

Accountability: The Challenge for Medical and Nursing Regulators

Obligation de rendre compte : le défi pour les organismes de réglementation médicaux et infirmiers



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Abstract

Little has been written about how regulatory bodies define and demonstrate accountability. This paper describes a substudy of a research project on accountability in healthcare. The aim was to increase understanding of how regulatory bodies perceive and demonstrate accountability to their stakeholders. Twenty-two semi-structured interviews were conducted with provincial/territorial CEOs from the two largest health professional regulatory bodies in Canada: medicine and nursing. The regulators indicated that accountability was essential to their mandates and provided the foundation for regulatory frameworks. However, they did not offer a common definition of accountability. They agreed that they were accountable to three constituencies: the public, government and their members. Regulators noted that protecting the public and meeting the demands of the government and their members creates tension. They were also concerned about maintaining independence in the regulatory role.

Résumé

Il existe peu de textes sur la façon dont les organismes de réglementation définissent et démontrent l'obligation de rendre compte. Cet article décrit une étude sur un projet de recherche portant sur l'obligation de rendre compte dans les services de santé. L'objectif était de mieux comprendre la façon dont les organismes de réglementation perçoivent et démontrent l'obligation de rendre compte auprès de leurs intervenants. Vingt-deux entrevues semi-dirigées ont été menées auprès de tous les DG provinciaux et territoriaux des deux plus grands organismes de réglementation professionnelle de la santé au Canada : la médecine et les services infirmiers. Ces personnes ont indiqué que l'obligation de rendre compte était un aspect fondamental de leur mandat et fournissait la base du cadre de réglementation. Cependant, elles n'ont pas donné une définition commune de l'obligation de rendre compte. Elles ont convenu devoir rendre compte auprès de trois entités : la population, le gouvernement et les membres de leurs ordres. Les personnes chargées de la réglementation notent que la protection de la population et la réponse aux demandes du gouvernement et des membres crée des tensions. Ils se disent également préoccupés par le maintien de l'indépendance dans le rôle de la réglementation.

ACCOUNTABILITY IS DEFINED IN MANY WAYS (DEBER 2014). IN THE FIELD OF governance, for example, it is often used synonymously with such terms as responsibility, fairness and transparency and associated with the expectation of account-giving (Brown et al. 2006). Citing Chandler and Plano, Koppell (2005: 94) noted that accountability in public administration is “a condition in which individuals who exercise power are constrained by external means and by internal norms.” Emanuel and Emanuel (1996: 229) observed, “Accountability has become a major issue in health care.” However, little has been written about how health professional regulatory bodies define and demonstrate accountability, even though regulation is considered an important policy instrument to enforce it. The study

upon which this paper is based focused on professional self-regulation and examined how regulators in Canada perceived and operationalized accountability when interacting with their stakeholders.

Background

Under Canada's constitution, healthcare, education and health human resources are provincial/territorial responsibilities (Marchildon 2013). The operational details for regulating health professions have been delegated to the provincially/territorially based regulatory bodies (usually referred to as colleges). However, there are differences in how (and which) professions are regulated in each jurisdiction.

The key role of regulatory colleges is to ensure the health and safety of the public (Federation of Health Regulatory Colleges of Ontario 2014). Individuals who want to work in a regulated health profession cannot practise unless they are registered with the self-governing body in their province/territory. Self-regulation implies that the professions develop and monitor their respective professional codes of conduct and licensing requirements and set standards of practice (College of Licensed Practical Nurses of Alberta 2014; Government of Saskatchewan 2014).

The federal government of Canada provides some legislation that eases the mandates of provincial/territorial regulatory bodies. For example, the Agreement on Internal Trade (AIT) allows regulated health professionals to apply for certification in another province/territory without having to undergo significant additional training, examination or assessment (Labour Mobility Coordinating Group 2014).

Depending on the province/territory, healthcare professions are regulated by varying combinations of overarching acts such as Ontario's *Regulated Health Professions Act*, Manitoba's *Regulated Health Professions Act*, or profession-specific acts such as Nova Scotia's *Registered Nurses Act*. In all cases, these regulatory bodies are self-funded through membership dues and do not receive government funding.

