Accountability in Ontario's Health Care System: The Role of Governance and Information in Managing Stakeholder Demands

Summary of Thesis

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THANK YOU TO ALL ORGANISATIONS AND PARTICIPANTS:
The participation of organisations and organisational leaders constituted a crucial condition to the realisation of this project. Through their generosity, the organisations that accepted the invitation and participants who took time out of their busy days to be interviewed made this project possible.

Abstract

This research focuses on nonprofit accountability because accountability failures, such as frauds and scandals, impede the ability of organisations to deliver on their mission and have raised concerns about their ability to manage their accountability demands. Despite concerns about accountability, little is known about how nonprofits in a Canadian context manage their accountability systems. While previous studies have focused on what accountability is and to whom it should be given, less focus has been given to how accountability is managed.

Through the concepts of stakeholder relationships, governance mechanisms and information strategies, the accountability system in figure 1 below was proposed and served as the conceptual framework to understand how nonprofit accountability is managed. This study argues that a systematic approach to accountability may help researchers understand the intricacies of nonprofit accountability and help organisational leaders improve their accountability management practices. Thus, this topic is both useful to management scholars and practitioners alike.

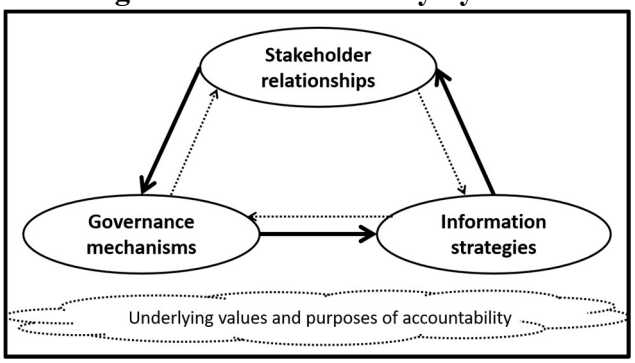
The table below presents the research objective, the general research question and specific research questions. To achieve the research objective, a multiple-case study research strategy using a cross-sectional sample of health care organisations was adopted.

The findings from this study provide rich insights into understanding the dynamics and intricacies of accountability management practices in the unique context of the health care system.

Research Objective and Questions

Research objective To gain a better understanding of the nonprofit accountability system.
General research question How do nonprofit organisations manage their accountability systems?
Specific research questions How do nonprofit organisations use stakeholder relationships, governance mechanisms and information strategies to manage their accountability systems? How do nonprofit organisations manage their stakeholder relationships? How do nonprofit organisations manage their governance mechanisms? How do nonprofit organisations manage their information strategies?

Figure 1 – Accountability System



The complete thesis is available at https://curve.carleton.ca/730fe3f6-2de1-4ccb-8f86-96e650bc0592

Summary of Thesis

Overview of Organisations within Ontario's Health Care System

The health care sector is of critical importance to the nonprofit economy. While hospitals only represent 0.5% of all nonprofits in Canada, they command 22% of all revenues and 24% of all paid staff; and of those revenues, the source of 82% of these is from the government (Hall et al., 2004).

Although Ontario's health care system is publicly administered, it is quite decentralised (Devlin, 2019b; Fierlbeck, 2011; Martin, 2017). A mixture of public, for-profit and nonprofit organisations provide health care (Deber, 2002). These organisations can be classified as funders, service providers, coordinators and philanthropic supporters. Figure 2 combines these categories and breaks down health care organisations into three different levels of public, nonprofit and private, and a fourth level that captures citizens within the health care system. Figure 2 illustrates the complex web of stakeholder relationships that exist within Ontario's health care system. Identified in bold are the organisations under study in this research.

