, CCO’s mandate has expanded beyond cancer care to include the Ontario Renal Network (ORN) and the Ontario Government’s Access to Care Program. The ORN organizes and manages chronic kidney disease across the province. The Access to Care program supports the Ontario Government’s Wait Times Strategy.
4 Although CCO’s role has expanded to support chronic kidney disease, cancer services still account for the majority of their funding envelope – with chronic kidney disease accounting for about $573 million of the total $1.5 billion budget (Cancer Care Ontario March 2014).
5 One RCP supports both the Central West Local Health Integration Network (LHIN) and Mississauga Halton LHIN, and the Toronto Central LHIN is served by two.
within a defined geographic area across the spectrum from prevention to palliation. The RCPs are roughly aligned with each of Ontario’s Local Health Integration Networks (LHIN). Each regional cancer program has a regional cancer centre within a host hospital, which acts as a kind of hub for a network of cancer services within the region.

### 2.2 Accountabilities

Figure 1 illustrates a high-level overview of Ontario cancer system accountabilities.

![Diagram of Ontario cancer system accountabilities](image-url)

**Figure 1.** High-level overview of Ontario cancer system accountabilities
Board of Directors

CCO is directly accountable to the Minister of Health and Long-Term Care through its Board of Directors. The Board is responsible for the overall governance of the affairs of CCO, subject to the provisions of the Cancer Act, CCO’s By-laws, CCO’s Memorandum of Understanding with the Ministry of Health and Long-Term Care, as well as all applicable Treasury Board/Management Board of Cabinet directives and legislation. The board is accountable for managing and controlling the affairs of CCO and responsible for supervising CCO management. The Board’s responsibilities include strategic planning, risk management, organizational and management oversight (internal financial and operational controls, governance and compliance) and communications with stakeholders (Cancer Care Ontario 2013).

CCO Executive Team

The Executive Team forms CCO’s senior management group and consists of the President and CEO, and the organization’s vice presidents. Three advisory councils, described below, support their work.

Advisory Councils

Provincial Leadership Council (PLC) is the forum for planning and coordinating the provision of cancer services in Ontario. The PLC advises on, and has input into, overall cancer control strategy of CCO. It is chaired by the President and CEO of CCO, and membership includes all Regional Vice Presidents (RVP). RVPs, who are the head of their respective RCPs, are accountable to both
the CEO of CCO and the CEO of the hospital in which their regional cancer centre is situated (Cancer Care Ontario 2007).

Clinical Council is the forum for setting clinical policies for the cancer system in Ontario. Clinical Council advises on all policies, standards, guidelines, and clinical care initiatives related to cancer control and cancer care. Clinical Council is co-chaired by two Executive Team members and membership includes Provincial Clinical Program Heads, a number of Directors of clinical programs (e.g., systemic therapy, radiation therapy, surgery, nursing, etc.), and other Executive Team members (Cancer Care Ontario 2003).

The Cancer Quality Council of Ontario (CQCO) is a quasi-independent arm’s length organization that advises CCO and the MOHLTC in their efforts to improve the quality of cancer care across the province. The CQCO is accountable to the Minister of Health, with blurred lines of reporting through the CCO Board of Directors and directly to the Minister. The CQCO monitors and publicly reports on the performance of the cancer system. The CQCO does not have the capacity to monitor performance independently, and relies on CCO for data collection and analysis. However, the role of the Councillors is to identify system level performance indicators, provide interpretation of the performance data and to assess CCO’s performance.

The CQCO works to identify and assess gaps in cancer system performance and quality, and advises on planning and strategic priorities. Its principal initiatives include: (1) the Cancer System Quality Index (CSQI), a web-based report published in partnership with CCO, which tracks progress towards better outcomes in cancer care and highlights where cancer service providers
can advance quality and performance of care in Ontario; (2) an annual signature event that brings together stakeholders and decision makers to address a specific quality gap to help better understand the issues; and (3) Quality and Innovation Awards that recognize significant contributions to quality or innovation in the delivery of cancer care. The CQCO membership includes a multidisciplinary group of providers, cancer survivors, and experts in the areas of oncology, health system policy and administration, performance measurement, and health services research, as well as patient representation.

### 2.3 Governance framework

The cancer services system is governed by a strategic model that aligns clinical, administrative, and public approaches to accountability at the provincial and local levels, and is supported by a comprehensive performance management system (Dobrow, Sullivan and Sawka 2008; Duvalko, Sherar and Sawka 2009).

Every three years, CCO develops the Ontario Cancer Plan (OCP). Developed with input from clinical and administrative leaders, the OCP sets provincial priorities and strategies for action, including explicit performance targets for each year. The OCP is submitted to the MOHLTC for approval and facilitates annual budget requests and approval processes with CCO.

The Clinical Council supports clinical accountability for providing safe and effective care, whereas the PLC supports administrative accountability for ensuring effectiveness and efficiency of health care delivery before health system governors. The CQCO supports accountability for quality and performance of the overall cancer system through public reporting.
Each RCP enters into a legally binding contract known as a Cancer Program Integration Agreement (CPIA) as a condition of funding. This agreement requires implementation of provincial standards and programs, timely data submission and accountability for meeting annual performance targets. Each month, CCO compiles a regional scorecard using program data and conducts formal quarterly performance reviews with each RCP (Cheng and Thompson 2006). CCO’s experience collecting wait times data and turning it into meaningful information to drive improvements is now being used to shape other, non-cancer-related performance management activities across the province (Martalog and Bains 2009).
Chapter 3. Methods

3.1 Design

This study was designed following the ‘qualitative description’ approach. Unlike other approaches to qualitative research, qualitative description is not rooted in any one philosophical paradigm or tradition (Sandelowski 2000). The goal of qualitative description is to provide low-inference interpretation and a minimally theorized account of a particular phenomenon, staying as close to the data as possible (Asbjoern Neergaard et al. 2009). However, within qualitative description, researchers may draw on and adapt particular techniques common to other qualitative approaches (Sandelowski 2000). As an approach, qualitative description is founded in existing knowledge, meaning that elements of what is already known about the issue are typically incorporated into the study design. Given the purpose and flexibility of qualitative description it is particularly well-suited to health services research oriented to issues of practical relevance (Asbjoern Neergaard et al. 2009).

To understand how accountability is valued and operationalized in the context of Ontario’s cancer services system, I drew primarily on key informant interviews. Documentary sources and informal observation were important secondary tools for providing an even richer understanding of the context.

This study was designed and conducted independently, but forms a piece of a larger team grant funded by the Canadian Institutes of Health Research to
examine various approaches to accountability across sub-sectors of Ontario's healthcare system and other Canadian jurisdictions.6

3.2 Sample

Key informants were sampled purposively to identify interview participants who were likely to have special insight into the cancer services system by virtue of their experience and expertise (Patton 1990). Senior healthcare leaders at the MOHLTC and CCO were identified using publicly available organizational charts. Thesis advisors who themselves have held senior leadership positions within both organizations were consulted to finalize sampling decisions. Their knowledge of the Ontario context places them in a privileged position to advise on informants.

Within the MOHLTC, key informants in senior leadership positions from the divisions with close links to CCO and the cancer system were invited to participate in an interview. Similarly, key informants in senior leadership positions at CCO were invited to participate, including members of the Board of Directors, Executive Team, and Advisory Councils (Clinical Council, PLC, CQCO).

3.3 Data collection

Key informant interviews were the primary method of data collection. Potential interview participants and their administrative assistants were

6 Findings from the team grant have been published in Healthcare Policy volume 10 Special Issue: Approaches to Accountability (http://www.longwoods.com/publications/healthcare-policy/23848), including preliminary findings from this particular sub-study (Bytautas, J, M Dobrow, T Sullivan, and A Brown. 2014. "Accountability in the Ontario cancer services system: A qualitative study of system leaders' perspectives." Healthcare Policy 10(SP):45-55.)
contacted up to two times two weeks apart by email (see Appendix 2 for email invitation). With informed consent (see Appendix 3 for consent form), face-to-face interviews were conducted between June and October 2012 in participants’ offices or in the community, at their discretion. Interviews lasted approximately one hour, and were audio recorded and transcribed verbatim by a transcriptionist. Transcripts were stored and managed using NVivo Version 10 qualitative analysis software (QSR International Pty Ltd. 2012).

A semi-structured interview guide consisting of open-ended questions and one ranking exercise was designed to explore participants’ views on (i) how expectations between the MOHLTC and CCO are established; (ii) whether and how each of the “promises of accountability” were valued and operationalized; and (iii) the lessons learned about accountability in general based on their experiences as a cancer/health system leader (see Appendix 4 for interview guide). The guide was developed in awareness of specific accountability mechanisms in use in the Ontario cancer system, but did not probe for them specifically. This decision was intentional, in order to allow participants to provide their unmediated perceptions of what was relevant in their view. The guide was pretested with three well-informed observers of the cancer and healthcare system in Ontario for reasonableness and general feedback. A journal was kept wherein first impressions and reflections were captured following each interview.

Participants were not offered compensation for their time and input, as it was not feasible given the small scale of the study and limited resources, nor deemed necessary given the nature of the target population. However,
participants were mailed hand written ‘thank you’ cards as a token of appreciation for their contribution. At the time of consent, participants were given the option to receive copies of any manuscripts produced as a result of this study.

Publicly available documentary sources were collected and informal observation of CCO advisory council and quarterly review meetings was conducted to supplement key informant interviews.

Legislative and media records were collected to provide a deeper understanding of the historical context in which the current incarnation of the cancer system emerged in Ontario around 2004. Ontario Parliamentary Debates (Hansard) and Canadian Newsstand Index were searched for any mention of “Cancer Care Ontario” between 1995 and 2011. A number of formal documents were collected through publicly available online sources, as well as from key informants. These include the commission reports, the Cancer Act, Memorandum of Understanding between the MOHLTC and CCO (both 1999 and 2009 versions), OCP (both 2008-2011 and 2011-2015 versions), sample accountability agreements between the MOHLTC and CCO, CCO orientation handbooks, and Ontario Broader Public Service Directives. Organization websites for CCO and CQCO were scanned for mission statements and other relevant background information.

Observation of CCO advisory council meetings was conducted. Monthly meetings of the PLC and the Clinical Council were attended from September 2010 to June 2012. In 2011, quarter 2 and quarter 4 performance management reviews were attended. The opportunity to observe these meetings served to
enrich understanding of the current context in which the cancer system is governed and managed. Observation notes captured key elements of process, as well as individuals and their dynamics. Since observation was not a formal method of data collection, these notes are not reported. However, observation helped to guide analysis by providing invaluable insights into organizational context and relationships.

3.4 Analysis

The goal of data analysis in qualitative description is to provide a rich description of the “facts” as told by key informants, while staying as close to the data as possible (Sandelowski 1995). Since an objective of this study was to consider the implications for Dubnick’s “promises of accountability” framework, elements of interpretive description were also incorporated into the data analysis (Thorne 2008). While similar, the key difference between qualitative description and interpretive description lies in the approaches to analysis. Where qualitative description tends toward bare renditions of accounts, interpretive description goes further to provide a more in-depth conceptual description and understanding of the phenomenon of study (Asbjoern Neergaard et al. 2009). Qualitative analysis in general is reflexive and interactive in the treatment of data and accommodation of new insights.

Prior to coding, transcripts were read thoroughly and detailed notes were taken about each interview. These notes were merged with the interview journal to create a thorough but unadorned reference book of participants’ accounts.
Interview transcripts were then coded in NVivo for both predetermined and ‘emergent’ themes (see Appendix 5 for codebook). First, a set of codes derived from Dubnick’s framework was applied to the data deductively, including ‘stage’ (input, process, outcome) and ‘value’ (instrumental, intrinsic). Specific accountability mechanisms were coded for as they emerged inductively. These mechanisms reflected various elements of accountability that had some role to play in participants’ understanding of accountability. Codes were then cross-tabulated to explore relationships.

3.5 Ethics

This study was conducted with ethics approval from the University of Toronto Health Sciences Research Ethics Board (#27763).
Chapter 4. Findings

This chapter describes study findings in two main sections. The first section provides a high level overview of the recent history of cancer control in Ontario. The purpose of this review is to help set the stage for where the cancer system is today. The second section describes the perspectives of senior healthcare leaders at the MOHLTC and CCO on the current context.

4.1 A crisis of accountability: brief history of Ontario's cancer services system

In this section, various media, Government and scholarly articles are drawn upon to tell the recent history of the cancer system in Ontario. Cancer Care Ontario in its current form is a fairly new incarnation of a governance body that has existed for nearly 100 years. The organization as it is today is a direct result of a series of very deliberate steps taken in response to a crisis of accountability. Indeed, it was not long ago that Ontario’s cancer system was described as “fractured and at times bewildering” (Hudson 2002).

Cancer control in Ontario can be traced back to the turn of the 20th century with the discovery of x-rays and radium. By the 1920s, both were being used for cancer diagnosis and therapy. By 1930, Ontario’s radium supply was felt to be inadequate and the Ontario Medical Association along with advocates of the centralization of cancer services pressured the Ontario Government to investigate the problems of cancer control in the province (Cowan 2004).

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7 For a comprehensive account of the history of cancer control in Ontario from the 1930s to 2000s, see Cowan, D. 2004. "Closing the circles: a history of the governance of cancer control in Ontario." Toronto: Cancer Care Ontario.
formal investigation was launched and in February 1932 the Report of the Royal Commission on the Use of Radium and X-Rays in the Treatment of the Sick was published (Cody 1932). It would take almost three decades for the major suggestions to take effect, including the creation of a Government agency called the Ontario Cancer Treatment and Research Foundation (OCTRFG) that would be responsible for the supply of radium and supervision of treatment and diagnostic centres across the province.

Fast forward to the 1990s and Ontario found itself facing another crisis relating to wait-times, which, it has been argued, can be directly related to policies established on recommendation of the 1932 Cody Commission (Hayter 1998). In response, the Government of Ontario announced in April 1997 that the OCTRF would be replaced by a new agency, Cancer Care Ontario. Guided by the principles established in the Cancer Act (Government of Ontario 1990), this newly branded agency was given a mandate to provide strategic direction to the Government for a much broader range of cancer services across the province (Sullivan et al. 2004).

4.1.2 A “cancer apartheid”?

By the end of 1998, ongoing concerns over wait times for treatment and a shortage of oncologists led the Government to consider sending patients from Southern Ontario to the United States. Beginning in April 1999, CCO began to do just that in a program known as re-referral.

Meanwhile, in the Legislative Assembly of Ontario, opposition parties took no time to criticize the Government’s decision to fund re-referrals for southern Ontario cancer patients (Debates (Hansard) 26 April 1999). The move
was characterized by some as inequitable and discriminatory as Southern Ontario patients were seen to be given preferential treatment over patients from northern Ontario (Debates (Hansard) 7 Dec 1999).

