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Community Accountability in Ontario's Healthcare Sector: A Case Study of Six Hospitals

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Abstract

Community Accountability in Ontario's Hospital Sector: A Case Study of Six Hospitals in Ontario

As the provincial cost of funding healthcare approaches an annual $30 billion, both government and the public are demanding greater accountability from Ontario's hospitals. Indeed, new legislation has been passed in Ontario to require hospital boards to enter into accountability agreements with the Ministry of Health. While broadly supporting the intent of *The Commitment to the Future of Medicare Act*, the Ontario Hospital Association (OHA) has warned that key sections of the Act will undermine local hospital boards by allowing the government to make unilateral decisions about management and patient care priorities in each hospital without regard to the oversight responsibilities of local volunteer hospital boards.

The OHA's call for governance renewal to prevent the loss of individual hospital autonomy has been premised on the argument that volunteer directors serve as a critical link between hospital and communities. This defense raises a fundamental question: What is the accountability relationship between communities and hospital boards?

A sample of six hospitals in Ontario is the basis of this study, which examines how community accountability is exercised by the governing boards of hospitals. Results indicate that hospital boards face a number of tensions and paradoxes that stem from directing their efforts towards the organization, government and the community.

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I. Introduction and Research Question

This research report examines community accountability in public administration, specifically in the context of hospital governance. As the annual cost of health care in Ontario approaches $30 billion, there are growing demands from both the public and government for increased accountability. Hospitals, as multi-faceted, pluralistic and publicly-funded organizations, provide an ideal backdrop for an analysis and discussion of accountability within a public administration framework. The hospital sector perhaps best represents the new and increasingly complex governance environment in which governments and citizens come together to demand accountability from those who provide public goods and services.

> "Public accountability is a fundamental right of citizens in a democratic polity. Without accountability, democracy does not work: there is no constraint on the arbitrary exercise of authority. But accountability is difficult to construct and enforce, even in democratic systems of responsible government. Accountability is even more challenging when states turn to markets for public goods, when the powers of the state are delegated and authority is one step or further removed. What accountability means, how it is constructed, and what measures are important are part of a much larger conversation about values and purposes. To ignore accountability, or to dismiss it as a technical problem best left to the experts, is to miss one of the most important conversations of post-industrial society." (Stein, 2001:139)

While accountability is not a new concept to health care, it has become increasingly prominent in public discourse. For example, Roy Romanow, the Commissioner on the Future of Health Care, recommended the five key principles of the Canada Health Act (accessibility, universality, medically

necessary, comprehensiveness, and quality) be supplemented by a sixth principle, namely, accountability (Commission, 2003). In addition, the 2003 First Ministers' Health Accord positioned accountability as a major priority. "First Ministers commit to enhancing transparency and accountability for our health care system while ensuring health care remains affordable...First Ministers agree to establish a Health Council to monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions" (First Ministers, 2003).

The accountability discourse is also occurring in an environment of annually escalating health care costs, rapidly growing hospital deficits and complex changes in the health care system. The restructuring of healthcare in Ontario has resulted in some cases in a shift from local, community-based hospitals to more complex, integrated and multi-facility organizations. These factors have raised concerns about the effectiveness of hospital governance and questions about the level of accountability exercised by hospitals. Over the past decade hospitals have been subjected to third party reviews, operational reviews, provincially-appointed supervision. These and other investigations have repeatedly identified governance flaws, including the lack of clarity regarding the boards' accountabilities to government and communities (Quigley and Scott, 2004). As a result a number of amalgamated hospitals and/or hospitals under supervision have initiated governance reviews; however, there is only anecdotal evidence

about their governance practices and conceptualization of accountability (Quigley and Scott, 2004).

Single hospital boards have been the traditional method of governance in Canada since the first hospitals were built in the 1600s (Brunelle, Leatt and Leggatt, 1998). While other provinces have moved toward health care system regionalization, Ontario's hospitals have maintained governance by independent boards of directors. Recently, the Ontario Hospital Association (OHA) has expressed concerns that the provincial government is attempting to undermine independent hospital governance through two pieces of legislation, specifically *Bill 18: The Audit Statute Law Amendment Act (2003)* and *Bill 8: The Commitment to the Future of Medicare Act (2004)*. Together, the Acts signal the government's intention to have the provincial auditor audit hospitals and to establish performance agreements with individual hospitals. As noted in the OHA's discussion paper on Hospital Governance and Accountability in Ontario:

> "While there is agreement in principle that performance agreement and hospital audits by the provincial auditor are appropriate, it is important to note that the consolidation of hospitals operating results, assets and liabilities in the government's financial statement would result in the de facto loss of hospital corporate independence as the government would be seen to be directly accountable as it is currently with ministries." (Quigley and Scott, 2004:8)

The OHA is particularly concerned that Bill 8 will permit the government to impose (not negotiate) performance contracts and sanction hospital administrators for failure to meet the performance deliverables. If hospital CEOs

were directly accountable to the Minister of Health, the oversight responsibilities of local hospitals boards could be compromised. Therefore, in order to demonstrate that hospitals are serious about improving accountability through governance, the OHA identified hospital governance renewal as a key strategic priority (OHA, 2004). The four strategies in support of this direction are to:

1. Identify and advance health care governance best practices.
2. Develop and promote initiatives that will result in greater joint accountability for government and providers, including accountability frameworks.
3. Support initiatives that will result in greater accountability of the community-at-large in how they access the health care system and what they expect of it.
4. Continue the development of hospital and system performance reporting.

A careful reading of these initiatives suggests the OHA tends to view accountability as a bilateral relationship between the provincial government and hospitals (see #2 above), while also wanting to hold the community accountable for proper use of the health care system and for maintaining realistic expectations (see #3 above). Although the latter initiative appears to put the community in the curious position of having to defend their use of hospital services, it does suggest the OHA recognizes some type of an accountability relationship with the community is required. The OHA further appears to endorse

the need for a community orientation by voicing their opposition to Bill 8 in terms of a loss of community accountability because it shuts "communities out of local hospital decisions by eliminating the responsibilities of local hospital boards" (OHA, 2004).

The OHA's call for governance renewal to prevent the loss of individual hospital autonomy has been premised on the argument that volunteer directors serve as a critical link between hospital and communities. This defence raises questions about the community accountability exercised by hospitals, given the current pressure for boards to focus on oversight responsibilities and accountabilities to government. As noted above, the lack of clarity with regard to the board's respective accountabilities to government and their communities has been frequently cited as problematic (Quigley and Scott, 2004), suggesting there may be a variety of different ways in which hospitals, governments and indeed citizens think about the concept of accountability.

Therefore, the approach of this research report is to offer a critical examination of the accountability discourse, specifically in the context of Ontario's hospital boards. Through the lens of public administration, I hope to take a multifaceted view of accountability with a view to understanding how community accountability is demonstrated through hospital governance structures and processes in an environment of multiple accountabilities. The critical analysis and discussion will

be grounded in empirical evidence by examining how community accountability is operationalized at six hospitals in Ontario.

The fundamental research question for analysis and discussion in this paper is:

What governance practices and structures do Ontario's hospital boards employ to demonstrate accountability to the communities they serve?

In order to answer this question, the next section will review the literature on accountability and non-profit hospital governance. The following sections will then:

- describe the methodology for applying the theoretical discussion to selected Ontario hospitals; and,
- report on the findings and their implications.

Finally, the analysis offered in this report, although focused on the health care sector, may also be applicable to the local government milieu. Municipalities operate in a complex environment with multiple accountabilities, which includes a significant upward accountability to the provincial government. It is my hope that the discussion contained in the report sheds light on the accountability challenges and opportunities that may exist in a variety of public administration settings.