Figure 2 – Overview of Organisations within Ontario's Health Care System

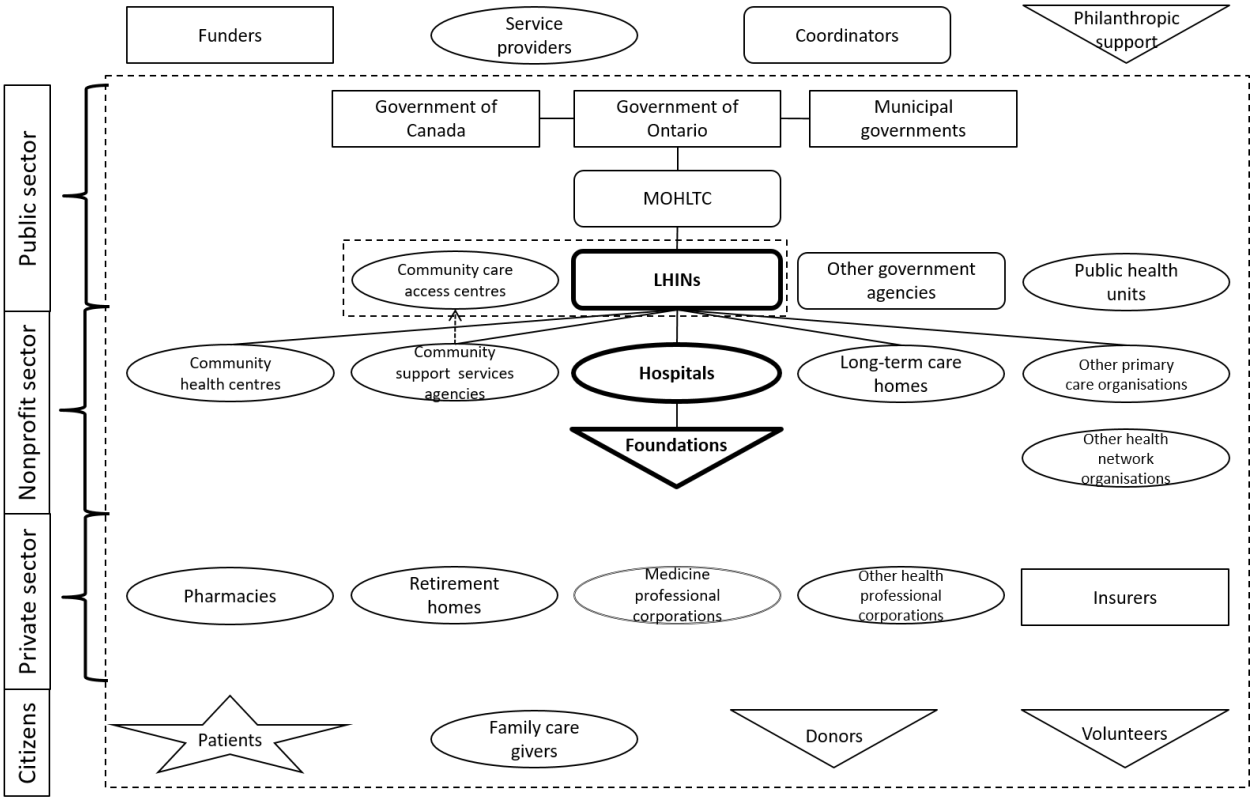


Figure 2 demonstrates that there is a large spectrum of care which requires the involvement of a plurality of organisations. As one can see, health care providers operate alongside a myriad of nonprofit, public, and private organisations with different resources and missions, offering services, ultimately, to a diverse, aging and demanding patient base. These organisations operate independently and have varying degrees of diverging interests which can complicate

collaborative efforts. However, these organisations must nonetheless interact with each other to achieve their individual objectives, as well as system-wide objectives. These interdependent relationships between the nonprofit, for-profit, government sectors become fundamental to their operations (Abzug, 1999).

Methods

To achieve the research objective, a qualitative research strategy using case studies was conducted at nine organisations within Ontario's health care system, with a particular focus on nonprofit hospitals and two of the hospitals' salient stakeholders, Local Health Integration Networks (LHINs) and foundations.

As nonprofits, hospitals were chosen because they represent the largest proportion of spending in Ontario's health care system (Martin, 2017). The hospital sector is also where the vast majority of health care capital infrastructure is invested (Wilson, Mattison, & Lavis, 2016). LHINs were chosen because they are the primary funders of hospitals. Foundations were chosen because hospitals in Ontario typically have one or several affiliated foundations which are responsible for generating donations, grants and fundraising revenues for its hospital.

In total, 5 hospitals, 2 LHINs and 2 foundations constituted the participating organisations for this study. Table 1 provides an overview of the nine participating organisations.

Table 1 – Overview of Participating Organisations

Type of organisation	Entity	Size ($ million)
Hospital	H1	$ 250
Hospital	H2	$ 450
Hospital	H3	$ 100
Hospital	H4	$ 60
Hospital	H5	$ 220
LHIN	L1	$ 5 / $1,500 *
LHIN	L2	$ 4 / $1,000 *
Foundation	F1	$ 3
Foundation	F2	$ 2

* Operating budget / Funding received from the Ministry. Dollar figures have been rounded.

Of the 5 hospitals, 3 were regional, 3 were tertiary, 3 were located in northern Ontario, and 2 were teaching hospitals.

Between two and six participants per organisation were interviewed and in total 37 interviews were conducted from the nine organisations. The average interview lasted approximately 84 minutes, with the longest being 2 hours and 31 minutes and the shortest being 36 minutes. Interviews were conducted in 7 different communities across Ontario. Interviews were collected between May 14, 2018 and February 8, 2019, with the majority being conducted over the summer of 2018. 12 interviews were conducted before the June 7, 2018 provincial election and all were conducted before the new government announced plans on February 26, 2019 to make substantial changes to Ontario's health care system, including the integration of multiple health care agencies, most notably the LHINs, into a single health agency called Ontario Health

(Government of Ontario, 2019; Ministry of Health, 2019). Table 2, panels A and B, provides a summary of the interview profiles of the participants.

Table 2 – Interview Profiles
Panel A (by participant title)

Participant title	Hospital	LHIN	Foundation	Total
Board member	7	1	2	10
CEO	4	0	2	6
CFO or equivalent	5	2	0	7
CNO or equivalent	3	0	0	3
Chief of staff	3	0	0	3
Manager or equivalent	3	5	0	8
Total	25	8	4	37

Panel B (by participant profession)

Participant profession	Hospital	LHIN	Foundation	Total
Accountants	9	4	1	14
Administrators (other than accountants)	6	3	3	12
Nurses	5	1	0	6
Doctors	5	0	0	5
Total	25	8	4	37

In addition to interviews, internal and external documents were obtained and reviewed. Approximately 80% of the documents were accessible publicly, although not always on the organisation's website or in an easily accessible location, and 20% consisted of strictly internal documents.

