Governance and Accountability

10

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Governance may not be a top priority when debating health care transformation for the twenty-first century but it is a critical instrument to strengthen public and institutional performance (Van Kersbergen and Van Waarden 2004; Chhotray & Stoker 2009). Governance matters, and never more so than in times of crisis. "For example, since 2008, in the UK approximately one in three NHS foundation trusts have been subject to formal regulatory action on at least one occasion, with poor governance a contributing factor in almost all the cases." (Monitor et al. 2014, p. 4). The first two sections of this chapter cover theoretical aspects, including how governance and accountability are conceptualized and specific considerations of governance and accountability in integrated health systems. The latter two sections focus on the practical aspects of implementing governance and accountability into integrated health systems and the tools needed to support its implementation. We have tried to present a balanced view by drawing on a wide range of published literature, thus, while many of the innovative examples we discuss originate in the UK, we believe, they can easily be applied in to types of health system.

10.1 What Is Governance and Accountability?

In the following, governance is understood as the policy tools and processes needed to steer a system towards population health goals (Barbazza and Tello 2014; Task Team 2013). Governance is a multi-faceted concept that became an established part of the health system lexicon in the early 2000s. With the publication of the World

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Health Organization (WHO) landmark report "Health Systems: Improving Performance" (WHO 2000), governance was adopted and adapted to health system contexts. Stewardship, leadership, strategic direction and regulation became important concepts to actualize health system priorities. The later 2000s saw the publication of a burgeoning literature on how to achieve large scale change, including WHO's 2007 'building blocks' framework for health system strengthening (WHO 2007). This reflected governments' ongoing struggle to manage health needs along with increasing health services expenditure.

The literature contains a number of different conceptualizations of health governance. They share some common features but none are universally accepted (Barbazza and Tello 2014; Mikkelsen-Lopez et al. 2011; Brinkerhoff and Bossert 2008):

- Governance must encompass all aspects of managing health services delivery to support health system goals, including financing, human resources, information and medicine and technology.
- A systems perspective is required to understand the interdependencies between these domains and devise appropriate governance mechanisms.
- Governance mechanisms and processes must support achievement of overall health systems goals; this requires a number of conditions:
  - Clear accountability of key actors to beneficiaries,
  - Responsible leadership and a clear vision,
  - An equitable policy process that allows influencing of policymaking by all players equally,
  - Transparency,
  - Sufficient state capacity to manage health care policy and service delivery effectively, and
  - Public engagement and participation.

There is agreement that 'good' governance leads to health improvement (Brinkerhoff and Bossert 2008; Mikkelsen-Lopez et al. 2011), but the lack of clarity in the nomenclature and in models and measures of governance has failed to produce clear evidence on the impact of governance models (Barbazza and Tello 2014; van Olmen et al. 2012). Developing appropriate governance processes that respond to the complexities of health care systems is important but so is understanding the situations in which governance is working and is delivering the outcomes desired by all stakeholders.

Most descriptions of governance highlight accountability as an important governance tool. Well-defined accountability structures, along with high-quality systems to monitor processes and outcomes towards agreed upon goals, are intertwined with successful governance (George 2003; Brinkerhoff 2004; Hammer et al. 2011; Lewis and Pettersson 2009; Barbazza and Tello 2014; Suter and Mallinson 2015; Baez-Camargo 2011).

Accountability discussions tend to focus on the relationships between different stakeholder groups on three levels (Fig. 10.1). Firstly, there is accountability at the level of the state, which may include various ministries (health, finance, social care,