II. Theoretical Framework

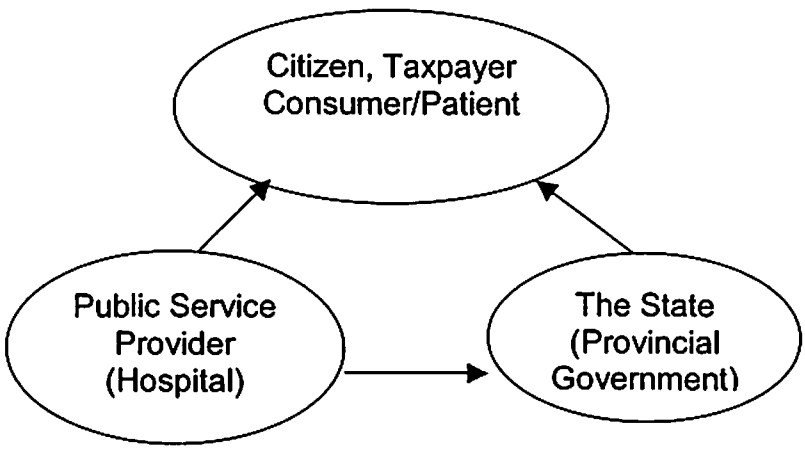
A) Accountability in Public Administration

The traditional way of thinking about accountability in public administration as coherently flowing upward through the civil service to elected politicians may be insufficient given today's complex public service delivery environment. Osborne and Gaebler (1992), who popularized the New Public Management (NPM) movement in their book, *Reinventing Government*, argue that governments should set policy priorities (steer) rather than participate in the direct production of public goods and services (row). This managerial reform of the public administration model has resulted in non-profits and other non-government organizations delivering public services on behalf of the government in order to improve efficiency, increase customer choice and satisfaction, and empower managers to seek innovative solutions (Kernaghan, Marson and Borins, 2002). However, as governments retreat from direct service delivery, the "post-bureaucratic" model of the state as contractor and regulator presents new accountability challenges.

While the state does not deliver medical care directly in Ontario, their role as public service contractor, primary health care funder and hospital regulator offers an excellent opportunity to discuss accountability issues within a public administration framework. As noted by Janice Gross Stein in her national

bestseller, *The Cult of Efficiency*, "accountability to the public by those who provide public goods should not be a revolutionary concept" (2001:76). Yet the tripartite configuration in health care of the state, hospitals and communities (see Figure 1 below), renders accountability as an increasingly complicated, often indirect and sometimes unclear concept. Citizens, as taxpayers, patients and stakeholders in the health care system, expect direct accountability from those providing health services, while health providers hold they are accountable to the purchaser (i.e. the state) of their services, and the state remains directly accountable to citizens.

Figure 1: Diagram of Accountability Relationship



The traditional public administration concept of accountability may not accommodate the requirements of the "post-bureaucratic state. A 1980s public administration study in Britain declared "accountability, answerability or responsibility as being directed to the community at large, rather than following the lines of constitutional accountability "(Day and Klein, 1987: 229). When seen

through the historical lens of public administration, the conceptualization of accountability has always moved along a continuum. The table below highlights the changing characteristics of, and mechanisms to ensure, accountability in public administration.

Table 1. Accountability in Public Administration

Perspective	Key Characteristics	Mechanisms
Traditional (Weberian)	Coherent chain of upward accountability from civil service to politician to citizen Administrators accountable for process/politicians accountable for policy outcome	Procedures and rule of law
Democratic	Representative and/or participatory forms of democracy as channels for holding public administration to account	Democratic renewal initiatives (community planning, local referenda)
Professional	Lateral accountability to peers through public sector professionalism	Professional qualifications (knowledge and values) Peer evaluation
Managerialist	Direct accountability between administrators and users of public service through reforms such as contracting out, privatization, etc. Citizens are viewed as customers or clients.	Performance targets Competition and choice
Regulatory	Accountability ensured through 'hands off regulation" (i.e. public auditor, ombudsmen) Upward accountability of service deliverers to government.	Rules/standard settings Management reporting and controls
Rational Choice	Behavioural factors in public administrators	Individual behaviour of public official determines what accountability is

Adapted from McGarvey, 2001

The above table demonstrates that rather than being sacrosanct, accountability is actually a socially constructed concept that varies over time and context (Ebrahim, 2003).

Today, accountability in public administration seems firmly grounded in the regulatory perspective as the new public management model of contracting out, coupled with calls for greater accountability, have increased the surveillance, audit, and regulatory capacity of government (McGarvey, 2001). While the regulatory method has been praised for improving the fiscal accountability and efficiency of agencies delivering services on behalf of the government (Mulgan, 2001), others have strongly criticized the impact of a contracting regime because it positions government as the ultimate body to which service deliverers must give account and thereby downplays accountability to citizens and the public (Haque, 2001, Shields and Evans, 1998).

The regulatory model may further disturb the chain of accountability from the perspective of the "common citizen" who may simply not be able to determine whether government or its contractors are responsible for a particular service (Peters 1993 cited in Haque, 2001). As well, the "common citizen" has greater interest in the accountability of a public service delivered directly, and is less concerned with the accountability tasks of regulation and evaluation that have little direct impact on them (Haque, 2001).

Finally the regulatory perspective has been criticized for framing the relationship as yet another neutral, apolitical way of ensuring accountability (Pollitt, 1986). Indeed the language of New Public Management - efficiency, effectiveness and "value for money" – arguably detracts from the more fundamental political question regarding the allocation of societal resources (Shield and Evans, 1998). Stein (2001) argues that efficiency has no inherent value. "Efficiency is about how we should allocate our goals, not what our goals should be". (Stein, 2001: 68). For example, citizens, whether they are patients or taxpayers, are likely to want a short (and therefore efficient) hospital stay, but it is also likely they are more interested in an improved health status.

There is a perhaps a cautionary warning about a governance environment that creates a confusing or insignificant accountability framework for citizens. In a study of public participation modes within the public administration framework, Cheryl Simrell King and her colleagues argue:

> "Administrative legitimacy requires active accountability to citizens, from whom the ends of government derive. Accountability, in turn requires a framework for the interpretation of basic values, one that must be developed jointly by bureaucrats and citizens in real world situations rather than assumed. The legitimate administrative state, in other words, is one inhabited by active citizens "(King et al, 1998: 319).

Thus no matter how intractable the problem of locating accountability has become, if new structures of governance are to retain legitimacy there must be some line of accountability to citizens and their communities.

B) Governance and Accountability

Interest in governance has greatly increased over the past two decades. Private sector corporate failures in Canada and the US, due in part to serious mismanagement and flaws in corporate governance have been a driving force behind numerous studies documenting problems and methods to improve governance in the for-profit sector (Cadbury Report 1992, Dey Report 1994). Governance failures in the non-profit sector (Canadian Red Cross, National Arts Centre, and the International Olympic Committee) have also received negative public attention and the Broadbent Report (1999) highlighted governance issues and challenges in the voluntary sector in Canada. Together these reports (a) acknowledge that public confidence in private and non-profit institutions has been threatened by governance failures and (b) assume that good governance is necessary for effective organizational performance and overall accountability (Gill, 2001).

Before continuing this discussion, a definition of non-profits is required in the context of this paper. In contemporary society, three broad sectors can be defined, namely (1) public/state sector, (2) the private/business/market sector and (3) the voluntary/non-profit/third sector (Shields and Evans, 1998). It has been argued that hospitals should be considered part of the broader public/state

sector because they are so heavily and directly dependent upon government funding (Shields and Evans, 1998); however, this position does not recognize that hospitals are independently governed. As a result, hospitals are more appropriately defined as non-profit organizations because they a) serve the broader public interest (i.e. through the delivery of public goods or services), b) do not distribute profits to owners/stakeholders, and c) are independently governed by volunteer trustees or directors.

As noted previously, a volunteer board governs each hospital in Ontario and there are over 3500 individual board members in the province (Quigley and Scott, 2004). Their key responsibilities are to:

- Define the purposes, principles and objectives of the hospital;
- Ensure and monitor the quality of hospital services;
- Ensure the fiscal integrity and long-term future of the hospital; and,
- Arrange for and monitor the effectiveness of hospital's management (Hundert and Crawford, 2002).

