

Accountability and the Migration of Authority in Provincial Health Care

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Elections, in the tradition of democratic theory, have been seen as an important mechanism of accountability through which the policy preferences of citizens can induce government action (Fearon, 1999: 57). However, the introduction of new forms of governance, including third-party decision-makers and arm's-length public corporations, have blurred the lines of accountability and introduced new challenges for the theory and practice of public accountability (Skelcher, 2007: 63). The migration of regulatory responsibility outside the boundaries of elected governments necessitates a different conceptualization of the accountability relationship between citizens and public policy decision makers. As argued by Peters and Pierre, the use of new governance actors and the dispersal of political authority across multiple layers bring to the forefront questions of democratic input and accountability (Peters and Pierre, 2006: 209).

In Canada, the remaking of provincial health care governance began in the 1970s with the creation of District Health Councils in Ontario. While having no decision-making authority, the councils identified areas of need, assessed health care alternatives, and established priorities at the local level (Ontario Health Review Panel, 1987: 14-15). In the 1990s widespread provincial healthcare reform occurred as every Canadian province but Ontario migrated a degree of decision-making authority to new governance bodies (Lomas et al., 1997: 371). Having implemented District Health Councils as advisory boards in the 70s, Ontario was the last province to devolve decision-making authority with the creation of Local Health Integration Networks in 2006.

In responding to concerns over democratic input and accountability brought about by the migration of authority to new governance bodies, this paper will explore the accountability environment that has emerged in the provinces of Alberta, British Columbia, Nova Scotia and Ontario with the migration of decision-making responsibility in healthcare. To do so, the formal accountability rules as stipulated in the provincial legislation enacted to delegate authority, and the perceptions of individuals active in the healthcare policy area will be assessed.

Authority Migration and Governance

One dimension along which governance can vary is centralization of authority. Authority can be highly concentrated in a single hierarchical entity that claims exclusive jurisdiction or dispersed among various nodes, each exercising only limited jurisdiction (Kahler and Lake, 2004: 409). The migration of authority can then be thought of as occurring along both a vertical and horizontal axis. Along the vertical axis authority can

be distributed to successively more local levels of government in which the more limited jurisdictions are nested within larger jurisdictions. Along the horizontal axis the authority can be dispersed to actors outside of government.

The dispersion of authority both vertically and horizontally is captured by Mark and Hooghe's idea of multilevel governance. The analytical focus of multi-level governance can be seen as the increasingly contested jurisdictional and territorial boundaries both within and beyond the state, the fundamental concern being how to explain the dispersal of central government authority both vertically to actors at other territorial levels and horizontally to special purpose actors (Bache and Flinders, 2005: 4). Marks and Hooghe put forward two contrasting visions to conceptualize multi-jurisdictional governance labeled Type I and Type II multi-level governance. Type I multilevel governance has its intellectual foundation in federalism, which is concerned with power sharing among governments operating at different levels. Type I multi-level governance is described as the dispersion of authority to a minimal number of jurisdictional levels into which a wide array of policy areas are bundled, with smaller jurisdictions nested within larger ones and only one relevant jurisdiction existing at each territorial scale (Marks and Hooghe 2005: 17-19). In contrast with Type I, Type II multi-level governance bodies are independent jurisdictions, such as provincial health authorities, that fulfill specific functions. Type II multi-level governance is defined as having intersecting memberships in the sense that borders will be crossed and jurisdictions may overlap; as being organized across a large number of levels in which authority is not neatly layered but diverse in scale; and being flexible in design, allowing it to respond to changing citizen preferences and functional requirements (Marks and Hooghe, 2005: 20-21). Type II multi-level governance can be conceptualized as a system where citizens are not served by 'the' government, but by several public service industries (Marks and Hooghe, 2003: 237).

While not the only approach to organizing governance that spans multiple jurisdictions,¹ Marks and Hooghe's Type I and Type II multilevel governance typology is useful for conceptualizing the migration of authority in Canada. The traditional national-provincial-municipal dynamics of Canadian governance is captured under Type I multi-level governance, while the emergence of special purpose jurisdictions are incorporated under Type II. Furthermore, the two types of multilevel governance can be viewed as complementary where the selected model is a function of the problem that needs to be addressed (Marks and Hooghe 2005: 29) and Type II multilevel governance structures can be embedded in legal frameworks determined by Type I jurisdictions (Marks and Hooghe 2003: 238, Marks and Hooghe 2005: 24). While Type II multilevel governance may occur when private actors play a dominant role in the policy making process, causing public actors to adopt privately negotiated regimes (Marks and Hooghe 2005: 25), it is the use of Type II multilevel governance as a tool of government that is the focus of this paper. Specifically, the paper focuses on the creation of special purpose Type II bodies by provincial governments to govern the healthcare system.

¹ For alternative conceptualizations of the dispersal of authority across multiple layers see Frey and Eichenberger's *The New Democratic Federalism for Europe* (1999) or James Rosenau's "Strong Demand, Huge Supply: Governance in an Emerging Epoch" in Bache and Flinders (eds.) *Multi-level Governance*. (2005).

Authority Migration and Accountability

While all provincial governments have opted to create Type II multilevel governance jurisdictions in response to policy challenges in healthcare, questions of accountability remain. The accountability challenge brought about by authority migration was broadly recognized in the 1999 Report of the Auditor General of Canada, which stated that the emergence of new governance arrangements shifts governance to entities that are no longer accountable to ministers or Parliament (1999: 23-7).