Accountability System

The accountability system presented earlier in figure 1 is the overall framework that proposes a sequential order of stakeholder relationships, governance mechanisms, and information strategies. Stakeholder relationships allow for dialogue and negotiations between the organisation and its stakeholders. Governance mechanisms support the accountability system and affect the way in which information is collected and communicated to stakeholders and how stakeholder relationships are managed. Once governance mechanisms are implemented, information strategies are selected. This makes the connection between the stakeholder relationships, governance mechanisms and information strategies a dynamic process as each construct affects the others. These 3 components are supported by underlying accountability values and purposes.

Stakeholder Relationships

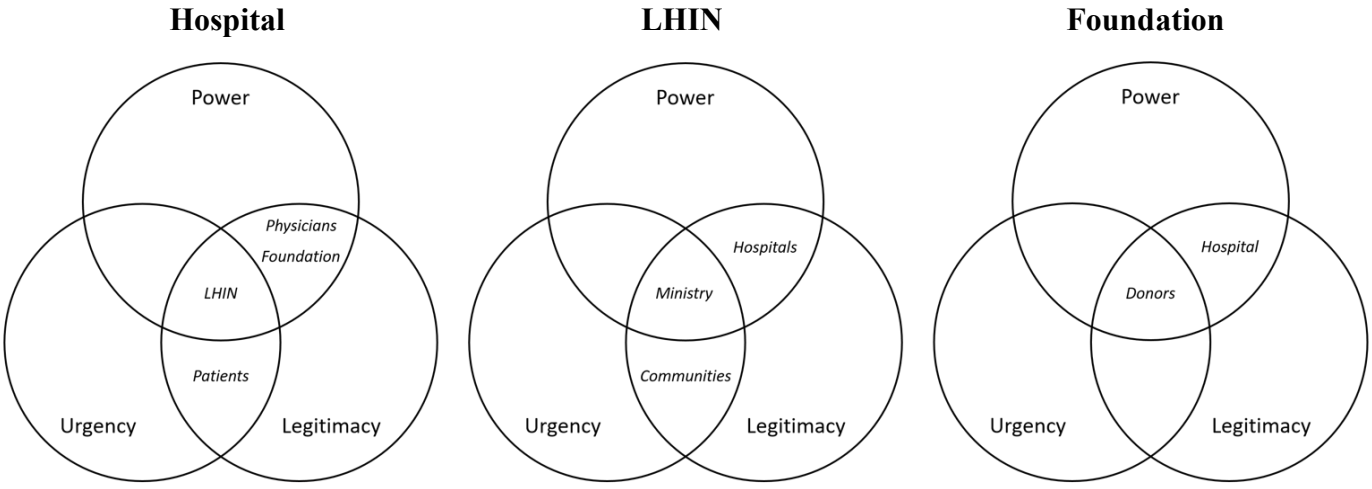
Stakeholder relationships were analysed by identifying salient stakeholders, reviewing their accountability demands, the nature of the relationships, the negotiation tactics and the modes of accountability evaluations.

Identification of Salient Stakeholders

Salient stakeholders are those that have some degree of power, legitimacy and urgency over the organisation (Mitchell et al., 1997). The stakeholder relationships described take into consideration the salient stakeholders identified by participants. The larger stakeholder typology is evidently broader and more complex.

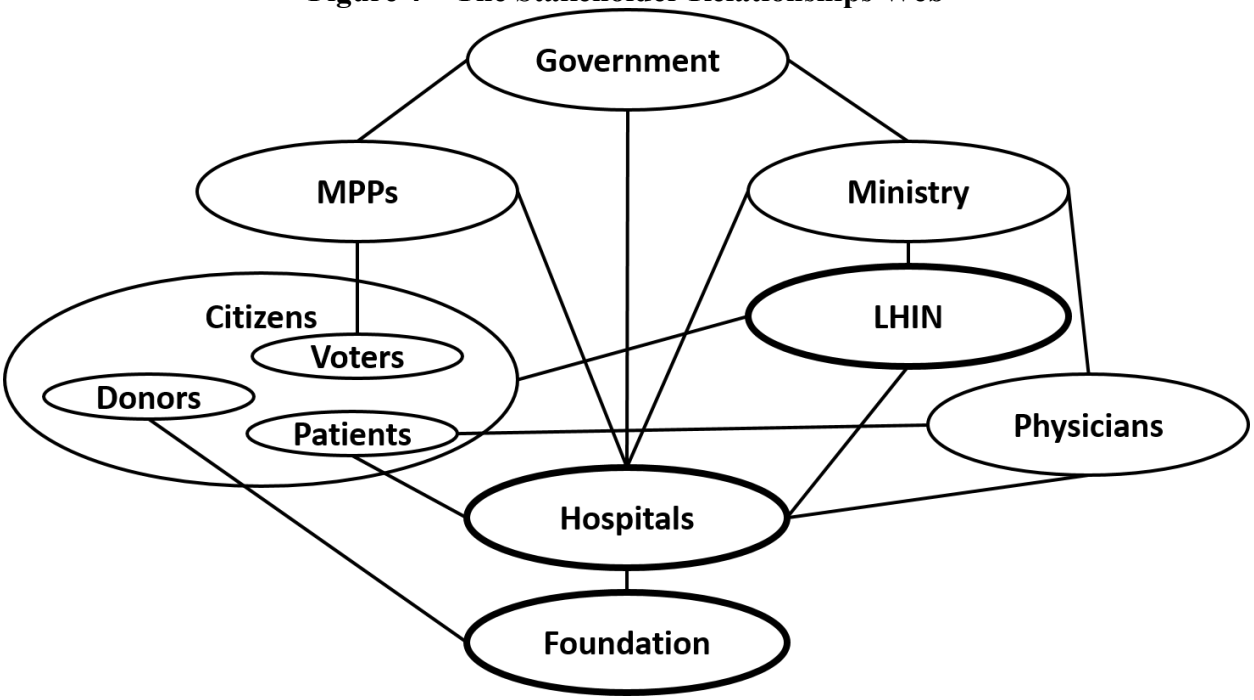
Participants identified salient stakeholders of hospitals as patients and their families, the LHIN, physicians and the hospital's foundation. In the LHIN context, participants identified salient stakeholders as the Ministry of Health and Long-Term Care (the Ministry), hospitals (and other health services providers), and the communities within a LHIN's geographic region. In the foundation context, salient stakeholders were identified as donors (both past and prospective), and its hospital. Using Mitchell et al.'s (1997) stakeholder typology, figure 3 conceptualises the salient classes of stakeholders.