In the 1992 report of the steering committee struck by the Ontario Ministry of Health to review the *Public Hospitals Act*, governance is defined as, "the exercise of authority, direction and control over the hospital by its board of directors" (Steering Committee, 1992:13). The report also identified a key governance challenge, namely the need for a clear definition of hospital accountability to patients, the public and government (Steering Committee, 1992). The issue

reflected concerns that board members were acting as community advocates without due regard for their performance and financial oversight responsibilities. The recommendations in the Steering Committee's report to strengthen hospital governance provisions of the *Public Hospitals Act* remain largely unimplemented today (Quigley and Scott, 2004), but serve to highlight that hospital governance, like non-profit governance in general, has often been found problematic (Cornforth, 2003). Carver succinctly summarizes these concerns as:

> "An extraterrestrial observer of board behaviour could be forgiven for concluding that boards exist for several questionable reasons. They seem to exist to help the staff, to lend their prestige to organizations, to rubber stamp management desires, to give boards members an opportunity to be unappointed department heads, to be sure staffs get the funds they want, to micromanage organizations, to protect lower staff from management and sometimes even to gain some advantage for board members as special customers of their organizations, or to give board members a prestigious addition to their resumes." (Carver, 1997)

A number of empirical studies about the problems of non-profit governance have lent support to managerial hegemony theory (Hung,1998) which argues that boards are powerless and essentially a legal fiction because only the professional managerial class has the expertise, time and resources to control the organization (Berles and Means, 1932). These studies suggest that board power in nonprofits is limited by a) management's control over the selection of volunteer directors b) the limited time volunteer directors have to perform their duties c) the superior expertise, information and advice available to management and d) the norms of board behaviour that limit volunteers board members from

acting together as critics of management (McNulty and Pettigrew, 1995). However, other research has focused attention on various types of contingency theories of board-management power relations to consider the situational variables, personal characteristics, and other contextual features that both constrain and enable non-profit board power (McNulty and Pettigrew, 1995, Cornforth 2001, Murray et al 1992: Wood, 1992).

Despite the problems and challenges of governance, hospital boards "sit atop" complex organizations delivering a valued public service, universal health care and therefore their impact cannot be dismissed as irrelevant. Carver has claimed that "boards are at the extreme end of the accountability chain" (Carver, 1997:16); however, as we have seen in the New Public Management environment, this conceptualization of a non-profit, publicly funded board as having ultimate accountability may be incomplete.

Webster's Dictionary defines accountability as "the state of being accountable, subject to the obligation to report, explain or justify something; responsible; answerable". In the Canadian non-profit sector, accountability has been defined "as the requirement to explain and accept responsibility for carrying out an assigned mandate in light of agreed upon expectations" (Broadbent Report, 1999). Shortt and MacDonald define accountability in Canadian healthcare as:

> "Set within an implicit ethical context, accountability is the obligation to answer to an authority that conferred a responsibility, by an agent who accepted, with the resources and delegated authority necessary to achieve it, and with the

> understanding that inadequate performance will result in intervention" (Shortt and MacDonald, 2002)

These definitions reflect the powerful normative legacy of traditional conceptualizations of accountability as flowing upward to an authority. However, in relation to nonprofits, other definitions have explored a broader perspective to suggest that accountability is about being "held responsible" by others and about "taking responsibility" for oneself (Ebrahim, 2003). Accountability in this regard has two dimensions. First, it is external in nature and achieved through a reactive response to overseers. Second, accountability is internal, motivated by "felt responsibility" (Fry, 1995) and achieved through a proactive effort to ensure the public trust and organizational mission is achieved. In other words, accountability may be defined as the means through which individuals and organizations are held externally to account for their actions and as a means by which they take internal responsibility for continuously shaping and scrutinizing organizational mission, goals and performance (Ebrahim, 2003).

C) Hospital Boards as Stewards OR Agents of the State?

Stewardship has been defined as "the willingness to be accountable for the well-being of the larger organization by operating in service, rather than in control, of those around us. Simply stated, it is accountability without control or compliance. Stewardship maintains accountability for keeping things under control but does not centralize the power or point of action" (Block, 1993). Indeed, non-profit governance has historically embraced the stewardship values of philanthropy,

voluntarism, and independence to advocate for services to meet client needs and to secure resources necessary to enhance the appropriate quantity and quality of those services (Alexander and Wiener, 1998).

However, this stewardship approach focuses board work on maintaining assets rather than monitoring the performance of management and ensuring financial accountability to stakeholders. As non-profits shift from organizations "doing good" to professional agencies delivering public services on behalf of government they have been increasingly required to justify their spending and management activities (Fitz Randolph, 1998).

> "The public is expressing concern that nonprofits, similar to government and market institutions need to justify not only what services they deliver but also how they operate. Citizens are demonstrating that focus on organizational mission is no longer sufficient and that organizations must demonstrate outcomes and efficiency. Mission based value is waning and nonprofits must prove their economic value through demonstration of programmatic and fiscal accountability." (Christensen, 2002: 9).

Thus non-profits may face pressure to balance the stewardship model with a more corporate governance approach. Indeed, hospital trustees/directors in Ontario have often assumed the role of community advocates to pursue more resources but in doing so have faced government displeasure as politicians and bureaucrats attempt to contain the financial demands of hospitals (Quigley and Scott, 2004). This strained relationship caused by fiscal challenges, and coupled with the trend toward private sector emulation in public administration, has resulted in arguments that the survival of non-profits depends on their becoming

more businesslike in form, structure, practices and philosophy (Fine 1990, Steckel et al 1987). Private sector corporate governance stresses the role of the board in strategy and policy development, risk management, competitive positioning and monitoring management. The table below highlights the significant differences between the two governance models.

Table 2: Differentiating Characteristics of Non-profit and Corporate Governance Models

Traditional Non-profit Model	Corporate Model
Large board size	Small board size
Wide range of perspectives and backgrounds	Narrow, more focused perspectives/backgrounds
Small number of inside or related directors	Large number of inside or related directors
Separation of management and governance	Active management participation on the board
Informal management accountability to board	Formal management accountability to the board
No limit to consecutive terms for board members	Limit on consecutive term for board members
No compensation for board service	Compensation for board service
Emphasis on asset and mission preservation	Emphasis on strategic and entrepreneurial activity

Source: Alexander and Weiner, 1998

The literature review yielded very little empirical evidence about the performance of nonprofits that adopt corporate governance models. There are some anecdotal reports, case studies, prescriptive articles, and commentaries advocating either for or against governance changes (Busch 1992, Cnaan 1996, Conger 2004, Eisenberg 1992); however, because arguments are largely value-based, it is difficult to assess the challenges and opportunities non-profits are

facing when attempting to affect governance changes or maintain their status quo.

One study entitled *Adoption of the Corporate Governance Model by Nonprofit Organizations* looked at nineteen hundred nonprofit hospitals in the USA. The authors, Alexander and Weiner (1998) found the for-profit governance model is neither feasible nor even a desirable solution to problems facing many nonprofit organizations. "Some non-profits may not find the corporate governance model appropriate because the priorities and design principles it endorses run counter to the institutions' missions, values and relationships with key stakeholders" (Alexander and Weiner, 1998:239). In other words, the corporate model may be appealing but difficult to adopt because there are strong pressures from internal and external forces to adhere to traditional values of voluntarism, constituent representation and stewardship. Alexander and Weiner also found that the corporate and philanthropic models of governance are "ideal types" because most hospitals exhibited hybrid combinations of the two models. The authors of the study did not offer an empirical explanation for this finding but suggested that hospitals may be attempting to strike a balance between competing accountability demands (Alexander and Weiner, 1998).