Without accountability there is no popular control. In a representative democracy, accountability is the principal mechanism through which mass publics exert control over their elected officials and is a central tenet of democratic theory (Rudolph, 2006: 99). Fritz Scharpf describes the democratic process as an exercise in collective self-determination that operates on two dimensions – inputs and outputs. On the input dimension political choices should be derived directly or indirectly from the preferences of the citizen with government held accountable by those they govern, while the output dimension denotes the effectiveness of policy to achieve goals (Scharpf, 1997: 19). The empowerment of new governance actors outside the traditional boundaries of government to make decisions, however, means that not only must government be held accountable, but all actors involved in the governance process. As Bell and Hindmoor state in elaborating on Scharpf's work, for governance arrangements to be considered legitimate, not only must the policy be effective in producing the desired outcomes, the governance process must be democratic and accountable (2009: 29). It is this combination of both input and output legitimacy that compels us to obey collectively binding decisions, even when they do not align with our own personal preferences (Skogstad, 2003: 956).

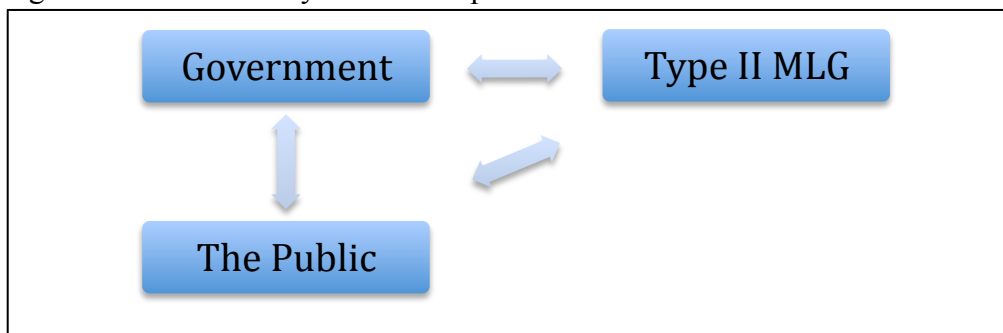
Within the democratic process, regular elections form the basis of an accountability relationship between the electorate and their elected representative. The elected representative is accountable to the electorate as the elected representative is expected to act in such a way that promotes the preferences of the electorate and if the electorate is not happy with the actions of their elected representative, they can vote them out at the next election. Moreover, in a Westminster-style parliamentary system such as Canada, the use of state power is governed by the principle of responsible government, meaning that those who exercise power are held to account. Rooted in the democratic institution of parliament, state power is exercised in accordance with the requirements of ministerial responsibility and parliamentary accountability. In this system ministers are answerable to Parliament for the actions of government and Parliament has the means to hold to account those who exercise the power of the state, be they elected or non-elected officials (D'Ombrian, 2007: 198-199). The result is a chain of accountability relationships connecting those who exercise state power to the electorate.

The shift from a single body to a plurality of actors, however, increases complexity and opens the system to problems of accountability which in turn lead to problems of coordination and strategic direction (Andrew and Goldsmith, 1998: 107). As stated by the Auditor General of Canada, accountability relationships have become more complex as public objectives are increasingly achieved through non-hierarchical relationships between governments and the private and voluntary sectors (Auditor General of Canada, 2002, 4-5). The result is the need for an understanding of accountability that includes both the traditional accountability relationships and the new relationships that emerge as new actors become part of the governance process. When

applying the concept of accountability and agency relationships to new governance bodies that exist outside government departments multiple accountability relationships may exist.

As illustrated in Figure 1, three different accountability arrangements are possible. While provincial governments may have migrated authority horizontally to Type II jurisdictions, governance can be seen to occur in what Scharpf identified as the “shadow of hierarchy” (Scharpf, 1994: 38-39). In the modern state, both public and private actors operate under the shadow of hierarchy where public actors set the legal rules of the game and intervene to correct distortions or outcomes that violate public interests (Börzel, 2010: 196-197). Accordingly, Type II jurisdictions can be viewed as accountable to government and by extension, accountable indirectly to the public through government.

Figure 1: Accountability Relationships



The emergence of new forms of governance, however, has also increased the number of private and public actors involved in the governance process (Sørensen, 2006: 98). Societal actors have become more engaged in the governance process, with government working with society to bring about mutually agreed upon solutions (Peters, 2000: 36). As societal actors take on more prominent roles in the governance process and assert greater influence a second accountability relationship in which Type II jurisdictions are directly accountable to the public is possible.

Given the accountability concerns associated with migration of decision-making authority a third possibility exists, the absence of either accountability relationship.

Authority Migration and Problems of Accountability

As authority migrates vertically up or down to different levels of elected government, elections remain a mechanism for accountability. However, when decision-making authority migrates horizontally to potentially unelected bodies, how decision-makers are held accountable requires consideration. While multiple possible accountability relationships exist, the introduction of new governance arrangements brings concern over the ability to hold new decision-makers accountable.

Concern over the growth and accountability of non-departmental forms of government in Canada is not new. In 1973, in his chapter titled “Structural heretics: the non-departmental forms,” J. E. Hodgetts positioned the expansion of non-departmental entities as the result of workload of conventional departments expanding to the point where tasks are unmanageable, as well as the taking on of new functions by government for which the traditional department structure no longer seemed appropriate (1973: 139).

