

Accountability and Health Systems: Overview, Framework, and Strategies

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- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

Improved accountability is often called for as an element in improving health system performance. At first glance, the notion of better accountability seems straightforward, but it contains a high degree of complexity. For accountability to serve effectively as an organizing principle for health systems reform, conceptual and analytical clarity is required. This paper elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. The role of health sector actors in accountability is reviewed. An accountability-mapping tool is proposed that identifies linkages among health sector actors and assesses capacity to demand and supply information. The paper describes three accountability-enhancing strategies: reducing abuse, assuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can: a) help to generate a system-wide perspective on health sector reform, and b) identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability.

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Executive Summary

Introduction

All health systems contain accountability relationships of different types, which function with varying degrees of success. Often it is the perception of failed or insufficient accountability that furnishes the impetus for reform. However, as a guide to what to do to improve health systems, simply calling for more accountability is not helpful. The idea of checks and restraints on power and discretion seems straightforward, but for accountability to inform action, further conceptual, analytical, and operational work needs to be done. This paper provides a framework and some guidance for filling this gap. Partners for Health Reform *plus* will use the concepts and framework to guide several case studies that will explore accountability issues. The paper addresses: definition and clarification of accountability, analytic framework for accountability and health service delivery systems, role of health sector actors in accountability, and accountability-strengthening strategies.

Defining Accountability

Despite its popularity, accountability is often ill-defined. The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions. Two types of questions can be asked: information provision and justification, what was done/spent and why? Sanctions constitute the other defining feature of accountability. These are usually equated with requirements and penalties embodied in laws and regulations, but sanctions can be thought of more broadly. They include, for example, professional codes of conduct, incentives such as market mechanisms, where accountability is enforced through the ability of service users to switch from low quality facilities to high ones. Other sanctions are public exposure or negative publicity. Self-policing among health care providers is an example of this type of sanction, where professional codes of conduct are used as the standard.

Defining accountability also relates to specifying accountability for what? Three general categories emerge: financial (the most commonly understood notion of accountability), performance, and political/democratic accountability. Financial accountability concerns tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. Performance accountability refers to demonstrating and accounting for performance in light of agreed-upon performance targets. Its focus is on services, outputs, and results. Political/democratic accountability has to do with the institutions, procedures, and mechanisms that ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens' interests, and responds to societal needs and concerns. The political process and elections are the main avenues for this type of accountability, but it also involves policy-making. A central concern here is equity, where an important government responsibility is to remedy health care market failures both through regulation and resource allocation.

Analytic Framework for Accountability and Health Systems

Applying the above classification to health services delivery develops a clearer picture of accountability issues. These can be assessed in terms of three purposes of accountability. The first and most fundamental is to control the misuse and abuse of public resources and/or authority. This relates directly to financial accountability. The second is to provide assurance that resources are used and authority is exercised according to appropriate and legal procedures, professional standards, and societal values. The third is to support improved service delivery and management through feedback and learning; the focus here is primarily on performance accountability. These three purposes overlap to some extent, but in some cases pursuit of one can lead to conflicts with the other. For example, accountability for control, with its focus on uncovering malfeasance and allocating “blame,” can conflict with accountability for improvement, which emphasizes managerial discretion and embracing error as a source of learning.

Achieving these accountability purposes faces numerous challenges. First, health services are characterized by strong asymmetries among providers, users, and oversight bodies in terms of information, expertise, and access. Second, public and private interests and incentives often diverge, which can limit efforts to increase accountability. Third, institutional capacity gaps often undermine efforts to enhance accountability for all three purposes.

Role of Health Sector Actors in Accountability

It is critical to identify and assess the various accountability roles that health sector actors play. Two questions emerge. First, who is accountable? Second, to whom are they accountable? The following actors can be identified: health service users/patients, ministry of health, agencies of restraint and enforcement, funding agencies, parliament, local government officials, non-governmental organizations, health councils and hospital boards, professional associations, unions, health care providers (facilities and individuals, public and private), and international donors.

Accountability-Enhancing Strategies

A systemic view of accountability highlights the interdependencies among health actors. An assessment matrix maps linkages and examines interactions. The matrix tracks the patterns of answerability and sanctions in terms of which actors demand information and impose sanctions, and which are charged with supplying information and are subject to sanctions. The table can indicate situations where there are either too few or too many accountability linkages. There is no universally “correct” number of accountability linkages. How many are appropriate will be situation-specific, and will depend upon the quality, not simply the number, of connections. The mapping exercise informs appraisal of actors’ capacity to fulfill accountability roles, helps to pinpoint gaps, and feeds into setting purposes and targets.

Accountability-enhancing strategies can focus on: reducing abuse, assuring compliance with procedures/standards, and improving performance/learning. In practice, efforts to increase accountability are likely to include more than one of these. Reducing abuse is both the “default” strategy and a pillar supporting the other two purposes; it focuses on containment of fraud, misuse, and corruption. Strategies for compliance with procedures/standards involve regulation, oversight, monitoring and reporting requirements. Sources of sanctions include the country’s legal framework and judicial system, administrative rules and operating procedures, markets and quasi-markets, professional norms and ethics, licensing and accreditation, and sociocultural values. Strategies for

improved performance/learning often include: clarifying chains of accountability to determine more precisely who is responsible for what, shortening the chains to make feedback on performance more direct and more timely, and/or making the chains more powerful to increase incentives for responsive performance. Strategies can select targets at three levels: the health system, facility, and/or individual service provider.