At the same time the non-profit sector is adopting the corporate model as part of a larger trend to emulate business; corporate governance in the private sector is also under-going reform in the wake of business scandals. The best practices,

voluntary guidelines and legal requirements in the private sector (Cadbury 1992, Dey 1994) are largely based on the principal-agent theory. Principal - agency theory (Jensen and Meckling, 1976), offers a normative approach for ensuring governance accountability by limiting managerial power. The theory assumes a) the goals of the principal (owner) and agent (manager) are in conflict; b) agents are motivated by external forces and c) the principal has the power to control the agent's behaviour by establishing incentives to ensure the agent contributes maximally to the principal's objectives. Under this paradigm hospitals and other nonprofits that are funded by the state may be described as agents of the state. Therefore, the state (principal) has the right to require an account from hospitals (agents) and also a right to impose sanctions if the account or actions are inadequate.

However the principal–agent framework has a series of limitations concerning accountability in nonprofits (Ebrahim, 2003). First, given that the goals of the principal and agent are assumed to be incongruent, the principal must control the agent's behaviour by (a) linking agent compensation to performance objectives and (b) monitoring activities of the agents. As a result, non-profits are required to spend more resources negotiating with government and monitoring and reporting on their performance. These administrative responsibilities may also require organizations to adopt private sector managerial priorities and in turn dismiss the democratic structures of community accountability (for example,

open board meetings, community consultations) as too costly and time consuming (Shields and Evans, 1998).

Second, a focus on external accountability measures may lead to the neglect of issues of accountability that are internal to the organization such as integrity and achieving mission. According to Fry, the central concern is "whether accountability is experienced as a monitoring or as an enabling process" (Fry, 1995: 186). The emphasis on meeting the external oversight requirements may also force organizations away from advocacy and towards a subordinate status as a service provider, which ultimately lessens their influence over public policy.

Third, principal-agent theory tends to focus on the behavioural requirements of agents while deemphasizing those of the principals. For example, the principal may require the agent to develop a multi-year business plan, yet only provide an annual funding commitment. Finally, principal-agent theory fails to recognize that non-profits are accountable to many stakeholders. The interests of multiple principals may coincide but they are more likely to be in competition. While businesses are accountable primarily to shareholders or their owners, non-profit organizations operate in a much more complicated environment where there may be no clarity of paramount duty. Certain non-profits such as trade associations or professional societies are clearly owned by their members. However, the community as a whole is often considered as having legitimate ownership of social institutions such as hospitals and schools. While not possessing the legal

status of a shareholder, this definition implies the moral equivalent of ownership (Carver and Carver, 1996).

D) Stakeholder Theory

The concept of moral ownership can be explored through the lens of stakeholder theory (Freeman, 1984), which argues that corporations have accountability to a broad range of stakeholders. Like other theories of the firm, stakeholder theory was developed to address accountability issues in the context of for-profit firms. However, as noted by Drucker (1992), one of the most significant differences between the two types of organizations is that non-profits have more stakeholders. Freeman defines stakeholders as "any group or individual who can affect or is affected by the achievement of the organization's objectives (1984:46). Savage et al (1997:7) add, "stakeholders are those individuals, groups or organizations who have a contractual, ethical, financial and/or political interest (stake) in the decisions and actions of a particular organization. Stakeholders attempt to affect those actions in order to influence the direction of the organization so that it is consistent with meeting the needs and priorities (stakes) of the stakeholders". By this definition, it is not possible for an organization to select its stakeholders since only the stakeholder decides whether to have a particular stake in the organization.

Donaldson and Preston (1995) argue that there are two possible perspectives why organizations should be responsive to their stakeholders. From a normative

or business ethics perspective, it is intrinsically desirable for companies to behave in a socially responsible way to satisfy their stakeholders. The social science or instrumental stakeholder approach argues it is good business for organizations to be responsive to stakeholders. Essentially, trustworthy and cooperative behaviour will lead to superior results than opportunistic and selfish behaviour.

The moral or ethics argument has been vilified by proponents of shareholder-based agency theory, who argue that the only moral obligation facing managers is to maximize shareholder return, which will ultimately (through the 'efficient' market) result in the best allocation of social resources (Jensen, 1991, Drucker 1982). However, in their best selling book, *The Naked Corporation*, authors Don Tapscott and David Ticoll argue that consideration of stakeholders' interest in combination with honesty, accountability and transparency is the foundation of competitive advantage for firms. The business case approach to stakeholder theory is supported by empirical research that suggests positive stakeholder relations can contribute to improved financial performance (Agle et al, 1999, Waddock and Graves, 1997). The culmination of empirical evidence has led to a suggestion that ultimately there is little inconsistency between the objective of agency theory (increased shareholder value) and the practice of a stakeholder approach in the private sector.

> "We consider that it is only by taking account of stakeholder as well as shareholder interests that companies can achieve long-term profit maximization, and ultimately, shareholder wealth maximization. This belief is principally based on a

> growing body of literature and empirical evidence that suggest that corporate accountability which takes into account a broad range of social, ethical and environmental factors is conducive to financial performance". (Solomon and Solomon, 2004:29)

The literature review yielded very little evidence of the application of stakeholder theory to nonprofits and Donald and Preston (1995) doubt the value of doing so because private sector firms are governed by different principles for different ends. However, Scholl argues that the normative and instrumental considerations can be equally applied to public sector stakeholder scenarios because "the shift from more hierarchical to more network-type of organizations further demands inclusion and management of constituencies" (Scholl, 2000).

Nevertheless, there are cautions to consider when applying stakeholder theory to the public sector and non-profits because most stakeholders cannot formally hold organizations accountable (Fry, 1995), and stakeholders vary in their relative influence and power (Savage et al, 1997). As a result, board members may feel more responsive (or accountable) to the more formal, urgent and powerful stakeholder. Thus, how boards define, reconcile and manage their multiple accountability obligations becomes a fundamental question.

The competing theories of stewardship, principal-agent and stakeholder offer different perspectives on how boards can manage or respond to their accountability pressures. However, Morgan (1989) has argued these many theories and ways of thinking about organizations do not match the complexity

and sophistication of the organizational realities of today. To address this weakness, Morgan argues that a multi-paradigm approach must be taken to "confront and manage contradiction and paradox, rather then pretend they do not exist". This has led to calls for a new conceptual framework to integrate different perspectives (Hung, 1998) and it has been argued that a paradox perspective can provide a new and powerful way of looking at non-profit governance (Cornforth, 2003). In the case of hospital boards, the paradox framework highlights the ambiguities and tensions at play as boards:

- Desire to take internal responsibility for continuously shaping and scrutinizing the mission, goals and performance of the organization (stewardship);
- Respond to powerful external demands to account for their actions (principal-agent); and,
- Attempt to assess and manage the demands of a host of other competing interests, including those of the community served (stakeholder).

E) Summary

As governments develop more networks and partnerships to deliver public services, the dominant public administration accountability mechanisms have become audits, surveillance, reporting and other managerial and regulatory procedures (McGarvey, 2001). While the market discipline approach and its corresponding emphasis on outputs and performance can result in greater efficiency, there may also be negative impacts on the ability of publicly funded

non-profit organizations to meet multiple accountability demands. Hospital boards have historically advocated on behalf of their communities by serving as stewards. In recent years, fiscal challenges have led to calls for improved governance by increasing the board's oversight responsibilities. However, the New Public Management environment has also increased boards' accountability to government through increased performance reporting and regulation. As a result, hospital boards may be functioning as both principals of their organization and agents of the state. The tensions and challenges created by multiple accountabilities, including the relative power of their stakeholders, may also impact boards' accountability to the communities they serve.

III. Research and Results

Having established a theoretical framework, the next section will describe the research process and report on the findings regarding the demonstration of community accountability by hospital boards.

A) Purpose

Historically hospitals have relied on the governing boards as the principal mode of exercising community accountability. The traditional role of the board member has been to reflect the community they serve and help form the public conscience of the healthcare organization, while also bringing a unique perspective to the board (Savage et al, 1997).