In adopting the new forms of organization, Hodgetts raises concern over the relationship with the Minister and the formal structure of ministerial command and responsibility, citing the obscuring of conventional channels of ministerial responsibility and diminishment of parliamentary supervision (1973: 143).

A contributing factor to the diminishment of parliamentary supervision is the increasing variety of accountability chains brought about by the formal dispersion of authority associated outside the traditional department structure. Chains of delegation are not new; parliamentary democracies exhibit multiple steps in the accountability chain between citizens and those who govern, Strøm identifies four distinct steps in the accountability chain: from voters to their elected representatives; from legislators to the executive branch; from the head of government (prime minister) to ministerial or departmental heads; from the heads of executive departments to the civil servants (2000: 267). Yannis Papadopoulos argues, however, that accountability problems increase with the length of the chain of delegation. As the chain of delegation increases, the policy process becomes visible only to those closer to decision-makers, the risk being a loss of direct accountability with delegated decision-makers subject to administrative rather than democratic accountability (Papadopoulos, 2007, 479). Papadopoulos concludes that delegation of authority weakens the direct accountability of policy makers as accountability becomes dispersed and does not form a coherent accountability system. While many mechanisms of accountability are believed to exist, they fail to operate in an effective manner (Papadopoulos, 2007: 483). Similarly, Andrew and Goldsmith point to increased complexity brought about by a multi-actor system in comparison to that of a single agency. A plurality of actors makes it more difficult for citizens to navigate the political system and more difficult to coordinate between the large number of special purpose bodies (Andrews and Goldsmith, 1998:107). As the number of bodies outside the hierarchy of traditional government departments increases so do the variations in accountability chains that link citizens to decision-makers.

While the organizational structures that troubled Hodgetts were not beyond the pale of ministerial responsibility and therefore may not have warranted the name structural heretics (Aucoin, 2003, 7), continued experimentation in governance structures in Canada have continued to raise concerns. The 1979 Royal Commission on Financial Management and Accounting stated that a group of corporations, labeled as quasi-public, sat at the edge of the public sector. The commonalities among the corporations included a government role in creation by way of legislation, government funding of the corporation, government appointment of some board members, and the absence of formal accountability linkages (Aucoin, 2003: 8). The Office of Auditor General raised similar concerns in 1999, stating that new governance arrangements involving external partners in planning, design and achievement of government objectives created situations where the partners were not accountable to ministers and Parliament (Office of the Auditor General, 1999: 23-5). The Auditor General's report stated that of the new governance arrangements examined, "accountability to Parliament was often weak and good governance not always assured" (Office of the Auditor General, 1999: 23-31). Peter Aucoin also raised specific concerns over the use of independent foundations to distribute public funds in 2003. According to Aucoin, the independent foundations retained the characteristics identified by the Royal Commission on Financial Management and Accounting (2003: 8), and the one-time endowments transferred to the independent

foundations effectively turned public funds into private funds, which made decisions in relation to the funds beyond the reach of government and the legislature (Aucoin, 2003: 10). In such cases, it is not a case of an overly complex accountability chain, but the lack of an accountability linkage altogether between government and decision making bodies. As stated by Timothy Heinmiller, one of the greater virtues of ministerial responsibility is the establishment of clear lines of accountability, however, if ministers no longer have meaningful oversight and control, then ministerial responsibility is little more than a constitutional fiction (2011: 125-128).

A related concern is the information costs of Type II multilevel governance. John Dunn has argued that in the modern state most citizens are incapable of forming a conception of most of what is going on politically (Dunn, 1999: 335). According to Dunn, without sufficient knowledge and understanding, interaction between citizen and decision-makers in which the behavior of the decision maker is rationally sanctioned is unlikely (1999: 335). While Dunn's analysis focuses upon the relationship between citizens and their elected representatives, the same argument can be applied to the relationship between citizens and Type II jurisdictions.

The existence of a multilevel system of governance creates further difficulties for citizens in attributing policy decisions to policy actors. As argued by Soroka and Wlezien, effective public responsiveness depends upon an accurate signal of what government is doing, while a vertical division of powers increases the number of different governments making policy in a given policy area thus making it less clear what government is doing (2004: 552; 2011: 33). Identified by Alexander Hamilton in *The Federalist No. 70*, the information challenges faced by citizens are further exacerbated by the actions of governments who engage in blame shifting and credit taking for policy outcomes (Hamilton, 1788). Moreover, the existence of a multilevel environment can create incentives for governments within the multilevel system to camouflage their responsibility for decisions and outcomes (Anderson, 2006: 450).

Cameron Anderson argues that as political decentralization increases, the ability of citizens to hold a government accountable for political outcomes decreases (2006: 459). Furthermore, as governance becomes more decentralized and multilayered, the ability of citizens to cope with increased challenges to democratic accountability becomes more pressing (Anderson, 2006: 459). While both Anderson, and Soroka and Wlezien focus upon Type I jurisdictions, many of the same challenges can be applied to Type II jurisdictions. Concerns already exist over the ability of citizens to accurately attribute which powers belong to which level of government (Anderson, 2006; Schneider et al. 2011). As authority migrates horizontally to a myriad of Type II bodies the likely result is the further clouding of citizens' perceptions of who is responsible for which policy decisions. It is possible that the increasing complexity of governance arrangements, including the use of autonomous and quasi-autonomous organizations, may bring the governance process closer to the citizen, while at the same time leading to citizen confusion when confronting problems (Peters, 2010: 211). In looking at government outsourcing of service provision, Lorna Stefanick draws attention to the 1995 and 1998 Alberta Ombudsman reports, which found that a major impediment to accountability in Alberta is the complex governance environment in which it is increasingly difficult to determine who is responsible. As cited by Stefanick, the 1998 report raises concerns over the ability of citizens to address concerns to the correct party,

as the Office of the Ombudsman itself often has difficulty determining responsibility (Stefanick, 2011: 248-249).