Conclusions

Increasing accountability is a key element in a wide variety of reforms, from government-wide anti-corruption campaigns, to national-level health system reform programs, to decentralized health service delivery at the local level, and community-based health funds. The accountability landscape is filled with a broad array of actors with multiple connections; these create layered webs of accountability with varying degrees of autonomy and sources of control/oversight. While the framework and analytic tools presented here cannot provide the specifics of answers for an individual reform effort, they can assist reformers to consider accountability from a systemic perspective and to be aware of the multiple connections involved. Field testing and fine-tuning of these tools can lead to sharper observations regarding accountability enhancement and its role in health sector operations and reform efforts.

1. Introduction

Around the world governments face pressures to provide health services effectively, efficiently and equitably. Reform and strengthening efforts in industrialized and developing/transitioning countries have adopted similar approaches to getting health systems to perform better: downsizing, privatization, partnerships, competition in service delivery, performance measurement and indicators, and citizen participation. All these approaches converge in emphasizing accountability as a core element in implementing health reform and improving system performance.

The current concern with accountability and health systems reflects several factors. First is dissatisfaction with health system performance. In industrialized countries, this has centered on cost issues, quality assurance, and access. In developing/transitioning countries, discontent has focused on these same issues, plus availability and equitable distribution of basic services, abuses of power, financial mismanagement and corruption, and lack of responsiveness. Policymakers and citizens want health care providers to exercise their responsibilities professionally and correctly according to regulations and norms, and with respect for patients. Second, accountability has taken on a high degree of importance because the specialized knowledge requirements, along with the size and scope of health care bureaucracies in both the public and private sectors, accord health system actors significant power to affect people's lives and well-being. Further, health care constitutes a major budgetary expenditure in all countries, and proper accounting for the use of these funds is a high priority.

All health systems contain accountability relationships of different types, which function with varying degrees of success. For example, health ministries, insurance agencies, public and private providers, legislatures, finance ministries, regulatory agencies, and service facility boards are all connected to each other in networks of control, oversight, cooperation, and reporting. Often it is the perception of failed or insufficient accountability that furnishes the impetus for change. This puts accountability front and center on the stage of current health system improvements. Strengthened accountability is widely called for as a remedy for health system weaknesses around the world.

This popularity is a plus for system reform because it can help to mobilize demand for change. Experience with policy reform, documented by the Partnerships for Health Reform Project (e.g., Gilson 1997, Gilson et al. 1999) and other USAID-funded analyses (Brinkerhoff and Crosby 2002), shows that demand-driven reforms are more successful and sustainable. However, as a guide to the specifics of what to do to improve health systems, simply calling for more accountability is less helpful. On the surface, the idea of checks and restraints on power and discretion seems straightforward, but in order for accountability to inform action, further conceptual, analytical, and operational work needs to be done. Often calls for more accountability are really efforts to change the focus and purpose of accountability, rather than simply to do "more of the same" (Romzek 2000: 35). Without sounder conceptual frameworks and more empirically-based recommendations, these nuances cannot be sorted out, and accountability risks becoming yet another buzzword in a long line of ineffectual quick fixes, or, worse, a one-size-fits-all bludgeon that encourages excess and overregulation.

2. Purpose of This Paper

This paper aims to lay the groundwork for investigating accountability as it relates to health systems reform. Partners for Health Reform *plus* (PHR*plus*) will use the concepts and framework that the paper develops to guide several case studies that will explore accountability issues. The analysis reviews and synthesizes the literature on the accountability theme, noting areas of convergence and of ongoing debate. The paper addresses the following topics:

- ▲ Definition and clarification of accountability. How can the term be more precisely defined and made more operationally relevant?
- ▲ Analytic framework for accountability and health service delivery systems. How can the various purposes and targets for accountability be structured to inform intervention design and reforms?
- ▲ Role of health sector actors in accountability. Who are the accountability actors in the health system? What are the roles of policymakers, service providers, financing bodies, the private sector, and non-governmental organizations (NGOs) with regard to accountability?
- ▲ Accountability-strengthening strategies. What are the linkages among accountability actors? How can accountability be improved? What strategies lead to which outcomes? What are the targets for accountability strategies?

The conclusions section notes that a focus on accountability can: a) help to generate a system-wide perspective on health sector reform, and b) identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability. A sharpened focus on accountability can help identify gaps in strengthening efforts and environmental constraints that extend beyond the health sector.

3. Defining Accountability

Despite its popularity, accountability is often ill-defined. For example, Mulgan (2000: 555) calls accountability a “complex and chameleon-like term.” As Schedler (1999: 13) notes, “accountability represents an underexplored concept whose meaning remains evasive [sic], whose boundaries are fuzzy, and whose internal structure is confusing.” General definitions of accountability include the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors.