> "Hospital boards represent an interface between the hospital and its environment insofar as members are drawn from, and have a primary affiliation with, organizations and agencies outside the hospital. This dual alliance with the organization and the outside locality not only permits direct exchanges of information and resources across boundaries but also serves as a mechanism for holding hospitals accountable to serving the needs of their communities." (Alexander, Weiner and Succi, 2000)

During the 1990s many Ontario hospitals responded to concerns about the quality of their governance by reviewing the roles and responsibilities of their boards. According to Quigley and Scott (2004), the Carver Policy Governance Model has been the most widely used approach by the Ontario hospital sector. The starting point for the Carver model is board accountability for the

organization it governs and the constituents it serves. The concept of moral ownership is a significant factor that contributes to a sense of felt responsibility and board members are encouraged to understand the principle that they have authority and accountability to serve the interests of the organization's mission, clientele and constituents (Carver and Carver, 1996).

However, as boards have become increasingly concerned with their oversight responsibilities and accountabilities to government, the Pointer and Orlikoff model (1999) has become more attractive (Quigley and Scott, 2004). Their model suggests that healthcare boards have five central roles: (1) defining organizational ends, (2) ensuring management performance; (3) overseeing financial performance; (4) overseeing the quality of patient care; and (5) providing for the board's own structure, composition and effectiveness. Boards carry out these roles in three ways: (1) by making policies, (2) by making decisions, and (3) by overseeing performance. Pointer and Orlikoff also argue that in order to meet their obligations boards must:

- Identify and prioritize key stakeholders and understand their interests and expectations; and,
- Represent stakeholders and ensure that the organization's resources and capacities are deployed in ways that benefit them (Pointer and Orlikoff, 2002).

Thus Pointer and Orlikoff, with their list of over seventy principles, offer a prescriptive model of healthcare governance that draws on both principal-agent

and stakeholder theories to improve governance. Although the focus of this study is not to determine the effectiveness of the Pointer and Orlikoff model, its growing popularity does suggest that hospital boards are seeking new tools and strategies to manage multiple accountabilities in a complex environment. Therefore, the purpose of this research report is to collect information about hospital governance in Ontario in order to identify the governance practices and structures currently employed by hospital boards to achieve community accountability.

B) Methodology

In order to conduct the research I used a multiple case study methodology. While case studies, as a research tool have been subjected to criticism, Yin (1994) and Stake (1995) have argued that they are a reliable methodology when executed with care. The methodology for this research project drew on Yin and Stakes design protocols to enhance reliability and validity. In particular, a short survey was emailed to staff members that provide support to their boards (see Appendix A for the survey instrument). The purpose of the survey was to gather descriptive information about current governance practices. The survey was followed by telephone calls to confirm data and provide an opportunity to ask supplementary questions. Conversations were documented. Additional information and evidence was gathered through reference material such as board by-laws and policies, board reference manuals, organizational websites, and reports. The rationale for using multiple sources of data is triangulation of

evidence, which increases the reliability of the data by limiting threats to both construct and internal validity.

The hospitals chosen as case studies represent large acute care academic teaching hospitals in Ontario. The hospitals are:

- London Health Sciences Centre (LHSC)
- Hamilton Health Sciences Corporation (HHS)
- The Ottawa Hospital

Two hospitals in Toronto were also selected:

- University Health Network (UHN)
- Sunnybrook and Women's College Health Sciences Centre (S&W).

In addition to providing resource-intensive patient care, these five organizations also function as teaching and research institutions in affiliation with their university partners.

As a further point of comparison a relatively smaller community teaching hospital, Toronto East General Hospital (TEGH) was included in the survey group. It is recognized that the small sample size limits the generalizability of the results; however, the focus of the paper is to develop an introductory understanding of community accountability at some of Ontario's leading hospitals.

C) Research Model

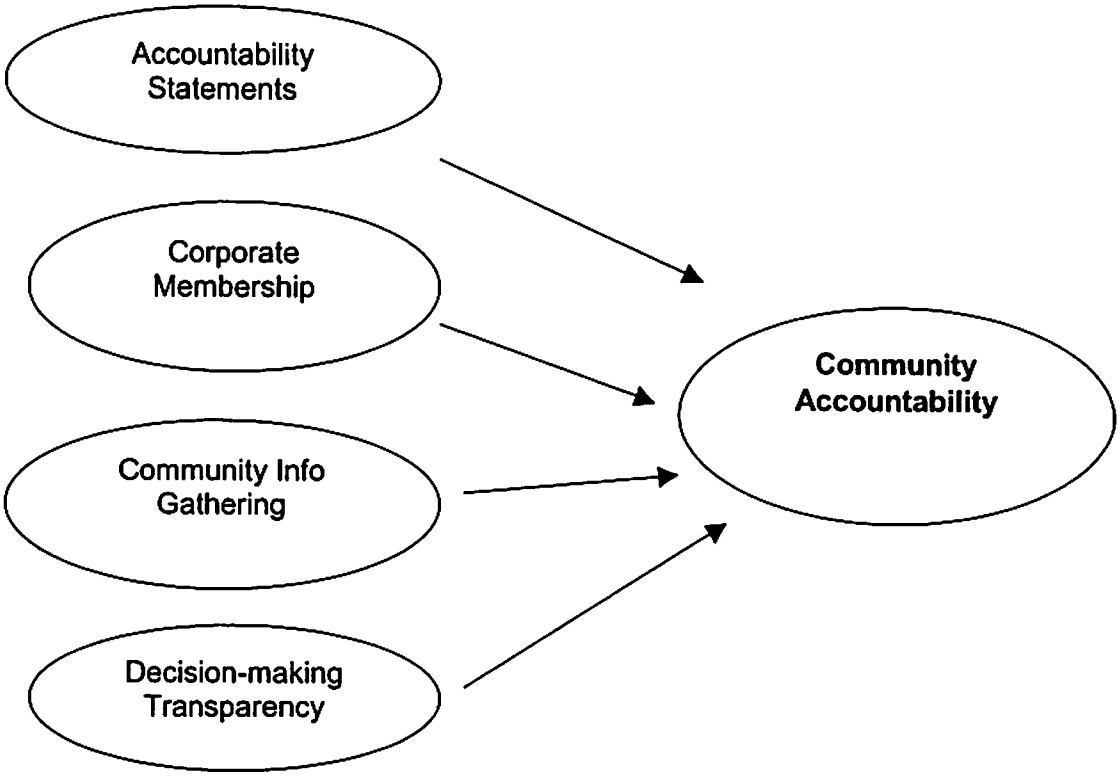
As defined earlier in this paper, accountability is a broad concept that implies a relationship of monitoring, control and answerability to superiors or public constituents (Fry, 1995). Community accountability applies these relationships "to the interests and needs of all individuals residing within a reasonably circumscribed geographic area in which there is a sense of interdependence and belonging" (Alexander, 2000). Accountability may also refer to the means by which individuals and organizations take internal responsibility for continuously shaping and scrutinizing organizational mission, goals and performance (Ebrahim, 2003), with the intention to improve accountability to the community (Alexander, 2000).

The literature on hospital governance suggests boards can demonstrate accountability to whom and how in a variety of ways and this paper will explore four dimensions of community accountability:

1) accountability statements;
2) corporate membership;
3) community information gathering; and,
4) decision-making transparency.

Below is a visual conceptualization of the research model employed to assess and evaluate hospital board practices and structures as demonstrations of community accountability.

Figure 2. Measures of Community Accountability



The four dimensions were selected because they can be readily measured and were often cited in the literature review. The first two dimensions seek to explore the question of accountability to whom, while the latter dimensions focus on how accountability to the community is demonstrated.

It is recognized that these dimensions do not address the fundamental issue of accountability for what? Some have argued that it may be difficult and even inappropriate to hold single hospitals accountable for anything other than the quality and cost of the care it provides (Brunelle, Leatt and Leggat, 1998). Alternatively, it could be expected that healthcare organizations must be

accountable to the citizens of their community for the health status of the population. "Accountability for what" is a crucial social question in today's complex health care environment; however, it is beyond the scope of this paper and as such the measures employed will address accountability to whom and how.