While numerous concerns have been raised over the weakening of democratic input and accountability, the possibility has also been put forward that accountability fears have been overblown. Bartle and Vass argue that problems of accountability can be overcome by new governance actors within the systems of transparency and accountability that are developing in the modern regulatory state, as decentralization does not mean disconnection from the state (2007: 897). The legitimacy and accountability of external actors can be tied to the ability and willingness of governments to exercise a credible response if the delegation of authority fails to engender compliance with the governance framework as stipulated by the state (Bartle and Vass, 2007: 897). The rise of the modern state has brought about institutions, processes, and mechanisms of regulatory governance that reinforce accountability, and these processes and mechanisms can be extended beyond traditional government to preserve accountability (Bartle and Vass, 2007: 898).

Methodology

This study explores the migration of health care decision-making authority to Type II jurisdictions in the provinces of Alberta, British Columbia, Nova Scotia and Ontario. The study looks at Alberta Health Services (AHS), British Columbia Health Authorities (BCHA), Nova Scotia's District Health Authorities (DHA), and Ontario's Local Health Integration Networks (LHIN). The four cases were selected based on institutional design, changes in institutional design, and a desire to include cases from across Canada. Alberta has moved from regionally distributed health authorities to one single provincial wide health body; British Columbia has also reduced the number of health bodies, moving from fifty-four to nine; Nova Scotia in contrast has moved in the opposite direction, expanding the number of health care bodies from four to nine and Ontario, unlike the other provinces, left existing hospital boards in place when migrating provincial authority.

To assess accountability of Type II health care bodies both the formal accountability rules as stipulated in the provincial legislation and the perceptions of individuals active in the healthcare policy area were examined. When assessing the formal accountability rules, Mark Bovens's definition of accountability, which states "Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences" (2007: 450), is used. For each piece of legislation, both the accountability relationship with government and the accountability relationship with society will be evaluated against the elements present in Bovens's definition of accountability: processes which force agents to explain and justify actions to their principals, processes which allow principals to question agents and pass judgment upon their actions, and processes which enable principals to sanction their agents.

Moving beyond the existence of formal accountability rules, semi-standardized interviews were conducted to assess how accountable the Type II healthcare jurisdictions were perceived to be by key individuals. Interview participants were selected from four categories: elected representatives, members of Type II body boards and management

teams, public employees, and representatives of special interest groups active in the healthcare policy area. For the elected representatives category interviews were sought with both ministers and health critics, however, attempts to interview health ministers were unsuccessful across all four provinces.

Interviews were sought with senior public employees, as the size, complexity, and number of functions undertaken by the government makes it impossible for elected officials to be involved in all aspects of how we are governed and as a result members of the public service perform large portions of government activities (Flynn, 2011: 43). As public employees perform much of the activities of government, they are attuned with the operational reality of accountability mechanisms. A member of the department responsible for health services was interviewed for each of the four provinces.

The views of interest group representatives were sought to gain insight into how the accountability of the Type II bodies was perceived outside of government and the organization. In each province the provincial associate of the Canadian Health Coalition and the province's medical association were contacted for interviews. The health coalitions were selected due to their position as coalitions of organizations and individuals who are active or interested in health care policy at the provincial level. Medical associations were selected as they represent an important constituency group in the delivery of health services.

Similar to the need to interview both elected politicians and public service employees, both board members and upper management were recruited from the health authorities. In each province members of both the board and management were recruited from the health authority responsible for the capital region. Participants from a second health authority – with the exception of Alberta, which has only one health authority – were recruited to allow for additional perspectives to be put forward. In selecting a second regional authority regions that include rural areas were selected to offset the largely urban characteristics of the capital region.

While ideally participants from each category and groups within each category would have been interviewed, this was not the case as not all possible interviewees consented to being interviewed. The number of participants per category by province is shown in Table 1.

Table 1: Participants by Category

	Alberta	British Columbia	Nova Scotia	Ontario	Total
Elected Representatives	1	1	1	2	5
Ministry Employees	1	1	1	1	4
Interest Groups	2	1	1	1	5
Type II Board	0	2	1	2	4
Type II Management	1	2	2	2	7
Total	5	7	6	8	26

Interviews were semi-standardized in design, with a set of predefined questions forming the general structure of the interview. The interview was comprised of two sections, the first approaching accountability from the perspective of the participant and focusing on whom participants believed the healthcare bodies were most accountable to

and whom they most represented in their decision-making. Both questions are based on questions asked by Lomas et al. in their study of the motivations, attitudes and approaches of regional health authority board members published in 1997 (Lomas et al., 1997a: 673). For each of the relationships identified participants were asked to further describe the accountability relationships. If the participant did not address the accountability relationship with either government or the public, participants were then asked to describe those relationships.

The second section focused on accountability as defined by Mark Bovens. As stated above, Bovens identifies three parts to an accountability relationship: the obligation of the actor to explain and to justify his or her conduct, the ability for the forum to pose questions and pass judgement, and that the actor may face consequences (Bovens, 2007: 450). For both the relationship between government and the Type II body and society and the Type II body each participant was asked to what extent there is an obligation on the part of the Type II body to explain and justify their actions; to what extent the ability exists to pose questions to the Type II body regarding their actions; and to what extent the ability exists to sanction the Type II body if their actions do not meet expectations. After each question follow-up questions are used to determine not only the formal existence of each of the three aspects of the accountability relationships, but perceived success or failure in enacting each component.

