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Seeking Accountable Health Care through Measurement

health policy; new public management; performance measurement; social marketing

The New Public Management (NMP) movement strives for market discipline and accountability through indicator-based measurement of performance. After presenting the NPM paradigm the paper reviews recent research findings to assess the extent to which NPM reforms in the case of the health care sector in Ontario, Canada have achieved their goals. The paper argues that the application of NPM policies has contributed to higher transaction costs, greater tension between managers and health professionals, and an exaggerated focus on achieving narrow performance targets. As a result, reforms did not deliver on expected efficiency and accountability gains. Despite this, government continues to use performance measures, in part, as a form of social marketing of their NPM reforms in an effort to demonstrate improved efficiency and accountability of government departments and government funded non-profit organizations.. The presented findings lend support to calls for greater caution in the application of NPM policies. They also raise the broader issue of how to reconcile cost and efficiency pressures with the need to safeguard public values under a reinvigorated Stewardship model. The paper concludes with a brief discussion of the implications for health care organizations and the need for further research.

I. Introduction

Concerns about inefficiency and a lack of accountability in public sectors have led to the broad acceptance of a basket of reforms loosely referred to as the New Public Management (NPM). These reforms seek to apply business principles and practices to government and the non-profit sector in order to improve efficiency and accountability (Charih/Daniels 1997; Moynihan 2006). As a result, government and non-profit institutions began implementing performance measurement programs and conducting thorough reviews of their programs and services. In part, governments have used these performance measures as a form of social marketing of their NPM reforms in an effort to demonstrate improved efficiency and accountability of government departments and government funded non-profit organizations.

This paper explores the implications of NPM policies being applied to the health care sector in Ontario, Canada, in terms of their contributions to efficiency and accountability, by examining some recent research findings. It begins with an overview of the rise of the NPM paradigm. The paper then reviews research findings to assess the extent to which

NPM reforms have achieved their goals within Ontario's health care sector. It briefly discusses broader implications of these findings for market reforms in the non-profit sector. The paper concludes with a brief discussion of the implications for health care organizations and the need for further research.

II. New Public Management, Efficiency and Accountability

The New Public Management is a management philosophy which has been embraced by governments since the 1980s in an effort to modernize the public sector. NPM is a broad reform paradigm that has inspired a wave of public sector reforms throughout the world which promote the use of private sector management practices (Terry 1998). Based on public choice and managerial schools of thought, the NPM model attempts to shift away from the bureaucratic style of command-and-control government to a greater reliance on market mechanisms. It is based on a neo-liberal understanding of the state and the economy: its main hypothesis is that incentive-focused market mechanisms, grounded in concepts of human behaviour as motivated primarily by self interest, will achieve greater cost-efficiency and accountability in the public and non-profit sector than traditional bureaucratic or stewardship models (Osbourne/Gaebler 1992; Pollitt 1993; Hoggett 1996; Hood et al. 1999).

The NPM, compared to earlier public management theories which were input oriented, is more focussed on linking inputs to outcomes in order to achieve improved efficiency and accountability. This is accomplished in part through policies such as those which promote better management of budgets, encourage internal and external competition, and use incentives to alter behaviour in government and non-profit organizations. The NPM reforms have promised:

> ... smaller, less interventionist and more decentralized government; improved public sector efficiency and effectiveness; greater public service responsiveness and accountability to citizens; increased choice between public and private providers of public services; an "entrepreneurial" public sector more willing and able to work with business; and better economic performance (Jones/Kettl 2003, p. 2).

Determining whether efficiency or accountability has actually been improved in organizations which are not driven by the profit motive is no easy undertaking (Pollitt 1995). Is it more efficient to provide services to a dozen moderately ill patients or one severely ill patient? Does cutting the cost of providing a health care procedure demonstrate efficiency even when it comes at the cost of reduced equality? Clearly, when it comes to health care, issues of efficiency are difficult to disentangle from those of quality, equity and accessibility. More fundamentally, the multi-dimensional goal character of health care services defies ordinal rankings of more or less efficient deliverables. The relative

importance accorded to different value parameters is ultimately a choice to be made by the community of citizens.

Likewise, defining accountability is a difficult task given the complex, multi-dimensional context of public management in western democracies (Romzek 2000). Fooks and Maslove (2004) have compiled a listing of definitions of accountability that have recently been used in a health care context. From this exercise it becomes clear that different concepts are given importance by different researchers; four main types of accountability can be distinguished, namely financial, managerial, political and professional (Fooks/ Maslove, p. 6). While these categories overlap to some extent, in this paper when NPM reforms are discussed the focus is on "managerial accountability," which is preoccupied with "demonstrating effective and efficient management of services or systems" (Macdonald 1999, p. 6).

