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Alternative Conceptions of Accountability

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Last month, Part 1 of this article began a discussion of the alternative conceptions of accountability in health administration. Part 2 continues that discussion and also examines the consequences of an analysis of accountability for the education of health administrators.

A Guidance Approach

The following view of accountability—the guidance approach—is the view closest to my heart. It took me 600-odd pages to explain it elsewhere.²⁸ Here I will simply suggest its chief points relevant to the issue at hand.

Accountability is based on a variety of interacting forces, not one lone attribute or mechanism. The direction health administrators take, in accountability as in other matters, is affected by all the factors already discussed and some others still to be mentioned. In part, administrators respond to articulations of rights by the community, its leaders, the press, etc., that is, to claims of accountability. In part, their accountability is circumscribed and delineated by the legalities and formalities of the state, etc. Hence, changes in any and all of these factors are effective ways to change the level and scope of accountability; none of them is all inclusive.

Moreover, several missing elements must still be added to complete the analysis. For example, in contrast to those who perceive power as the core explanatory factor, I perceive accountability as having both a power and a moral base, in the sense that the values which administrators internalize (as well as those of other participants, both in the health unit under consideration and persons acting on it from the outside), do affect the direction the health unit takes. Thus, in a recent study by the Center for Policy Research, Steven Beaver, PhD, and Rosita Albert, PhD, found that the administrators of several hospitals studied were more progressive on several counts than either the people in the area served by the hospital or their patient-advocate, activist leaders.

For example, neighborhood residents, community leaders, and hospital administrators in a major U.S. city were asked:

Which of these three kinds of health care do you think is the most important for this community? The three types are: 1. Routine problems (checkups, maternal and child care, dental and eye care, ordinary sicknesses); 2. care of major body illnesses (heart problems, cancer, operations); 3. care for socially relevant problems (drug addiction, mental illness, alcoholism).

While a full 80 per cent of the administrators chose the socially relevant problems as the most important kind of health care problem for the neighborhood, smaller proportions of the neighborhood residents (60 per cent) and community leaders (52 per cent) chose this alternative. Routine problems were judged as most important by 31 per cent of the community residents, 35 per cent of the leaders, and 20 per cent of the hospital administrators. Major body illnesses were considered the most important health care problem to nine per cent of the neighborhood dwellers, to 14 per cent of their leaders, and to none of the administrators. Thus, while majorities of all three groups believe that problems such as drug addiction, mental illness, and alcoholism are the major health problems of the community under study, a clearly higher percentage of the hospital administrators took this view. While the differences are not sizable, it is nevertheless significant that these percentages remained consistent across a broad spectrum of questions answered by the three groups.

This study illustrates what we all know from personal experience: Administrators are not neutral beings. They have sentiments, preferences, and above all, values—although, of course, they differ greatly among themselves concerning what they value, how clearly they perceive their values, and how far they are willing to go in promoting their values against those of others if a difference should become evident. The content and intensity of these value commitments are in part affected by the administrator's education, a point to which we shall return.

The administrator need not be merely a broker of power, a meeting point of various internal and external pressures to which he adapts the way a vectorgram would. He need not adapt to the strongest pressure at the moment, although quite a few administrators act in this way. Aside from his personal values and position of authority in the structure which give him a separate backbone, i.e., a measure of direction other

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The education of administrators should provide them with a set of values to guide their behavior, thus encouraging accountability. Ethical education may best be advanced by presenting appropriate case studies for group discussion and by interaction with experienced, committed individuals with high standards. The educational program should sensitize administrators to the contrasting conceptions of accountability.

than the realpolitik of give and take, there is, in addition, an opportunity for creative leadership.

I do not perceive the capacity for leadership as consisting of abstract, moralistic character traits; I perceive these as specific skills. The object is not to fly in the face of reality or power groups, nor to wildly pursue utopian notions of social justice or accountability—such an administrator is all too likely to be quickly expelled—but to help shape, mobilize, and combine the vectors which determine the health unit's direction and accountability model so as to bring them closer to the desired system. To shape these forces requires educating the various groups to definitions and demands which are closer to what is legal and ethical and just. This is probably the most difficult part of the creative administrator's job.