While a general framework for asking questions was employed, there were cases when the participant's definition of accountability was consistent with Bovens's, which resulted in questions from the second section being answered in the first. In such cases, the unanswered questions from the second section were asked as part of the first section of the interview.

Formal Accountability Rules

As stated above, the formal accountability rules are first evaluated using Bovens's definition of accountability. For each of the four cases, the legislation is assessed in terms of the requirement of Type II bodies to explain and justify their actions, the opportunity for government or societal members to question the Type II body and the opportunity for government or societal members to impose sanctions on the Type II body.

Alberta Health Services

In the Alberta case, the formal accountability rules specified in the *Regional Health Authorities Act* and the accompanying regulations suggest a strong accountability relationship between government and Alberta Health Services. AHS is required by law to submit an annual report, including both financial and performance information, to the Minister who must then table the report in the Legislative Assembly. In addition to the annual report, the Minister receives quarterly financial reports, AHS audit reports (including observations and recommendations), board meeting minutes and may request in writing any records, reports or returns deemed necessary to assess the performance of AHS. Beyond written reports and records, the Minister has inspection powers that authorize the Minister or a person delegated by the Minister to enter and inspect any place under the jurisdiction of the health authority and access for the purpose of examination any documents or records in the possession of AHS. In combination, the

above measures produce a legal requirement for the AHS to explain and justify actions and the right of government to ask questions and pass judgment.

Beyond the capacity to ask questions, the government has substantial tools to sanction AHS. The most powerful mechanism at the province's disposal may be the dismissal of all members of the AHS board. As stated in the *Regional Health Authorities Act*, if the Minister believes that AHS is not properly exercising its powers, carrying out its duties, or acting in the best interest of the public the Minister may dismiss the board and appoint an official administrator in the board's place. While less dramatic, the Minister also has the power to not reappoint a board member upon completion of their term, meaning that poor performance can be sanctioned by not renewing the member's appointment.

The accountability relationship between AHS and the public as specified in the legislation is centered on the obligation to explain and justify and to a lesser extent the ability to ask questions. The legislation dictates that all meetings of the AHS board must be open to the public unless holding the meeting in public would result in the release of information relating to the personal interests, reputation or privacy of any one person, or that would impair the ability of AHS to carry out its responsibilities. Furthermore, when a meeting is held in totality or part in private, no resolution relating to the subject matter discussed may be passed without the meeting reverting to being public. AHS must also make all meeting minutes available for inspection by the public. A limited potential for the asking of questions can be seen in the requirement to establish community health councils. In accordance with the legislation, community health councils must be established to act in an advisory capacity to AHS on the provision of health services.

Missing from the accountability relationship between AHS and the public is the formal ability to sanction. While the legislation allows for either elected or appointed board members, the Minister appoints all AHS board members.

British Columbia Health Authorities

The accountability relationship between government and BC's Health Authorities as specified in the *BC Health Authorities Act* is again strong. Each Health Authority is required to send to the Minister an annual report detailing the Authority's operations and fiscal statements for the proceeding fiscal year. The Minister may also require an Authority to report on any matter deemed necessary by the Minister for the purpose of monitoring the Health Authority's performance. Each Authority is also required to have its books open for inspection by the Minister or a designate at all times and the Minister may direct the Comptroller General to examine and report to the treasury board on any or all financial or accounting operations of a Health Authority board. In terms of sanctioning power, the government appoints board members and the government has the power to dismiss the board and appoint a public administrator to undertake the functions of the board. The Minister may also issue a special directive with respect to the exercising of the board's powers and performance of duties. Boards are legally obligated to comply with all such directives.

Legislated accountability rules governing the relationship between BC's Health Authorities and the public is comparatively sparse. While the *BC Health Authorities Act* dictates that all board meetings be open to the public, creating an obligation on the part of

Authority boards to explain and justify decisions, there is no legislated capacity for members of the public to ask questions or sanction decision-makers.

District Health Authorities (Nova Scotia)

Consistent with Alberta and British Columbia, the legislated accountability rules in Nova Scotia provide for a strong accountability relationship between the District Health Authorities and government. Satisfying the obligation to explain and justify, the *Nova Scotia Health Authorities Act* requires each DHA to produce an annual report detailing financial statements and results achieved in respect to performance objectives over the previous year. The annual report is submitted to the Minister who then must table it in the House of Assembly. Moreover, each DHA is required to provide the Minister with monthly and quarterly financial statements and an audited year-end financial statement including any management letters issued by the auditors. The Minister may also appoint an individual to carry out an audit or review a District Health Authority or any program, facility or service, which satisfies Bovens's second criteria, the ability to ask questions and pass judgment. In terms of sanctioning power, the Minister has the power to appoint DHA board members and Chairs, and has the power to remove or suspend any member of a board of directors.

In looking at the accountability relationship between the District Health Authorities and the public, DHA are required to hold a minimum of two public forums each year for the purpose of providing information on the operations and activities of the DHA and seek input from the public. In this regard the legislation obligates the DHAs to explain and justify their actions and provides the opportunity for those it serves to pose questions and pass judgment. Again what is missing is the capacity for the public to sanction.