III. Measuring and Monitoring Performance under the NPM

Measuring performance is not a new concept (Drucker 1974). However, its use in government and the non-profit sector represents a significant departure from the broad organizational goals typically given to senior management in the private sector. The goals used in government and non-profit sector typically incorporate a very narrow, or targeted, range of program measures of performance. The concept behind measuring performance and the results-based management movement is that by identifying and measuring key metrics organizations would have clear indicators of achieving program objectives.

An evolution in the results-based management movement was the creation of the "balanced scorecard". Developed by Robert Kaplan and David Norton, the balanced scorecard was devised as a tool to move beyond earlier results-based management models by connecting an organization's performance metrics with its overarching strategy. Originally designed for use in the private sector the balanced scorecard is now commonly used by governments and non-profit organizations. It includes four broad categories to be measured since Kaplan and Norton believe that in order for an organization to succeed it must account for more than simply its finances. Customer satisfaction, internal business processes, innovation and learning, and finance are considered equally important (Kaplan/Norton 1996; 2001). Kaplan and Norton argue that if a company is able to perform well in all four of these areas its likelihood of success and overall performance will be improved.

The introduction of accountability agreements represents the formal incorporation of the results-based management into most organizations receiving government funding. Accountability agreements are essentially documents which outline expectations between government or its funding agencies with the organizations which are receiving the funds in exchange for the delivery of services. The notion of an accountability agreement may seem odd to the for-profit sector as it has traditionally made use of formal legal contracts which spell out the requirements of each party to the contract. However, in the context of

government and its funding agencies, having such formal contracts seemed redundant as it would be, in many circumstances, the equivalent of government having a contract with itself.

However, as governments devolve decision-making authority and the public demands greater accountability for its tax dollars, the notion of an agreement clarifying the expectations of a government agency or a government funded non-profit organization seems more reasonable. It is argued that these agreements further enhance accountability by clearly identifying the services to be provided and the performance targets that are to be achieved by the organizations which receive funding. Consistent with the goals of NPM reforms, these accountability agreements have become an attractive means for governments to demonstrate that they are improving management practices and enhancing public accountability; in part as a form of social marketing.

In Canada, performance measurement was viewed by many as a tool that health care organizations could (and should) use to enhance their efficiency while promoting greater accountability. In Canada, report after report recommended that various types of NPM reforms should be adopted in order to fix problems in the health care sector (Mazankowski 2001; Kirby 2002; Romanow 2002). In fact, concerns about growing health care costs and lack of accountability in the system have been a dominant theme in Canadians' dialogue about their health care system since the 1980s (Mendelson 2002). For instance, the Romanow (2002) report notes that, "Canadians no longer accept being told things are or will get better; they want to see the proof. They have a right to know what is happening with wait lists; with health care budgets, hospital beds, doctors and nurses; ... and whether treatment outcomes are improving" (p. xix).

In an effort to alleviate public concerns, government and non-profit agencies in the health care sector began evaluating their programs and services, albeit in a somewhat haphazard manner. Many hospitals voluntarily implemented performance-measuring initiatives to better ascertain the quality of their operations. In recent years governments have enacted legislation requiring hospitals and other health care organizations to make their activities more accountable and transparent thus institutionalizing the results-based management movement (Government of Ontario 2007).

While there is a desire on the part of public officials to use performance measurement they are often unsure which metrics are really the most useful (Pollanen 2005). Adcroft and Willis (2005) argue that because of their unique nature performance metrics simply are not effective when applied within the public sector and that they will inevitably be more harmful than helpful. Others believe that performance metrics can successfully be adapted within the health care sector (Natarajan 2006).

IV. NPM Policies Applied to Health Care in Ontario

In Ontario, Canada, most health care service provider organizations such as hospitals and Community Care Access Centres (CCACs) operate at arms-length from government but

rely primarily on funding from government through the province's public health insurance plan (OHIP). Despite this, there has traditionally been a lack of clarity regarding the accountability relationship between the government and these health care provider organizations. This lack of clarity contributed to the slow pace with which measuring performance was embraced in practice, despite broad support for the concept in theory (Try/Radnor 2007). Delays in implementation were in part related to the absence or inadequacy of systems in place for collecting data, and in times of financial constraint there was resistance among most health care organizations to devoting financial recourses to improving data collection capabilities. In fact, it was common for hospitals (as well as other health care organizations) to have minimal reliable information about outcomes and clinical effectiveness as well as what it costs to perform a given procedure.

