Alternative Conceptions of Accountability: The Example of Health Administration

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The alternative conceptions of accountability are the focus of this article. While this is an issue of increasing importance to administrators in all sorts of institutions, for clarity and unity, the example of health administration will be relied upon to illustrate these alternative formulations.

The Symbolic Uses of Accountability

Speakers and writers calling for greater accountability typically employ the term in three concrete contexts: to refer to greater responsibility and responsiveness; to allude to greater attention to the "community" (generally a euphemism for blacks, Mexican-Americans, American Indians, or other minorities); or the greater commitment to "values" (e.g., as in the phrase "higher standards of morality"). The unifying thread is the symbolic use of the term accountability. Though it may not necessarily be—indeed perhaps rarely is—the consciously intended meaning, the chief definition of this term which in fact emerges is that of "accountability as gesture." The hallmark of accountability as gesture is that it is pure norm with little or no instrumentality attached. That is,

Four alternative conceptions of accountability are discussed and illustrated through examples in health administration. The symbolic use of accountability is as a gesture only. An administrator may make vague promises about improving accountability mechanisms, but never follow through. He may use accountability as a rallying point to mobilize a constituency or banner calling for moral education.

Accountability may be an ongoing political process as the administrator reacts to the pressures of particular interest groups, depending on the power they wield. Here only a change in relative power will produce a significant change in accountability.

A formal system of checks and balances promotes accountability. Often, however, behind the scene the real power wielders make decisions, then legitimate them through the formal system.

Finally, the guidance approach sees accountability as the interaction of all these factors plus a moral base, with the administrator playing an active role in mobilizing, educating, forming new alternatives, and coalition building.

the speaker or writer advocating accountability fails to follow up the use of the term by outlining specific arrangements, e.g., that patients be made the controlling force on hospital boards; or, if such suggestions are made at all, the virtue held out for them is fully matched by their vagueness (e.g., making "more information" available to the public).

The sociological significance of such expressions, gestures, utterances, however, is more varied than one might immediately think. The point can be readily illustrated by reflecting on the differential significance of the word "integration" as used in the early '60s, in each case symbolically,
by the following types of persons: a white legislator endorsing integration to black constituents, but failing to introduce or support bills enforcing specific aspects of integration; a black civil rights leader such as Martin Luther King or Roy Wilkins building a social movement; a white minister exhorting his white congregation in Scarsdale against racism.

The first use is inauthentic and manipulative. When divorced from any systematic efforts to promote actual attainment of the desired values, “accountability” becomes a thin cover for inaction, a “Sunday only” value mechanically acknowledged in a secular form of lip service. This kind of “accountability” can be easily and vociferously endorsed by boards of trustees, insurance lobbyists, and others in positions of power whose recitations of the phrase serve as a substitute for actual accountability. It becomes then only a verbal concession, like the rhetoric of the Kerner Commission Report, with little provision for follow-through, as a direct drain of the pressures to “do something” about the situation.

Murray Edelman, in his book The Symbolic Uses of Politics, devoted a good deal of space to a discussion of such hortatory uses of political slogans. According to Edelman, there is the solemn ritual incantation of political slogans by those in charge of formulating or carrying out policy that is unaccompanied by any effective attempts to achieve the goals incanted. This is particularly likely to occur in a situation where a large but politically unorganized group which feels itself threatened, desires certain resources or the substantive power claimed. Under such circumstances, it is tempting for the politicians or administrators to satisfy the desires of those in the first groups through symbolic reassurance (that they are not being ignored or that their interests will be protected).

Often, symbolic reassurance from power wielders will provoke quiescence in an unorganized group—at the very least because it takes the edge off dissatisfaction and makes the difficulties of mobilization greater. This quiescence may be quite temporary, soon yielding to a reawakening of demand and a resentment over being manipulated. But those who merely mouth “accountability” do not concern themselves with the longer run.

Following the analogy made to the word “integration” earlier, political and social movement leaders also use slogans and cue words in their attempts to mobilize followers. Perhaps they even use the same word that is being used by the power wielders in an attempt to provide symbolic reassurance to potential followers. In this context, however, though the use is still symbolic, the meaning is quite different. While group leaders may still be dealing largely with gestures rather than mechanisms, “accountability” in this instance serves as a rallying point around which mobilization can be affected and a movement built. In such a situation the demand for “accountability” becomes a shared symbol of all those individuals galvanized into a political force which aims at seeking and gaining specific concessions. Once there is such an organized force, the question of how accountability can be actualized may be: confronted immediately, only a step away, or deliberately deferred as a bargaining technique.