Local Health Integration Networks (Ontario)

In the Ontario case, the formal accountability rules set out in the *Local Health System Integration Act* suggest a strong accountability relationship between government and the Local Health Integration Networks. Satisfying the obligation to explain and justify, each LHIN is required to submit an annual report to the Minister and the Minister is required to table the report in the Assembly. As the LHINs are subject to the powers of the Auditor General there is the capacity to pose questions and pass judgment. Government is also capable of sanctioning LHINs through its appointment power, which includes the appointment, reappointment and termination of board members and board chairs and vice-chairs.

Adding additional strength to the accountability relationship between the LHINs and government is the legislated requirement for each LHIN to have an accountability agreement with government. The accountability agreements set out detailed reporting obligations, the ability of government to request meetings to discuss performance factors, government inspection authority, and a performance management framework that allows the government to initiate performance management activities including increased reporting, external reviews and changes to the governance structure. In essence, the accountability agreements strengthen each aspect of the accountability relationship as defined by Bovens.

Turning to the formal rules governing the accountability relationship between LHINs and the public, all full board and committee meetings are open to the public and each LHIN must carry out some form of community engagement. LHINs are required to engage the community of diverse persons and entities involved with the health care system on an on-going basis, and the methods of engagement may include community meetings, focus group meetings, or the establishment of advisory committees. Again missing from the formal accountability rules is the capacity to sanction.

Overall Results

Across all four provinces, the formal accountability rules as specified in the provincial legislation satisfied all three elements of Bovens's definition of accountability. Based on legislation, the Type II health bodies created in each of the four provinces are obligated to explain and justify their actions to government and governments are able to question, pass judgment and impose sanctions. The legislated accountability rules that govern the direct relationship between the Type II bodies and the public are much weaker by comparison. In each case, the Type II bodies are obligated to explain and justify, however, the ability for members of the public to ask questions is more limited and the ability to sanction is non-existent.

Perceptions of Accountability

As discussed above, interview questions were divided into two sections. The first section approached accountability from the perspective of the participant, and was aimed at determining who participants believed Type II healthcare bodies were most accountable to and who their decisions most represented. The second section looked at accountability from the perspective of Mark Bovens's definition.

In identifying whom the Type II healthcare bodies were most accountable to, the majority of respondents stated that they were most accountable to government or to both government and the public. Participants most frequently identified government as the most prominent accountability relationship; this was true across all categories of participants. The least frequent response was that the healthcare bodies were most accountable to the public, with all such respondents falling under the Type II healthcare bodies' senior management category. Just over a quarter of respondents identified both government and the public as the most important accountability relationship. In describing the dual nature of accountability, one participant described the existence of both a legal and a moral accountability. Starting that there is a legal accountability to government that ties back to the community through the election process, and a moral accountability that is directly to the community.

When assessing who the decisions of the healthcare bodies most represented, the most frequent response was the interests of the people they served. The next most frequent response was government, followed by both government and the public. When distributed by category of participant, board members and management of the healthcare bodies consistently felt that their decisions reflected either the public or a combination of the public, government, and those who provide the healthcare services. All members of the public service suggested that decisions reflect the interests of both government and the public, while elected representatives from opposition parties and interest groups were more likely to believe that the decisions were ultimately in the interest of government.

One participant provided a particularly nuanced perspective, claiming that a constant struggle exists to balance the needs of different stakeholders and that when making decisions you need to consider which stakeholders are impacted and to what degree, and orient yourself accordingly.

When participants assessed the accountability relationships between the Type II healthcare bodies and both government and the public, the results, for the most part, mirrored that of the formal accountability rules. All participants believed that the healthcare bodies were obligated to explain and justify their actions to government, and that government was able to ask questions and pass judgment on the actions of the healthcare bodies. All participants also stated that government had the capacity to sanction the healthcare bodies if they were not fulfilling their obligations as set forth by government, however, not all participants believed that the sanctioning capabilities were effective or used. Concerns were raised that poor performance was only met with either “a slap on the wrist” or prolonged discussion without repercussions for poor performance. Concerns over the effectiveness of sanctions were raised in all provinces with the exception of Ontario, and concerns came from participants both internal and external to the healthcare bodies.

When looking at the accountability relationship between the Type II multilevel governance healthcare bodies and the public, the results highlight some differences between the formal rules and perceptions. In regards to an obligation to justify, participants agreed that there is an obligation on the part of healthcare bodies to communicate decisions with the public, however, concern was raised by some interest group members and elected representatives for opposition parties that the obligation to fully explain and justify the actions of the healthcare body was either absent or not adhered to. In responding to the ability of members of the public to question and pass judgment, responses indicated that while there is a lot of work done to engage the community prior to decisions being made, there is limited capacity for members of the public to pose questions afterwards. In two cases, once by an elected representative, and once by a board member, freedom of information requests were listed as a mechanism by which members of the public could question and access information on how decisions were made after the fact. On a positive note, in three instances the participants’ responses suggest that the legal requirements were treated as minimal requirements with members of the public either able to speak and pose questions at board meetings or other formalized proceedings. In responding to the ability to sanction, two-thirds of the respondents indicated that while no formal sanctioning capacity existed, the public has the means to informally sanction the healthcare bodies through the use of the media, demonstrations, complaints to elected officials, or any other venue that would bring the issue to the forefront.