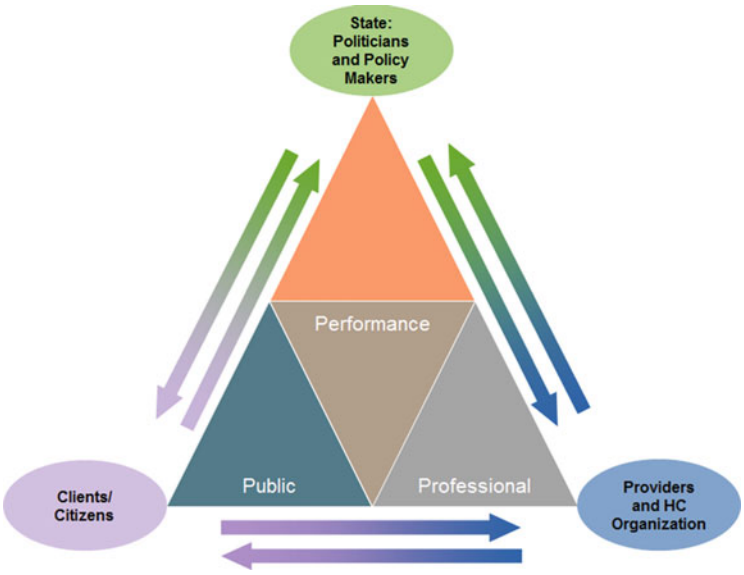

Fig. 10.1 Accountability relationships in integrated healthcare systems. Adapted from Brinkerhoff and Bossert (2008)

education). Secondly, there is accountability at the level of healthcare organizations, regulatory bodies, and service providers. Thirdly, there is accountability to clients/citizens (individuals and families, communities, and populations). Accountability mechanisms with the State have traditionally been vertical and unidirectional (Kickbusch and Behrendt 2013) with a focus on financial accountability and health system performance (Brinkerhoff 2003, 2004; Deber 2014). Service providers and healthcare organizations are accountable to state funders for the ethical use of resources and to clients for service delivery. Mechanisms focus on organizational performance and oversight and service delivery according to legal, ethical and professional standards (Brinkerhoff 2003, 2004; Deber 2014; Fooks and Maslove 2004). Failure to meet the goals and objectives needs to trigger real and enforceable actions. Lastly, accountability to clients/citizens has a number of potential functions: helping the public to hold the state and local healthcare organizations to account on electoral promises and services; supporting public engagement through increased transparency which, in turn, is a mechanism for checking that health systems represent the public's interest, values, needs and expectations (Brinkerhoff 2003). The interweaving of transparent public accountability mechanisms with improved public engagement can lead to better informed, accountable and legitimate decision-making (Abelson and Gauvin 2004; Kickbusch and Behrendt 2013).

10.2 Appropriate, Agile, and Effective: New Directions for Governance and Accountability in Integrated Health Systems

In the second decade of the twenty-first century, the thinking around governance underwent a shift. Governments, organizations, communities and individuals began grappling with the changing global context in which influences on health and well-being transcend traditional boundaries in an increasingly globalized 'knowledge society' (Wilke 2007; Kickbusch and Gleicher 2014). This has required a re-focusing on whole-system health, one which cuts across political, economic, and social landscapes, and demands an evolution in governance models (WHO 2013). This has in turn led to a distinction being drawn between health governance (i.e., structures, processes and mechanisms that govern health care) and governance for health. Governance for health is a much broader idea, tying in wider changes in globalization, knowledge, participation, and co-production of health (Kickbusch and Gleicher 2012).

In parallel with calls to refocus on the broader idea of governance for health there has been an evolution in health service integration. Integrated care systems, networks or models, often regarded as Complex Adaptive Systems, are moving beyond horizontal integration between organizations at same level or delivering similar services. There are efforts to integrate more broadly across community-based services, including other sectors, and partnerships between communities, primary and acute care [i.e., vertical integration, Evans et al. (2013)]. The challenge is that many innovative cross-sectoral service arrangements require more flexibility and different accountability mechanisms to initiate and sustain change. They create new and ambiguous governance and accountability relationships (Brinkerhoff 2004; Deber 2014; Fooks and Maslove 2004; Kickbusch and Behrendt 2013; Maybin et al. 2011). In this context, the focus is increasingly on relationships and alliances, management of boundaries, shared information, best practice guidelines, and establishing a common culture.

In addition, organizations have to respond to an increasingly informed public that demands better leadership in publically funded organizations and greater accountability for allocation and use of resources (WHO 2008). Some authors maintain that creating a strong public voice through appropriate governance and accountability is critical for the success of integrated health systems (Abelson and Gauvin 2004; CIHR 2012; Fooks and Maslove 2004). There is also a key role for people in monitoring system quality and performance, including reporting on people's experiences in the health system. These broader trends—global interdependence, a new understanding of the complexity of health, the changing roles of citizens in co-production of health and health care—are the impetus for new and smarter governance approaches (Kickbusch and Behrendt 2013). Governance and accountability processes have to keep pace with the diverse contexts within which they operate, and be responsive to people in diverse roles and relationships. A recent high-level review of governance in UK health services (Grant Thornton 2015) suggested that partnerships needed agile governance rather than the

command and control styles of more traditional, siloed models of health service delivery. The review also noted the need for a mature risk management strategy and for genuine empowerment for governance boards so their 'risk appetite' (Bullivant and Corbett-Nolan 2012) allows innovative arrangements to flourish. The problem for health system leaders is that these dimensions of new governance depend on a degree of culture change.