Method

This exploratory descriptive study is one component of a larger study designed to connect the complex concepts of accountability in Canadian healthcare. In 2012, interviews were conducted with provincial/territorial CEOs from the two largest health professional regulatory bodies in Canada. Twenty-five were invited to participate and 22 accepted the invitation to participate in semi-structured interviews. The data were supplemented by an electronic review of annual reports and other public documents, such as vision and mission statements and professional standards of practice. Eleven nursing regulators and 11 medical regulators participated in individual targeted 30-minute semi-structured interviews conducted in person or by telephone. The interview schedule was pretested for clarity. Participants provided informed consent prior to data collection.

The Research Ethics Board at McMaster University granted approval. The interviews were audiotaped and transcribed verbatim. Transcripts were anonymized to preserve confidentiality. Interview data were analyzed using NVivo10 (QSR International Pty Ltd., Doncaster, Victoria, Australia). Texts were interpreted through thematic analysis (Boyatzis 1998). Preliminary coding was completed by three members of the research team, who coded several texts independently for comparison. Inter-rater reliability of the coding was determined. Team members then collaborated to develop a refined scheme to code the transcripts.

Results

Our key findings were categorized under the following major themes, which arose from the analysis.

Regulatory organizational structures

With regard to nomenclature, all 10 provincial medicine regulatory bodies are called College of Physicians and Surgeons, while the three territorial medicine regulatory bodies are called departments or councils. Five of the provincial nursing regulatory bodies are referred to as colleges; four are associations, and one is a combination of a college and an association. In the territories, one nursing regulatory body governs both the Northwest Territories and Nunavut, and the other governs the Yukon; both are titled associations.

Perceptions of accountability

The regulators indicated they had no common definition of accountability. However, one said, “We certainly use the term a great deal.” Some offered definitions that described accountability in relation to such concepts as responsibility, answerability, fairness and transparency. One regulator noted, “For me, regulatory accountability is about fair, transparent, legally defensible processes that support the accountability to the public.”

In terms of whom, there was consensus among regulators that they were accountable to the public, the government and regulatory body members. They agreed that legislative requirements make them answerable to the public first:

We are accountable more broadly to the public ... that’s our primary owner. ... Our legislation clearly states that we regulate in the public interest.

In terms of means, the regulators indicated they demonstrate accountability to the public through transparency:

When we talk about accountability, we talk about ensuring that we are transparent in our processes, that we are evidence-informed and that when we make decisions based on evidence, we clearly articulate what that evidence was that led us to the decision that we made.

However, in practice, limits were placed on what information would be made accessible, to whom and how:

There are some things that won't go on the [regulatory body] website. Our rule is that everything should be transparent and open unless there is a very good reason legally or otherwise not to put it there.

Regulatory body membership varied. All had members of the profession, but many jurisdictions also had public representation on their boards, and some had government appointees. The number of public seats varied across the provinces. One regulator noted that the role of public representatives "is not to go and then report back to somebody. They are there to represent the public interest." Most regulatory bodies have board meetings that are open to the public.

Accountability to government

Health professional regulatory frameworks vary across provinces. Consequently, regulators varied in their freedom to interpret legislation and their perception of accountability to government. There was consensus that accountability was influenced by legislated requirements, including financial reports, registration numbers, types and categories of registration relative to complaints, and discipline hearings. However, legislation often left room for interpretation:

Our ... profession's Act is pretty [vague] in terminology ... we have a lot of latitude as to how we interpret things.

We have to have a complaints mechanism in place, but [the Act] doesn't ... dictate in great detail what it looks like, which is fortunate for us because it allows us some flexibility.

Some regulators were concerned that growing government prescriptiveness was restricting this flexibility.

Regulators varied in their perceptions of accountability to government. Some saw providing information as a moral obligation:

I feel a sense of accountability to government because I have this job, basically, as a result of the courtesy of the government.

Other regulators emphasized their autonomy:

Our only role with government is our annual reports, our activity. I don't perceive us to be accountable to government.