As support for collecting data grew, emphasis shifted to standardizing the quality and reliability of the data being collected in order to compare or benchmark across organizations. Government began requiring that greater data be provided from all government funded health care provider organizations such as hospitals, home care programs, long-term care facilities, mental health programs and public health agencies. In November 2003, the provincial government attempted to rectify this situation through the passage of legislation which introduced clear accountability and governance requirements for both hospital Boards and CEOs. The government in conjunction with the Ontario Hospital Association created a template for hospital accountability agreements for the 2005/2006 fiscal year. While terms and conditions of the agreements are the same for each hospital, the specific performance targets may vary due to hospital specific circumstances such as geography, patient population, or specialty services provided. Failure to comply with the terms of the agreements could result in a variety of consequences including financial penalties.

Despite the fact that provincial governments in Canada agreed to reporting standardized measures or indicators in 2000, this effort has not resulted in all data being comparable across similar provider organizations (Fooks/Maslove 2004). In a broader review of the impact of results-based management in Canada, Try and Radnor (2007) go even further and report that they found "disincentives to greater accountability for results" and that problems "identifying quantifiable outcome measures" limited the value of the reforms (Try/Radnor, p. 666).

In recognition of the need to collect performance data, compare it among like organizations and make it available to the public, the Ontario Hospital Association (OHA) began publishing "The Hospital Report" in 1998. It is a macro-level reporting of key metrics for the province's hospitals. The preliminary information collected by the OHA was used to measure "clinical utilization and outcomes, patient perceptions of Ontario hospitals, measures of financial performance and condition, and system integration and change" (Ontario Hospital Association 1998, p. 2). The report produced macro-level findings but did not reveal the scores received by individual hospitals to the public. The initial findings were instead refined and the following year a subsequent report was released containing more in-depth analysis. The second Hospital Report presented a balanced score-

card summarizing the aggregate results in addition to separate scorecards for all of the participating hospitals (Ontario Hospital Association 1999). Although participation was not compulsory, over ninety-one percent of Ontario's acute care and day surgery care hospitals participated in the study.

More recently the Ontario government has become more proactive in monitoring performance of health care provider organizations which receive government funding. For example, it has implemented requirements for hospitals to submit standardized performance measures, much like a balanced scorecard, referred to as HAPS (Hospital Annual Planning Submission) on an annual basis (Government of Ontario 2007a).

While there are significant benefits associated with collecting quality performance data, there are also some serious drawbacks which tend to be underreported. One potentially negative aspect of NPM reforms is that their focus on measuring performance may take away from actually completing the tasks at hand. Clark and Swain (2005, p. 455) argue that, "there is a fundamental tension between actually getting the job done and trying to demonstrate adherence to the precepts of utopian management frameworks." In the health care sector, this often means paying too much attention to meeting targets and performance metrics while issues of quality, equity, and accessibility are relegated to secondary importance. Beven and Hood (2006) note that a significant problem associated with performance measures is that what is measured gains a disproportionate importance over meeting the organization's broader goals. One of the areas where the Ontario government has recently focused its health care measurement energies has been seen in its wait time strategy. More resources and attention have been dedicated to reducing wait times for a limited number of procedures. While there has been evidence of some reduction of wait times for these targeted procedures there has also been growing evidence that wait times for other procedures have grown (Institute for Clinical Evaluative Sciences 2006).

Recent evidence from Ontario highlights some additional negative aspects of NPM reforms. In an evaluation of Cancer Care Ontario's efforts to implement a performance management system, Cheng and Thompson (2006) note that

> "the system does not manage a set of measures, which adequately reflects overall systems performance.... Compounding the issue of appropriate and relevant performance measures is the lack of accepted targets for some of the performance measures currently under the performance measurement system. CCO has yet to tie quantitative targets to clinical care quality–related performance measures. As a result, the ability to demonstrate incremental improvements in the system on an annual basis is difficult (p. 341)."

Another problem associated with NPM reforms is that there is typically a higher cost of administering programs and monitoring quality when they are based on competition and mistrust rather than a more collaborative model. Randall and Williams (2006) have shown that the implementation of a competitive model for awarding contracts for the delivery of home care services in Ontario (through its Community Care Access Centres or

CCACs) have resulted in dramatic increases in the cost per patient visit for some services. These cost increases were shown to have been in large part related to the increase in administrative costs to both manage the Request for Proposals or bidding process and to monitor the ongoing performance of the successful provider agency. Prior to this bidding model services were almost exclusively provided by non-profit agencies which determined pricing and assessed quality of services using an informal collegial process.