Somewhere in between the “co-opting” inauthentic use of slogans as a political tranquilizer unresponsive to basic needs and its issue-flagging, group-rallying use by leaders seeking to mobilize a constituency is the use of “accountability” as the banner of a campaign for moral education. Typically such a campaign is undertaken by one professional vis à vis colleagues or by a concerned but unself-interested outsider. The moral educator views those proselytized in a manner very much akin to the way a socially conscious minister views his congregation: as persons who are basically anxious to do right by their values but whose behavior is not what it should be because of lack of knowledge and having been improperly taught, or because they have not been reminded of their duties, or because insufficiently “good” models suitable for emulation have been set before them. Thus, exhortation, moral suasion, lay preaching, and example setting are relied upon instead of introducing new accountability mechanisms—not to be inauthentic, but because these approaches are sincerely believed to be effective.

Dr. Avedis Donabidian attributes the tendency in health administration to emphasize moral education over regulation to the norm of collegiality among physicians and the weakness of the formal and informal controls administrators have vis à vis physicians. He writes,

The administrator must . . . determine the proper balance between the educational objectives of quality assessment and the need to deter and detect careless or incompetent practice. . . .

In real life, the answer appears to depend in part on the role and influence of the practicing physicians on the
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program. Wherever this influence is small, as in some health insurance programs, there is either no responsibility for quality or, at best, emphasis is placed on the identification and correction of abuse that borders on the criminal. Wherever the role of the practicing physician is significantly large or dominant, the emphasis may fall so predominantly on the educational objective that the disciplinary objective is in danger of being ignored or explicitly excluded.

As different as the different uses of the term "accountability" that have been discussed so far are, however, they all rely upon it as a symbol rather than as a social force and, unfortunately, tend to "run into" one another. As a result, on many occasions, when administrators talk favorably about accountability, one has a difficult time discerning whether their gestures are inauthentic, rallying, or educationalistic. Moreover, their social consequences will depend in part on the other accountability processes, which are explored next.

Accountability as Realpolitik

A contrasting view of accountability is that of an existing pattern of administration and government which reflects at any particular point in time the sum total of the forces working on the system, those working to maintain the status quo, and those seeking to reshape it. Such an outlook adapts the interest group theories of politics espoused by such political analysts as Robert Dahl, David Truman, V. O. Key, and Earl Latham. From this perspective, the hospital, for example, is viewed as a polity, affected by its members and by outside forces, in the continual act of restructuring. Apart from its bookkeeping and managerial functions in the narrow sense, hospital administration is seen as a political process through which various groupings negotiate, confront, or adjust their claims. Thus, "accountability" becomes the actual degree to which the hospital administration is responsive to the claims and demands of the particular interests of doctors, nurses, union activists, patients, etc.

The hospital administrator is seen as being locked at the center of this process—the focal point of the pressure—not at the top, in charge. The hospital administrator's position in this theory in fact is analogous to that of a billiard ball in a physics diagram upon which various forces impinge. Typically, the administrator's actions are seen as almost totally determined by various partisan interest group pressures; predicting the behavior of the administrator then is a matter of knowing the coefficients of strength of the various groups.

Even when administrators are seen as having views of their own and a modicum of autonomy, they are not seen as representing the interests of the polity as a whole—but of having their own "vested interests," which are similarly parochial to those of the other pressure groups. In general, the interests imputed to administrators are those of the bureaucrat seeking either to expand his domain and, most especially, to defend his own incumbency in authority. Such a view of administration and "accountability" we label as "Realpolitik" because it is characterized by the fact that power is viewed as the only significant variable.

The rules of Realpolitik are fairly well known. To list them here, briefly, is, of course, to report and not to bless their existence. By and large, groups with more status, income, and education have more power and hence make the system relatively more "accountable" to them. That is, they have more leverage. Accordingly one would expect a typical American voluntary hospital (and its administration and administrator) to be most "accountable" to the physicians and/or trustees, less so to the nurses and aides, least so to the patients, and especially inattentive to the poor, uneducated, non-paying customers. In terms of the typical American community, one would expect the hospital to be most responsive to the local business community, and less so to other groups. As a rule, following Realpolitik we would expect more responsiveness to government agencies of various levels, less to "consumer" groups and advocates.

Different types of hospitals—municipal, proprietary, voluntary, etc.—are expected to vary in the groups they respond to most readily and in the kinds of power base which has the greatest leverage. For instance, we might expect voluntary hospitals to be rather more insulated from the pressures of city politics than the municipal hospitals, but rather more dependent upon the good will and continued munificence of the cities' "first families."

According to a Realpolitik analysis, groups will also differ in their leverage over time, depending on the extent to which they are organized and mobilized to affect the particular polity under consideration. Thus, if the physicians act chiefly as individuals, they will obtain fewer resources than if they set up hospitalwide committees, aiming to
insurance that their collective preferences will carry the day. And, as a rule, unionized hospital workers will be more “accounted to” than unorganized ones. Even patients, represented by patients’ advocates, ombudsmen, lawyers, or consumer representatives—being weak and easy to deflect—will, according to this view, gain in more ways than they would without any of these organizations and mobilizing devices.