The regulators stressed governmental collaboration, categorizing their relations with the government as “formal or informal.” Formal relations included submission of an annual report and financial accounts demonstrating the fulfillment of the regulator’s mandate. Informal collaboration included “regular meetings with the ... directorate.”

Regulators indicated that recent legislative changes, such as the federal AIT, the *Regulated Health Professions Act* (RHPA) and the *Fair Registration Practices Act* (FRPA) created challenges for demonstrating accountability. As noted above, the AIT attempts to give regulated professionals the freedom to move among provinces, but they must still become registered by the applicable provincial/territorial regulatory body. In general, regulators spoke favourably of the AIT, particularly as an impetus to cross-provincial collaboration in setting standards:

The good thing from the regulatory perspective is that we have defined Canadian standards for admission – full certificate of registration.

However, one regulator noted that provinces with lower standards might find harmonization difficult. Furthermore, harmonization might cause local shortages in some regions by facilitating mobility to other areas in Canada.

The provincial/territorial regulatory Acts are intended to create overarching statutes that provide uniform standards and practices that apply to all professions governed by the legislation. Some participants favoured the Act in their province/territory:

It gave us better bylaw-making authority ... [and] set out explicit requirements for quality assurance programs The minister of health can ... set benchmarks or targets or expectations on the colleges. ... I think that our legislation over the last five years has improved.

Others feared that the Acts would lead to greater accountability requirements that could undermine the autonomy of the professions:

[If] the RHPA ... in essence says that if it’s in the public interest, the Ministry of Health can impose all kinds of things on a college and create new standards of practice, or change things and replace a council, or can appoint an administrator to assume any role or the functions.

At the present time the RHPA exists in four provinces to ensure that regulated professions are governed by transparent, objective, impartial and procedurally fair registration practices. Regulators commented:

[The Act] maintains self-regulation of each health profession while enabling collaboration.

It's an enabling legislation and not top-down government oversight legislation.

Other regulators suggested that the Acts increased their need for vigilance because provinces could be fined if regulations prevented health professionals from moving between provinces/territories. One regulator suggested that an independent arm's-length body should review decisions of the college with respect to registration practices and complaints in order to increase transparency, accountability and fairness.

Accountability to regulatory body members

Regulators acknowledged their responsibility to registrants, who pay licensing fees with the understanding that these fees will be used to regulate the profession:

Accountability to the members would be that we provide a reasonable service in terms of licensing registration to ensure public safety ... in a cost-effective manner.

Regulators used their websites as well as annual meetings and other official occasions to demonstrate both the fulfillment of their mandate and fiscal accountability to their members:

We see our members as customers of our services. They receive the annual report and there's an annual meeting. ... We communicate changes, regulatory changes, that might impact on the employers, [and] send [the information to] ... the union as well.

Regulators indicated that they educated their members about qualifications, standards of practice and complaints investigation.

Metrics supporting accountability

Metrics are an important aspect of demonstrating accountability. In some jurisdictions, legislation specifies the statistics that regulators must provide:

The content of the report is included in the bylaw under the Code of Professions. It is decided by the minister of justice, the Office of Professions and the Order of Professions.

Other provinces have fewer legal requirements. Minimally, statistics reported included such information on registrants as licence renewal, professional examinations, disciplinary matters and financial data.

The extent to which self-reported information was collected or audited varied. Small jurisdictions with few financial resources and few members used no metrics beyond basic

statistics that described their membership. Larger jurisdictions used metrics to improve their performance by monitoring the efficiency of registration or complaints processes, or measuring stakeholder satisfaction.

Some jurisdictions used or planned to use metrics to support strategic planning. Larger jurisdictions envisaged creating sophisticated measurement tools. One regulator had developed a 10-year plan for improving data collection and tracing. Another noted that his organization had established goals, strategies, targets and measurements and provided both progress and financial reports to its council.

Several jurisdictions were interested in trending and tracking complaints and their outcomes to demonstrate public accountability and stimulate improvement. However, even regulators with larger memberships indicated it was hard to identify whether the figures represented random variation or actual trends. Regulatory bodies in small jurisdictions received too few complaints to identify trends.