Figure 3 – Hospital, LHIN and Foundation Salient Stakeholders



In summary, starting with hospitals as the central focus of this study, salient stakeholders identified during data collection include LHINs, patients, physicians, foundations, the Ministry, communities, and donors. Of the stakeholders identified, figure 4 illustrates the broad stakeholder relationships web.

Figure 4 – The Stakeholder Relationships Web



Accountability Demands

Accountability demands on the organisations under study are wide ranging and were not all necessarily addressed here, as to keep the discussion focused on the more predominant demands that emerged from the data collection. Table 3 summarises the organisations' accountability demands.

Table 3 – Summary of Accountability Demands

Accountability Demands	**Stakeholder Relationships**	
	Stakeholder	**Accountor**
Quality and timely care close to home	Patient	Hospital
Coordinate care with community resources	Patient	Hospital
Scope of service	LHIN	Hospital
Fiscal responsibility	LHIN	Hospital
Respect time and make necessary resources available	Physicians	Hospital
Collaborate to raise funds	Foundation	Hospital
Provide funding to meet service needs	Hospital	LHIN
Provide guidance and system-wide strategic direction	Hospital	LHIN
Identify system problems and propose solutions	Ministry	LHIN
Act as an oversight body	Ministry	LHIN
Be a voice for the region	Ministry	LHIN
Ensure equity in access and quality of care	Community	LHIN
Help citizens navigate the health care system	Community	LHIN
Flow funds in a timely manner	Hospital	Foundation
Comply with donation restrictions	Donors	Foundation

Table 3 demonstrates how different stakeholders are interested by different types of demands, and based on this, it is possible for hospitals, LHINs and foundations to have multiple conflicting accountability demands among stakeholder groups. Health care system organisations, and particularly hospitals, have a large diversity of stakeholders, and incongruences between their demands are common (Eeckloo, Van Herck, Van Hulle, & Vleugels, 2004). Some types of accountability may push away other types of accountability (Romzek & Dubnick, 1987) and any perceived imbalance between organisational accountabilities can be detrimental to an organisation's success (Connolly & Hyndman, 2013). As such, trade-offs are continuously required.

Health care organisations are challenged by the need to manage the diverging accountability demands of different stakeholder groups. Looking at hospitals for instance, patients' demand for quality care or physicians' demand for resources may be at the expense of the LHIN's demand for fiscal responsibility. Therefore, managing service level expectations against resources is a delicate balancing act that is ongoing and highly dependent on the contextual environment surrounding hospitals. The capacity of partner organisations, disease outbreaks, elections, and changing government priorities can all affect the level of service a hospital can provide.

These difficult decisions by those responsible for an organisation's governance go beyond calculations because not all accountability demands can be measured. This puts an ethical burden on organisations, and by no other option, to privilege one accountability demand over another at different points in time (Messner, 2009). The burden of reconciling these accountability demands should not necessarily only be assumed by one organisation, but with and between the stakeholders themselves.

Another observation of accountability demands shows that population health outcomes are not directly tied to the performance of health service providers. Improving population health outcomes is an important objective of any heath care system. However, there does not appear to be any clear line of accountability for improving population health outcomes, a finding consistent with the reports from the Premier's Council on improving healthcare and ending hallway medicine (Devlin, 2019a, 2019b). Outcome performance appears to be less relevant and rarely measured in the health care system (Office of the Auditor General of Ontario, 2015). This is likely due to the inability to hold any one organisation responsible for the long term health outcomes of a population, since it inevitably implicates the integration of poverty, crime and other socio-economic factors. For instance, the LHIN-Hospital accountability relationship is generally based on output performance (Office of the Auditor General of Ontario, 2015), as the focus of the Hospital Service Accountability Agreement (HSAA) is based on output volumes (e.g. wait times, number of visits, number of surgeries).