About a year later, a group of northern Ontario officials began to lobby the Government to implement a similar funding program for Northern Ontario cancer patients who had to travel equal if not longer geographic distances to receive treatment in the north (Debates (Hansard) 26 April 1999). The Chair of CCO’s Northeast Ontario Advisory Committee was quoted as saying that the “Government is practicing a form of health care apartheid for patients in northern Ontario” (Debates (Hansard) 3 May 2000). Opposition Members of Provincial Parliament (MPP) adopted the this powerful characterization of the re-referral program for southern Ontario cancer patients as a “health care apartheid” (Debates (Hansard) 4 May 2000; Debates (Hansard) 5 June 2000).

In September 2000, the New Democratic Party presented a formal petition to the Legislature called “Northerners Demand Harris Government Eliminate Health Care Apartheid” (Debates (Hansard) 26 September 2000). On October 30, the Liberal Party proposed a motion to the house, that “The Government of Ontario is perpetuating a policy of discrimination against residents of northern Ontario” and “that 100% of the costs of travel to receive cancer care must be covered, regardless of whether the cancer patient resides in northern or southern Ontario” (Debates (Hansard) 30 October 2000). The motion was ultimately defeated.
4.1.3 Private after-hours clinic and audit of Cancer Care Ontario

In February 2001, the Government quietly approved a contract between CCO and a private after-hours radiation clinic at Toronto-Sunnybrook Regional Cancer Centre, which the Conservative Minister of Health argued would “eliminate the need for cancer victims to travel outside the country” (Debates (Hansard) 23 April 2001). Indeed, by June of that same year, CCO announced it would no longer be sending southern Ontario patients to the United States (Debates (Hansard) 2 October 2001). Some of these patients would simply be re-referred to northern Ontario, which was perceived by the media as a reflection of a “new, surrealistic tier to health care” and CCO’s attempt to “generate less bad press” (McLaren 9 June 2001). However, many southern Ontario cancer patients would be re-referred to the new private clinic.

Suspicion and distrust was fueled when the CEO of CCO was quoted in the House as saying that the clinic was arranged “in a very quiet manner because the public would be outraged if they knew” (Debates (Hansard) 24 April 2001). A Vice President of CCO was a co-owner of the private clinic at the time the contract was tendered. After several months of pressure from Opposition MPPs demanding to know the details of the contract and the process by which it was tendered, the House passed a motioned in June that the Provincial Auditor should review CCO (Debates (Hansard) 6 June 2001).

The Provincial Auditor’s review of CCO was issued on December 13, 2001. To summarize its findings, the Provincial Auditor said, “It’s good news and bad news. We have indeed reduced the cost to the program by stemming the flow of patients that had to seek treatment in the US, but the bad news is that CCO did
not follow a sufficient process to ensure that those services are actually acquired at the best possible price. Particularly, it did not use an open and competitive process when it awarded this contract” (Standing Committee on Public Accounts 2001). The CCO Vice President and co-owner of the clinic was quoted as saying that he “acted in good faith”, but this did not prevent the move from being perceived as Government exploitation of the wait-times crisis by rushing through approval of the private clinic (Toronto Star 14 Dec 2001). To many, the Provincial Auditor’s report revealed a crisis of accountability that necessitated immediate and swift change.

4.1.4 Cancer Services Implementation Committee report, 2001

Days before the decision to audit CCO, rumours abounded in the media that the Government was going to eliminate the provincial agency altogether. The Government was unhappy with CCO’s progress in terms of reducing wait-times for certain cancer services. On June 4, 2001, the media reported that the Conservative Minister of Health had informed CCO’s Board of Directors that its responsibilities would be divested to regional hospitals (Debates (Hansard) 4 June 2001). An uproar ensued among supporters of the agency and that same day the Conservatives were accused of intending to turn CCO into “an empty shell,” to which the Minister of Health backtracked by saying, “We think it is important for the betterment of cancer treatment in Ontario to have a better integration of those services at the local level. I’m not equivocating, I’m not trying to deny anything; I’m saying that’s where we’re going and we are doing so in a way that has a very serious role for CCO in the present and future” (Debates (Hansard) 4 June 2001). In response to this controversy, the Government struck
the Cancer Services Implementation Committee (CSIC) in June to review the cancer system and its ability to meet the growing needs of cancer patients. Any policy changes regarding the future of CCO would be put on hold until the results of this review.

Although the cancer system was widely recognized as ripe for and in need of change (Thompson and Martin 2004), many people inside the cancer system felt strongly that discontinuing the activities of CCO was not the solution. A widely respected healthcare administrator and provider, Dr. Alan Hudson, was appointed Chair of the CSIC along with 20 other senior and experienced members (Guy 6 June 2001). The CSIC’s mandate was to “recommend ways to improve the integration of cancer services at the local and regional levels, the quality of patient care, and the productivity and efficiency in the cancer services component of the Ontario health system” (Hudson 2001). This review would be conducted over the next 6 months. Focus groups suggested that there existed “a profound and mutual lack of confidence between the Government and its own agency” (Hudson 2002). In a public hearing, cancer activists pleaded for a continued role for CCO arguing that “without a strong centralized system, variations in treatment will grow worse” (Lu 31 Aug 2001).

In December 2001, shortly after the Provincial Auditor’s report, the CSIC released its report with a number of major recommendations for restructuring the cancer system in Ontario. Several options for restructuring were considered, but ultimately the CSIC recommended that the role of CCO needed to be expanded to steward all cancer services (not just radiation and systemic therapy), the relationship between Regional Cancer Centres and their host
hospitals needed to be integrated, and a quality council to monitor quality and performance be established. The CSIC’s review would prove to “save CCO from extinction and leading to an extensive structural and cultural change in the organization” (Cowan 2004). On April 1, 2002, Hudson was appointed CEO of CCO (Sudbury Star 19 May 2002). The vision of an integrated cancer system where all cancer services are aligned would unfold rapidly over the next three years.

4.1.5 Reconstructing Ontario’s cancer services system

The first of two major restructuring efforts to occur was the creation of the Cancer Quality Council of Ontario announced in September 2002 (Hudson 2002). The first of its kind in North America (Dobrow et al. 2006), the CQCO would be an arm’s-length organization of experts in cancer medicine, research, and policy, responsible for monitoring and publicly reporting on quality and performance in the delivery of all cancer services. The CQCO was designed to be a quasi-independent council with its own specified budget envelope from the Ministry of Health and Long-Term Care (Sullivan et al. 2004). To this end, most members are external to CCO; however, the secretariat is housed at CCO. A scorecard was developed from an initial set of indicators selected based on CCO’s strategic priorities. Reports would have a system-level focus “to correct the legacy of ad hoc performance measurement focused in great detail on a small portion of cancer service delivery; to demonstrate to the public that the system as a whole was being monitored and was accountable; to be useful across all modalities of cancer care; and to complement and support a range of detailed
program-level performance indicators already in use in Ontario” (Greenberg et al. 2005).

The CQCO’s benchmark publication on the state of quality in Ontario’s cancer system was issued in October 2003 (Sullivan et al. 2003). Overall, the CQCO found that the cancer system was “unresponsive” and “largely unaccountable” (Toronto Star 18 Oct 2003). Chief among its conclusions was that Ontario did not collect cancer data well, and that without an accurate picture of the problems, it would be impossible to improve the system (Toronto Star 21 Oct 2003).

Through the CQCO, the ability to publicly report on cancer system performance across the province was a key step in the reconstruction of a deliberately more accountable cancer system. Within a year, the CQCO would release its baseline Cancer System Quality Index (CSQI), a web-based report developed to evaluate progress and point out where improvements could be made (Canada NewsWire 25 April 2005). Public reporting of cancer system performance served two functions – to motivate health care providers and administrators to make changes where necessary and to generate awareness among citizens about how lifestyle affects cancer and how screening can save lives (Mulligan 27 April 2005).

The second and most dramatic step to be taken was the formal integration of CCO’s regional cancer centres with their host hospitals. When the Government began using the language of integration in 2001, it was perceived by many to be a kind of threat to CCO’s existence and a “way of burying the fact that cancer patients have to wait for treatment” (Debates (Hansard) 2 October 2001;
Debates (Hansard) 26 September 2001). The view of integration as a forced merger persisted well after the CSIC’s report (Debates (Hansard) 26 November 2002).

Meetings were held in early 2002 with future stakeholders – host hospital CEOs, hospital board chairs, senior teams and staff within the regional cancer centres. Although everyone agreed that, done properly, integration would improve the quality of patient care, the prospect of what some perceived as a merger caused unease. With key funding and labour issues resolved, a target date of June 2003 was set for a master contract to be agreed upon by all parties. In the end, with provisions made to individual hospitals for specific items, all of the 11 host hospitals agreed to the Cancer Program Integration Agreement (CPIA) and on January 1, 2004 the Regional Cancer Centres were formally divested to the host hospitals forming Integrated Cancer Programs (now referred to as Regional Cancer Programs) (Sullivan et al. 2004).

With integration, CCO moved from being a regional provider of radiation and most systemic therapy services to becoming a purchaser and steward of a much more comprehensive set of services. By reconstructing regionalized cancer services, a model of governance that emphasized accountability would come to “turn around a crisis situation” (Sullivan 18 Sept 2010) and signal the beginning of a “new era” of cancer control in the province (Sullivan et al. 2004; Thompson and Martin 2004). This “new era” forms the current context in which this study takes place.
4.2 The Ontario cancer system today: cancer system leaders’ views

In this section, senior healthcare leaders’ views on accountability in the Ontario cancer system today are described. The views are organized thematically by Dubnick’s “promises of accountability” framework. A participant overview is provided, followed by key informant interview findings and a simple ranking exercise of the “promises of accountability.”

4.2.1 Participants

Interviews were conducted with 19 participants (Table 2). Overall, participants included 5 from the MOHLTC, 7 from CCO’s Board of Directors and Executive Team, 4 from the advisory councils (PLC and Clinical Council) and 3 from the CQCO.

Table 2. Key informant interview participant overview

<table>
<thead>
<tr>
<th>Organization</th>
<th>ID Code</th>
<th>Invited</th>
<th>Declined/ No Response</th>
<th>Participated</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOHLTC</td>
<td>#-MOHLTC</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>63%</td>
</tr>
<tr>
<td>CCO</td>
<td>#-CCO-AC-CC</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisory Councils</td>
<td>#-CCO-BD/ET</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>#-CCO-AC-CC</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#-CCO-AC-PLC</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>#-CCO-AC-CQCO</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>24</td>
<td>5</td>
<td></td>
<td>19</td>
<td>79%</td>
</tr>
</tbody>
</table>

Legend:
#-CCO-AC-CC – Cancer Care Ontario, Advisory Council, Clinical Council
#-CCO-AC-CQCO – Cancer Care Ontario, Advisory Council, Cancer Quality Council of Ontario
4.2.2 Perspectives on the promises of accountability

To structure the findings, representative quotes are presented thematically within each subsection. Findings are presented by each ‘stage’ of the organized effort (inputs, processes, outcomes). These are:

- Inputs – Control and Integrity
- Processes – Appropriate behaviour and Legitimacy
- Outcomes – Performance and Justice or fairness

Appendix 6 contains supplementary quotes for each subsection.

Participants are identified using the following coding scheme:

- CCO-AC-CC – Cancer Care Ontario, Advisory Council, Clinical Council
- CCO-AC-CQCO – Cancer Care Ontario, Advisory Council, Cancer Quality Council of Ontario
- CCO-AC-PLC – Cancer Care Ontario, Advisory Council, Provincial Leadership Council
- CCO-BD/ET – Cancer Care Ontario, Board of Directors or Executive Team
- MOHLTC – Ministry of Health and Long-Term Care

4.2.2.1 Inputs – Control and integrity

Perspectives on the inputs stage were considered first, focusing on the promises of control (instrumental) and integrity (intrinsic).
Control

The promise of control assumes that hierarchy, standardized procedures and orders will result in greater accountability. Control mechanisms directly determine the acquisition, use and disposition of material and human resources. Participants highlighted legislative and contractual tools, the role of strategic planning, funding and agency-wide bureaucratic controls.

Control – Legislative and contractual tools

There are a number of legislative and contractual tools that lay the formal groundwork for the relationship between the Ministry and CCO. The Cancer Act and the MOU are foundational to defining the terms of engagement between the Ministry and CCO, and inform funding agreements.

CCO has “a legislated mandate to oversee management and improvement of the cancer system in Ontario” [2-COBD/ET]. This legislated mandate, through the Cancer Act, affords CCO a certain independence that other Government agencies might not have.

*We have a fair degree of independence as compared to other provincial agencies. I think a portion of that is because our existence is mandated under the Cancer Act instead of being just a creation of the bureaucracy so we’re a bit more hands off.* [6-COBD/ET]

The MOU helps to clarify roles and responsibilities and is supplemented by various accountability agreements between the MOHLTC and CCO.
...we’re required with all the classified Government agencies to both have a memorandum of understanding, which is an MOU that clarifies the roles and responsibilities of the parties, being the Government and the agency. And then, the accountability agreement is really to supplement that and say, “here’s the money we give you annually and this is what you’ll deliver for that. And, this is how we’ll work together to monitor how you’re achieving the results” [4-MOHLTC]

Since cancer system restructuring in 2004, participants highlighted an increase in attention paid to accountability by both the MOHLTC and CCO. This has manifested largely in the latest iteration of the MOU.

So, definitely, the accountability and the structure around accountability has changed significantly in the last number of years. Post restructuring even in the last, I would say, the last three years. So, it’s almost a significant leap toward more accountability. So, we had an MOU which goes back probably... in early 2000. It was very much a very high level MOU. And, I think the MOU that we signed was in December of 2009, which basically provided a tighter leash from the ministry to CCO. So, it was basically to ensure that CCO has to... whatever it needs to do it basically has to comply with all kind of ministry directives and we’re not going rogue and doing whatever we want without the ministry. [...] So, that was basically ministry recognizing that, you know, CCO is a big agency. And, they don’t really have a very tightly knit memorandum of understanding with CCO. So, and that MOU becomes tighter and tighter as time goes on. [7-CCO-BD/ET]
However, these tools – specifically the Cancer Act and MOU – are seen by some to be ineffectual on their own.