The idea of 'soft governance' to support collaborative care across multiple stakeholders is not new, but, as Fierlbeck (2014) argues, it has become particularly relevant as governments grapple with complex health problems across overlapping jurisdictions. She concludes that new 'experimental' governance models need to respond to limitations of hierarchical, vertical governance arrangements that do not allow a constellation of interests to negotiate alternative health care models. Kickbusch and Gleicher (2014) highlight global examples of whole-of government (WOG) and whole of society (WOS) approaches to manage complex policy processes that govern health and might be fitting for integrated health systems. WOG indicates a commitment to health at all levels of government with joint working across sectors as a core premise. WOS goes beyond institutions and influences/mobilizes communities and other relevant policy sector, media and the private sector to co-create health. WOS approaches emphasize coordination through normative values and trust building amongst actors, which ultimately strengthens resiliency of communities. Their focus is on new forms of communication and collaboration in complex network settings, using social movements and negotiation to align diverse priorities, values and approaches.

Overall, this new vision points to the diffusion of governance from a state/health services centred model to a collaborative model where a range of actors including state, private industry, the public, media and international organizations across levels co-produce governance by Kickbusch and Gleicher (2012).

10.3 Implementing Innovation: Next Steps for Governance and Accountability in Integrated Health Systems

Although many health systems in developed nations are experimenting with integrated health care systems, recent policy initiatives and implementation projects in the UK provide a timely and interesting example of the drive to move integration forward. Successive UK governments have explored ways to tackle health system pressures through integrated health systems. Substantive policy changes in the Health and Social Care Act (Department of Health 2012) and increasing focus on the challenges of improving health care quality compel a new look at how services are organized, regulated, monitored, and directed. In the following, we describe these new developments in more detail with special consideration of their impact on governance.

In *NHS Five Year Forward,* the National Health Service sets out a vision for an updated agenda View (NHS England et al. 2014) that reflects the significant changes in science and technology and the increasing complexity of health and

social care delivery. Central to the vision is a renewed focus on prevention, public health and primary care through new partnerships that cut across traditional boundaries. A combined health and social care budget and capitated arrangements are some of the innovations outlined on the financial side. There are also a series of new care models in primary, emergency and specialist care, many of them focusing on multidisciplinary teams and networks. The challenge, as encapsulated in this plan, is the need for meaningful local flexibility in service delivery models, funding mechanisms and regulatory requirement to accommodate diverse contexts. These are vital to build new relationships with patients and the community that enhance patient empowerment and engagement in care decisions.

The new care models envisioned in the NHS Five Year Forward View will have implications on all domains of governance and accountability. Shared budgets and capitated arrangements will challenge how funds are distributed and managed between social and health care partners; local flexibility in service delivery models puts more onus on service providers and organizations to maintain quality standards; the focus on patient and communities demands more effective mechanisms for engagement and public reporting. Two commissioned reports have explored the governance challenges inherent in the new vision in more detail.

The Dalton Review (Dalton 2014) explored the organizational forms needed to support the vision of the renewed NHS. The review strongly promotes the creation of different organisational models that are adaptable to local contexts. Organisational models comprise the structures of governance, accountability and management to achieve specific aims and objectives in delivering services. The report outlines a number of different models of service integration with different types of partnership and degrees of integration. They caution that embracing different models would require a shift in mind-set of boards towards achieving what is best for patients and communities through joint ownership. Such collaborative arrangements require careful consideration of governance structures and processes that will likely have to deviate from the status quo.