This focus on output performance over outcome performance may result in what is known as a performance paradox. Performance paradox results from the introduction of performance measures that may result in lower performance over time "when organisations or individuals have learned which aspects of performance are measured (and which are not), they can use that information to manipulate their assessments" (Van Thiel & Leeuw, 2002, p.271). The more organisations are scrutinized, the better they get in responding to the demands of their stakeholders, but not necessarily better at performing and achieving their organisational objectives (Van Thiel & Leeuw, 2002). What has emerged in the health care system to

compensate for the performance paradox is a large amount of performance indicators. However, even with all this data, it is unclear to what degree and in which area population health outcomes are improving. Government agencies, such as LHINs, Health Quality Ontario (HQO) and the Canadian Institute for Health Information (CIHI), have improved their collection and reporting of outcome measures, but these measures should be tied to health service provider accountability where possible.

Nature of Relationships

It is important for nonprofit organisations to understand and manage their stakeholder relationships as a way to achieve their organisational objectives (Shaw, Zink, & Lynch, 2014). This research identified two types of relationships, which can be characterised as professional or personal.

Relationships between hospitals, LHINs, the Ministry, physicians and foundations can all be characterised as professional as the lines of formal accountability are strong and negotiations between these parties are evidence-based. In contrast, relationships that associated with patients, communities and donors can be characterised as personal, as the lines of accountability are much more informal and negotiations with these parties are much more emotionally-driven than evidence-based.

Overall, the nature of the relationships within the health care system can be described as positive, as many of the parties' goals were aligned. For instance, hospitals, patients, donors, communities, and even physicians have a mutual interest in maintaining hospital services. As such, the interests of various stakeholders can align.

However, stakeholder relationships can be challenged when a party feels they are being treated inequitably. Expectation gaps between what the health care system offers and the expectations of patient and community members can create frustrations. Such was the case for patients and communities that felt they were losing a service or not receiving a service to the same level of care as elsewhere. Due to resource constraints, managing expectations is therefore an important aspect of stakeholder relationships. Health care organisations, such as hospitals and LHINs, must manage the expectations of their patients and communities between achieving health equity objectives and the reality of maintaining standards of care through clear and ongoing communications in order to maintain positive relationships.

Relationships were also challenged when goals were not aligned. The nature of the relationship between hospitals and their physicians appeared to be the most adversarial, as both parties have some degree of power over the other and compete for the same resources. Both parties enjoy a high degree of community legitimacy and independence, neither being a downward stakeholder to the other (Mainardes, Alves, & Raposo, 2012).

Relationship challenges between LHINs and the Ministry originated from role ambiguity and legitimacy threats. Specifically, participants did not agree on LHINs' advocacy role. This challenge was similar to the one faced in the Hospital-LHIN relationship. Some felt LHINs should have competed for more funding for their regions, while others saw LHINs purely as a flow through of Ministry directives. This contradiction relating to role ambiguity created feelings

of frustration. In addition, when the Ministry used its power to bypass or overrule the LHIN, it negatively affected the LHIN's legitimacy and its ability to be an effective oversight body.

Stakeholder relationships were also challenged by an uncertainty about where responsibilities lie, which seemed to be at the heart of relationships which at times could be adversarial, rather than collaborative. This challenge was particularly present within hospital-LHIN and LHIN-Ministry relationships. The inability to establish clear lines of responsibility made it difficult to hold others to account and be accountable and also hindered the development of strong relationships because it bred distrust. LHINs were left to decipher if hospitals were shirking responsibility or if performance results were outside a hospital's scope of responsibility. There is therefore a need for clear direction and lines of responsibility, which is an ongoing challenge due to the complexity and interdependent nature of health care in Ontario.

Negotiation Tactics

The impossibility to satisfy all stakeholders requires nonprofits and their stakeholders to negotiate. Efforts to appease one stakeholder group can alienate another. A difficulty in measuring or evaluating performance further compounds this issue (Fowler, 1995).

The study has demonstrated that stakeholders interact with and negotiate the specifics of their accountability demands in numerous ways. Negotiation tactics used by different parties to advance their objectives include using equity as a guiding value, building coalitions, compromising, using intermediaries, collaborating, and using political interventions.

Equity is a value that drove much of the decision making surrounding accountability demands. Equity was part of a community's accountability on the LHIN to ensure fairness in access and quality of care for residents. When determining what services to cut, LHINs and hospitals try to identify core services and meet the equity demands of communities. Equity was also used by hospitals as an argument when applying for more funding or requesting a change to the funding formula. Hospitals negotiated with LHINs by providing supporting data in attempting to demonstrate that any funding shortfall was due to inequity in revenue sharing, rather than for other reasons such as inefficiency. Equity was also evoked by physicians in their need to help hospitals control spending and use resources efficiently.