...their legislation, you know, is not particularly good. It’s not very specific. I mean, you can drive a truck through it. [...] So, it's not a particularly instructive document...sometimes the ministry will use that as a threat though. “Hmm, I guess it’s time to redo the Cancer Act because you won’t do this, that or the other thing.” It can sometimes be used as a club. But, it’s not a particularly effective piece of... well, it’s a non-existent really. It doesn’t really define the relationship. It doesn’t define goals and expectations particularly clearly. So, there’s an MOU. So, that would be another document, probably the principal document. And, that really is a negotiation...where the ministry tries to set down its expectations and CCO would either agree or not or modify or whatever and then establish some of the measures that both agree are important measures to keep track of in terms of monitoring performance and outcomes and so forth. [8-MOHLTC]

Another participant echoes this sentiment by saying that although the MOU exists and helps to define expectations, “nobody ever sort of pulls those out and lays them in front of each other or anything like that, but they expect us to live up to our part of the bargain and we expect them to live up to their part of the bargain I think is what it comes down to.” [15-CCO-BD/ET]
Control – Strategic planning

The Ontario Cancer Plan, developed by CCO in partnership with MOHLTC and the regions, helps to shape future priorities on a three year basis, which are fed into the business plans and funding/accountability agreements.

...we have an Ontario Cancer Plan that says that we have these big strategic objectives. And, so, it's understood that that's what we're driving towards. So, ensuring that wait times are acceptable, improving them to an acceptable degree, ensuring that services are high quality, all of that is part of our cancer plan; it's declarations of what we're doing. It's embedded in our business cases. And, we actually develop indicators and performance metrics that would actually align with that. [1-CCO-BD/ET]

While the value of strategic planning is recognized, it is not without its downside. Strategic planning allows one to focus efforts, but it can mean missing out on other initiatives.

I would think that Ontario actually has one of the better cancer control plans in the world. Measurement and evaluation. And specific goals. As much as it drives us crazy on the delivery side that we are focusing on [for example] colorectal cancer screening. Forget if you have some other cancer. That’s too bad. At least it gets done. So, on the one hand, if you’re a clinician, it drives you crazy that there’s focus on specifics, but from planning perspective it’s really good. It allows you to focus, which means you make progress faster. It allows you to evaluate, measure. You can’t do
everything. You know, people say, “you can’t boil the ocean.” You have to pick and choose. [17-CCO-AC-PLC]

Control – Funding

In a publicly funded healthcare system such as in Ontario, money is a major lever that both the MOHLTC and CCO have at their disposal to affect change.

Their [MOHLTC] biggest lever in terms of making sure that things are going in the direction they want to go is money because... When you think about other systems and what kind of levers they have, in the U.S. where there’s an overcapacity of service providers they’ve got the lever of market share, right. If you don’t perform the way we want you to, we’ll take our business elsewhere, right. We don’t have that system in Ontario. We don’t have unused capacity sitting there waiting to be used. So, it doesn’t leave the ministry or us really very many other options. [1-CCO-BD/ET]

Ultimately, it is a combination of the Cancer Act, the MOU, and the funding agreements that form the basis for the promise of control between the Ministry and CCO.

I think their [MOHLTC] expectations are laid out in the Memorandum of Understanding and the Cancer Act. So, we’re legislated to have a mandate to look after cancer. And, we have an annual business plan that we provide them every year about that mandate, what we’re going to do, what we’d like to do. And then, when they actually do provide us funding or agreement to do certain things they lay out the accountabilities to us in terms of what
they would expect from us. Mostly it’s in the funding letter usually. And, it’s about, we’ll give you this much money. We’ll expect this much volume to be done. And, it isn’t, you know, a hundred pager kind of thing, right. It’s more about, you know, “you shall do”, you know, “six thousand cancer surgeries this year and here’s how much money.” That’s what’s in the letter, but in order to get to that point there’s been a lot of documents back and forth and reports and details about, well, what types of surgeries are they going to be? What are we going to pay for? What’s our wait time on all these different surgeries? They monitor or at least accept reports from us on all that kind of stuff. So, it’s a bit of a back and forth, very organic sort of working relationship. You know, emails daily about Q&A about what’s going on and what we need. So, we work quite closely with them. But, the actual accountability is the MOU, the legislation and the funding letter each year.

[15-CCO-BD/ET]

Control – Agency-wide bureaucratic controls

Bureaucratic controls, such as agency-wide directives around procurement/ expense reporting, are perceived by those at CCO as a necessary nuisance. On one hand, there is a recognized need for Government agencies in general to make sure “their house is in order”:

I would say in the current environment, for organizations to be successful, they have to be impeccable in terms of their administrative oversight and controllership. Like, they can’t have any deviation from the rules. And, so, that’s just a given, a must; but if they can do that, then I think they’ll be free to kind of really concentrate on why they were created, which is to advance
the care of the sector they’re working with because I think there have been organizations that have been tainted by that. And, to try to come back from that is very, very difficult. [...] I think if organizations want to excel, they just have to make sure that their house is in order. And, I’m just seeing more and more of that. [16-MOHLTC]

On the other hand, those within the agency feel the burden of streamlining multiple levels of oversight. Although based on sound principles, the implementation can become “absurd”:

...we are subject to all of the directives of agencies. And, but the ministry, the Government in general has had way more oversight and scrutiny of what goes on in agencies and hospitals. And, I think that that has been helpful to a point, but I think it can... too much oversight can sometimes hinder. I think that all of these directives have their origin in sound problem solving, right. You know, there have been issues with people who’ve hired consultants without proper procurement, proper competitions, proper oversight. So, the directive is that everybody has to do it according to the new procurement rules, which are fine. It’s good practice, but it requires us to set up systems and our own level of oversight. So, you have multiple levels of oversight that are... one has to get used to working more slowly because one has to actually go through all of these channels. And like anything, things might have started based on sound problem solving, but they get taken to an extreme that becomes absurd, right. [...] Nobody objects to having the policy in place. Everybody wants to adhere to it. We’re not perfect, so sometimes it’s hard to remember what rule applies to what situation, but the
inefficiency of having multiple levels of oversight is... it’s not... You know, it’s pretty obvious to us. [1-CCO-BD/ET]

Integrity

The promise of integrity assumes that individuals and groups wish to be accountable or part of an accountable culture. Integrity mechanisms create a culture of competence and trust in those who control material and human resources. Participants emphasized the value of trusting and healthy relationships and the altruistic nature of health and cancer care.

Integrity – Trust and healthy relationships

From the perspective of this MOHLTC participant, CCO has successfully overcome the crises it faced in the late 1990s and early 2000s.

I think in the nineties I was involved in a program where we didn’t have enough capacity here and we had to send breast and prostate cancer to the States. And, that’s where I’ve kind of seen, you know, them build back up. [16-MOHLTC]

Comparing the relationship between MOHLTC and CCO now and then, this participant feels strongly that there is good trust on both sides of the relationship.

I think that if I compare the system today to that of ten years ago, I think what the Ministry and the Government expects agencies to do and how they expect them to behave and what they’re holding them accountable for is much clearer than it was ten years ago. [...] I think everybody has a
heightened sense of the code under which we operate, right. I think probably just general maturation of healthcare as an organizational structure that needs to be handled in a professional kind of manner in a businesslike manner. That’s probably one. Second is people are pretty good at learning from their mistakes, right. Nobody wants to repeat the mistakes. Third is that there’s pretty good trust now on both sides, right. I think that the ministry trusts CCO to do a good job. And, I think CCO trusts the ministry to do the right thing in aid of a common agenda, right. [1-CCO-BD/ET]

This sense of partnership and trust is true not just of the MOHLTC and CCO relationship, but it filters down to the regions, too.

I think that this has been a good partnership. So, the ministry has benefitted enormously. We have a fixed cancer system. It is a healthy part of the healthcare system because of Cancer Care Ontario. And, Cancer Care Ontario has benefitted because it has become the primary advisor – in fact, I would say it’s reached a global brand around performance improvement in the cancer system or, for that matter, any healthcare system because the ministry place in it, in the organization a trust to do it better. I think that trust has actually built the environment to allow both organizations to succeed. And, I think that’s a strong lesson. So, I also think that within that trust is the fact that when the changes have been made it’s been because people have wanted to do better. And, that goes right down to the grassroots. So, that goes right down to the nurse in the clinic. That goes down to the pathologist at the pathology bench looking at his or her result
under the microscope. And, that goes to the surgeon at the operating room
table, so that people wanted to do better. And, so, I think there has been a
trust to form the relationship. And then, there has been a want to do it
better. [3-CCO-AC-CC]

Integrity – Nature of health and cancer care

The healthcare system in general was seen to attract individuals with
integrity. Many participants recognized that organizational success is ultimately
rooted in interpersonal relationships and that all partners in the system must be
treated well if change is going to succeed.

By and large, the people who are involved in healthcare delivery services,
professionals, have very, very high integrity. I would argue the profession,
these professions in the health system draw people who have that sense of
integrity. But, no system’s perfect and no population of people is perfect, so
I’m not naive in the sense there aren’t people who don’t have that sense of
integrity, but it’s not one that I’ve worried about a lot. [...] I think the
majority of practitioners though have a very high sense of integrity. You see
it in the way people behave, the way they interact, the way they approach
their work, the way they make decisions. It’s very rooted in interpersonal
relationships. And, you can’t screw around with people and expect to
survive, right. [8-MOHLTC]

Further, the cause of cancer specifically was seen to promote cooperation.

...a lot of people just will come to the table because you’re talking about
cancer, right. So, you can get a thousand people in a room or a hundred
people in a room if you’re talking about cancer where you might only get
two in the room if you’re talking about hips and knees or something, right.
[15-CCO-BD/ET]

Overall, the cancer system as it is today is understood to be one that
fosters integrity and attracts altruistic individuals who have personal integrity.

There’s an incredibly (pause) good, conscientious, well-meaning, ethically
responsible group of people working in CCO and the cancer system. And, so,
I do think those institutional structures that are in place, within which all
that happens, does promote integrity, yeah. [...] I think a lot of people who
are working in cancer already have that kind of personal...you’re almost
looking at a subset of people who have a really strong clock of being
accountable and wanting to make a difference and wanting to do good. [18-
CCO-AC-CQCO]

4.2.2.2 Processes – Appropriate behaviour and legitimacy

Perspectives on the process stage were considered second, focusing on
appropriate behaviour (instrumental) and legitimacy (intrinsic).

Appropriate behaviour

The promise of appropriate behaviour assumes that corruption and
inappropriate behaviour can be prevented, ameliorated, or corrected through
procedural accountability mechanisms. Mechanisms of appropriate behaviour
promote and ensure actions that meet standards of operations within an
organized effort. Participants considered the impact of internal and agency-wide
directives, and detailed the importance of formalized structures around due process.

*Appropriate behaviour – Internal and agency-wide directives*

Internal and agency-wide directives are also recognized to have some impact on ensuring appropriate behaviour in the day-to-day operations of the organization.

*I think the sad reality is these sort of mechanisms or processes do serve – and that’s why we put them in place, right – do serve to remind people of what’s right and what’s wrong and the importance to stay out of trouble.*

*[14-CCO-BD/ET]*

*Appropriate behaviour – Structures ensuring due process*

However, it is the deliberate and elaborated structures around due process that have the greatest effect on appropriate behaviour.

*[At the board level] I think we’re quite good at surfacing [conflicts of interest], dealing with them, checking that there’s no problems, you know, forming kind of barriers around them where we need to. And, so, it’s not like people are really feathering their nests or anything through relationships they have with CCO.* [14-CCO-BD/ET]

CCO has been very careful to establish principles around how funding is allocated and to make those principles transparent.

*When we are giving out 55 or 60 million dollars in [clinical program] funding last year to thirty-five hospitals, that’s a lot of money, right. […] So,*
it’s a big... That’s a lot of power. [...] And yet, no one has ever said, “you’ve
got a conflict of interest.” The reason is because... before we started the
[funding] allocation we established principles. [...]
So, we established the
principles before we even looked at the data. And, we’ve done it
transparently. So, we’ve established the principles in a fairly large group of
maybe ten people. We’ve communicated those principles to the clinical
provincial leads and each of the regional leads as well as the RVPs for
feedback. Everyone’s essentially embraced those principles. And, it’s
become essentially tradition over the seven years that there isn’t very much
change because it’s served all of us well. And, so, there’s a perception that
this is a principle and data based driven process. There was a process. It
was transparent. It was communicated. We’ve changed it over time where
there are areas where it didn’t seem quite to work. [3-CCO-AC-CC]

The advisory councils work to help to “shine a light” on what needs to be
done next.

So, now we’ve got sort of three different arms of agencies or organizations,
structures if you will, telling us that there’s some things that should be fixed;
there’s some things we should be looking at. And, so, that really, what it
does is it provides us a library of to do lists. [15-CCO-BD/ET]

Provincial Leadership Council provides strategic direction for the cancer
system overall, as well as highlighting specific regional issues. This PLC member
describes the process, as well as highlighting room for more meaningful
consultation.
Well, what [PLC is] supposed to do is provide input into the shaping of the Ontario Cancer Plan and specific initiatives and areas of development through the planning days that occur. And, on a monthly basis, they kind of evaluate how we are collectively performing and issues that are arising in our regions that may make it difficult to move forward on either the Cancer Plan or, you know, specific issues that are arising in the healthcare system generally like drug shortages or that sort of thing. So, we’re giving the core people on 620 [University Avenue – location of CCO head office] feedback on how the system’s performing, but also our views on issues about how the provincial people are moving things forward. We do presentations with clinical side, clinical program and from other areas, prevention et cetera; we’re always providing feedback as to how these programs might impact us. You know, to be honest, I don’t think we give enough or we’re not consulted perhaps enough. There’s a tendency in having them part of the provincial office. I know it’s very easy to fall in the mode where you pull the ideas together of the great people you have around you at 620 and then you present them to the regions almost as a fait accompli rather than a truly consultative process. [13-CCO-AC-PLC]

Clinical Council advises on areas for improvement. This Clinical Council member describes the principle driven process that guides their approach.

I think that the [Clinical] Council has a lot of feedback. Like anything, I don’t think it’s a grassroots thing where we sit around Clinical Council and say this is the plan. We start with a sort of framework that the Executive Team and Board have sort of developed. And, we then flesh out the details
on the clinical side. So, the overarching themes sort of come to us. We may have some input into the overarching themes, but more so I think we take those themes and we work with the themes and the strategic priorities in order to translate those into, you know, what we see as the areas where we can improve things. [7-CO-AC-CC]

As part of their process, the Cancer Quality Council of Ontario ensures a variety of skill sets have input into selection of indicators and the interpretation of that data to avoid “cherry picking”. This participant and CQCO member sees the role of CQCO as holding CCO accountable to the public.

\[11-CCO-AC-CQCO\]

We report to the people of Ontario. That’s our audience. And, we always provide the Ministry out of courtesy and CCO with a copy of what we’re going to say ahead of time. Members of Cancer Care Ontario are ex officio members of the council, so they’re engaged in the debate. And, it’s a good debate. [...] we say to Cancer Care Ontario, “here’s the data we need. Here are the indicators that we want to look at this year.” You know, “find us the best solutions to what the indicator... what evidence needs to be made available to us in response to our request for these indicators.” So, it’s Cancer Care Ontario that’s held accountable by the Cancer Quality Council.