It has also been shown that NPM reforms which require non-profit provider agencies to compete as if they were for-profit organizations can result in a loss of diversity, innovation and creativity in the delivery of services. Randall (2008) describes a situation in the reform of Ontario's home care system where organizations are less likely to take risks or novel approaches to the delivery of services and instead attempt to mimic organizations that are perceived as successful. This may further inhibit the benefits that the NPM reforms were expected to realize as the behaviour of for-profit and non-profit organizations begins to converge. This finding is consistent with research assessing the impact of NPM reforms at the federal level. Phillips and Levasseur (2004) conclude that the impact of accountability reforms on voluntary organizations have been "significant and overwhelmingly negative [...] affecting their willingness to take risks and opportunities to be innovative" (p. 453).

Perhaps even more problematic are recent findings that NPM reforms have resulted in heightened tensions between managers and health care professionals and indirectly reduced organizational effectiveness. For instance, Kapiriri et al. (2008) described how government defined targets for cardiac surgery and the implementation of a bureaucratic process for determining patient priority at one Ontario hospital has resulted in greater conflict between policy makers (both government bureaucrats and hospital managers) and cardiac surgeons. Moreover, physician resistance has rendered the reforms partially ineffective. This tension between managers and health professionals has also been seen in other health care reforms in Ontario. Randall (2007) has shown how the competitive model for delivering home care services has led to conflict between the case managers in Ontario's CCACs and the health professionals employed by the agencies which provide the home care services. This conflict was the result of case managers feeling compelled to restrict the decision-making ability of health care professionals as a means of limiting services provided in an effort to control costs.

V. Alternative Governance Approaches

In considering the impact of NPM reforms in Canada, Gabriel Sékaly (2007) asks if there is "too much accountability." This is a question which may not have received sufficient attention given the financial and human resources that have been shifted to this endeavour.

From a citizen accountability perspective, there continues to be a debate about whether Canadians actually want or use all of the health care metrics that are reported (Hibbard

2002; Schneider 1998). Fooks and Maslove (2004) note that, "Increasing evidence from Canada, the US and the UK is leading experts to question whether report cards and comparative indicators are really a citizen accountability mechanism or perhaps more suited to clinical and system managers" (Fooks/Maslove, p. 19).

Despite the seemingly endless demand by government for measuring performance, there has been an increasing chorus of cautiousness that these efforts may not deliver all that has been promised. In a recent report, the Auditor General of Canada (2003) concluded that despite efforts to apply results-based management to the public service, it has proven to provide limited impact on efficiency and accountability. Phillips and Lavasseur (2004) conclude that "it is doubtful whether such a strict accountability regime has, in fact, achieved its primary goal of enhancing financial management and reporting [...] What is evident is that [it] has significant transaction costs and unintended consequences" (p. 464).

In the face of a growing body of research and empirical evidence, it remains unclear to what extent performance measurement tools developed for for-profit industry can be effectively adapted to government and non-profit organizations. This raises serious questions about whether we may have gone too far in diverting scarce health care resources into measuring and monitoring performance rather than providing health care services.

To be sure, as institutional theory would predict, organizations have adopted these performance-driven tools to conform to the dominant institutional environment and thus secure resources including legitimacy. At the same time, we need to consider the possibility that these "practices" have often been adopted only formally without necessarily changing underlying actual practice (Meyer/Rowan 1977). Yet, nevertheless, the obsession with performance measurement may lead to dysfunctional outcomes, given the complex multi-dimensional goals in the non-profit sector.

"Commercial organizations are judged on financial performance [...] Not-for-profit organizations [...] are stewards of resources that have been provided by and for people and organizations other than the not-for-profit organization itself" (Harris/Mainelli/O'Callaghan 2002). As such, non-profit organizations are not agents in a contractual theory perspective (Sundaramurthy/Lewis). Rather, non-profit organizations are mission driven. A reinvigorated "Public Value" approach requires a broader and multi-dimensional set of metrics than normally found in NPM models in order to incorporate complex elements of quality, equity, accessibility, transparency and innovation (Kelly/Mulgan/Muers 2002). There is no doubt that this type of approach will not allow for an easy comparative assessment of policy alternatives as difficult value judgements and trade-offs that involve deliberation through the political process are required. But it may be more suitable for measuring services offered within the health sector. A set of metrics based on the recognition that, next to cost and efficiency concerns, a set of complex public values needs to be considered may provide public health practitioners (and the public) with superior information, compared to a uni-dimensional focus on ordinal efficiency. This information could then help policy makers, practitioners, and the general public to better judge the quality of their health care services.