D) Results

In order to provide context and report on the findings, the following section will explain each dimension of community accountability and summarize the results of the primary research.

1. Accountability Statements

In a recent survey of hospital board chairs in Canada, Brunelle, Leatt and Leggat (1998) found that boards revealed ambivalence about to whom they are accountable and did not demonstrate a high level of accountability to the community. In response to the question, "To whom do you feel your board has the greatest accountability?" only 43% of the board chair respondents felt most accountable to the local citizens. Hospital boards were also criticized for failing to define in their mission statement precisely to whom they are accountable, stating "Shouldn't all boards define in their Mission Statements precisely to whom they are accountable and for what?" (Brunelle et al, 1998). While the mission statements can provide a very public articulation of the board's message to the community about accountability expectations, the Administrative By-laws

governing each board offer additional context and background. By identifying to whom accountability is defined in both mission statements and board by-laws the intention of community accountability (Hancock, 1992) or articulation of felt responsibility (Fry, 1995) by the board can be assessed.

A key word search was employed to assess to whom accountability is defined in mission statement and by-laws. The selected words and appropriate synonyms are identified in the chart below:

Table 3: Key Word Search

	Key Words	Synonyms
1	accountable	answerable held responsible
2	accountability	answerability responsibility liability
3	commitment	promise obligation
4	community	society the public the people

In order for hospital boards to articulate accountability to the community, one of the key words or synonyms in the first three rows should be combined (by the word "to") with a word from the fourth row.

All six hospitals post mission statements to their websites and the analysis for this paper was conducted using the versions that appeared on the respective websites as of June 2004. Hamilton Health Sciences (HHS) and Sunnybrook and Women's College Health Sciences Centre (S&W) are the only hospitals to

use the words "accountable" or "accountability" in their mission statement, while just S&W identifies to whom it is accountable by stating "*We are **accountable to our communities** for the human and fiscal resources entrusted to us".* HHS lists accountability as a key value but does not define to whom, rather stating "*Accountability: We will create value and accept responsibility for our actions".*

London Health Sciences Centre (LHSC), University Health Network (UHN), Toronto East General Hospital (TEGH) and The Ottawa Hospital (TOH) have mission statements that do not contain the words "accountable" or "accountability". However, LHSC and TEGH use the word "commitment" in their mission statements. TEGH is *"committed to delivering quality, compassionate patient care and to working in collaboration to improve the quality of life of our diverse community".* LHSC is the only hospital of the six to position its mission statement as a series of commitments to eight stakeholder groups, including:

- patients and families;
- physicians, employees and volunteers;
- researchers;
- students and trainees,
- health care partners;
- funders (government and donors);
- the people of London and Middlesex; and,
- the people of Southwestern Ontario and beyond.

The use of the word "community" in the mission statements greatly varies. UHN notes that it has been "*providing care to the community for more than 200 years*", while TEGH states that its mission is "*to improve the quality of life of our diverse community*". The Ottawa Hospital's mission is in part to play "*an active role in promoting and improving health within our community*".

The mentions of the key words in the board by-laws further reflects the inherent tensions of hospital governance and the struggle to define accountability in an environment of many stakeholders. Consider the following statements taken from the board by-laws

- *"The Board serves the community in carrying out its responsibilities... and shall be sensitive to the needs of the communities served." (The Ottawa Hospital)*
- *"The Board is accountable to the patients, the Ministry of Health and Long-Term Care, the Foundation and its donors." (TEGH).*
- *As a Member of the Board, which is ultimately accountable to the Ministry of Health and Long-term Care, a Director shall...act honestly and in good faith.." (LHSC)*
- *The board ... shall act at all times in the best interests of the Corporation, while having regard for the needs of the community served."(HHS)*

The examples show a range of accountability statements from specific categorization of stakeholders (TEGH) and declarations of ultimate accountability

(LHSC) to more broadly defined statements regarding service to the community (HHS and the Ottawa Hospital).

2. Corporate Membership

Some authors have stressed the importance of board structure and composition, arguing that hospitals have greater community accountability when their boards comprise a mix of experts and community representatives (Griffith, 1987; Hast 1989, Arkus, 1993; Gamm 1996). However, others (Hadelman and Orlikoff, 1999) have challenged the notion that board composition must reflect the community, suggesting this approach hinders efforts to create well-performing boards with the right mix of skills and expertise. Indeed there has been some limited advocacy for paid trustees to ensure a "professional governing board" to steer hospitals through the complex clinical, financial, marketplace and strategic environments of modern healthcare (Hadelman and Orlikoff, 1999).

Nevertheless, consumer and/or citizen involvement in healthcare has been encouraged by governments to make the healthcare system more accountable to the communities they serve (Charles and DeMaio, 1993). Therefore, hospital corporate membership may provide an alternative means to assess a board's community accountability. The majority of public hospitals in Ontario are corporate entities and it can be argued, based on the principal-agent paradigm, the hospital board's ultimate accountability is to the organization's members. Thus how membership to the hospital's corporation is defined could demonstrate

the board's most direct accountability relationship. Quigley and Scott identify four predominant corporate membership models used in Ontario's hospitals (Quigley and Scott, 2004).

I. *The Board Membership (Closed) Model*: The Board of Directors reserves to itself the membership by designating the board members as the sole members of the corporation.

II. *Electoral College/Closed Constituency Membership:* The Board of Directors approves different grouping of stakeholders and invites them to elect a certain number of members out of a designated total number of members for the corporation. The members, once elected become the membership of the corporation for a fixed term.

III. *Membership by Application:* The Board of Directors must approve the applications before the applicant becomes a member. With this model the membership criteria and approval process can help to ensure members support the objectives of the hospital.

IV. *Open Membership Model:* Anyone can be a member (usually an annual token fee is required). This model is often criticized because it cannot preclude the potential for inappropriate members or discourage special interests from hijacking the board (Quigley and Scott, 2004).

The model chosen by a particular hospital may be considered to reflect the board's commitment (or felt responsibility) to community involvement and

engagement as a method for achieving community accountability because as corporate entities hospitals boards could position their ultimate accountability relationship to the organization's ownership, which is arguably the corporate membership.

However, the research found that some boards do not have the authority to define their corporate membership. The respective Acts under which the amalgamated hospitals were created dictates both University Health Network and Sunnybrook and Women's College Health Sciences corporate membership models. The results of the research are summarized below.

Table 4. Summary of Corporate Membership Models

Corporate Membership Model	Hospital
CLOSED MEMBERSHIP: The Board reserves membership to the corporation to board members	• London Health Sciences Centre • Toronto East General Hospital
MEMBERSHIP BY APPLICATION: Subject to approval and a small annual fee	• Hamilton Health Sciences • The Ottawa Hospital
CLOSED BY LEGISLATION: Closed to members of the board as per the UNH Act, 1997	• University Health Network
NO CORPORATE MEMBERS: The corporation has no members as per the S&W Act, 1998	• Sunnybrook and Women's College Health Sciences Centre

Despite the fact that the government has discouraged closed membership (Quigley and Scott, 2004), two of the six hospitals employ this model. That none of the six hospitals are using the stakeholder model (electoral college/closed constituency) suggests further research may be required. Are hospital boards

familiar with the model and/or is it too complex to implement and maintain? Is significant internal or felt responsibility to community involvement in decision-making a prerequisite for adopting this model?

3. Community Information Gathering

Hospital boards also demonstrate community accountability through the monitoring and collecting of information about the community from the community (Proneca, 1998). Yet as hospital governing boards move away from a community, or philanthropic, model to adopt a more corporate governance model, they may also potentially give up a primary source of community information. This is because health care organizations using a corporate governance model tend to select "expert" board members with health care industry backgrounds or experience in strategic planning and other complex business knowledge, skills and abilities (Axelrod et al, 1994).