Building on the Dalton Review, the NHS Governance Review (Grant-Thornton 2015) offers a comprehensive discussion of NHS governance challenges emerging from the Five Year Forward View vision. In a similar vein to Dalton (2014), the authors stress the need for "...NHS leaders to engender cultural change, support innovation and build a modern workforce—all will need to be underpinned by robust corporate and quality governance arrangements." (p. 5). The report authors argue that cultural changes depend on transparent and robust performance monitoring across all major care pathways, especially where they are linked to payment mechanisms. However, their survey indicated ongoing uncertainty about accountability and delegation of authority between Care Commissioning Groups and NHS Trusts (p. 2). Collaboration and partnership governance with all health and wellbeing partners (including social enterprises, third sector, HealthWatch, and private sector) is essential but the relationships and systems are still evolving.

10.3.1 Vanguard Integration Sites

The Five Year Forward View is using three waves of Vanguard sites to operationalise different integrated care models (NHS England 2014). All share the fundamental aims of improving patient experience and continuity of care while also dealing with the financial and resource pressures facing the NHS. This translates into four core values for the re-design: clinical engagement; patient engagement; local ownership; national support.

The Northumbria Healthcare NHS Foundation Trust, for example, is one of eight Vanguard sites to spearhead the implementation of an integrated primary care-acute care model (https://www.northumbria.nhs.uk/about-us/vanguard). The trust already had a strong integration record and effective governance and accountability mechanisms in place to advance the integration agenda. An established Integration Committee had created a detailed integration plan (Freake 2013) and a dashboard to track progress against integration objectives, including patient experience.

As a Vanguard site, the focus is on the development of the primary care-acute care systems integration with partners at Northumberland Care Commissioning Group and Northumberland County Council (https://www.northumbria.nhs.uk/sites/default/files/images/Vanguard_270815_LR.PDF). Specifically, Northumberland Vanguard will create a new Specialist Emergency Care Hospital that will act as an extension of primary care to create 'hubs' of primary care provision across the county. This new model will allow patients to access their primary care physician 7 days a week. Cutting across organisational boundaries, the model will enhance access to community nursing services and coordinated discharge through shared information technology. The ultimate goal is to provide care closer to home.

Although the launch of the first group of Vanguards in spring 2015 was reportedly met with lots of goodwill, they have a difficult balancing act to perform. They must embrace local context with innovative, experimental forms of service delivery while also setting the pace for system-wide transformation. Vanguards use a 'learn as we go' approach that emphasizes the importance of ongoing monitoring of outcomes for patients, staff and the wider population. Sharing of processes, metrics, and learnings from high performing integrated systems is also being encouraged, and all Vanguards who are implementing variations of a component will be asked to participate in 'action research' (NHS England 2015, p. 9).

This approach to health care reform may seem much riskier because it builds on demand-led rather than supply-led local service planning and extends well beyond traditional organizational boundaries. Collaborative leadership, commissioning and delivery of care will depend on agile governance supported boards that are open to risk. Clearly, this kind of innovation depends on leadership that advances system-wide cultural change, but there are concerns about whether organizations can overcome the inertia that has characterized previous cycles of reform. Vanguards will have access to appropriate national, clinical, and program expertise to collaborate in the change process. As such they will be able to share clinical pathways, outcome based commissioning, and improvement methodologies. Evidence-based,

replicable models and frameworks built for scale are the driving force for the implementation process. Joint leaders and supporting groups are responsible for developing processes to monitor impact for all stakeholders at national and local levels to support shared learning. Identifying appropriate tools to measuring patient-centred care is a particular area of interest. Initially, a suite of core metrics for each of the Vanguard models along with a standard dashboard showing its trajectory compared to its baseline and to other Vanguards is being proposed (England, N. H. S. 2015, p.11–13).

10.4 Tools for Governance and Accountability

The Dalton Report (2014) and the NHS Governance Review (Grant-Thornton 2015) have both highlighted the formidable governance and accountability challenges facing integrated care networks. In the sections below, we highlight some of the growing number of frameworks and tools available to help governments, health care organizations, and citizens grapple with governance and accountability in innovative integrated care models.