Recent research suggests that mission-driven, global, non-profit organizations command unprecedented levels of trust, and non-profit brand valuations are on par with major international corporations. The multiple roles and stakeholders that global non-profit brands must address make non-profit brand building complex and challenging. Despite the complexity, international nonprofit organizations may have an advantage over for-profits in leveraging public trust and brand communication (i.e., social marketing) (Laidler-Kylander/Quelch/Simonin 2007).

VI. Conclusions

In our case exploration of the impact of NPM reforms in Ontario's health care sector, we have observed that rather than promoting efficiency and accountability, the application of NPM principals and practices within government and non-profit health care delivery organizations has contributed to higher transaction costs and an exaggerated focus on achieving narrow performance targets over issues such as quality, equity, accessibility, and innovation. At the same time, efforts to both develop acceptable metrics and monitor the extent to which targets have been achieved leads to greater tension between managers and health professionals, who resent efforts by managers to limit their clinical discretion in utilizing organizational resources. As a result, the expected efficiency and accountability gains have not been fully, if at all realized. Similar findings have recently been reported by other researchers (Lapsley 2009; Simonet 2008). While some would argue that this added cost to the system is necessary in order to encourage efficiency and achieve accountability, others view these added costs as a drain on already scarce health care resources. In particular, a reliance on competition seems to be in conflict with a health care system which was built upon principals of trust and collaboration.

As such, this case study contributes to the growing literature calling for greater caution in the application of NPM policies to health care and other non-profit sectors around the world. In order to optimize potential efficiency and accountability returns from NPM reforms, there is a need to take into consideration the broader, multi-dimensional goals of government and non-profit organizations, which go well beyond financial concerns and involve delicate value judgements and trade-offs that defy ordinal rankings of policy alternatives. This will also require preserving some elements of collegiality and cooperation between managers and health professionals. The legitimate desire for efficiency and accountability under NPM reforms needs to be balanced and reconciled with the need to safeguard public mission values such as equity, and accessibility, rather than giving priority to uni-dimensional and often arbitrary performance targets. By incorporating public value considerations into performance measurement policy makers and health practitioners gain access to information that better evaluates the quality of the services they are providing. Given the complexity of the "bottom-line", this will not be an easy feat. But ultimately, the goal of evaluation is to ensure that citizens are receiving, in the most effi-

cient possible manner, the kind of high-quality health care that they as a political community choose to aspire to.

Public managers are clearly under pressure to ensure that expenditures achieve value-for-money. In the traditional model of public management, government provided base funding to non-profit institutions, which provided a level of funding consistency. With the NPM model, funding has become contestable, based on a procurement process. The objective of the NPM was to achieve superior program outcomes based on performance measurement and results-based management. The observed failure to deliver these outcomes underscores calls for more integrated approaches that help public managers to reconcile a public values approach with the need to establish performance based metrics in an increasingly cost-driven policy-context. This case study highlights the need for further research to be conducted which evaluates not only the success of NPM reforms but also to what extent governments attempt to use related performance metrics as a form of social marketing in support of NPM reforms.

Abstract

Glen E. Randall, Burkard Eberlein und Arthur Barrows; Verantwortliche Gesundheitsversorgung durch Leistungsmessung?

Gesundheitspolitik, Leistungsmessung, Neues Steuerungsmodell, Sozialmarketing

Die „New Public Management (NPM)" Bewegung strebt nach Marktdisziplin und Verantwortlichkeit durch auf Indikatoren beruhende Leistungsmessung. Der vorliegende Artikel präsentiert Ergebnisse einer Fallstudie, die am Beispiel von NPM-Reformen im Gesundheitssektor der kanadischen Provinz Ontario untersucht, inwiefern die Reformziele erreicht wurden. Die Studie zeigt, dass die Einführung von NPM-Massnahmen zu höheren Transaktionskosten, zu größeren Spannungen zwischen Managern und medizinischem Personal, sowie zu einer übertriebenen Konzentration auf die Erreichung enger Leistungziele geführt haben. Im Ergebnis haben die Reformen die erhofften Effizienz- und Verantwortlichkeitsgewinne verfehlt. Dennoch hält die Provinzregierung an der Leistungsmessung fest, nicht zuletzt, um Erfolge in der effizienten Verwaltung gemeinwirtschaftlicher und öffentlicher Dienste im Sinne eines Sozialmarketings nach außen, demonstrieren zu können.

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