When describing the overall effectiveness of the accountability relationships three themes emerged: first was a lack of role clarity, second was a lack of knowledge at the citizen level, and third was the type of information provided to the public. Concerns over a lack of role clarity were raised by at least one participant in each of the four provinces. While such concerns came mostly from interest group representatives, the issue was also brought forward by at least one public servant and an elected representative. Not surprisingly, individuals working within the healthcare bodies did not raise concerns over clarity of roles. When describing role clarity as a problem,

participants suggested that an inability to clearly delineate the role of the healthcare bodies in relation to other actors in the healthcare field limited the ability of the public to hold the correct actor accountable for decisions made.

The issue of low levels of citizen knowledge was also expressed by participants in each of the four provinces. Just under two-thirds of participants, from all categories, expressed the belief that citizens held a limited understanding of either the role of the healthcare body in their region, the decision-making process, or the work that their healthcare body is undertaking. This raised concerns over accountability; as expressed by one participant, you cannot hold someone to account if you do not know who they are or what they are responsible for. While a number of participants did state that public knowledge around the role and activities undertaken by healthcare bodies is increasing, the same respondents frequently acknowledged that in terms of public education there is still a ways to go. On a positive note, multiple healthcare body representatives, from both the executives and the boards, spoke of the need for healthcare bodies to continue to educate the public.

Closely tied to citizen knowledge is the type of information provided by the healthcare bodies to the public. At least one participant from each province called into question the information provided to the public. The most prevalent concern was that the information provided to the public was the same information produced for government consumption, which may be overly technical and bureaucratic and not accessible to a majority of the public. A second type of accessibility was also raised, with a small number of participants questioning the likelihood of citizens knowing where to look for the information that is available.

Discussion

Taking into account the formal accountability rules as described in the legislation and perceptions of interview participants, a strong accountability relationship exists between government and the healthcare bodies alongside a decidedly weaker direct accountability relationship between health care bodies and the public. In terms of democratic accountability, however, both relationships may be undermined by challenges of clarity and citizen knowledge.

As stated above, effective public responsiveness depends upon an accurate signal of what government is doing, and a vertical division of powers increases the number of different governments making policy in a given policy area thus making it less clear what each government is doing (2004: 552; 2011: 33). The same problem is evident when distributing power horizontally in healthcare governance. As power was distributed horizontally the number of actors making decisions in healthcare increased and thus made it less clear which governance actor was responsible for what aspect of the healthcare system. This lack of clarity around roles and responsibilities limits the public's ability to hold decision-makers accountable either indirectly through elected officials or directly. The result is, as Papadopoulos articulated, a loss of direct accountability with delegated decision-makers subject to administrative rather than democratic accountability (Papadopoulos, 2007, 479).

Likewise, as it is unlikely that a decision-maker will be rationally sanctioned without sufficient public knowledge and understanding (Dunn, 1999: 335), it is unlikely given concerns over citizen knowledge that healthcare bodies will be sanctioned by the

public. Based on participants' remarks, there exists a weak understanding of the roles and responsibilities of actors involved in the healthcare system, as well as a limited knowledge of the decisions being made and the measures put in place to judge the performance of healthcare bodies. Without the background knowledge, citizens do not have the tools to make rational conclusions over the effectiveness or appropriateness of a healthcare body's actions, let alone sanction them.

Conclusion

While sufficient legislated rules exist to hold Type II bodies in public healthcare accountable, either directly or indirectly through their elected representatives, a lack of role clarity and citizen knowledge lends credence to accountability concerns. In shifting authority to new governance bodies it is not sufficient to build accountability rules into the system, sufficient knowledge must also exist to make the accountability mechanisms meaningful. While the results suggest that government is fully capable of holding healthcare bodies to account, a gap exists between the powers to hold healthcare bodies to account and public knowledge. The shifting of decision-making authority horizontally has resulted in the camouflaging of responsibility, which coupled with insufficient knowledge at the citizen level continues to present challenges for democratic input and accountability.

Fortunately, both board members and senior management feel an obligation to act in the best interests of the public they serve. The challenge now is to ensure a clear delineation of roles, adequate public information, and a venue for public input that ensures the standards of democratic input and accountability are met.

References

- Anderson, Cameron. 2006. "Economic Voting and Multilevel Governance: A Comparative Individual-Level Analysis." *American Journal of Political Science* 50: 449-463.
- Andrew, Caroline and Michael Goldsmith. 1998. "From Local Government to Local Governance: And beyond?" *International Political Review* 19: 101-107.
- Aucoin, Peter. 2003. "Independent foundations, public money and public accountability: Whither ministerial responsibility as democratic governance?" *Canadian Public Administration* 46: 1-26.
- Auditor General of Canada. 1999. "Chapter 23: Involving Others in Governing: Accountability at Risk." in *The November 1999 Report of the Auditor General of Canada*. <http://www.oag-bvg.gc.ca/internet/docs/9923ce.pdf> (October 30, 2012).
- Auditor General of Canada. 2002. "Chapter 9: Modernizing Accountability in the Public Sector." in *The December 2002 Report of the Auditor General of Canada*. <http://www.oag-bvg.gc.ca/internet/docs/20021209ce.pdf> (accessed Oct. 30, 2012).

Bache, Ian and Matthew Flinders. 2005. "Themes and Issues in Multi-level Governance." *Multi-level Governance*, eds. Ian Bache and Matthew Flinders. New York: Oxford University Press.

Bartle, Ian and Peter Vass. 2007. "Self-Regulation Within the Regulatory State: Towards a New Regulatory Paradigm?" *Public Administration* 85: 885-905.