10.4.1 Frameworks

Well-led framework for governance review
Monitor, the national regulator for health services in England, developed the Well-led framework for governance reviews (Monitor et al. 2014). The framework aims to support the NHS Foundation trusts, in line with the Code of Governance, to complete an external review every 3 years. This tool allows boards to have robust oversight of quality, operations, and finance in the face of uncertain future income and new care models. It also supports Trusts in regular reviews of governance to ensure they remain fit for purpose.
The four domains for governance reviews are:

1. Strategy and planning—how well is the board setting direction for the organisation?
2. Capability and culture—is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
3. Process and structures—do reporting lines and accountabilities support the effective oversight of the organization?
4. Measurement—does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

The framework is a 'core' reference document to shape the depth and focus of assurance processes. It also contains helpful guidance on how to conduct a governance review.

Good Governance Handbook
The Health Quality Improvement Partnership (HQIP) and the Good Governance Institute have released a new edition of the Good Governance Handbook (Corbett-Nolan et al. 2015). HQIP is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices in the UK (http://www.hqip.org.uk/). Established in 2008, HQPI promotes quality in healthcare by enhancing the impact of clinical audit. To that effect, HQIP commissions a series of clinical outcomes review programmes that complement the work of other agencies such as the Care Quality Council.
Structured around ten themes, the Good Governance Handbook includes self-assessment questions for good governance at the levels of the board, division and department.

Pathway to accountability II
The Global Accountability Framework originated from the One World Trust (Blagescu et al. 2005) and incorporated self-check lists in the areas of transparency, participation, evaluation, and complaint and response mechanisms. The Pathway to Accountability II (Hammer et al. 2011) is a revised version aimed to support capacity building and system development. The revised version still focuses on the four domains of transparency, participation, evaluation and complaints but acknowledges the interdependencies and hence the need for a crosscutting, intersectoral approach. It introduces a graded scoring system and a series of quality management indicators within each of these domains. It is being widely used in WHO initiatives to support global accountability assessments across health systems.

Results-based accountability framework
This framework was developed by the Fiscal Policy Studies Institute and Mark Friedman (Friedman 2015). It involves "turn the curve" thinking—reverse-engineering solutions to problems by identifying desired outcomes and working back towards appropriate mechanisms and processes to achieve those ends, along with the data required to track performance. It focuses on three key questions: How much did we do? How well did we do it? Is anyone better off? It has been widely applied in social and community programs, and is being adapted to health system applications. For an example, see work in New Zealand (New Zealand Ministry of Health 2015) or Washington (Washington County Mental Health Services 2015).

10.4.2 Tools

The frameworks described above help to assess the status quo of governance and accountability in integrated care networks and highlight gaps. Other tools target more specifically accountability domains of performance, financial and public accountability. For example, the ***Health Data Navigator*** (Hofmarcher and Smith 2013) is an interactive platform for researchers, policy makers, and healthcare

professionals to access health data from Austria, Estonia, Finland, France, Germany, Israel, Luxembourg and the UK. It contains information and links to support performance measurement of the health system including a list of international frameworks that can be adapted to national settings and methods for performance measurement. There is also a toolkit to promote generic standards for performance assessment and relevant data sources for comparative evaluations under the OECD health care quality indicators domains of quality, efficiency and access (Kelley and Hurst 2006).

Dashboards of health information have emerged to support public reporting on performance. One used by the Department of Health in Vermont, US allows the public to easily track the health status of Vermont residents through more than 100 goals in 21 focus areas (http://www.healthvermont.gov/hv2020/). This real-time dashboard presents measures, indicators and trends and helps to keep the Vermont government accountable in their health strategy. Similarly, the Canadian Institute for Health Information (CIHC) has developed an interactive website that allows the public to review performance data and health systems spending (http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001).

Citizen/community score cards and surveys are a mechanism to promote civil engagement and demand-side accountability, and empower individuals to express their views to government bodies. The surveys allow citizens to contribute to oversight and regulation and therefore aim to improve the quality and integrity of public services (Singh and Shah 2007). Different types of citizen report cards and community score cards can be found at the World Bank's participation and civic engagement webpage: http://www.worldbank.org/socialaccountability_sourcebook/Resources/pub4.html

Identifying new governance and accountability mechanisms for financial management of resources and for engaging patients and the public will need to be a priority for the Vanguards and other innovation sites. People Powered Health was an innovative programme in the UK between 2011 and 2013 that focused on co-production of health for people and by people (Horne et al. 2013). They advocated bottom-up redesign of monitoring and outcome assessment as a mechanism to drive change. NESTA and the Innovation Unit bring together examples of collaborative action from across the UK in a ***Coproduction Catalogue*** to illustrate what co-production looks like on the ground (Nesta 2013).