Also, for the administrator to mobilize one or more of the relevant groups is to bring about a change in the balance of vectors to which the administrator must later respond. Thus, if the physicians are unduly pressuring him to take a course of action he considers undesirable, he may instigate greater activity by the board or consumer representatives to serve as countervailing forces, somewhat changing the vectorgram. This course often cannot be followed because it leads to a measure of countermobilization by the other group, realizes next to no net change, and serves only to create a higher level of conflict all around.³⁰

Coalition forming offers a somewhat better opportunity for creative leadership. Coalitions arise, not necessarily explicitly, when two or more groups favor the same or a similar course of action. These groups may be composed of insiders only, outsiders only, or varying combinations thereof.

For example, when he was First Deputy Commissioner of the New York Department of Public Health, Lowell Bellin, MD, succeeded in forming a coalition between his agency and the consumers to push a number of voluntary hospitals into giving more resources and attention to ambulatory care.³¹ The context was the New York State Ghetto Medicine Program which institutionalized the coalition between the Public Health Department and consumers by requiring each hospital desirous of obtaining funds under the program's provisions to 1. Subject its ambulatory care services to contractual standard setting, monitoring, and enforcement by the New York City Department of Health, and 2. to become associated with an ambulatory services advisory committee, comprising a majority of consumer members. Twenty-two voluntary hospitals in

New York City participated in the program. As Bellin *et al.* note, hospital-based ambulatory care services have always been low in comparison to inpatient services in the hierarchy of priorities of hospital administrations. The primary incentive for these hospitals to allow their ambulatory care services to be scrutinized by the health department and a consumer group, in marked opposition to their autonomous institutional traditions, was desperation for funds. Yet Bellin *et al.* also point out that the simple mechanism of a contract between the hospitals and the agency would never have sufficed to insure that the monies earmarked for ambulatory care actually were spent in that manner.

How to prevent the regulated industries from regulating the regulators is a notorious problem in public administration, and by itself the agency would never have had the resources to keep the hospitals from re-allocating the funds according to their own internal priorities. Though originally skeptical about the value of working with relatively uninformed and inexperienced consumers of hospital ambulatory services, the department concluded, however, that its alliance with the consumers was vital in giving it the leverage which resulted in the hospitals' widespread obedience to contractual stipulations. In addition, quite a number of spinoff improvements in ambulatory care which were not part of the original stipulations were achieved via pressure put on the hospitals by the advisory committees, the department, or the two in concert. In speaking about the accomplishments of the Ghetto Medicine Program, Bellin listed the number of advances that have emerged from this program of active collaboration between consumers and professionals in private voluntary hospitals:

1. Instituting a unit record system;
2. Hiring an interpreter;
3. Establishing a primary physician system;
4. Developing a list of services for distribution;
5. Hiring a full-time director of ambulatory care;
6. Holding two open public hearings;
7. Adding preventive medicine services;
8. Assigning additional physicians, nurses, and clerks to the outpatient department;
9. Eliminating underutilized clinics;
10. Starting a community outreach program;
11. Starting a new clinic or other services;
12. Remodeling clinic and/or emergency room areas;
13. Running patient attitude surveys;
14. Providing music and snack machines;
15. Establishing a communication link between the medical board, administrators, and the consumers;
16. Changing the referral system;

17. Changing x-ray and laboratory follow-up; and
18. Extending clinical hours.³¹

Coalition building is often effective because each vector, while relatively given and unchangeable in isolation, may be combined to neutralize, to partially reinforce, or to fully back up one another. The ultimate success lies in building a coalition in favor of greater accountability which is either very wide or all-inclusive. Then the desired changes are introduced almost as if by themselves.