Accountability Challenges

Stakeholder understanding

To be accountable, regulatory bodies sometimes had to instruct members and the public about their role. Participants noted this was a challenge:

You are constantly trying to help ... the public understand who you are.

[Members] sometimes think that [we] ... just take their money and do policing kind of work, but a lot of what we do is to support members.

In some provinces, nursing organizations have the dual mandate of protecting the public and representing their members. Since these mandates can be conflicting, there has been a trend towards establishing separate organizations, a process that requires educating members about the parameters of the regulatory role:

We were an association that regulated and then we transitioned out of that role into the role of sole regulator. The association sort of advocacy role was lost. ... I think as a result ... nurses are confused about the purpose of the college, why it doesn't represent the voice of nursing anymore.

Both medicine and nursing regulators indicated that younger registrants and internationally educated healthcare professionals do not understand the distinct roles of the association and the college. New registrants believe the former acts as an advocate while the latter appears to be "the dark side." Members need to understand that the regulators "support them in their practice and make their practice better":

I think we find that the biggest challenge is helping them to understand and realize what profession-led regulation means.

One regulator felt that education would help new members and the established membership gain a clearer appreciation of their professional responsibilities and was “looking very closely at introducing education on jurisprudence for a licensee.”

Transparency and privacy

The regulators acknowledged that the reconciliation of transparency with privacy was a challenge:

Although we are responsible to the public, we provide our members with whatever degree of privacy and personal protection we possibly can.

A regulator noted that regulations such as the RHPA mean that “all terms and conditions for all practitioners will be public unless they are related to the [practitioner’s health].” Competing pressures to be open and to protect privacy were influenced by provincial policies and legal or regulatory structures, and regulators had to make decisions about how to deal with them.

Use of social media

All regulators discussed inappropriate use of social media by members and stated that they either had or intended to develop guidelines on social media use. Many senior members of the regulatory organizations did not personally use social media, but they felt under pressure to adopt such communication to inform or demonstrate accountability to their members and the public. They found the prospect daunting and were concerned about the potential spread of misinformation; they also cited lack of resources, time and expertise to implement social media infrastructure. Most regulators perceived Twitter as too informal a communication tool. However, they believed social media were the answer to the apparent invisibility of regulators to the public, and that such media were helpful in small jurisdictions in which membership was scattered over a large area.

Organizational costs

The regulators indicated that changes to legislation caused financial strain and generated competing priorities. Increases in regulatory costs are borne by members. In particular, smaller colleges have similar obligations as larger colleges, but they have fewer resources. Because producing accountability data consumes resources, regulators stressed the need to ensure that data supported solutions:

I think we ask for too much information ... [that] we cannot properly interpret ... and for which there is no real follow-up.

Several regulators suspected that government-mandated data was not always utilized:

...we are required to collect data we didn't previously collect. That increases complexity of work [and] increases cost. ... some of the data they want us to collect, we have no clue what they are going to do with, and they don't either. That's very frustrating.

Regulators indicated that data are expensive to produce and that their use should be carefully assessed.

Discussion

Although variously perceived and defined, accountability is a key concept in regulation. How it is demonstrated depends on the size of the province/territory, government relations and transaction costs inherent in regulatory processes. The regulators in this study did not provide a common definition of accountability, but they agreed on a triad of accountability constituencies (the public, government and their members) and saw their responsibility to report to them similarly. However, despite their efforts to the contrary, the regulators felt the public had little awareness of the regulatory presence and function, and that their members had a mixed understanding of the regulatory role.

As noted by Benton and colleagues (2013), lack of a "common set of indicators" makes measuring accountability a challenge. Regulators cited pressure to provide more metrics and expressed reservations about increasing fees to pay for additional accountability measures. All the provinces/territories had Acts and regulations that addressed the fulfillment of accountability in the interest of better serving the public. There was consensus among the regulators that legislation was important, and they valued the privilege of self-regulation. They noted that competing priorities, such as privacy versus transparency, depended on context. They also identified tension between self-regulation and government oversight.

Limitations

The current study was a substudy with a limited sample of healthcare regulators from one country. Therefore, the findings may not necessarily apply to regulators in other sectors and other jurisdictions.

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