The catalogue outlines a number of different projects and models of co-production. It also lists a range of tools to assess impacts and outcomes from different perspectives when service innovations are rolled-out. For example, the NHS Five Year Forward View calls for new ways to distribute and manage funds and an example of this are the personal health budgets introduced for specific populations receiving health and social care services. A national evaluation of the pilot projects in over 60 primary care trusts showed favourable results with positive user feedback. Current work focuses on using a ***personal outcomes evaluation tool*** for annual, routine evaluation of user experience (Hatton and Waters 2015). It focuses on meaningful goals and capacity for people and communities. This includes a broad set of patient reported outcomes with focus on confidence and

control over own health, behaviour change and lifestyle, measure of quality social networks and social support. Wider measures could look at satisfaction with equal and effective relationships, level of patient engagement using tools like the Patient Activation Measure, and levels of participation.

These are just a few examples of the guidance and tools that are available to support service integration and build collaboration. For a more complete description of innovative governance and accountability tools see Suter and Mallinson (2015).

10.5 Conclusions

We are at the advent of new relationships in integrated services. Large health systems are unpacking the challenges of whole system approaches to health and the best ways to meet future challenges is through new organizational forms. There is a push for radical, bottom-up change with patients, clinicians and communities as co-creators in all aspects of health service design, delivery and governance. As the roles of patients, communities and other stakeholders as partners for health evolve, we need tools and processes that create clear and transparent accountability relationships.

The challenges for governing these new models are significant and given their novelty there is little evidence about what works in a given context. Commentators have noted that the monitoring of accountability is the least developed element of health system leadership and governance (Smith et al. 2012). Some have pushed for "integrated governance", which focuses on partnerships between and within organizations (Delaney 2015; Jackson et al. 2008; Nicholson et al. 2014). Managing the interactions of governance structures associated with the different partnerships may be one of the biggest challenges (Delaney 2015). Jupp (2015) posits that we may be able to draw on experiences of other sectors that have undergone significant restructuring (such as education or the prison services in the UK).

Despite the uncertainty of what these new governance structures will look like or how they will operate, there is general agreement that governance will be an essential element of successful integrated care system reform (Brinkerhoff and Bossert 2008; Mikkelsen-Lopez et al. 2011). Some argue for a new or enhanced role of independent inspectorates to deliver on public accountability promises (Kickbusch and Behrendt 2013; Michels and Meijer 2008; World Bank 2013). Such agencies may also have a role in collecting and disseminating information on good practice and performance. One example is the Canada Health Council, implemented on the recommendation of an expert committee report on the state of the Canadian health care system. The agency had a vital role in monitoring progress on electoral promises and during its life span released a series of critical public reports (http://healthcouncilcanada.ca/reports.php). It also hosted a health innovation portal profiling best practice approaches across the continuum of care. Stacked with political appointees and representatives, however, it faced an up-hill battle to earn the trust and credibility it needed to make a difference and to satisfy

citizens' demands for greater accountability (Flood and Archibald 2005). It disbanded in 2014.

Investing in good, smart systems to increase transparency across a wide variety of indicators of quality is likely to be central to improving accountability in a system with more autonomous providers (Jupp 2015). In addition, mechanisms for co-creation and patient empowerment will continue to play an important role. Power imbalances have been on the agenda for many years but unravelling traditional relationships to respond to new partnerships and shared-responsibility remains challenging. Strategic policy frameworks combined with effective coalition building and governance remain important tools to strengthen the coordination and integration of health services delivery (Goodwin 2002; Kickbusch and Behrendt 2013; Kickbusch and Gleicher 2012; Maslin-Prothero and Bennion 2010; Suter et al. 2009; Williams and Sullivan 2009; WHO 2013). In contrast to earlier governance approaches that focused on structures and organizational boundaries, newer approaches will need to pay increasing attention to the dispersion of power within integrated systems and accountability relationships across the four domains.

In summary, the multiple models of integrated care that are evolving globally raise the possibility of a period of experimentation and learning (Jupp 2015). Governance that is agile and can respond quickly to emerging changes is required to manage the complex interdependent partnerships in integrated care systems.

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