In order to compensate for the loss of "community voice" on the board, research has found the establishment of an advisory committee to the larger board or community task force to be essential in keeping the board informed on issues of importance to various external stakeholders (Savage et al, 1997). The survey revealed a variety of board committee approaches, which are described in the chart below:

Table 5. Community Information Gathering Models

Organization	Model	Membership	Mechanism
Community Relations as the purview of the board			
Sunnybrook and Women's	No formalized committee		Members of the public can address the Board of Directors – procedures and instructions are provided on the S&W website
London Health Sciences Centre	No formalized committee – the Community Advisory Committee was replaced with a Strategic Partners and Affiliates Committee		Members of the public cannot address the Board of Directors. Guests may attend only upon: • Invitation by the Chair; • Resolution of the Board; or, • Invitation of the CEO
Community Advisory Committee with community members			
Hamilton Health Sciences	Two Community Advisory Committees in Development	Chaired by Board member with the community representation	Multicultural Committee to reflect community diversity Rehabilitation & Accessibility Committee
The Ottawa Hospital	Community Advisory Committee	2 Board members (one is CAC Vice Chair) and specific representatives from provider groups and consumer/patient groups at the invitation of the Board Chair	CAC is the formal mechanism to exchange community ideas and concerns as it relates to the hospital
Community Advisory Committee with no community members			
Toronto East General Hospital	Community Advisory Committee	CEO Board Chair or Vice Chair Foundation rep, board member 2 additional elected directors 2 non-director members	Advisory Committee to Board Does not provide a direct mechanism for community participation; however the committee is expecting to consult with the community.
Non-Board (Management) Committees			
Hamilton Health Sciences	CEO's Advisory Committee	Retired employees	Members meet regularly with CEO and act in an advisory capacity
University Health Network	Site specific community advisory committees	Community members	UHN replaced the former CAC with a site specific CAC acting in an advisory capacity to the site COO

In addition, although Sunnybrook and Women's College Health Sciences Centre does not have a committee per se they did provide a copy of their Board Reference Manual in order to share information about how their board views community information gathering in the context of accountability. In particular, S&W promotes "Accountability for Reasonableness" as the ethical framework for describing the conditions of a fair decision-making process. Adopted from Daniels and Sabin book, *Setting Limits Fairly: Can We Learn to Share Medical Resources*? (2002), the model stresses the importance of a consultative approach to decision-making to ensure stakeholders know and understand why decisions are being made and how they can participate in the decision-making process. The goal is to make reasonable decisions that are inclusive and transparent.

4. Decision-making Participation and Transparency

Finally, according to the Broadbent Report (1999) a crucial task for accountable and effective non-profit boards involves "being transparent, including communicating to members, stakeholders and the public and making information available." In both the private and public sector, a clear policy direction of governance reforms (Sarbanes-Oxley Act, Saucier Report, Cadbury Report) is that transparency regarding financial, operational and governance matters enhances accountability. In order to measure decision-making transparency, the research focused on board meetings as the setting in which decisions are made.

Since 1998 the OHA has had a policy of open board meetings to encourage hospitals to enhance transparency and links with external and internal stakeholders; however, the OHA may also be revisiting the policy because open meetings "contribute to and reinforce the misconception (by both board members and the public) that the hospital board is accountable only to the community and undermine the board's focus on its fiduciary obligations and accountability to the Ministry of Health and Long-Term Care" (Quigley and Scott, 2004). Open meetings have also been criticized as ineffective because of a lack of attendance by media and public and a reluctance of board members to engage in full discussion when media do attend.

Despite the ineffectiveness argument, open board meetings may actually serve a valuable accountability function. Open meetings provide an opportunity for citizens to "convey information to officials, influence public opinion, attract media attention, set future agendas, delay decisions and communicate with other citizens" (Adams, 2004). Perhaps most importantly they provide a measure of legitimacy to the decision-making process undertaken by the boards because citizens are increasingly cynical about traditional institutions of society (Gill, 2001). In short, open meetings may benefit the community more than the board (Adams, 2004) but they also serve as a powerful, if not intuitive, measure of accountability to the community.

In order to assess the board's meeting activities vis-à-vis the community, a number of questions were asked concerning the transparency of the board's discussion and decision-making process, particularly concerning open meetings, notification of meetings and ensuring agendas and minutes are publicly available.

Meetings:

Board meetings are by and large are open to the public, although private and "in-camera" sessions are also conducted. Only TEGH and LHSC have private, invitation-only board meetings as per their by-laws. It should be noted that an open meeting does not mean that members of the public can participate; it simply means they may view the board proceedings in person. Survey participants were not asked to comment on the attendance levels of internal or external stakeholders at board meetings.

Notification:

Most hospitals post notifices of board meeting times, locations and sometimes agendas on their external and internal websites. In addition, Ottawa Hospital places an advertisement in the local paper, while S&W places a notice in their staff newsletter. TEGH and LHSC do not provide public notifice of meetings.

Availability of Reports and Minutes:

All surveyed hospitals, except LHSC and TEGH, ensure that their board-approved minutes are available to the public. UHN and Ottawa post minutes to

their internal and external websites. The board minutes from S&W and Hamilton Health Sciences are available upon request. The Chair of the TEGH Board provides a written summary report that is posted on the internal website only.

Table 6. Decision-Making Participation and Transparency

Hospital	Open meetings	Notification of meetings	Agendas and/or publicly available
London Health Sciences Centre	No	No	No
Hamilton Health Sciences	Yes	Yes	Yes – upon request
University Health Network	Yes	Yes	Yes – posted on website
Sunnybrook and Women's College	Yes	Yes	Yes – upon request
Toronto East General	No	No	No (although summary is posted on internal website)
The Ottawa Hospital	Yes	Yes	Yes – posted on website

E) Summary

The four dimensions of community accountability described above may reflect the internal or "felt responsibility" proposed by Fry (1995) to ensure adherence to mission and an attempt to manage the competing and complex demands of multiple stakeholders. While not necessarily as formal as the audit and reporting mechanisms used to demonstrate accountability to higher authorities for the fulfillment of performance goals and financial integrity, the dimensions offer a a description of community accountability:

- to whom (through accountability statements and membership models); and,
- how (through information gathering and decision–making participation) community accountability .

The findings show that there are a variety of approaches to, and levels of, demonstrable accountability to the community by hospital boards. Similar to previous research findings (Brunelle et al, 1999), the mission statements are not typically used to outline to whom accountability is defined. The exceptions in the research were Sunnybrook and Women's Health Science Centre and the London Health Sciences Centre. LHSC's mission statement, which clearly articulates commitments to major stakeholder groups including the people of London and Middlesex, is the only one to position the hospital within a complex environment and to acknowledge many partners, stakeholders and competing demands.

The boards' by-laws provide the greatest range of accountability to whom statements. Sunnybrook and Women's Health Sciences Centre and University Health Network have no statements of accountability in the by-laws. Hamilton Health Sciences and The Ottawa Hospital including statements about the community; while London Health Sciences Centre and Toronto East General Hospital did not. The variety of accountability statements in the by-laws reveal the tensions facing all boards in fulfilling multiple roles as resource stewards, principals of the organization, community advocates, and agents of the state.

The corporate membership models were also considered as a dimension for assessing to whom hospital boards' define their accountability relationship. On a relative scale, Hamilton Health Sciences and The Ottawa Hospital have a more open process for joining the hospital corporation through the application model and therefore would appear to more inclusive of the broader community in their accountability outlook. On the other hand, by limiting membership to the corporation to board members only, London Health Sciences Centre and Toronto East General Hospital appear less inclusive in this dimension of community accountability. In addition, the two hospitals (S&W UHN) with legislated corporate membership models do not have the ability to demonstrate in this particular dimension to whom they define the accountability relationship.

Finally, community information gathering at the board level and the transparency of decision-making were used as measures of how accountability to the community is demonstrated. Only two of the surveyed hospitals (HHS and the Ottawa Hospital) have a board committee that includes community members. Other hospitals have a less defined board role in this dimension. For example, UHN has site-specific community committees that act in an advisory capacity to management.