Building coalitions among stakeholders was seen as a way to negotiate, particularly with upward stakeholders. Building coalitions on congruent objectives was seen as an effective way of exerting bottom-up pressure by changing power dynamics in the negotiation process. For instance, foundations and donors built coalitions to raise funds and put upward pressure on hospitals to purchase equipment that hospitals did not prioritise. Having actual funds raised in the community put bottom-up pressure on hospitals to move a particular project of interest in the community forward and purchase the equipment. Also, a hospital attempted to negotiate with their LHIN and the Ministry by building coalitions with other institutions with similar interests. Such was the case when mid-sized hospitals worked together along with the Ontario Hospital Association (OHA) to obtain more funding.

Compromise was used as a negotiation tactic when both parties reduced their demands in order to come to an agreement. For instance, compromise was used by hospitals during their

negotiations with foundations. In one case, a hospital provided a capital purchase list well above what the foundation could acquire, and the foundation then chose items from that list. The hospital agreed to purchase these items, even though it may not have been purchases that were its top priority in order to settle for purchases that were marketable to the donor base. The hospital, LHIN and the community were also able to align their priorities and find a comprise by moving non-acute health care services from the hospital into the community to private providers or through public-private partnerships. This alignment was, however, at the cost to patients using these services.

A negotiation tactic that was particularly subtle was the use of intermediaries as an indirect channel to advance stakeholder objectives. Communities used LHINs as intermediaries in negotiating with the Ministry to maintain or increase service levels in their regions. Foundations also acted as intermediaries between donors and hospitals. When dealing with the accountability demands from both sides, foundations acted as a liaison between both stakeholder groups to find a program that was needed by the hospital and of interest to donors.

Interestingly, the media played an important intermediary role in the dialogue and negotiation process by applying indirect pressure. In the health care system, the media acts as a conduit for a community's interests. At times, the media can be an ally of hospitals, by which hospitals may avoid or transfer blame to LHINs for the suppression of a program. Hospitals may also at times use the media to try to put pressure on LHINs. As such, hospitals leverage their community legitimacy, using the media as a conduit when negotiating with LHINs. However, the media may not always report a story accurately due to the unavailability of key information, and so it can create confusion in the community and frustrations for hospital, LHIN and Ministry leadership. These parties may also suppress community participation mechanisms because of challenges in dealing with the media. This approach is not entirely without merit, as media stories can distort realities when the facts are not entirely known by the community, further exasperating relationships between health care organisations and the broader community. Nonetheless, the media is used as an important negotiation tactic at different times.

Collaboration was used as a negotiation tactic when the strengths of several parties were combined to achieve results that were greater than what could have been achieved individually. For instance, collaboration was at the forefront of the relationship between hospitals and foundations in the latter's fundraising efforts. Hospitals and LHINs also regularly collaborated on projects to fix system wide problems and share best practices. Furthermore, a hospital and physicians were able to work collaboratively to address a clinical documentation problem. In this case, common ground needed to be found for their collective objectives to be met. This was achieved when both parties were able to revisit the clinical documentation and work collaboratively on a solution to align their objectives. In return for better clinical documentation, the physicians were able to maintain or increase the availability of their resources and the hospital was able to increase its revenue.

A negotiation tactic that was particularly heavy-handed was the use of political interventions. Political interventions were used by upward stakeholders to advance their agendas when other means of negotiation failed. This was particularly the case in the LHIN-Ministry relationship in instances where the Ministry overruled the LHIN, threatening the latter's legitimacy.

Accountability Evaluation

To better understand how organisations managed stakeholder relationships, participants were asked how stakeholder relationships were evaluated. Participants were quick to respond that formal mechanisms were in place to enrich dialogue with patients through patient satisfaction surveys, patient and family advisory committees, patient experience surveys, and risk event feedback surveys. These dialogue mechanisms allowed organisations to identify challenges or barriers in managing stakeholder relationships. Hospital boards and committees also conduct regular self-evaluations.

However, many participants were caught off guard by the question as it relates to non-patient stakeholders. While acknowledging the importance of managing accountability with stakeholders, participants conceded that no formal mechanism was in place to evaluate relationships, other than with patients and to some extent communities, and not on a regular basis.

Therefore, it appears that while participants noted the importance of managing stakeholder relationships and that engagement can assist in relationship building, there remains a gap in how it is measured and subsequently managed. As such, it appears that the quality of stakeholder relationships may be hindered by a lack of formal mechanisms to evaluate and subsequently manage non-patient relationships. A more systematic approach to evaluating stakeholder relationships may help determine how relationships have evolved over time and assess when relationships are strained and in need of strengthening.

Governance Mechanisms

The analysis conducted has shown that the health care system as a whole uses a combination of internal, external and collaborative governance mechanisms to manage its accountability. Examples of internal governance mechanisms included case reviews, a management philosophy of ‘tone at the top’, tracking of adverse events, and risk analysis. Examples of external mechanisms included benchmarking, disclosure requirements, performance reviews, audits, external third-party reviews, accreditation, best practices and government laws and regulations.

Beyond internal and external governance mechanisms, many participants emphasised the need for collaborative governance mechanisms. Unlike distinct internal or external governance mechanisms, collaborative governance mechanisms were found to straddle organisational boundary and were an important part of the governance system given the interdependencies that exist in the health care system. Collaborative governance “has been used to describe the mechanisms by or through which two or more independent governing bodies can achieve a common goal” (Ontario Hospital Association, 2015, p.15). Examples of collaborative governance mechanisms and their purposes included cross-board representation to ensure strategies were clear and coordinated between organisations, working groups and steering committees to advance joint projects, web-based forums to share information, taskforces to monitor system-wide progress, care coordinators to ensure the efficient and effective flow of patients between discreet organisations, as well as medical advisory committees (MAC) and patient and family advisory committees (PFAC) to improve both clinical and administrative processes.