However, another CQCO member points out the “murkiness” around who exactly is accountable to whom in the MOHLTC-CCO-CQCO relationship, as well as calling out the potential problems with this relationship.
What is the role of the council? [...] So, our areas of focus: we’re an advisory group, obviously. We’re a council. We don’t make decisions. We advise. So, we’re guiding CCO and the Ministry obviously around quality of cancer care. But, there’s a monitoring and public reporting function established by the Minister, quasi-independent body, given a mandate to monitor and report publicly, make recommendations to the Minister of Health via Cancer Care Ontario’s board of directors. So, we no longer report to the Minister; we now report to the Ministry. And, we guide CCO. So, I have to say that I think this is in flux. And, so when I think of accountability or ultimately who are we accountable to for our work, yeah, I think there’s some murkiness around that I would have to say. I am now hearing that there’s a desire to be less connected to Cancer Care Ontario, to be more arms’ length. That’s definitely a shift I’ve seen under the new leadership. I mean, I understand it at a basic level that you... if you’re trying to advise, you don’t want to be beholden to the very group who... for whom you may be looking to critique, right. [18-CCO-AC-CQCO]

Overall, this “matrixed” approach to decision-making ensures no one individual interest dominates and is also echoed at the regional level.

Well, at many levels there are sort of deliberative processes, aren’t there? So, whether it’s at CCO with the PLC or its Clinical Management Team or Executive Management Team. And, you know, I have [regional clinical leads]. And, again, it’s deliberative. I have a regional cancer planning priorities committee. So, you know, they get information. They deliberate on how we’re going to roll things out. So, there’s so many puts and takes in
It’s, like, hard for any one faction so to speak to kind of overrun, dominate, steal all the resources at the expense of others sort of thing. It’s complex. It’s matrixed in many ways. But, it’s... I think it leads to pretty good decisions. [13-CCO-AC-PLC]

While the structures around due process are deliberate, the matrixed nature of these relationships can give rise to a kind of ambiguity around lines of accountability. Rather than this being a weakness, this participant describes it as a strength.

I mean, it’s... in most of health care right now there is a sort of matrix relationships. And, people who are not comfortable working in matrix relationships may have a problem with that. So, one thing that I enjoy is the fact that it gives me an opportunity to get comfortable with ambiguity and a matrix and not necessarily having a sort of lines that are single lines of responsibility and accountability. [17-CCO-AC-PLC]

Legitimacy

The promise of legitimacy assumes the creation of vertical and horizontal procedures of accountability will result in ‘democratic’ outcomes. Mechanisms of legitimacy include the establishment and sustainability of procedures associated with ‘democraticness’. Participants reflected on CCO’s “branding” that feeds its legitimacy, as well as the Ministry’s reliance on CCO’s perceived legitimacy; crucially, clinician engagement feeds and is fed by this sense of legitimacy.

Legitimacy – CCO’s “brand”
CCO’s approach to ensuring appropriate behaviour through evidence and principle-based decision-making has contributed greatly to its perceived legitimacy across the board.

So, you’ll see a lot of that sort of style of CCO to get results is with being evidence based and have clinical expertise. So, I’m not sitting there as a [bureaucrat] and talking about, you know, how often you should have a colonoscopy. You know, so, it’s a literature. It’s clinical. It’s supported. So, I think that has led to a lot of good credibility for CCO with respect to a lot of areas in clinical programs. I think that’s really the evidence-based program that CCO runs in McMaster University. I think all of that has created a huge credibility within the medical community and really there hasn’t been a lot of other success stories for the Ministry of Health. [7-CPO BD/ET]

Indeed, CCO’s credibility has become an integral part of its “brand”.

I think [the leadership team] do know that protection of the Cancer Care Ontario brand is paramount. So, to get back to that brand we were talking about before, which is process driven by a foundation of principles around guidelines and standards and transparency and communication and all those things which has served itself well that if it were to transgress those principles, it would probably undermine the organization more than if it were to kowtow to the Government of the day. [3-CPO AC CC]

**Legitimacy** — MOHLTC reliance on CCO’s perceived legitimacy

The Ministry will rely on CCO’s perceived legitimacy to help justify difficult decisions.
I think CCO probably prides itself on being able to make the tough decisions. And, I don’t think they’re very comfortable if you try to push them off that. If the evidence says this is how it has to be done, this is how it has to be done. And, that’s it. “The evidence is this.” It’s almost, don’t you think, it’s a culture that they feel that’s their job to withstand that kind of... I mean, if they started every time they got a complaint, “ok, we’ll pay for it.” I mean, it would just be ridiculous. There’s just not kind of a comparable organization at that stature. So, I think its history and its stature, it allows it to act like that quite a bit. We’ve gone to them a number of times, [for example] on the out-of-country we said “on all our cancer requests, can you review them for us?” They’ve done that. So, I think to a large extent they probably have creditability across the system. If they do their work and they say “this is what the evidence is. This is what we should pay for”, then they don’t get a lot of people saying, “we don’t believe your evidence.” [16-MOHLTC]

This is especially evident around drug funding.

Do you remember, there was an issue last summer? It was someone whose tumour wasn’t big enough to qualify for Herceptin. [...] I mean, full credit to the ministry because, in some ways, we help the ministry out in that regard because we’re... we can be a bit of a buffer quite frankly because we bring the clinical authority to bear on those things and kind of can allow the minister, him or her, to distance themselves from kind of the decision making. [...] there’s a piece of CCO that is about, a big piece of CCO that is actually about kind of removing decision making from the political arena and depoliticizing stuff. So, in that sense, I mean, there is an element of this
that’s about taking stuff away from the political. I mean, the drug stuff would be a good example. And, I would say just a lot of stuff around making sure that we’re doing things for the right clinical reasons as opposed to kind of what might play on Main Street from politicians. [14-CCO-BD/ET]

*Legitimacy* – Legitimacy is fed by and feeds further clinician engagement

Perhaps most importantly, CCO’s perceived legitimacy is fed by and feeds further clinician engagement. Clinicians are understood to be key partners and CCO has made great efforts to foster clinical leadership.

*I think that the template of getting strong clinical involvement and having an agenda for ensuring good access and quality improvement and where it’s really not just driven by Ministry or by administration, but by strong clinical leadership and involvement I think is a really good approach. I think that twenty years ago or fifteen years ago it just felt like, as a provider, it felt like it wasn’t our, it wasn’t my system. But, I think we’ve at least taken some steps in the right direction so that providers feel really part of the system and can have an impact on the system. And, I get the feeling that that is unusual. I just don’t see it with my colleagues doing cardiology or doing other things. And, I think it’s because we have this system approach to things. [5-CCO-BD/ET]*

CCO’s ability to bridge administrative with clinical accountability has helped generate meaningful communities of practice and has become one of CCO’s key distinguishing features.
I think that that’s one of the distinguishing features of Cancer Care Ontario from (pause) either a hospital or the Government is that we’ve actually got very good clinical links. So, we have clinician through our clinical council. We have provincial clinical leads. We have regional clinical leads. They have a clinical accountability framework that makes it pretty clear what roles and responsibilities of each party and the basic functions that need to be performed. And, it’s not all about performance management; it’s about building communities of practice and tapping into the desire of clinicians to continuously improve their performance and want to do right by their patients. [1-CCO-BD/ET]

While clinician engagement is key, some participants cautioned against slipping CCO into a disciplinarian role.

We’re in the behaviour change business and not really the discipline business, right. We’re trying to get a whole broad base of healthcare providers to change the way they deliver care. [...] So, we don’t want to get into [disciplining clinicians] because people will get nervous and they won’t participate, and they won’t play. And, we need them to participate to raise the bar, not to use as discipline. [15-CCO-BD/ET]

However, for all of CCO’s achievements with respect to clinician engagement, many participants felt there was room to improve.

And then, the other part of the accountability is doctors. I really think there is a lot more work that we need to do to hold doctors accountable... I think a lot of physicians, just because of their status in the health system, because
they work independently that they are accountable to no one. And, I’m not saying it’s their fault. It’s the system that hasn’t... It’s historical. It’s the system that has to demand that accountability. And, we also have that problem here where we have physician leads for various programs and we’re not always keeping them as accountable as... it’s almost like, if you’re a physician you get a sort of carte blanche special status, right. [7-CO-BD/ET]

4.2.2.3 Outcomes – Performance and justice or fairness

Perspectives on the outputs stage were considered third, focusing on the promises of performance (instrumental) and justice or fairness (intrinsic).

Performance

The promise of performance assumes that individuals or groups held to account for their measurable performance will perform better. Performance mechanisms are designed to improve performance by focus on outputs and outcomes. Participants described performance management between the MOHLTC and CCO, and CCO and the RCPs, as well as considered the role of public reporting and its potential pitfalls.

Performance – CCO and MOHLTC

Although CCO is held accountable for its performance by the Ministry, it is not clear to participants how the Ministry would handle a situation where CCO failed in some way to meet its mandate.

We have accountability agreements with CCO. So, there are clear indicators and results. And I think there’s kind of an audit and an evaluation and then
working together. I don’t know if there’s something kind of formal as a kind of a remedy if the results aren’t achieved. I would say the relationship clearly has, what are the targets, what are the kind of... the goals. And then, we’ll be reviewing those together and decide what we collectively have to do to kind of meet them. [16-MOHLTC]

Performance – CCO and the regions

CCO was recognized by the MOHLTC as “ahead of the curve” [10-MOHLTC] with respect to their internal performance management system.

Between CCO and the Regional Cancer Programs, funding is tied in part to the requirement to report on a certain set of indicators. These scorecards are compiled monthly and reviewed formally on a quarterly basis.

There are four [quarterly reviews] done in a year. Two of them are sort of two day marathon sessions through video conferencing. And, the other two are sort of shorter where they submit a lot of data, a lot of information. It goes to the fact that... to make sure there’s an oversight, that people are doing what they’re doing and accountable to somebody, right, because all of us are accountable to someone, even the CEO or even the Board. And, the Government is accountable to the taxpayers. If you pay somebody to come and paint your house, you want to make sure you inspect it to make sure they’ve done a good job, right. You just don’t pay them and say “ok, I’m going to go on a vacation and then come back in a year to see what you’ve done”, right. So, it’s that follow up. It’s the follow up to make sure that, not only you have contracts in place to keep people accountable to what they’re supposed to do but make sure one follows up. [7-CCO-BD/ET]
While recognizing the importance of “face time” for fostering trust and healthy relationships between the regions and CCO provincial head office, some questioned the impact of quarterly reviews. This Clinical Council member explains at length her/his disregard for quarterly reviews, and how the “real” review takes place beforehand and behind closed doors.

See, I think quarterly reviews are stupid. Because you get the pa... you get the rose coloured glasses version. I mean, I’m not going to embarrass someone in public. I mean, that’s not what I’m going to do. So, what you see in quarterly reviews are wonderful people sitting around a table talking about performance. Some of the people may show up. Some people may not. But, in fact, the review that really happens for me is a week before when I talk to each of the clinical leads. You know, I’m not going to embarrass someone in public. That’s not my style. Or, at least, generally I don’t do that. I mean, basically we talk about areas where someone can or should improve, not necessarily them, but that their region can improve and how we can help them to do so. So what you get at quarterly reviews is the oatmeal of interaction with the region, which is face time and what you’re doing. Here’s a score card. And, you know, here’s your wait times. Oh, you know, it improved a little bit, but not as much as we thought. I mean, that’s why I think it’s a totally waste. [...] Well, first of all it’s a performance around the quarterly performance, right. It’s a performance. I mean, we may have some formal articulations of disappointment. But, they’ll be couched and based on a foundation that would have occurred outside that room and would not be news to those individuals who were receiving it,
right. We’re never going to broadside someone at that table. It’s not going
to happen. Well, it just would be inappropriate. That’s not the way you’re
going to get change is to embarrass someone in front of their peers and
even in front of those who report to them. So, yeah, I don’t particularly
think quarterly reviews are useful, but on performance management I think
what they do do is they give the required face time of their team together
and our team together. So, it’s a Kumbaya, but in some cases it’s not going
to be a region performance changing event. It is about getting people
together, articulating some good things, articulating some challenging
things and articulating some potential plans for improvement for the
future. [3-COO-AC-CC]

However, from the other side of the table, this PLC member is
unequivocal in her/his support of quarterly reviews as a valuable forum for
RVPs to voice their issues and support their regional team.

I think signals are sent in more polite ways. “I noticed that your wait times
on such and such are pretty long.” And, they’re really looking to see, “are
you addressing it? Are you on this or not?” And, no, I don’t think it’s all
theatre. I think there is an element of theatre where I take advantage of it
to make my points to CCO. And, I also make my points to the people on my
own team that the fact that I’m advocating for them or identifying that
there are issues in this area that CCO should be helping us with. So, there’s a
whole complex dynamic. [13-COO-AC-PLC]
Public reporting on the cancer system happens primarily through the work of the Cancer Quality Council of Ontario.

*First of all, the idea is that there should be some independent look. There’s no point in [CCO] just reporting on ourselves because the results could be perceived as biased. So, the CQCO was set up to be an independent look that would say, “ok, CCO’s got this plan they’re implementing, but here’s how the cancer system is doing – so CCO and partners who are delivering services are doing well here, but they’re not doing so well here.” So, the idea is that it would shine a light also on opportunities for improvement. Now, to set it up as completely independent would have been complicated, expensive because [CCO has] all the data. [CCO] collects data. So, it was decided at that time that it was... would be set up as quasi-independent in that [CCO] would support [CQCO’s] work. So, it’s an independent council, but [CCO] provides the data and [CCO] provides the programmatic support for the work that needs to be done to produce that annual report each year; but, the Council has to approve all the indicators that we’re going to measure and the message that goes out around those in terms of whether we’re doing well or not. The Council decides that. And, they report through the Board of Directors up to the Ministry of Health in the Government.* [2-CCO-BD/ET]

Public reporting provides transparency and strengthens CCO overall.
It’s very helpful actually to have that kind of public spotlight scrutiny because it provides some pressure to move the bar higher not only for us, but for all our partners. [2-CO-BD/ET]

A few participants reflected on the potential pitfalls of public reporting. Some took issue with the lack of nuance in the publicly reported data and also the difficulty of ensuring data accuracy.

So, you’re held accountable for your wait time by public reporting, but there’s not really enough... There’s not enough nuancing of it. There’s no appreciation. And, the data is not as sophisticated as it could and should be, which is always an issue with... You know, being held accountable for data which is meant to reflect performance, if the data is in any way flawed – and I think this is one of the things that irks a lot of us because it’s so hard to get it right. [13-CO-AC-PLC]

Another potential pitfall of public reporting is that the data are not always presented in a way that is accessible to the public. This CQCO member uses the CSQI as an example.