On the other hand, the demonstration of community accountability through decision-making transparency and participation was much stronger. All hospitals,

with the exceptions of LHSC and TEGH have open board meetings, provide notice of board meetings and will share board minutes and agendas.

To facilitate comparing the accountability dimensions between the hospitals the results of the research findings are summarized below:

Table 7: Summary of Research Findings

Hospital	TO WHOM: Accountability to the community is articulated in:			HOW: Accountability to the community is demonstrated through:			
	Accountability Statements		*Corporate Membership Models*	*Community info – gathering by board*	*Decision Making Transparency and Participation*		
	Mission Statement	Board By-Laws			Open Meetings	Notice of Meetings	Sharing Agendas
LHSC	Yes	No	No	No	No	No	No
HHS	No	Yes	Yes	Yes	Yes	Yes	Yes
UHN	No	No	N/A	No	Yes	Yes	Yes
S&W	Yes	No	N/A	No	Yes	Yes	Yes
TEGH	Yes	No	No	Yes	No	No	No
Ottawa	No	Yes	Yes	Yes	Yes	Yes	Yes

IV. Conclusion

Hospital boards are often viewed as a link between the organization and its larger community. Cornforth (2003) has noted that non-profit boards face a number of tensions and paradoxes. Specifically boards struggle with:

- The tension between board members acting as representatives for particular stakeholder groups and as "experts" charged with driving organizational performance.
- The tension between the board roles of driving organizational performance versus ensuring conformance (behaving in an accountable and prudent manner).
- The tension between the contrasting board roles of controlling and supporting management.
- The tensions that stem from accountabilities to multiple stakeholders.

This paper has assumed that hospital boards in Ontario ought to be directly accountable to the communities they serve because:

- they spend public money;
- make claims of community responsiveness; and,
- have objectives that have implications for the community as a whole.

In this context, the primary research question was to determine the governance practices and structures employed by a sample of Ontario hospital boards to demonstrate accountability to their communities.

In order to explore the research question through the lens of public administration, the various conceptualizations of accountability were first consider. As a result of the New Public Management movement and private sector emulation, non-profit boards in general have been adopting corporate sector governance models to demonstrate efficiency and fiscal accountability for resources. Audit, regulation and other surveillance and reporting mechanisms have become the dominant way to demonstrate accountability in an environment where the state sets policy and third parties deliver public goods and services. The introduction of Bills 8 and 18 by the Ontario government lends support to the notion of accountability as best achieved through a contractual and/or audit framework.

Accountability in the context of non-profit governance was also considered by reviewing the organizational governance theories of stewardship, principal-agent and stakeholder. The complex environment of non-profit governance may require boards to explore a variety of theoretical foundations to create hybrid governance models. Ranging from a traditional philanthropic model to a more business-like corporate governance model, non-profit boards are looking for solutions to assist them as they:

- Ensure adequate resources to achieve the organization's mission (stewardship);
- Respond to powerful external demands to account for their actions (agent);
- Oversee the performance of management (principal), and;
- Attempt to assess and manage the demands of a host of other competing interests, including those of the community served (stakeholder).

In the environment of multiple accountabilities, the Pointer and Orlikoff model of health care governance has grown in popularity (Quigley and Scott, 2004). Their model combines principal-agent and stakeholder theories to achieve effective governance. Indeed the stewardship model seems to be less relevant to non-profit governance in an environment of aggressive provincial oversight and severe fiscal restraint.

Clearly, hospital boards (as agents) are being held to tighter and more stringent accountability requirements by the governments (acting as principals). Yet despite the powerful influence of government with its financial and regulatory leverage, the research shows most of the surveyed hospitals demonstrate accountability to other stakeholders, specifically the community in which they were established to serve.

In terms of the research approach, accountability to the community was assessed through four dimensions. All six hospital boards articulated accountability to the community in one of two sources of accountability statements (i.e. mission statements or board by-laws). The use of corporate membership models as a dimension to articulate accountability to the community was not as strong as the accountability statements.

In the dimensions to assess how community accountability is achieved, some hospital boards clearly demonstrate a much stronger community orientation then others, based on the results. LHSC and TEGH are perhaps the least demonstrative of community accountability based on the dimensions utilized in the scope of this research. However, most hospital boards still appear to value accountability to the community and strive to maintain governance process and practices that benefit both the organization and their communities.

In closing this study has provided evidence of how six of Ontario's leading hospitals express community accountability. These findings give rise to an obvious question: Are the differences in how (or how much) hospitals demonstrate community accountability associated with the specific governance model employed by the hospital? For example, does a corporate governance model compromise the level of demonstrated community accountability? Further research is required to answer such questions.

Finally, policy makers and community members often seek ways to influence large social institutions such as hospitals. In Ontario, hospital boards have defended independent volunteer governance as the key to community responsiveness and accountability. Through an exploration of accountability concepts and governance models, this paper has provided an introductory understanding how accountability to the community is actually demonstrated and achieved at some of Ontario's leading hospitals.

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Appendix A:

Survey Questions

General Governance Questions

1. What do you call your governing body (Board of Directors, trustees, governors, etc)
2. How many members does your board have?
3. How many directors are elected and how many ex-officio?
4. Is there a dedicated function providing administrative and/or professional support to the Board?
5. If yes,
    a. what is the name of this function (eg. Office of the Chair of the Board, Board Secretariat, etc)
    b. Please indicate the number of staff, staff titles, annual budget, responsibilities, etc.
6. If there is not a dedicated function, how is support provided to the Board (preparation of minutes, agendas, reports, AGM support, annual report, etc)?
7. Is there a separate board for fund raising (ie. foundation board?)
8. If yes, do the two boards share issues and information?
9. If yes, what mechanisms are used to facilitate the interrelationship?
10. How many committees of the Board are there?
11. What are the committee names?
12. Can you provide us with your board organizational chart?

Community Input

1. Are board meetings open to the public?
2. Are meeting dates/locations and times publicly posted?
3. If yes, how or where do publicly post information (ie. website, bulletin boards, community papers, etc)
4. Do you publicly post agendas and minutes of Board meetings (how/where?)
5. Does the Board consider it a priority to maintain links with community organizations and other stakeholders in the region?
6. Does the Board have mechanisms or by-laws for seeking community input on the organization's directions, policies and services as they affect the community?
7. Are community members who are not directors of the board appointed to serve on committees of the board?
8. Is there a committee that focuses on community relations and community affairs?
9. If yes:
    a. What is the name of this committee?
    b. What is the committee's mandate and terms of reference? (please provide a copy if available)
    c. Do the members represent specific "communities" or "interests"?

   d. Does this committee also oversee strategic alliances, affiliations, partnerships and other business-to-business activities?
   e. If no, does another committee oversee strategic alliances, affiliations, partnerships and other business-to-business activities?

Board Orientation Program

1. Do you have a board manual for new members?
2. If yes, could we receive a copy of the manual (or the manual table of contents)?
3. Do you have a board orientation program?
4. If yes:
   a. how do you deliver the board orientation program?
   b. what are the main objectives of the orientation program?
   c. how often is the program offered?
   d. who maintains and delivers the orientation?
   e. how is the orientation funded?
   f. What is the cost?
   g. What type of material is in the orientation package?
   h. Could we receive a copy of your orientation package?
5. If no, what informal processes are followed to orient new members?
6. Do you have on-going education programs for Board members?
7. If yes, please describe how the program is delivered and the objectives?
8. Do you have a mentorship program for Board members?
9. Do you have a private website for board members? If yes, what material is posted to this site?
10. Do you have other methods to provide information and promote communication between board members?
11. Do you have anything to add that we should consider when developing a board orientation program?

Conclusion

Is there anyone else you would recommend we talk to?

Optional Information

This questionnaire was completed by:
Name
Title
Organization