Governance mechanisms were used to manage accountability demands. Some of the more administrative governance mechanisms, such as 'tone at the top', risk analysis, audits, and external third-party reviews were used to manage the hospitals' accountability demand for fiscal responsibility and the LHINs' accountability demand to act as an oversight body, and identify systemic problems and propose solutions. While the more clinical governance mechanisms, such as the tracking of adverse events were used to manage hospitals' accountability demand for quality and timely care. Some governance mechanisms accomplished both administrative and clinical objectives, such as benchmarking, accreditation and case reviews. In contrast to internal and external governance mechanisms, collaborative governance mechanisms between health care organisations were used to meet hospitals' accountability demand for coordinated care, to collaborate with its foundation and to manage the demands of physicians, and the LHINs' accountability demand to provide system-wide strategic direction and address system problems.

Table 4 summarises the organisations' accountability demands from table 3 and ties them to examples of governance mechanisms used to manage these demands.

Table 4 – Summary of Accountability Demands with Governance Mechanisms

Accountability Demands	**Stakeholder Relationships**		**Examples of Governance Mechanism**
	Stakeholder	**Accountor**	
Quality and timely care close to home	Patient	Hospital	Tracking adverse events, patient and family advisory committee, best practices, benchmarking, disclosure requirements
Coordinate care with community resources	Patient	Hospital	Working groups, care coordinators
Scope of service	LHIN	Hospital	Hospital Service Accountability Agreement
Fiscal responsibility	LHIN	Hospital	Case reviews, benchmarking, disclosure requirements, 'tone at the top', audits, external third-party reviews, accreditation, best practices
Respect time and make necessary resources available	Physicians	Hospital	Medical Advisory Committee
Collaborate to raise funds	Foundation	Hospital	Cross-board representation
Provide funding to meet service needs	Hospital	LHIN	Hospital Service Accountability Agreement
Provide guidance and system-wide strategic direction	Hospital	LHIN	Working groups
Identify system problems and propose solutions	Ministry	LHIN	Patient and family advisory committee, benchmarking, audits, accreditation
Act as an oversight body	Ministry	LHIN	Risk analysis, benchmarking
Be a voice for the region	Ministry	LHIN	Steering committees
Ensure equity in access and quality of care	Community	LHIN	Benchmarking
Help citizens navigate the health care system	Community	LHIN	Care coordinators, patient and family advisory committee
Flow funds in a timely manner	Hospital	Foundation	Cross-board representation
Comply with donation restrictions	Donors	Foundation	Canada Revenue Agency regulations

One way to explain the importance of collaborative governance mechanisms in the health care system is to look at the paradox of managing agency and stewardship approaches. An agency approach privileges control and monitoring, and treats the relationship as mistrusting. A stewardship approach privileges collaboration and trust, and treats the relationship as a partnership.

While interdependencies in the health care system require stakeholders to work together, too much stewardship-based governance and LHINs forgo their oversight responsibilities, which may result in increased opportunism from hospitals to shirk responsibility. However, too much agency-based governance breeds distrust, inhibits information flows and can lead to performance failures (Sundaramurthy & Lewis, 2003), which may ultimately put health care system performance at risk. LHINs also need reliable and timely information from their health service providers to accomplish their objectives as health system coordinators and to demonstrate accountability to the Ministry. As such, stakeholder relationships between health care organisations can fluctuate between agency and stewardship approaches as situations merit. These governance approaches work together (Hyndman & McDonnell, 2009) to achieve health care system objectives. The agency-stewardship governance paradox can be viewed as having one foot on the gas, and one foot on the brake, but not necessarily at the same time.

This paradox between agency and stewardship highlights the real-life complexities of nonprofit accountability and why health care organisations might have difficulty managing their accountability systems. Because of this paradox, organisations often need to make conflicting choices between alternatives which are not always obvious to outsiders.

Information Strategies

The multitude of information choices that are required to communicate and their importance to stakeholder relationships make the transfer of accountability information a strategic process. Information strategies refer to whom, for what, and how information is communicated.

Information strategies were adapted to the needs of both corporate and personal stakeholders and can be split along two characteristics of accountability communication: the rational level and the emotional level (Davison, 2007). A rational strategy was communicated towards corporate-level stakeholders, and an emotional strategy was communicated towards personal-level stakeholders. Information strategies towards corporate-level stakeholders were more prescriptive, structured and characterised by formal and regular reporting. In contrast, information strategies towards personal-level stakeholders were less prescriptive, less structured and more informal than with corporate-level stakeholders, because the former's information needs could change, and organisations had to adapt. Table 5 summarises the information strategies of hospitals, LHINs and foundations.