We need to start putting [CSQI] indicators in a different kind of framework so it would be more accessible to the public because the fact that we are... the council is accountable to the public to release this information. It shouldn’t be in a way that is communicated from CCO. [...] I don’t think they know necessarily that [the Council] exists. I think when people know that we exist they go, "oh, thank goodness." (laugh) [...] I think it speaks to the fact that public means a lot of things. [...] You know, like, even just the accessing
of the information then becomes a challenge. How can we start looking at our products or our work in a way that’s going to be accessible to many?

And then, that really then makes it accountable to the public because then everyone is actually able to access the information that’s in there. So, I think we’re achieving our mandate right now, which is that we are accountable to the public and we release things publicly. [9-CCO-AC-CQCO]

This participant elaborated the idea that there are many different “publics”. The participant takes it one step further and questions the goal of public reporting in a non-market driven healthcare system like Ontario. Again, lack of nuance and data inaccuracies has the potential to do more harm than good.

The way you report to publics versus cancer system people – like, I’m talking about LHINs and people, you know, delivering cancer care – versus the ministry of health versus CCO, very different ways of doing that, and particularly, the distinction between reporting to public versus health system folks. And, so, to think that you can do it all and that you should do it all and that you can do it all well, I just think that is problematic just from the very beginning. Not to mention the fact that public reporting on quality has not been shown to be particularly effective in actually… So, what is the goal of that? One of our goals is to report to the public on the performance of the cancer system. To what end? What do we expect to see from that?

Ok, we did it. It’s kind of a, you know, accountability, transparency thing, reporting, you know, that. The evidence I’ve seen is that it actually doesn’t do a whole lot towards changing behaviour. So, why would we do that?
What would the behaviour be? How would they choose different?

Ultimately, in a public system such as ours? So, the idea behind reporting – and, again, this is very much a U.S. context, right where a lot of this comes from is in a marketplace where you actually have choices. I think transparency is… I won’t say it’s always a good thing. I think you have to be careful what you’re being transparent about, but, for example, I think at one time CCO was committed to putting wait times, publishing wait times on their website. And, I just kind of thought, why are we doing that, especially because I think there was a lot of debate about what they really mean and are they actually accurate. And, there was just a whole bunch of issues there. And, I thought, well, why are you doing that? You’re just putting information out there without any context and potentially alarming and misinforming… and, not to mention making the healthcare providers pretty angry I think about this… who have to deal with the aftermath of this. So, I think… I won’t say that there isn’t a reason, like, it’s just useless, futile to actually report. I actually understand the notions behind it, the motivations. And, I actually have no problem with it, but I think just being incredibly careful about what you’re reporting on and, again, to what end. [18-CCO-AC-CQCO]

Justice or fairness

The promise of justice or fairness assumes the opportunity to seek justice in light of some claimed act or possible act will result in accountability. Mechanisms of justice or fairness are symbolically and culturally associated with just and equitable treatment. Participants described the ways in which appealing
Justice or fairness – Appealing to a healthy sense of competition

Providing performance data at the provincial, regional and, in some cases, local levels is seen to “hold people’s feet to the fire” [3-CCO-BD/ET] and to drive change by appealing to a healthy sense of competition among both administrators and clinicians.

We also have lots of information and data backbone. So, we can provide, you know, if a physician or a regional vice president in a region says, “I’d like to know what... how I compare to another region” in terms of what they might be doing in a particular area, we can provide them that feedback. And, we do change behaviour through information a lot. And, in fact, I could show you slide decks where we’ll show one region, one year they were worst at something. The next year they were the best. And, that change was made only by showing them the data not by spending a penny, right because nobody wants to be the worst if you will. So, you create this sort of healthy competition by a public display of information and comparative information that makes people want to be different. We also rank our regional programs in terms of their performance. So, you can be one out of fourteen or you can be fourteen out of fourteen. And, that creates some good, healthy competition as well. Nobody wants to be fourteen out of fourteen. And, in fact, we have made some leadership changes because some places continue to be fourteen out of fourteen, right. [15-CCO-BD/ET]
Similarly, funding is a catalyst for change, but it is the data that appeals to individuals’ own sense of wanting to improve that drives improvement.

*I think that the catalyst is funding. We got their attention. The data is actually the driver because people want to do better. I truly believe that most people want to do better. Most people want their region to do better. They want their hospital to do better. They want their patients to do better.*

This is especially true for clinicians, who are generally perceived to be a group of high achievers.

*In the cancer system, we actually spit it out to you to say, “did you know that, you know, your thirty day mortality for this kind of surgery is the worst in the province?” They’d be devastated. It’s like, “holy crumb. I didn’t know that. We thought we were doing great care.” I mean, you probably were, but you’re missing a couple of elements. Or, you know, if you change a technique here, you can raise the bar; and we can help you change that technique. Let’s bring in some expert whatevers and help you work through your processes to get you there. And, people will rally around that in a big way. You have to remember, doctors are generally top of class, right. They’ve gone through their whole lives being the straight A student, top of class. They don’t want to be B students much less F students, right. So, my god. So, you can leverage that, that human element of coming together to do the right thing just because it’s the right thing to do.*
It is important that indicators are perceived to be legitimate, and to avoid over measurement. CCO is aware that they can at times over measure, so they try to make it clear why certain things are being measured to not add extra burden.

*I think one of the things we’re quite conscious of is that we can at times over measure. Having too many measurements isn’t necessarily a good thing either. So, part of what we try and deliberate about is not just, let’s measure this, but what can we do about it? Is it really telling us something valuable and so forth and so on? So, I think that that’s very important because providers at the front lines can get sort of exhausted by the amount that we’re asking people to measure. So, I think we need to be very clear that it’s clinically relevant and make sure that it’s for a good reason that we’re measuring it.* [5-CCO-BD/ET]

As this CCO participant put it, CCO has a very rich data set to work with, but it can break down.

*That’s why we have fairly rich data sets much richer than a lot of places. But it breaks down; with the more data you require, obviously the bigger burden is on the people submitting the data and there’s a practical limit* [6-CCO-BD/ET]

This is especially true of public reporting. In order for the report to be meaningful, it needs to be accessible to its target audience. This participant questions whether it is to anyone who is not already intimately familiar with the workings of the cancer system.
[Speaking about the CSQI] You know, once again, I see a lot of the reports. And, I think, my goodness, how could anybody – you know, like, forget general public, but even Ministry, senior level folks – get this stuff. It seemed very much geared towards the cancer system people. They get it. They read this stuff and they see it right away and they know what to look for indicator-wise. It’s almost become just a machine of how many different indicators can we pump out and how much it’s this data driven thing versus what are we really trying to look at here. What are we concerned about? Maybe a little more about prioritizing. [18-CCO-AC-CQCO]

Justice or fairness – Issues with ranking

This particular PLC member highlights how regional ranking is not necessarily done in a fair way, because it does not reflect the organizational differences that have a material impact on regional outcomes.

So, having an aspirational goal, a vision, setting the standards, guidelines, having developed indicators, measuring them, reporting them, putting them out there publicly, rank ordering your cancer centres knowing that people are fundamentally competitive; nobody comes to work to be the last in class. It’s [ranking] not fair. It’s across all of the, not all of the CSQI indicators, but across the ones that CCO particularly reports on a quarterly basis. And, for each one, you’re sort of ranked from one to fourteen. Your ranking’s determined whether you’re at or exceeding target, whether you’re within five percent of it or you’re off below that and in the red. You’re colour coded green, yellow or red. And, for each metric there’ll be a number so you can be ranked one to fourteen. And, when you put all those one to fourteens
together, then you roll out where you are overall. But, it means that every indicator is given the same weight as every other, which isn’t necessarily fair. Well, you’ve got centres that see four or five hundred patients in a year and centres that see seven thousand. And to implement any change in an organization with as many bodies as [in large centres] requires?? a lot more work than implementing it in [smaller centres]. It’s also hard when you’re trying to change an old culture versus you’re hiring people into a brand new facility. So, there’s an element of nimbleness. There’s new versus old. There’s academic versus community based. There’s a lot of different factors. And, so, just to be homogenized as overall the same I’ve objected to it. I’ve been trying to get that changed, but it’s not an easy battle because it’s hard to know what would be more fair to showcase how we’re all doing. The value of it is nobody wants to be last. Nobody wants to be near the bottom. So, we all work to try to be better than we have been. [13-CO-AC-PLC]

**Justice or fairness – Avoiding “gaming”**

Many participants recognized the potential for “gaming” indicators, but see the problem as something of a red herring – what’s important is not the number but what is actually being produced.

*I mean, people are working the system, but they can rationalize why they work the system, right. But, generally, I don’t find that motivation is the problem, I don’t find that people cheat on purpose. Oh yeah, everybody games the indicators. But CCO games the indicators for the Ministry, right. Well, it’s easier to game the indicator than give fifty-five thousand reasons to the minister why these things didn’t work. So, what I think is important in*
any system is to know the difference between gaming indicators and what you really produce. [...] Introspectively, internally, you have to know where your weaknesses and your vulnerabilities are and correct them and minimize them, right. But, it just takes too long to explain every little vulnerability and problem to somebody in the ministry who gives you twenty minutes. So I’m sure that everybody games everything. [17-CCO-AC-PLC]

4.2.2.4 Closing the loop

Table 3 provides a summary of findings. At the inputs stage, control is addressed through legislation and memoranda of understanding, funding, and agency-wide bureaucratic controls. The Cancer Act and MOU are seen as foundational to the relationship between the MOHLTC and CCO, yet largely ineffective on their own. Funding is a major lever for change, especially for the MOHLTC, yet the relationship is about more than just money. Agency-wide bureaucratic controls are acknowledged as necessary, yet the implementation of these controls can be burdensome for the agency.

Integrity is addressed through trust, the nature of the health and cancer care systems, and bureaucratic controls. Trust between the MOHLTC and CCO creates the foundation for organizational success, which has the effect of filtering down to the grassroots level. The nature of health and cancer care is seen to attract individuals with integrity. Bureaucratic controls help to promote integrity.

At the processes stage, appropriate behaviour is addressed through agency-wide and internal codes of conduct and formal structures created to
ensure due processes. Codes of conduct serve as helpful reminders of how to behave, but it is the elaborated and deliberate structures around due process that are most important.

Thanks in large part to these structures, CCO is perceived across the board to have \textit{legitimacy}. The MOHLTC will rely on CCO’s credibility to help justify its decisions. Crucially, CCO’s ability to engage clinician leadership at the provincial and local levels both feeds and is fed by this credibility.

At the outcomes stage, \textit{performance} is addressed through CCO’s sophisticated internal performance management system. Interestingly, the MOHLTC recognizes that there is some uncertainty around what they would do if CCO failed to meet its mandate. Internal quarterly performance reviews are key to providing oversight, but there was some disagreement regarding different aspects of the quarterly review that achieve desired accountability effects. Similarly, public reporting is valued for providing transparency, yet it is complicated by the existence of various ‘publics’ and recognition of the need to be careful about messaging. Finally, participants caution against over-measurement and the need to ensure indicators are clinically relevant.

The aim of \textit{justice or fairness} is addressed by appealing to a healthy sense of competition among administrators and clinicians. There is recognition of indicator “gaming”, yet it is not seen to be a cause for concern. Ranking the regions remains problematic, as different organizational characteristics are not adequately accounted for.
Ultimately, “outcomes” feedback into “control” by informing the priorities that will in turn inform the “processes”. The better the regions perform, the better CCO performs as an organization, and the agency is then more likely to secure the resources it needs from the Ministry going forward.

There’s a tension about asking for more money without necessarily seeing a deliverable. And, that’s why [the Ministry has] kind of fallen in love with the whole CCO model because it’s a very simple model; but if you have guidelines and standards and you create indicators that reflect on how well you’re following the guidelines and standards, you measure them and do performance management and you learn from that and you go around the cycle, they love that. And, so they should because it means that you’re spending money on things which are being measured, being publicly reported and which are leading to system improvement which leads to more things that can be done to improve the system. And, as long as you’re demonstrating that you’re moving towards your targets, you’re concordant with your guidelines, you’re achieving the standards, you’re becoming more efficient, and so on and so forth, then they’re inclined to give you more money. And, CCO’s had a wonderful reputation over the last five years of getting more resources to do more things. Where has money been invested in a? quality healthcare system anywhere else? [13-CCO-AC-PLC]
### 4.2.3 Ranking the promises of accountability

At the end of each interview, participants were asked to complete a simple ranking exercise. Considering everything that had just been discussed, participants ranked each of the six “promises of accountability” against each other, with “1” being considered most important and “6” being considered least important. Table 4 describes how participants ranked the “promises” within and across groups. In a few cases, participants chose to double rank particular promises; this was permitted because the goal of the exercise was not to achieve

<table>
<thead>
<tr>
<th>Stage of Accountability</th>
<th>Accountability valued...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Instrumentally</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td><strong>CONTROL</strong></td>
</tr>
<tr>
<td></td>
<td>• Legislation and memoranda of understanding are foundational, yet ineffective on their own</td>
</tr>
<tr>
<td></td>
<td>• Funding is a major lever for change on both sides</td>
</tr>
<tr>
<td></td>
<td>• Agency-wide bureaucratic controls are necessary but burdensome</td>
</tr>
<tr>
<td><strong>Processes</strong></td>
<td><strong>APPROPRIATE BEHAVIOUR</strong></td>
</tr>
<tr>
<td></td>
<td>• Agency-wide and internal codes of conduct are helpful reminders</td>
</tr>
<tr>
<td></td>
<td>• Elaborated structures around due process ensure deliberation and principle-driven decision-making</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>PERFORMANCE</strong></td>
</tr>
<tr>
<td></td>
<td>• Uncertainty about what would happen if CCO underperformed</td>
</tr>
<tr>
<td></td>
<td>• Internal quarterly reviews ensure oversight, yet some equivocation regarding importance</td>
</tr>
<tr>
<td></td>
<td>• Public reporting provides transparency, but is not straightforward</td>
</tr>
</tbody>
</table>

![Table 3. Summary of participants' perspectives on Dubnick's “promises of accountability”](chart.png)
statistical rigour but instead serve as a tool for understanding how participants prioritized the different promises.