Closely related, but even more productive, is the formulation of new alternatives. Groups rarely have fully developed positions and almost always can find alternative ways to achieve their goals.³² If ways can be found to allow them to advance their goals which at the same time lessen their opposition to other groups and to higher levels of accountability, then the program's success will be particularly pronounced. For example, the strength of the HMO pattern is said to be that it is both responsive to the doctors' legitimate needs and more responsive to the patients' needs than is solo practice; if this is the case, it is indeed a creative alternative.³³

To advance any and all of these strategies, the administrator needs a considerable understanding of how social systems work, how politics function, what the various groups' values and needs are, and what alternatives are practical and acceptable. He can get the needed knowledge partially from proper training and partially from continual interaction with the various groups inside and outside his unit which impinge on it. Experience suggests that without fixed, institutionalized opportunities for communication, such regularized interaction is unlikely to occur with sufficient frequency. An explanation of the mechanisms of institutional communication cannot be undertaken here, but they constitute a vital element of any effective accountability system.³⁴

From Unit to System; New Definition of Health

Thus far, we have deliberately followed the prevailing tradition, dealing with the health unit (hospital, clinic, and nursing home) as if it were a world unto itself. While the administrator has repeatedly been described as dealing with both internal and external forces, these forces were viewed as impinging on a unit of considerable integrity and cohesiveness. While this view is both necessary (we cannot take in the whole world; we must divide it into units to think about and to deal with it) and favored (especially in nongovernmental health units), health units are increasingly becoming part of large systems (not necessarily neat,

well-consolidated systems, but simply more encompassing entities).³⁵ The concern with accountability is, to a significant extent, a concern with these larger entities.

This is the case partially because accountability is greatly affected by supervisory, regulatory, higher order structures, especially government agencies and professional bodies. This also is the case because administrators must manage health systems, not just health units, and the manner in which these systems are managed greatly affects the performance of the individual units. Last, but equally important, greater accountability in one service area such as health often requires corrections of ills in other sectors of the society—sanitation, pollution control, highway safety, and education—which can be activated only via higher level units or interunit give and take.

As an article by Blumstein and Zubkoff on government health policy explains: "The concept of health has a large social component. Illness may to a large degree be conditioned by culture, and its definition may be the product of a social bargaining process."³⁶ The authors also note that:

... health maintenance has begun to receive attention among health professionals, but the concept still carries with it a top-heavy medical service orientation. Most significant for our society, there are a considerable number of environmental factors which contribute substantially to our health problems; any governmental decision to become involved in the health sector must consider possible allocation alternatives in personal and nonpersonal areas as a means of promoting health.³⁷

These environmental factors affecting health are divided into three categories: 1. technological factors resulting from industrialization, such as air pollution and unsafe working conditions; 2. personal health maintenance factors such as life styles encouraging overeating and underexercising; and 3. socioeconomic status, especially such health related conditions associated with poverty as inadequate sanitation, overcrowded housing, and bad nutrition.³⁸

Educational Implications

1. Educational programs which train health administrators but fail to provide them with a set of values to guide their behavior serve to encourage a lack of accountability. Every program should make a cardinal commitment to developing the normative backbone of the health administrators it trains.³⁹ To increase the sensitivity of doctors and other health professionals to these matters, Senators Javits, Williams, and Mondale have submitted bill S 954, which amends the Public Health Service Act to provide "in the training of health professionals, for an increasing emphasis on the ethical,

social, legal, and moral implications of advances in biomedical research and technology."

Such training can be achieved only partially via the lecture course. Ethical education perhaps may be best advanced by presenting suitable cases for guided group discussion and through interaction with persons themselves committed to high normative standards. Hence, the faculty entrusted with the education of health administrators should include persons such as clergy who have dealt with dying patients, a hospital ombudsman, and a community leader.