Thus, Realpolitik, a “hard-headed” view, suggests that the phrase “more accountable” is meaningless; the question is: to whom? The implication is that accountability to one group means almost by definition less accountability to another. Implicit in the Realpolitik position is that values per se—e.g., as represented by the moral education of the administrator—count for almost nil. A change in the relative power of the various groups is the only factor which could be expected to produce a significant change in accountability.

The Formal, Legal Approach

Many subscribe to a view of accountability which defines it in legal or formal terms. The emphasis is on instituting “checks and balances.”

In the academic world, such an approach was once current in political science. While it has lost in following over the past 20 years, it is still quite popular in the field of public administration. Game theory and cybernetics are chiefly in this vein of thinking.

In hospital administration, this approach sees the administrators as having to be made “accountable” to one or more authorities—the board, his superior, the law, etc., and much ink is shed to clarify these legalities. A case point is the following question: if a doctor misbehaves in a hospital, who is legally accountable: the doctor alone, the hospital and its administrator alone, or both?

Thus, there have been attempts to make hospitals more accountable to the public-at-large by requiring them to file detailed financial statements, and various mechanisms have been proposed to make such financial statements easily accessible to interested parties. In addition, laws have been put through requiring the participation of consumers on Hill-Burton advisory councils and on state and regional Comprehensive Health Planning organizations.

Recent changes in hospital accreditation procedures are permitting consumers and consumer organizations to participate in the accreditation process. Citizens do this by learning when the biannual accreditations surveys of hospitals in their areas are to be held and by being present at an information interview to state complaints as they relate to the standards of the Joint Commission of Accreditation of Hospitals.

And in an effort to make doctors and hospitals more accountable to the government in the spending of Medicare and Medicaid monies, Congress recently enacted the PSRO legislation designed to subject old and poor patients’ admission to a hospital to pre-admission review in all but emergency cases by local committees of doctors. A tougher proposal requiring an in-hospital committee review of Medicare admissions to crack down on needless hospitalization or protracted stays was dropped by the Social Security Administration after drawing heavy fire from the AMA.

Structural changes within the hospital are similar measures, because they work on the basis of changes in formal definitions. Thus, requiring that hospitals have a consumer representative on the board is a case in point; it is said to make the hospital more accessible. Following this logic, the OEO guidelines dictated that OEO and other neighborhood health centers funded by the Public Health Service had to form either governing boards or advisory committees composed of at least one-third “democratically selected representatives of the poor.”

Many social scientists are skeptical of such formal and legal accountability mechanisms. According to the most popular introductory textbook in sociology:

The rules of the formal system account for much but by no means all of the patterned behavior in associations. The phrase “informal structure” is used to denote those patterns that emerge from the spontaneous interaction of personalities and groups within the organization. … An organization’s informal structure is made up of the patterns that develop when the participants face persistent problems that are not provided for by the formal system.

In the health care system the consumer representative often turns out to be not “the people’s” representative, but a businessman rather similar to the other board members in background and outlook. In addition, consumers on hospital boards often learn that formal entitlements do not necessarily confer real power just as stockholders long ago discovered in business corporations. The power wielders may hold their own meeting in a back room prior to the formal meeting which then becomes a mere ceremony. Or, the doctors and
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administrators may have their way via the phenomenon of "partisan analysis"—if the consumers have no independent source of information they may have no way of arriving at and documenting a point of view opposing the administrative one. Similarly, the aura of expertise surrounding doctors and administrators vs. the low social status of the consumer representatives can be expected to contribute to the likelihood that the consumer representatives defer to the hospital officials. In addition, while the doctors and administrators have a continuing personal vested interest in the affairs of the hospital, the motivations of consumer representatives are more likely to be altruistic. Unless the position of consumer representative is one which confers great prestige in the person’s social circle, or there is some other reward, there seems little incentive to attend meetings often and regularly and to engage in the necessary self-education. It seems almost inevitable for enthusiasm to decline over time.  

At first glance, the social science caveat, “not all that glitters with accountability truly enhances it,” seems to be revalidated from data on the health system. Nevertheless, on balance, formal mechanisms do have an effect—especially when coupled with efforts to build consensus around values and to mobilize power through coalition building as discussed below. Thus, a study of the accomplishments of 37 Massachusetts Mental Health and Retardation Area Boards on which citizen participation had been required by legislation revealed four separate types of board accomplishment. Each one resulted from a different strategy pursued by the board: service creation of improvement, mobilization of outside resources (from state and federal government), achievement of local autonomy (mobilization of resources from the private sector or the local government), and coordination (integration of the efforts of a variety of social agencies).