Table 4. Ranking the "promises of accountability"

<table>
<thead>
<tr>
<th>Inputs</th>
<th>MOHLTC</th>
<th>CCO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BD/ET</td>
<td>Advisory Councils</td>
<td>All CCO</td>
</tr>
<tr>
<td>Control</td>
<td>3.2 (2-5)</td>
<td>3.3 (1-6)</td>
<td><strong>4.2 (1-6)</strong></td>
</tr>
<tr>
<td>Integrity</td>
<td>3.8 (3-5)</td>
<td>3.3 (2-5)</td>
<td>2.8 (1-6)</td>
</tr>
<tr>
<td>Appropriate behaviour</td>
<td><strong>5.0 (4-6)</strong></td>
<td><strong>4.7 (3-6)</strong></td>
<td>3.4 (1-6)</td>
</tr>
<tr>
<td>Legitimacy</td>
<td>3.4 (2-5)</td>
<td>3.5 (2-6)</td>
<td>3.0 (1-5)</td>
</tr>
<tr>
<td>Performance</td>
<td><strong>2.0 (1-6)</strong></td>
<td><strong>1.7 (1-5)</strong></td>
<td><strong>2.5 (1-5)</strong></td>
</tr>
<tr>
<td>Justice/Fairness</td>
<td>3.0 (1-6)</td>
<td>2.7 (1-4)</td>
<td>3.2 (1-5)</td>
</tr>
</tbody>
</table>

1=most important; 6=least important

Legend:
MOHLTC – Ministry of Health and Long-Term Care
BD/ET – Cancer Care Ontario, Board of Directors or Executive Team
PLC – Cancer Care Ontario, Advisory Council, Provincial Leadership Council
CC – Cancer Care Ontario, Advisory Council, Clinical Council
CQCO – Cancer Care Ontario, Advisory Council, Cancer Quality Council of Ontario

Overall, there was a fairly high degree of consistency between groups in terms of how they ranked the most and least important promises. Looking at the total score, performance ranked most important and appropriate behaviour the least, with the others lumped ambiguously together. This was consistent across both groups, with the exception being CCO’s advisory councils. The advisory councils ranked control least important, but agreed that performance was the most valued promise. There was some variation within the advisory councils, but
given the low numbers within each group, aggregate results are presented here for the purpose of analysis.

Comparing the results of the ranking exercise to the qualitative interviews, it is not a surprise to see *performance* so highly valued. CCO is seen and sees itself as a paragon of performance management, and the organization's ability to demonstrate its performance further feeds its ability to secure the resources it needs as well as enable compliance with due process. Despite the limitations of the ranking exercise employed, it does suggest where the interview data deviate – highlighting areas for further consideration. The ranking exercise deviates from the interview data most prominently with respect to participants’ ranking of *appropriate behaviour*. While the ranking exercise suggests that appropriate behaviour is least important, the qualitative data suggest that the deliberate and elaborate structures around due process are a key element in accountability in this context. Overall, there is clarity regarding the most and least valued promises. However, there is considerable ambiguity in the middle group of promises.
Chapter 5. Discussion

5.1 Interpretation

This is a study about accountability – how it is valued and how it is understood to work – in a healthcare governance context. To keep the focus at the system-level, this study aimed to understand how healthcare leaders on either side of a government-agency relationship made sense of accountability. Much ado has been made of accountability, yet one does not have to scratch too far below the rhetorical surface to find it is a garbled mess. The problem is not a lack of attention to accountability, it is that despite volumes of work there is a persistent lack of consistency regarding how accountability is conceptualized and therefore understood to work (Dubnick and Frederickson 2011).

This insight has motivated Mel Dubnick’s work on accountability in the public sector. As a critic of accountability-as-a-panacea, his body of research converges on a still-evolving framework of the so-called “promises of accountability”. The overall objective of this study was to apply this theoretical framework in an empirical study of system-level accountability between a Government and its specialized agency. Within this overarching objective, there were three research questions: 1) How is accountability valued? 2) How is accountability operationalized? and 3) What, if any, are the implications for Dubnick’s “promises of accountability” framework?

The study was designed using qualitative description and included informal observation, review of historical documents, and interviews. On a very practical level, observation provided a kind of crash course about relevant governance structures and organizational processes. On a more abstract level,
relationships and interactions were observed between individuals and between administrative and clinical groups. When putting study findings together, the importance of these inter-personal and inter-organizational dynamics have come into relief.

Document review provided needed historical context to understand the cancer system in Ontario as it is today. The cancer agency in its current form is not an accident. In fact, its governance structure can be seen to have arisen as a direct result of a crisis of accountability – between the Government and its agency, the clinical community, and the public. It was fascinating to weave the story together, as the events leading up to the crisis, the public and political response, and ensuing restructuring process are all well documented. Of course it is not possible to know what went on behind closed doors, but one can imagine much of the action took place in those private spaces.

Throughout the interviews, the “promises of accountability” resonated with most participants. The instrumental promises (control, appropriate behaviour, performance) were particularly meaningful to participants. The intrinsic promises (integrity, legitimacy, justice) were seen as vital, yet it was less clear that most participants saw a meaningful distinction between them. Participants identified concrete tools for each of the instrumental promises (e.g., contracts, bureaucratic controls, performance measurement), whereas the intrinsic promises relied on more abstract efforts (e.g., creating trust and communities of practice, appealing to healthy sense of competition). The accountability mechanisms associated with the instrumental promises are very similar to the contractual, monitoring and performance tools central to the New Public Management (Hood 1995). However, findings from this study underscore
the importance of abstract efforts like building trust and communities of practice. Looking at participants’ views, the instrumental promises seem to create the conditions for ensuring the intrinsic promises are met; yet without the intrinsic promises in place, the instrumental promises would not work as well as they do.

The ranking exercise tells a slightly different story about accountability than the interviews. Although a number of participants resisted ranking the promises against each other because they were viewed as equally important “like the walls of a house”, taking the exercise at face value, performance rose to the top. On the flip side, appropriate behaviour was least valued – quite different from what was heard in the interviews. This discrepancy could have arisen because of the way the ranking exercise was presented, which may have led participants to think about appropriate behaviour in a different way. In contrast, during the interviews, participants could think through and expand on their ideas about appropriate behaviour. This promise came across as particularly important because of the link between principle-driven decision-making and fostering clinical engagement, which in turn feeds CCO’s perceived legitimacy.

Overall, the mean rankings were consistent across groups, with the exception of CCO’s advisory councils. With performance most valued and appropriate behavior least valued, the other four promises were ranked roughly equally in a mushy middle – an interesting finding considering that three of these are the intrinsic promises. This is consistent with the interview data, where intrinsic promises were not discussed in a way that suggested participants saw a clear distinction between them.
What, then, does this mean for Dubnick's framework? From the interview and ranking data we learned that the instrumental promises were seen as distinct and the stages as sequential. Instrumental promises were distinct in that informants could speak specifically to each of the three individually, and sequential in that most informants clearly described a step-wise progression through the three promises. This progression may be somewhat artificial, as in practice the steps may overlap. The intrinsic promises were perceived as essential but not as clearly distinguishable from one another. Most informants referred to many aspects of intrinsic promises but could not clearly or consistently differentiate their meaning. Taking these insights into consideration, the Dubnick framework could be modified in two ways.

In the first version (Figure 2), the instrumental promises are kept distinct but the intrinsic promises are collapsed. The emphasis is on the interaction between the intrinsic, taken as a whole, and each instrumental promise. Here, the main contribution to the framework is to reflect the empirically derived observations regarding the challenges in clearly distinguishing how accountability is valued intrinsically.
In the second version (Figure 3), the focus is on the stage axis, which is not well described in Dubnick’s work. A modification to Dubnick’s framework here adds emphasis to the sequential relationship between each stage. Taking a more mechanistic understanding of accountability by emphasizing the stages, the focus is put on the better defined instrumental promises (rather than the poorly distinguished intrinsic promises) and how each works both instrumentally and intrinsically. This approach provides practical guidance through inputs, processes, and outcomes stages, rather than a focus on the different ways accountability is valued, and may be a better fit for how decision-makers really think or apply their knowledge about accountability in their work.

Figure 2. Modified "promises of accountability" framework 1: Focus on value
Figure 3. Modified “promises of accountability” framework 2: Focus on stage

These modifications highlight a pre-existing tension between accountability as such and the mechanisms applied in its pursuit. Is accountability something that exists outside the act of its doing? Is accountability in fact a verb and not a noun, or is it both? Dubnick himself has struggled with this, which led him to retool the framework by dropping the “instrumental” and “intrinsic” distinction altogether (Dubnick 2012b). Instead, Dubnick’s new version emphasizes the “discourses” of accountability and their attendant “narratives”, where narratives encapsulate the now familiar “promises of accountability” (Dubnick 2012a).

However, I would argue that there is value in keeping the distinction between instrumental and intrinsic ways of thinking about accountability. In my proposed modifications to Dubnick’s original version of the framework, the first version of the revised framework (Figure 2) privileges accountability as a thing unto itself, whereas the second version (Figure 3) places the prerogative on accountability as an action, but both uphold the distinction Dubnick dropped in his new version.
Future research will need to be attentive to these differences. Building on this study, one could choose to look at a similar Government-agency relationship. In this case, the first modified version of the framework, where the emphasis is placed on value, could be utilized to unpack whether and how there are in fact meaningful differences between the intrinsic promises. Alternatively, one could examine different types of accountability relationships. Here, the focus would be on the second modified version of the framework. Different contexts could be compared and contrasted to understand how the instrumental and intrinsic promises work together at each stage and, crucially, how each stage is linked sequentially to the next. Whether future research is conducted in similar or different contexts, the work could be a hypothetical exercise or conducted using existing accountability relationships; in either case, findings could be leveraged to identify a set of measures that could then be used to assess the relative condition of these relationships.

5.2 Policy implications

The implications for policy derived from this work are both theoretical and practical. From a theoretical perspective, Dubnick's framework is critiqued by highlighting a lack of clarity regarding the individual intrinsic promises as well as emphasizing the stages at which the “promises of accountability” occur.

From a practical perspective, policy makers, particularly those in healthcare contexts similar to the one examined in this study, may consider a couple of options to improve the accountability within the broader system. One option may be to pay closer attention to distinguishing the individual intrinsic promises of accountability and the levers at their disposal to bolster them.
Another option may be to identify relevant tools that can help achieve the goals of accountability both instrumentally and intrinsically. Further, healthcare leaders could be guided by the stages of accountability as much as the promises themselves as signposts for the steps needed to improve accountability.

5.3 Limitations

This study was conducted in very specific context, namely, the cancer services system in Ontario. I looked specifically at the relationship between the Ministry of Health and Long-Term Care and the Government’s cancer agency, Cancer Care Ontario. The findings of this study may not be extendable to other public sectors or to non-public, market-driven contexts. However, I would argue that there are lessons to be learned about the underlying complexity of accountability and the lingering uncertainty.

Initial study designs intended to include the Regional Cancer Programs as part of the accountability relationship within the cancer system, but it was decided early on that primarily for feasibility considerations, this study would focus solely on the relationship between the MOHLTC and CCO. It was suspected going into the study that the Ministry would play an essential role, albeit peripheral, and that the bulk of the accountability story would take place within the agency. Most of the people I spoke with at CCO were either directly involved in the cancer system restructuring process or had held a leadership position in the cancer system at the time. They were able to draw on their institutional memory in a way that most at the Ministry could not. However, this is not so much a limitation as simply a reality in most types of Government-agency
relationships – especially where the Government acts in the kind of stewardship role advocated in New Public Management theory.

Observation was not incorporated into the study design as a formal data collection method, because it was initiated at a very early stage to become acclimated with the context and before specific research questions or study methods were determined. At that point, it was determined not reasonable to pursue ethics approval and obtain necessary permissions in order to meet ethics standards. However, the opportunity to observe nearly two years worth of advisory council and quarterly review meetings served to enrich my understanding of the context beyond what could be found online or in the published literature. That direct observations cannot be reported does not diminish the importance of having had this invaluable opportunity.

The ranking exercise was intended to help interview participants reflect on the discussion that just took place. It was not designed to be a rigorous survey tool; rather, the ranking exercise functioned almost like a diagram to elicit final thoughts from participants. A basic analysis was conducted to simply illustrate patterns in perspectives and to avoid overstating results.

5.4 Conclusion

For broader public sector theory, this study complicates unexamined notions of accountability. Within New Public Management theory, there is tremendous emphasis on a mechanistic understanding of accountability – sign the contract, follow the rules, report your performance data – that this study challenges. These mechanistic tools are absolutely essential, but will not work as
well without certain intrinsic qualities alongside. Similarly, to have integrity, legitimacy and justice, the instrumental promises must also be in place.

For the healthcare governance community, this study helps to show that there is more to system-level accountability than just a strict focus on performance. Accountability encompasses a system of relationships between all stages of the organized effort. Perhaps most importantly, accountability requires not just the application of mechanistic tools characteristic of New Public Management, but also more abstract tools to foster meaningful inter-personal and inter-organizational relationships. There is a constant push and pull of the externally imposed and the internally motivated and the goal must be to strike a balance.

In conclusion, this study found that healthcare leaders in a particular Government-agency relationship value accountability for both its instrumental and intrinsic promises, though the latter were less clearly distinguishable. Accountability is operationalized through instrumental and intrinsic promises working symbiotically at each stage of the organization; inputs inform processes, processes inform outcomes, and outcomes feedback to inform the inputs. Taking these empirical observations together, two ways of modifying Dubnick’s “promises of accountability” framework are proposed: one that emphasizes the value of accountability, and the other that emphasizes the stages at which accountability promises occur.
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Appendices

Appendix 1. Ontario cancer system map

Accessed at:
https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=8623
Appendix 2. Email invitation

*First Contact Email*

Subject line: Accountability in Ontario’s cancer services system – request for brief interview

Dear Dr./Mr./Ms. **:

I am conducting a research study on accountability in Ontario’s cancer services system as part of my MSc thesis research in Health Services Research at the Institute of Health Policy, Management and Evaluation at the University of Toronto. The goal of this research is to understand the ways in which cancer system leaders value accountability-based solutions to the problems of health system governance and the consequences – intended or otherwise – of applying these solutions.

You are being invited to participate in a brief one-on-one interview because you are involved in system-level cancer services accountability in your capacity as [**]. If you agree, the interview would take approximately 30-45 minutes of your time. I recognize that you are very busy, so I am happy to meet at a time and place most convenient for you.

This work is part of a larger study funded by the Canadian Institutes of Health Research examining approaches to accountability across various sub-sectors of Ontario’s health care system and has received ethics approval from the University of Toronto Health Sciences Research Ethics Board.

Many thanks in advance for considering this request.

Sincerely,
Jessica
Second Contact Email

Subject: Accountability in Ontario's cancer services system – request for brief interview

Dear Dr./Mr./Ms. **:

Two weeks ago we contacted you to request a brief one-on-one interview about your experiences with system-level accountability in Ontario's cancer services system. As a **, your perspective is invaluable – we are hoping that you will help us fill in the gaps in our knowledge about best practices to achieving accountability in this context.

If you agree to participate in the study, the interview will take approximately 30-45 minutes of your time and will be conducted at a time and place more convenient for you.

Many thanks for considering this request.