Bell, Stephan and Andrew Hindmoor. 2009. *Rethinking Government: The Centrality of the State in Modern Society*. New York: Cambridge University Press.

Börzel, Tanja. 2010. "Governance: Negotiation and Competition in the Shadow of Hierarchy." *Journal of Common Market Studies* 48: 191-219.

Bovens, Mark. 2007. "Analysing and Assessing Accountability: A Conceptual Framework." *European Law Journal* 13: 447-468.

D'Ombra, Nicholas. 2007. "Ministerial Responsibility and the Machinery of Government." *Canadian Public Administration* 50: 195-217.

Dunn, John. 1999. "Situating Democratic Political Accountability." in *Democracy, Accountability, and Representation*, ed. Adam Przeworski, Susan Stokes and Bernard Manin. Cambridge: Cambridge University Press.

Fearon, James. 1999. "Electoral Accountability and the Control of Politicians: Selecting Good Types versus Sanctioning Poor Performance." in *Democracy, Accountability, and Representation*, ed. Adam Przeworski, Susan Stokes and Bernard Manin. Cambridge: Cambridge University Press.

Hamilton, Alexander. 1788. *The Federalist No. 70: The Executive Department Further Considered*. <http://constitution.org/fed/federa70.htm> (accessed Aug 24, 2012).

Heinmiller, Timothy. 2011. "Ministerial Responsibility: The Cornerstone of Administrative Accountability in Canadian Government." in *Approaching Public Administration: Core Debates and Emerging Issues* ed. Roberto Leone and Frank Ohemeng. Toronto: Emond Montgomery Publications.

Hodgetts, J. E. 1973. *The Canadian Public Service: A physiology of government, 1867-1970*. Toronto: University of Toronto Press.

Kahler, Miles and David Lake. 2004. "Governance in a Global Economy: Political Authority in Transition." *PS: Political Science and Politics* 37: 409-414.

Lomas, Jonathon, John Woods, and Gerry Veenstra. 1997. "Devolving authority for health care in Canada's provinces: 1. An introduction to the issues." *Canadian Medical Association Journal* 156: 371-377.

- Lomas, Jonathon, John Woods, and Gerry Veenstra. 1997a. "Devolving authority for health care in Canada's provinces: 3. Motivations, attitudes and approaches of board members." *Canadian Medical Association Journal* 156: 669-676.
- Marks, Gary and Lisbet Hooghe. 2003. "Unraveling the Central State, but how? Types of Multi-level Governance." *American Political Science Review* 97: 233-243.
- Marks, Gary and Lisbet Hooghe. 2005. "Contrasting Visions of Multilevel Governance." in *Multi-level Governance*, ed. Ian Bache and Matthew Flinders. New York: Oxford University Press.
- Ontario, Ontario Health Review Panel. 1987. *Toward a Shared Direction for Health in Ontario: Report of the Ontario Health Review Panel, June 1987*. Toronto, ON: Ontario Health Review Panel and Toronto, ON: Ontario Ministry of Health.
- Papadopoulos, Yannis. 2007. "Problems of Democratic Accountability in Network and Multilevel Governance." *European Law Journal* 13: 469-486.
- Peters, Guy. 2000. "Governance and Comparative Politics." in *Debating Governance: Authority, Steering and Democracy*, ed. Jon Pierre. New York: Oxford University Press.
- Peters, Guy. 2010. "Bureaucracy and Democracy." *Public Organization Review* 10: 209-222.
- Peters, Guy and Jon Pierre. 2006. "Governance, Government and the State," in *The State Theories and Issues*, eds. Colin Hay, Michael Lister and David Marsh. New York: Palgrave MacMillan.
- Rudolph, Thomas. 2006. "Triangulating Political Responsibility: The Motivated Formation of Responsibility Judgments." *Political Psychology* 27: 99-122.
- Scharpf, Fritz. 1994. "Games Real Actors Could Play: Positive and Negative Coordination in Embedded Negotiations." *Journal of Theoretical Politics* 6: 27-53.
- Scharpf, Fritz. 1997. "Economic Integration, Democracy and the Welfare State." *Journal of European Public Policy* 4: 18-36.
- Schneider, Sandra., William Jacoby and Daniel Lewis. 2011. "Public Opinion Toward Intergovernmental Policy Responsibilities." *Publius: The Journal of Federalism* 41: 1-30.
- Skelcher, Chris. 2007. "Does Democracy Matter? A Transatlantic Research Design on Democratic Performance and Special Purpose Governments." *Journal of Public Admin Research and Theory* 17: 61-76.

Skogstad, Grace. 2003. "Who Governs? Who Should Govern?: Political Authority and Legitimacy in Canada in the Twenty-First Century." *Canadian Journal of Political Science* 35: 955-973.

Sørensen, Eva. 2006. "Metagovernance: The Changing Role of Politicians in Processes of Democratic Governance." *American Review of Public Administration* 36: 98-114.

Soroka, Stuart, and Christopher Wlezien. 2004. "Opinion Representation and Policy Feedback: Canada in Comparative Perspective." *Canadian Journal of Political Science* 37: 531-559.

Stefanick, Lorna. 2011. "Government Outsourcing of Service Provision: Be Careful What You Wish For." in *Approaching Public Administration: Core Debates and Emerging Issues* ed. Roberto Leone and Frank Ohemeng. Toronto: Emond Montgomery Publications.

Strøm, Karre. 2000. "Delegation and Accountability in Parliamentary Democracies." *European Journal of Political Research* 37: 261-289.