Table 5 – Summary of Information Strategies

To whom (Stakeholders)	Information Needs	What information is shared (content)	How information is shared (methods of communication)
Corporate-level: Hospital LHIN Ministry Physicians	Accurately report financial and performance results	Financial statements, variance analysis, funding reports, board and committee minutes, QIP, performance results (stocktake reports, HSP performance reports), program outcomes, budgets, forecasts, operational plans, cash flow projections, stewardship reports	Emails, web portal, board committee meetings
Personal-level: Patients Communities Donors	Details of care treatment	Ongoing health care requirements	Verbal, face-to-face, through family physician
	Changes that effect patient experience and navigate health care system	Brochures, educational material	Website, newspapers, walls of hospital, waiting rooms, phone calls
	Demonstrate transparency	Photographs, storytelling, positive basic statistics, board minutes, business plans, expense reports, performance results, audited financial statements	Website, AGM, annual reports, newsletters, newspapers, public presentations, blogs, social media
	Demonstrate how donations have impact	Storytelling, 'thank yous'	Public presentations, campaign videos, commercials and social media, mailing campaigns, thank you letters, donor recognition walls

The challenge is in effectively managing these two different information strategies. While formal reporting requirements at the corporate-level are complex, information must be simplified when communicating at a personal-level in order to increase understandability and relatability. This was accomplished by making the information communicated less medically and financially technical and through the art of storytelling.

Overall, stories were found to be more important to personal-level relationships, while performance metrics were found to be more important to corporate-level relationships. From the corporate perspective, stories are dismissed as being isolated and anecdotal. From the personal perspective, performance metrics are hard to understand and difficult to transmit and convey meaning persuasively. Storytelling 'pulls at the heart strings' of readers to encourage an emotional reaction and a connection to the organisation (Hyndman & McConville, 2018b). Therefore, for hospitals, LHINs and foundations, consistency and comparability of quantitative information communication with personal-level stakeholders were not deemed as important as was telling a compelling story.

To demonstrate transparency to personal-level stakeholders, many corporate-level reports were provided to the public, such as board minutes, business plans, expense reports, performance results and audited financial statements. Other reports were humanised through nontextual information, such as images, pictures and graphs, and by telling patient stories and providing basic statistics such as the number of people helped, the number of babies born, the number of

volunteer hours, wait times, infection rates and awards won. Much of this communication occurred to recap the year that happened. These communications are less evidence-based and professional, and more emotionally-driven. Storytelling and especially success stories were particularly prevalent. Photographs and storytelling through beneficiary testimonies is seen as a particularly effective way of communicating outcome performance to the public (Yang & Northcott, 2019). Much of this communication occurred in the annual reports, which were sometimes combined between hospitals and their foundations, blurring the lines of organisational boundaries in order to show a common front.

Consistent with the literature, organisations focused on 'individual outcome' (Hyndman & McConville, 2018) rather than societal outcomes as a means of demonstrating outcome performance. This can be seen as filling a communication void because it speaks to outcome performance, but without holding organisations accountable to specific performance metrics because it does not speak to outcome performance in any way that allows for comparisons over time or against a standard.

For instance, foundations and hospitals may struggle to establish a link between the purchase of a piece of equipment and the related outcome performance of patient health due to its indirect nature. To compensate, outcome performance may be communicated through storytelling because it resonates and gains the most traction with donors. Sharing stories helps organisations demonstrate the impact of past investments and the potential of future investments to purchase capital equipment and make a difference in the lives of the patients who will benefit from this equipment.

As the literature suggests, donors might have difficulty understanding quantitative measures, and so charities, such as foundations, rely on storytelling to convey performance (Connolly, Hyndman, & Liguori, 2018). Charities may also be reluctant to share quantitative results publicly, as it increases the risk of misinterpretation by the media (Connolly et al., 2018). While stories humanise health care, they also provide organisations with a way to avoid having to quantify their performance with the general public. In presenting information this way the Auditor General of Ontario criticised LHINs for a "lack of quantifiable targets" (Office of the Auditor General of Ontario, 2015, p.337).

These personal-level communications appear to be driven to build legitimacy and trust, and to a lesser extent, demonstrate performance. Consistent with findings of Hardy and Ballis (2013) who reported that account giving was refocused to develop commitment and loyalty around the organisation rather than to report organisational performance, highlighting "an account giving that is selective, partial and asymmetrical" (p.554). Such a strategy could be viewed as a form of impression management, such that the reporting of key facts was not undertaken in a systematic manner, but was instead timed to promote the organisations to their target audience in order to reduce any potential public criticism. This was occasionally apparent in the annual reports of health care organisations. As such, there appears to be evidence that some of the accountability communication at the personal-level attempted to control the message in order to persuade readers. While simplifying information may increase user usefulness by making the information more understandable, too much simplification may reduce information quality characteristics of faithful representation and comparability.

Conclusion

The complexity in managing accountability is aided by the proposed accountability system which helps clarify how nonprofit organisations could better operationalise their accountability management practices through stakeholder relationships, governance mechanisms and information strategies. The visual schematic of the accountability system could be used as a governance tool for organisational leaders. Based on the interviews conducted, there is interest from organisational leaders for such a framework. As such, a better understanding of how nonprofits manage their accountability systems should help improve practices and allow nonprofits to be more resilient in difficult times, use available resources more efficiently and effectively, and compete more effectively for scarce resources.

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