Best,
Jessica
Appendix 3. Consent form

INTERVIEW PARTICIPANT INFORMED CONSENT FORM

Qualitative case study of accountability in Ontario’s cancer services system

Investigator: Jessica Bytautas, MSc Candidate
Institute of Health Policy, Management and Evaluation, University of Toronto

Thesis committee members: Dr. Mark Dobrow
Dr. Terrence Sullivan
Dr. Adalsteinn Brown

Research Sponsors: Canadian Institutes of Health Research

You are being invited to participate in this study because you are a cancer system leader in a core division of the Ministry of Health and Long-Term Care or Cancer Care Ontario. This research is being conducted by Jessica Bytautas in conformity with the requirements for the degree of Master of Science in Health Services Research at the Institute of Health Policy, Management and Evaluation, University of Toronto.

Purpose of the study: Accountability is a widely used term in discussions of health system governance. Yet the concept remains ambiguous and, arguably, lacks both the theoretical and empirical bases on which to support evidence-informed decision-making. This tension between importance and lack of clarity suggests accountability is a key feature of our health system, but that our ability to maximize its impact is still in its infancy. As part of a larger study examining approaches to accountability across various sub-sectors of Ontario’s health and public health care system, this study aims to: (1) explore the values ascribed by cancer system leaders to accountability-based solutions, the mechanisms applied in pursuit of these goals, and whether tensions or unintended consequences are perceived to occur, and (2) examine the utility of Dubnick et al.’s ‘promises of accountability framework and adapt it to the cancer system context. If leaders in Ontario’s cancer services system perceive inconsistent goals and mechanisms of accountability, then there is an opportunity to improve communication and clarify agreements between those who are involved in system-level accountability agreements.

Procedures involved in the research: We would like to invite you to participate in an in-depth interview, either face-to-face or over the phone, at a place and time convenient to you. The interview will consist of several open-
ended questions about your role in Ontario’s cancer services system, your understanding of existing accountability structures, mechanisms and aims, and your perceptions of any un/intended consequences of their implementation. With your consent, the interview will be audio recorded for transcription and analysis by the study team. The interview will last approximately one hour.

**Potential harms, risks or discomforts:** There are no physical risks to participation in this study. However, while we will keep your identity and information confidential (if you so choose), because of the small number of senior cancer system administrators there is a minimal risk that informed observers may surmise your identity from final reports or publications of study data. This could have negative peer or professional consequences.

You have the option to decide how the information you provide will be used. For example, you may allow us to name you as a respondent, or you may prefer anonymity. You might also request the option of reviewing all uses of your data, such as quotations, before publication. If you elect to have your information remain anonymous, all identifying material will be kept separate from your data, and will be kept in a locked office, with data stored on a password-protected computer accessible to only core members of the research team (i.e., student researcher and committee members). All data and identifying information will be kept for seven years after completion of the study (i.e., data collection) and will then be destroyed.

**Potential benefits:** This study may provide a modest benefit to participants. By making sense of the concept, mechanisms, and consequences of accountability in the context of Ontario’s cancer system, this study aims to advance research in an understudied area while producing knowledge relevant to public policy makers on what is known about effective and appropriate models of governance.

**Confidentiality:** Interview data will be audio recorded and transcribed for later analysis by the research team (i.e., student researcher and committee members). If you elect to remain anonymous, data from interviews will be kept confidential by removing identifying information from data, maintaining data in a locked office and in a password protected computer. Anonymity will be maintained for research participants through anonymous quotation in the final report and in all presentations and publications, unless consent to reveal identity has been given.

**Legally required disclosure:** We may have to reveal certain personal information if the law requires it (e.g., child abuse).

**Participation:** Participation in this research study is entirely voluntary. You are free to withdraw at any time and without prejudice. If you decided to withdraw before the interview is conducted, the interview will be cancelled. If you withdraw during the interview, the interview will stop and the recording will be destroyed. If you decide to withdraw after the interview, but before the final study report or publications are written, you may contact the student investigator to do so. You will receive a copy of this consent form for your records.
Rights of Research Participants: If you have questions or require more information about the study itself, please contact:

Jessica Bytautas, MSc candidate
Institute of Health Policy, Management and Evaluation
University of Toronto
155 College Street, 4th Floor
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This study has been reviewed and approved by the University of Toronto Research Ethics Board. If you have questions about your rights as a research participant, please contact:

Daniela Gyewu, Health Sciences Ethics Review Officer,
Ethics Review Office, University of Toronto,
416-946-5806 or zaid.gabriel@utoronto.ca

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8. I would like to receive an executive summary of the final report or copy of any publications when it/they are available.

9. I would agree to be re-contacted if necessary.

I have read the information presented in the information letter about a study being conducted by Jessica Bytautas of the University of Toronto. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

____________________________
Name of Participant

____________________________
Signature of Participant

In my opinion, the person who has signed above is agreeing to participate in this study voluntarily, and understands the nature of the study and the consequences of participation in it.

____________________________
Signature of Researcher or Witness
Appendix 4. Interview guide

Preamble: Many thanks for generously agreeing to speak with me today. I am conducting this research as part of a larger study of best practices to achieving accountability across various sub-sectors of Ontario’s health care system. Using Ontario’s cancer services system as a case study, our work explores the concept of accountability, its scope, and how it works. In particular, we are interested in learning more about your thoughts on system-level accountability between the MOHLTC and its cancer agency, Cancer Care Ontario.

1. You wear many hats, but today we approached you as a member of CCO/ MOHLTC ________________.
   a. Would you tell me about your role in the organization?
      i. How did you come to be in this role?
      ii. How long have you been in this role?

2. It has been argued that a defining feature of accountability is the exchange of information between parties in a relationship based on mutual expectations.

   a. From your perspective as a member of CCO/ MOHLTC ________________, what are CCO’s expectations of MOHLTC?
      i. Typically, how are these expectations established?
      ii. When have these expectations been met? Or not?
      iii. What has made it easier or more difficult to meet these expectations? (I.e., barriers/ facilitators)

   b. Again, from your perspective, what do you think the MOHLTC expects of CCO?
      i. Typically, how are these expectations established?
      ii. When have these expectations been met? Or not?
      iii. What has made it easier or more difficult to meet these expectations? (I.e., barriers/ facilitators)

3. The term ‘Accountability’ is often used in discussions of health system governance, but the concept itself remains nebulous. It has been argued that accountability can accomplish a number of things – we would like to know what you think of each of the following values of accountability in the context of Ontario’s cancer services system. Do these values resonate with you?

   a. To what extent is CCO held to account by MOHLTC for getting results? [Performance]
      i. What does CCO do to demonstrate performance?

   b. To what extent does MOHLTC stipulate certain processes by which CCO operates (e.g., through rules, regulations, standards)? [Control]
i. Do these types of bureaucratic controls help or hinder CCO’s operations? How/why?

c. How does CCO attend to or ensure justice/fairness? [Justice/fairness/equity]
   i. Does accountability actually enable the delivery of real justice? How/why?

d. How does CCO deal with situations where political pressures are brought to bear? [Democracy/Legitimacy]
   i. What happens when CCO and MOHLTC priorities are not aligned?
   ii. Is transparency always good and preferable? Why (why not)?

e. To what extent does the current system foster an organizational culture of integrity? [Integrity]
   i. How are individuals encouraged to act with integrity?

f. To what extent are mechanisms in place to ensure ethical or appropriate behaviour of senior leadership? [Ethical/appropriate behaviour]
   i. How is inappropriate behaviour prevented? Corrected?
   ii. Do standard operating procedures, conflict-of-interest rules, and financial disclosure rules, for example, always produce ethical behaviour?

4. Having talked through these six values, is your sense that certain values of accountability assume priority over others in the cancer care context?
   a. What is most/least important?

5. Finally, what do you think are the big lessons that could be learned from MOHLTC/CCO’s experiences with system-level accountability for the broader community interested in questions of health system governance?
   a. If you could redesign the existing accountability relationship between MOHLTC and CCO, what would it look like?

Is there anyone you recommend I speak with? Are there any documents you suggest I review? Any final thoughts?

THANK YOU FOR YOUR TIME!
Appendix 5. Coding framework

Focus on...
Inputs – Control, Integrity
Processes – Appropriate behaviour, Legitimacy
Outputs – Performance, Justice/ fairness

Value...
Instrumental
Intrinsic

Specifics...
Access to Care
Agency directives
Audit
Business plans, contracts, funding letters, accountability agreements, CSIA
Cancer Act
CCO advisory councils – PLC, CC
CCO as principal advisor and overseer
CCO brand, image
CCO internal policies
Clinical guidelines and standards, evidence
Clinician and expert engagement
CQCO, CSQI
eHealth
Herceptin
Leadership
Memorandum of Understanding
Ontario Cancer Plan
Ontario Renal Network
Performance indicators, data, gaming
Public reporting, messaging
Quarterly reviews
Reconciliation by MOHLTC of CCO
Regional cancer programs, centres, RVP
Restructuring
Role of the agency
Transparency
Trust
Appendix 6. Supplementary quotes

Inputs

Control

_I should mention there is a Memorandum of Understanding that is a kind of contractual document. It’s quite outdated. It doesn’t have... So, CCO does... You know, the mandate that is documented is its cancer mandate, which is all around driving kind of a quality agenda and dealing with kind of population issues in cancer._ [14-CCO-BD/ET]

_...we have a Memorandum of Understanding with the ministry that is very, very... it’s a legal document that says what we do...it’s really renegotiated on an irregular basis._ [1-CCO-BD/ET]

_“Give me the money and shut up” would be the most cynical response I could give you. (laugh) Yeah, “provide the resources and stay out... I mean, if that’s what you want us to do, we’re happy to do it. Stay out of our way in us doing it.” Like, “we don’t need you to come in and then second guess everything or stick your finger into something where you’re...for Ministry reasons or political reasons might be appealing to you, but it has nothing to do with clinical efficacy or systems thinking and so on and so forth.” So, to me that’s kind of the deal._ [8-MOHLTC]

_[CCO] is an agency of Government. So, the Ministry just doesn’t say, “here you go” (laugh) and like they kind of did with ORNGE. And, so, we are subject to, as you put it, bureaucratic controls that apply to agencies in general. So, there’s a provincial travel policy for instance or procurement policy or a hospital policy, et cetera, et cetera. So, we’re subject to that same framework of regulation. In addition, we, like any other agency of Government, are subject to oversight in terms of (pause) communications for instance. So, we can’t go take out a TV ad just because we want to; that has to be coordinated. Certainly, finance and budget, so we’re not independent of Government, but we are mandated to do our job within the framework of Government but not under the day-to-day direction of Government._ [6-CCO-BD/ET]

_So, the way we basically articulate what we want to do to the Ministry every year is through our business plan, through our annual business plan, which is a three-year plan. And, it describes here’s what we need and here’s what we’re going to do with it. We have the strategic documents – the Cancer Plan, the ORN Plan right now. [...] So, one of the areas where CCO has really been skillful is to ensure that it’s getting the resources it needs from the Ministry. You know, right now, getting too much money is kind of a taboo right now these days. It’s, like, oh yeah, you know, because we’re in the fiscal constraints and all of that. So, you can’t brag about the fact that we’re good at getting money from the ministry because then that’s a bad thing where a few years ago it was a good thing, but you can’t really change the system; you can’t really do a lot of what you need to do without any money._ [7-CCO-BD/ET]
I think agencies, by their nature, have specific accountabilities. There’s directives. They’re operated... They operate on behalf of the Government. And, I think it’s a bit of an important distinction because we also have lots of transfer payment recipients that are not agency status. So, agencies are I think, you know, large organizations of the Government that, you know, undertake to deliver their agenda. Cancer Care Ontario and any [inaudible] 2:28, even if you go beyond health, is always one of the Government’s, you know, largest and most significant agencies. [...] You know, I’ve done a fair amount of thinking about this because, you know, the Government has, you know, taken a fair amount of criticism, you know, recently and probably previously; but, you know, from the public’s perception, I think the Government isn’t always seen to be in control of the payments it makes. So, you know, the Ministry of Health, like, say, has thirty billion dollars. That’s a lot of money. Can... Are we accountable for every dollar we put out there? No. And, so, we’ve... We have, you know, standard processes. We spent a lot of time on the content of our contracts and whether we can execute the remedies if the contracts are not delivered. So, a very basic thing is when we give money to other entities, do they spend it for the purpose intended? I mean, that seems very basic. So, I don’t have a problem with Cancer Care Ontario on that. But then, you know, you get in kind of beyond that, you know, are they spending it for the purpose intended. And then, are they following all the guidelines and directives? So, the Government has, you know, in the last five years, has transfer payment directives, agency directives, procurement directives, staffing directives. So, there’s a whole administrative overlay. [16-MOHLTC]

We are accountable to the Ministry and to the Government directly in terms of our corporate business processes – so for things like... there are many directives in terms of how agencies are to operate that we are directly accountable for being aligned with. And, those are around things about procurement travel and expenses, ethical conduct. There are many directives. And, they’ve increased recently in terms of the number and detail of those as to how agencies like ours are to operate in terms of our business processes not so much how we operate with partners. [...] So, we are essentially a transparent organization. And, as I say, we do have to comply with a whole set of directives in terms of how we’re to operate as an organization. It’s mostly a good thing. You know, there is a... obviously a cost and work involved in making sure that one complies with all of those. Most of them, I would say the vast majority of them are good in that they are consistent with good business practice. When they change there’s work to do to change to align them. We’ve had quite a few changes. And, so, that has a cost to the organization to be able to institute those changes. But, I would say, by and large, the accountability directives in terms of how we’re to operate are reasonable. And, we have been able to continue to be effective in that environment of much greater public scrutiny in terms of how agencies like ours operate. I think we should be transparent in our... and we should be able to defend how we operate and how we use taxpayer dollars. So, in general, I think it’s good that organizations are held up to... public organizations are held up to scrutiny. What you don’t want to happen is that the burden becomes so great that it ends up not adding value. [...] And, transparency is real value because that’s public confidence and trust, but that there’s a real gain to be made by doing this and that the cost is reasonable to do that. [2-CCO-BD/ET]
We don’t really see any evidence of bureaucratic controls I would say any adverse bureaucratic controls on business issues, on, you know, issues around cancer care and delivery of cancer care. [...] this would all be around administrative kind of just stuff, which, ultimately, most of it doesn’t really in the end have much of an influence on what really matters. (inaudible 32:45) around expenses, sign-offs on various, you know, financial transactions. [...] I mean, there’s been a real clamp down on lots of administrative regimes. I mean, I think CCO, as I say, I mean, for the most part we... I mean, I think there aren’t really issues. No... There’s nothing we need to fix there. I mean, there’s some things that are an aggravation. We get into all kinds of issues with out of country travel. [...] At the end of the day, you know, it’s a hassle. It’s a pain in the neck. It’s... You know, I don’t find it’s (pause) undermining cancer care or anything like that. And, it’s not political or self-serving. It’s not like, you know, we’ve got people trying to cover their backsides or lay blame on us for things that are their problems. [14-CO-BD/ET]