2. The educational program should sensitize future health administrators to the different conceptions of accountability as outlined above. The trainees should come to understand deeply the benefits and drawbacks of passive (or neutral) v. active (or creative) administration; the limits of morality not backed by social forces; the role of formal factors; the significance, dangers, and limitations of mobilization v. coalition building, etc. *In effect, the preceding analysis can be viewed as a course outline in accountability to be backed up by more extended preparation in appropriate portions of social and political science curricula.*

I say "appropriate" because these disciplines contain segments that are as limited in their perspective as some of the monofactorial schools of accountability discussed above. For instance, some stress the role of free will and values per se; others are mesmerized by formal functions, and still others by realpolitik. True, the more a student is exposed and sensitized to even these partial analyses of administration as a social and political system—instead of merely to accounting, financial management, and operations analysis—the more he will understand the processes of accountability and his own range of maneuverability. He may then, per-

haps with the help of the above outline, piece together his own synthesis. Better still would be a program built around a social-political science approach which is encompassing and includes the necessary material.

Here again, lectures at best will do only part of the work. Case studies, in conjunction with guided group discussions, backed by dialogue with experienced administrators would be more helpful. Later in the student's career, a regular (say, weekly) workshop for administrators-in-training, during their internship period, might be most effective, because here the participant's own experience can be studied and incorporated as educational experience.

None of these ideas is novel, either as general educational procedure or as efforts in the training of health administrators. Novel would mean new systematic combinations, along the suggested lines, for the suggested purposes.

3. The preceding discussion has taken as its cornerstone an implicit assumption that should be explicated, both for the purposes of this article and for the purposes of the educational effort I hope will be built around accountability: the administrator is at the center of the guidance health units and systems and has a leading responsibility for their direction. While special interests are real, the administrator need not be merely the handmaiden of interest groups or a pawn of social forces. Neither is he only on the second string of accountability while doctors man the first line; such a hierarchy is neither reliable nor just. The administrator should have the ultimate responsibility. At the same time, he would be woefully mistaken to perceive himself as all powerful; an accountable system can arise only through broad support, where the administrator may mobilize and educate, but cannot dictate. ★

FOOTNOTES

28. Amitai Etzioni, *The Active Society*, The Free Press, New York City, 1968.
29. *Ibid.*, chs. 15, 18.
30. Lowell Elliezer Bellin, Florence Kavalier, and Al Schwartz, "Phase One of Consumer Participation in Policies of 22 Voluntary Hospitals in New York City," *American Journal of Public Health*, October, 1972, pp. 1,370-78.
31. Lowell Elliezer Bellin, "How To Make Ambulatory Care Start Ambulating," presented at the Joint Workshop, sponsored by the American Hospital Association and ADAC, Cherry Hill, Pa., November, 1971, p. 11.
32. See Gabriel A. Almond and G. Bingham Powell, Jr., *Comparative Politics: A Developmental Approach*, Little, Brown and Co., Boston, 1966.
33. For an examination of some of the pros and cons of existing prepaid programs such as Kaiser-Permanente and HIP, see Merwyn R. Grunlick, "The Impact of Prepaid Group Practice on American Medical Care: A Critical

- Evaluation," *The Annals of the American Academy of Political and Social Science, The Nation's Health: Some Issues*, January, 1972, pp. 100-13.
34. For additional discussion, see *The Active Society*, ch. 20.
35. On the different types of systems which emerge, see Edward W. Lehman, "Control, Coordination and Crisis: Interorganizational Relations in the Health Field," Center for Policy Research Monograph, 1973.
36. James F. Blumstein and Michael Zubkoff, "Perspectives on Government Policy in the Health Sector," *Milbank Memorial Fund Quarterly, Health and Society*, Summer, 1973, p. 398.
37. *Ibid.*, pp. 399-400.
38. *Ibid.*, p. 400.
39. In *Genetic Fix*, Macmillan, New York City, 1973, especially pp. 183-204, I discuss the formation of a Health-Ethics Commission. (Sen. Walter F. Mondale, D-Minn., has introduced a bill for the formation of such a commission on the national level.)