Although consumer representation on decision-making and advisory bodies overseeing health units has received the most attention as the solution to the problems of instituting accountability to the public-at-large, it is by no means the only mechanism available. Another promising approach is that of the regularly scheduled Comprehensive Health Audit (CHA). The principle behind the notion of the Comprehensive Health Audit is essentially the same as that behind the annual financial audit in the corporate world. In the case of the corporate financial audit, the law requires that an outside expert licensed by the government (a CPA) review the books of the joint stock company on a yearly basis so as to insure “accountability” of the firm and its managers to the stockholders or legal owners of the corporation.

The Comprehensive Health Audit would entail a regular assessment of cost-consciousness and quality of care delivered in each hospital by an outside team of health auditors licensed by the government. The chief advantages of the Comprehensive Health Audit are that: (1) it accords well with the American philosophy of harnessing the profit motive in the service of the public interest; (2) it avoids the necessity of setting up a costly and cumbersome governmental regulatory apparatus (which as we know from historical experience has typically ended by serving the purposes of those it was intended to watchdog); and (3) it relies upon a tried and true mechanism, known to be efficient in one area, and transfers it to a closely related field. The chief disadvantage of the Comprehensive Health Audit is that “input” measurements are so much more refined than “output” measures. Until more accurate output indices are developed, CHAs will have to employ fairly crude measures and their evaluations will not be nearly so reliable as the traditional financial audit.

A “Guidance” Approach

The following view of accountability—the “guidance” approach—is, I should hasten to admit, the view closest to my heart. It took me six hundred-odd pages to spell it out elsewhere. Here, I will simply suggest its chief points relevant to the issue at hand.

As I see it, accountability is based on a variety of interacting forces, not one lone attribute or mechanism. The direction administrators take, in accountability as in other matters, is affected by all the factors already listed and some others still to be mentioned. In part, they respond to articulations of “rights” on the part of “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, and so on. 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 see power as the core explanatory factor, I see 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 both affect the direction the health unit takes. Thus, in a recent study by the Center for Policy Research, Dr. Steven Beaver and Dr. Rosita Albert found (in a study of which I am the principal investigator, supported by NIMH) 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.

This study but 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 as to 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.

The administrator need not be merely a broker of power, a meeting point of various internal and external pressures which he adapts the way a vectorgram would; adapting to the strongest pressure at the moment—although in reality 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 than the Realpolitik of give and take, there is, in addition, an opportunity for creative leadership.

I do not see the capacity for leadership as consisting of abstract, moralistic character traits; I see 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 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 physicians are putting undue pressure on an administrator to take a course of action he considers undesirable, he may instigate a greater activization of the board or of consumer representatives to serve as countervailing forces, somewhat changing the vectorgram. This course can often not be followed because it leads to a measure of countermobilization by the other group, in this case the MDs, realizing next to no net change but creating a higher level of conflict all around.17

Somewhat better opportunities for creative leadership are open to the administrator in the area of coalition forming. Coalitions arise, not necessarily explicitly, when two or more groups favor the same or a similar course of action. They may be composed of insiders only, outsiders only, or varying combinations. For example, Dr. Lowell Bellin, when first deputy commissioner of the New York Department of Public Health, succeeded in forming a coalition between his hospitals into giving more resources and attention to ambulatory care.18 In speaking about the accomplishments that have emerged from this active collaboration between consumers and professionals in private voluntary hospitals, Bellin listed the number of advances:

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.
10. Starting a community outreach program.
11. Starting a new clinic or other services.
12. Remodeling clinic and/or emergency room areas.
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.
18. Extending clinical hours.19
The reason coalition building is often effective is that while in isolation each vector is relatively given and unchangeable, on the other hand, the ways in which they may be combined to neutralize, to partially reinforce, or to fully back up one another is less fixed. 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 toward their goals. 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 than solo practice; if this is the case, it is such a creative alternative.

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. In part, he can get the needed knowledge from proper training; in part, 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. The explanation of the mechanisms of institutional communication cannot be undertaken here, but they constitute a vital element of any effective accountability system.

Notes

2. Ibid.
8. For more information on this, see the chapter entitled "Consumer Influence on the Federal Role" in *Heal Yourself*, Report of the Citizens Board of Inquiry into Health Services for Americans.
11. For more on this, see "The Health Rights Defenders: All Power to the Patients," *Health-Pac Bulletin* (October 1969).
15. For an example of a prototype Comprehensive Health Audit, see Carol Brierly, "Hospital Costs: What the Figures Really Say," *Prism* (February
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Louis Brownlow Award – Best Article by Practitioner
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Neely Gardner
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