The only part that truly affects me is part of the, you know, the Ministry requirements of good business practice, right. [...] it can be being buried in paperwork, but it is for a purpose to make sure that the money’s being spent wisely, that there’s three quotes for things, that you’re doing your due diligence on some of those some of those pieces. It’s just caused a few late nights, but (laugh) that’s allowed, right? (laugh) [9-CO-AC-CQCO]
right. You think they’re special, but, I mean, I think that [cancer care] is a special situation I believe. [5-CCO-AC-CC]

I think that, you know, people who are inclined to want to pl... to behave differently won’t... don’t work here... because they can’t survive. It’s just not... doesn’t suit their temperament. [1-CCO-BD/ET]

Processes

Appropriate behaviour

Ok, so, there’s a couple of levels of that. One is within CCO we have a philoso... an HR philosophy that has embedded sort of codes of conduct and, you know, a requirement to foster a respectful workplace and that kind of thing. So, at a personal level of behaviour and conduct that’s now embedded in our policies. In terms of ethical conduct, we have an ethics officer. And, we have whistleblower protection and have mechanisms in place really for people to raise issues if they feel they’re not being addressed or if they identify them and they’re inappropriate. [1-CCO-BD/ET]

Well, the public has a right to know. And, accountability is partly bound up in healthcare system, your history has been one of mystery and closed doors and “come on in, we’ll take care of you.” But, technology has changed, information has changed. The internet’s here. We can Google anything we want to know. There’s an ex... a growing expectation that what you do and how you do it needs to be open to scrutiny. Now, we won’t fight you on, yeah, there’s evidence to support, but that’s what we want to know; we want to know the basis on which the thing operates. And, so, you need to approach accountability from that perspective as opposed to a terrible thing we now have to comply with. Use your strengths, so use evidence, use your knowledge base to make your arguments and just bring those to the forefront; and, you’ll be fine. [8-MOHLTC]

We’ve had some very difficult cases come through as well where we’ve had to challenge CCO folks and they’ve had to challenge us around, “ok, well, if we’re saying, ‘yes’ or we’re saying, ‘no’, why are we saying ‘yes’ or ‘no’? Are we being true to the evidence? Or, are we trying to kind of bend the evidence around a little bit?” [...] If we are saying, “no”, we often go back and say, “well, if a clinician is saying... is recommending we should fund it, why are they doing that?” So, you have to go back and... You know, maybe that’s what their final recommendation is, but when you actually go through all of the process that is leading to that recommendation there may be some inconsistencies. And, you know, they may be negative at the beginning and then slowly start turning themselves around. So, that’s where... You know, it’s more integrity around decision making that we’re being fair. We’re being consistent. We’re not taking into consideration elements that we’ve... just because it’s this patient as opposed to another patient. So... And, the fact that we consult external experts in this process and it’s not just, you know, the bureaucrats making a decision with CCO staff, I think that helps ensure some level of integrity within the decision making process as well. [12-MOHLTC]
The Advisory Councils, you know, they’re... They are... The PLC is, you know, a collection of the Regional Vice Presidents. They come in. It’s like a fire hose meeting where they are given tons of PowerPoint presentations about this and that and keeping them in the loop. It’s not a decision making body. I mean, they may make recommendations or CCO will seek recommendation from them, take their input, but they’re not a decision... Same thing with Clinical Council. [7-CCO-BD/ET]

Because this is part of being the quasi independent part is that CCO has such a wealth of both information and expertise that the... as well as clinical expertise too, right – so, scientific expertise, clinical expertise and then informatics and measurement expertise that having access to what is already in existence makes it so much easier for us to have those conversations where we look at the data and we say, “we think it says this”, but in talking with the clinical programs they know the regions and they can say, “no, actually, this is the true meaning of what this means” and have that dialog, but when it comes to the what score that indicator’s going to get – green, yellow or red – that’s for us to do. We have the conversation with the programs. We have a methodology about, you know, you have to have a target; if you don’t have a target, a clinical aim or a benchmark. And then, we say, “if it’s, you know, ten percent off or if it’s x off, that’s how we’re going to do the rankings.” Although, if the data says it should be green and the program says, “no, there’s still an issue. It should be yellow”, we will make that change in the reverse to say, “although this may look ok, there’s still more work to be done.” [...] And, that’s where the clinical input and being so close to the clinical people is to our benefit because we might be saying something or have an interpretation that’s actually not the case. [9-CCO-AC-CQCO]

I think that we’re often given latitude in my view is that, I think latitude on the process as we know what we’re trying to do, be it implement something or... it’s usually implement something. It seems to me I feel quite a lot of latitude of freedom to implement the way we feel the best. And, I pass that to my directors because I give them a lot of freedom to innovate. [...] if you really are prescriptive – you will do thus and so – you may not get the, you know, the best ideas. And, they may not be... you know, if... it’s very prescriptive out of Toronto. Each of the LHINs is different. And, so, just one approach isn’t going to do it. So, I think CCO is not, you know, is not that prescriptive. And, if it were, you know what, PLC, there’s always a pushback because we don’t want to be, you know, do it exactly this way. I’ll get to the goal you want, but try and use my resources and my knowledge of the region and my people’s knowledge of the region to get there. [13-CCO-AC-PLC]

Well, you’re given the pot of money and the problem and you solve it. You’re not told how to solve it, right. Yeah, and there’s need for local innovation. The, you know, patients are different. Cases are different. The relationships are different. There’s local cultures. There’s local things. So, while it’s great to standardize and any industry standardization improves quality, right, but if you remove... [...] If you are a sort of thought worker, anything that involves judgment, initiative, higher level of performance and not just mechanical execution, that money doesn’t drive performance; but, it’s autonomy, mastery and purpose. So, you have to believe that you’re doing a higher purpose, that you’re becoming good at something. So, you
have opportune professional development and you have certain autonomy in how you do your job, right. I think that people have a lot of autonomy; yet, they work within a standard, right. But, they’re all contributing to higher standards. They work more as a sort of community. [17-CO-AC-PLC]

So, there are principles. Underlying this, first of all, ensuring that you’ve got the right skill sets around the table to evaluate what you’re... the data that you’re going to look at from a variety of different perspectives. Patient/family perspective is as important as the provider perspective, also to have folks like yourself there who can interpret data, folks who are used to governing. I mean, these are the four skill sets that we look for. And, I think that sets us up well in terms of the kind of output that we would have. How do you ensure that integrity will be served? I mean, one way is to define what we’re interested in looking at before we see the data so we’re not cherry picking. We’re saying, “here are the directions that we want the cancer system quality index to go in. Here are the things we want to be analyzing”. And then, to set benchmarks before seeing the data as well. You know, this would be according to plan if it’s above this level. You know, if it’s not above this level, then it’s clearly not proceeding according to plan. [11-CO-AC-CQCO]

Legitimacy

...a large part of [CCO’s] success formula has been that it’s always done it through working with clinician leadership and getting, you know, people who are recognized in the field, who are credible onside and working, so it’s never been sort of perceived as a bunch of bureaucrats that are kind of driving a, you know, an efficiency agenda or a cost savings agenda even though there is some of that involved. [14-CO-BD/ET]

We have the lever of appealing to clinicians’ sense of wanting to do a good job through communities of practice, collective problem solving. So, we do have a... we have a variety of levers, but the ministry... I mean, we have a planning lever, right. We can plan services in a way that would actually foster quality care. And, but the Ministry, you know, when you think about it, yeah, they don’t have that many levers in the Ontario healthcare system. [1-CO-BD/ET]

I think the concept of working with the Ministry of Health as a partner because it’s quite common in the medical community to bash the Ministry – bureaucrats, they don’t know what they’re doing. It’s not productive. I think we’re respectful of them. They’re... You know, the ADMs, a very committed group, you know, and very committed to the public good. So, we’re partners. The second thing is we bring the clinical engagement and the, everything we do is evidence based as much as possible. So, we bring the science and the clinical engagement to the table, which are key assets that Government doesn’t have at least the Ministry of Health in the same way that we do. So, those are key. [19-CO-BD/ET]

I think the more we can engage clinicians and patients per... patients and providers in the work that we do, the more I think we can feel good about answering that question. I think that compared to five years ago we have definitely sort of done a
better job than the way it used to be in terms of trying to engage as many people as possible so that things are clear and transparent and people are involved in decision making. But, again, we’re probably still falling short on the clinician side. I mean, some of it is not necessarily because we don’t reach out, but just, you know, it’s hard to involve everyone. It’s hard to involve even a majority. [...] Again, we’ve got regional networks. So, it’s sort of... And, we try and have two-way communication all the way along, but, you know, you’ll have... It’s still a minority of physicians that are involved, that are interested in trying to make the system better. [5-CCO-AC-CC]

Outputs

Performance

So, we also do quarterly reviews. So, we meet with each one of these programs and their entire team. And, that is done... It’s not just a meeting. There’s a lot of prep work and detailed reports and data spits out with the red, green, yellow. And, people have to tell us why they are where they are, what they’re doing about it, what their plans are. So, that’s the toing and froing in terms of how can we help as well. So, what can CCO do to help you with making changes out in your region? [15-CCO-BD/ET]

I mean, we will have a set of operational indicators in terms of the actual initiatives that we’re working on with regions and hospitals that particular year and what our targets are, what we’re trying to achieve. And, we do a, you know, regular quarterly performance management process with them. And, those are very detailed indicators. Some of those are in the CSQI, but they might have higher level broader system indicators as well – things like survival from cancer, those kinds of things – which we wouldn’t have in a regular kind of quarterly operational report that we have with hospitals and regions where we’re working on a set of specific initiatives to drive improvements and we want to see milestones against those improvements. So, there is some overlap in terms of our operational indicators, but the CSQI I would say is a broader, higher level set of indicators on how the system is doing overall. [2-CCO-BD/ET]

I think it’s, again, by relying... you know, basing your decisions on evidence, having your decisions transparent and publishing your results. You know, just this letting the sunshine in on everything so that it’s all open for everybody to view. I think Cancer Care Ontario does a good job of that. [10-MOHLTC]

Yeah, it’s part of its accountability to basically publish to be transparent; and, that’s what we try always to be, to be transparent. If you’re trying to create the best cancer system in the world, you have to be transparent. You have to basically... You know, when you do something well, you can gloat about it. And, when you’re not, take your lumps when you’re, you know, you haven’t done well. So, that’s a good thing about this. But, obviously, the decisions as to what is presented, what indicators are presented, it’s all done within the board of CQCO and CCO. Which is... I think it’s a good thing. I think if an organization is transparent and can basically
do self-analysis, both in its weakness and in its strengths, it really strengthens the organization. [7-CCO-BD/ET]

Justice or fairness

I mean, you know, you have to be practical about it, but that’s... there’s not much point in declaring a maximum interval or a, you know, a proportion if you’re not really prepared to work towards it, right? [1-CCO-BD/ET]

The fact that you keep calling a larger tune of adding more and more metrics and more and more programs, more and more elements that we have to focus on, which sometimes are in conflict with what the hospital has because the hospital has a set of priorities which, as the president of the hospital and cancer centre, I have to see that those things happen in the hospital and, where relevant, happen in the cancer centre. And, CCO’s giving me a set of priorities that have to happen in the cancer and the regional program. And, they don’t necessarily, you know, you know, totally overlap. [13-CCO-AC-PLC]

I think the way we sort of see indicators is that if there’s varia... regional variation in performance, but some regions are actually at target; well then, it’s... becomes more of a regional issue to fix, right. But, if nobody can reach the target, well then there’s a system problem that is largely sort of in our hands. [1-CCO-BD/ET]

I mean, there are people who say, you know, “oh, well, the reason this data looks good...” and, like, I don’t know what example I could use, but, you know, some random clinician x could say, “well, people are working around the system” or, you know, “they’re choosing this...” Yeah, gaming the system. But, that’s... That is making sure that if incentives aren’t aligned to what you’re measuring, then that could be the case or it may speak to a greater gap or a greater issue. But, that’s the only piece that I could think that, you know, not all these people in cancer are altruistic, but there are... There’s still that avenue that if people want to be able to game, you can do what you can to try and reduce that, but, at the end of the day, if you’re... if things aren’t aligned that could happen. [9-CCO-AC-CQCO]

My impression is that there’s been a very positive relationship between the ministry and the organization. And yet, I think in the last year or two, as money gets tighter, I think we need to really be showing more and more where the value is for the work that we’re doing. I mean, we’ve got a lot of things that we measure. And, a lot of those reflect positively on the system in general, but the area of being able to demonstrate value is one that, number one, isn’t easy and number two, I think we’re just entering into that era where it’s becoming front and centre. [5-CCO-AC-CC]

You sometimes wonder whether the metrics that you measure are the best (pause)... They’re not necessarily the best measures of access for every single patient but for a broad consideration of population they’re very good metrics. So, there’s a difference... the difference in system performance and a difference... and the difference on a personal level, right. So, you can have ninety percent of patients
having – and that’s a metric – ninety percent of patients being seen within two weeks, right. But, ten percent may be seen in two and a half weeks. And, that’s not a problem. You could have ninety-nine percent performance where ninety-nine percent get seen in two weeks, but one percent get seen in six months and they fall through the cracks and die. You know, so, for overall measurement of performance is [good] but it’s not assurance that an individual doesn’t get lost in the shuffle. So, but you can’t measure everything. So, you have to measure something. [17-CCO-AC-PLC]

I think performance is also a difficult one and the idea of, you know, the game playing, right. Controlling game playing is probably the hardest thing in any sort of funding model. The data system, how you code stuff, right...you can do it quite easily. [...] So, this human element of being, “oh, I’m going to get punished, so I’d better cheat” which isn’t the purpose, right. You know, that’s, again, one of the lessons learned is... I keep telling our Board. They say, “why are we all... the scorecards are all red?” It’s, like, you know, “we’re in the behaviour modification business, not the discipline business”, right. And, so, it’s just trying to influence that to make it right for a better system overall. [15-CCO-BD/ET]

I think [trust] only comes from a track record. It comes from a track record of, yes, when... that an organization is able to plan and implement change. And, they were able to demonstrate that they were... that that was implemented. It had the result. It only comes from... I think trust and confidence only comes from what you have done. [2-CCO-BD/ET]

I don’t think we have the word “justice”, but that’s embedded in those thoughts I guess. But, if we think about when we do allocation of funding, we try to make sure that we do it equitably... No, I shouldn’t say that. We try to do it data driven. And, so, if you use information and data, the funding flows to where the work is done, where the population is or whatever and it takes away the subjectiveness of, “I don’t like people in Sudbury so I’m not going to send them any money.” That doesn’t happen. [15-CCO-BD/ET]

...we’ve had the luxury of being able to apply a coordinated set of levers for cancer because we had clinical leadership. We’ve got programmatic infrastructure. We’re able to collect data. And, we have the funding. And, we can tie those together through accountability for implementing change in the regions. [2-CCO-BD/ET]