3.1 Answerability and Sanctions

The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions (see Schedler 1999). Two types of accountability questions can be asked. The first type asks simply to be informed; this can include budget information and/or narrative description of activities or outputs. This type of question characterizes basic monitoring and implies a one-way transmission of information from the accountable actor(s) to the overseeing actor(s). In democratic governance terms, the informing aspect of answerability relates to transparency. The second type of question moves beyond reporting of facts and figures, and asks for explanations and justifications (reasons); that is, it inquires not just about what was done but why. Justification questions incorporate information transmission, but go beyond to dialogue between the accountable and the overseeing actors. This dialogue can take place in a range of venues, from internal to a particular agency (e.g., medical personnel answering to their hierarchical superiors), between agencies (e.g., facilities reporting to health insurance funds), to more public arenas (e.g., parliamentary hearings where health ministers answer to legislators, or community meetings where local health officials answer to residents). The justification aspect of answerability links to the World Health Organization’s (WHO’s) notion of “stewardship” in its contribution to government responsiveness and good governance (see Travis et al. 2002).

The availability and application of sanctions for illegal or inappropriate actions and behavior uncovered through answerability constitute the other defining element of accountability. The ability of the overseeing actor(s) to impose punishment on the accountable actor(s) for failures and transgressions gives “teeth” to accountability. Answerability without sanctions is generally considered to be weak accountability. Most people equate sanctions with requirements, standards, and penalties embodied in laws, statutes, and regulations. Legal sanctions are certainly at the core of enforcing accountability, but sanctions can be thought of more broadly. They include, for example, professional codes of conduct, which do not have the status of law. They also include an array of incentives that are intended to reward good behavior and action and deter bad behavior and action without necessarily involving recourse to legal enforcement. One category of such incentives relates to the use of market mechanisms for performance accountability. For example, if public health clinics are required to compete for clients on the basis of publicly available information on quality and performance, accountability is enforced through the ability of clients to switch from low quality/performing clinics to high quality/performing ones. The ability of health clinic users to hold clinics accountable by exercising their exit option creates incentives for responsiveness and service quality improvement (see, for example, Paul 1992). Health sector reform in many countries seeks to

establish these types of incentives. Another category of “softer” sanctions concerns public exposure or negative publicity. This creates incentives to avoid damage to the accountable actor’s reputation or status. For example, investigative panels, the media, and civil society watchdog organizations use these sanctions to hold government officials accountable for upholding ethical and human rights standards. Self-policing among health care providers is another example of the application of this type of sanction, where professional codes of conduct are used as the standard.

Sanctions without enforcement significantly diminish accountability. Lack of enforcement and/or selective enforcement undermine citizens’ confidence that government agencies are accountable and responsive, and contribute to the creation of a culture of impunity that can lead public officials to engage in corrupt practices. Enforcement mechanisms are critical, from broad legal and regulatory frameworks to internal agency monitoring systems. A lively debate regarding enforcement concerns the extent to which service delivery markets can be created such that accountability is automatically enforced when poor quality providers are eliminated as purchasers select higher quality, more entrepreneurial providers.¹ When actors turn to the legal system as the ultimate arbiter of enforcement, problems arise where the courts are subject to political influence or control, and the rule of law is not respected.

3.2 Accountability for What?

Defining accountability more precisely also relates to specifying accountability for what? Three general categories emerge from answering this question (see Brinkerhoff 2001). The first addresses the most commonly understood notion of accountability, financial accountability. The literature in this area deals with compliance with laws, rules, and regulations regarding financial control and management. The second type of accountability is for performance. The literature here is arguably the largest, encompassing public sector management reform, performance measurement and evaluation, and service delivery improvement.² The third category focuses on political/democratic accountability. Literature here ranges from theoretical and philosophical treatises on the relationship between the state and the citizen, to discussions of governance, increased citizen participation, equity issues, transparency and openness, responsiveness, and trust-building.

¹ In the governance literature, this debate is reflected in a concern that market mechanisms transform citizens into consumers. When service providers are responsive only to citizen-consumers who “vote” with their dollars, what happens to accountability to those with limited purchasing power? See Blanchard et al. (1997). Regarding the role of markets and the private sector in the health sector, the literature is extensive. See, for example, Appleby (1999) and Enthoven (1999) on the U.K.’s National Health Service. See Bennett et al. (1997) on private provision of services in the developing world.

² These reforms consist of a loosely bundled set of concepts drawn from the pioneering administrative change efforts in Australia, New Zealand, and the United Kingdom (the New Public Management or NPM), and later from the United States (the Reinventing Government movement). For an analytic overview of NPM, see Ferlie et al. (1996). On Reinventing Government, see Osborne and Gaebler (1992) and NPR (1996). Regarding the application of NPM in developing countries, see, for example, Polidano (1999). For a discussion of NPM in the health sector in developing countries, see Russell et al. (1999) and Shaw (1999).

3.2.1 Financial Accountability

Financial accountability concerns tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. The operational basis for financial accountability begins with internal agency financial systems that follow uniform accounting rules and standards. Beyond individual agency boundaries, finance ministries, and in some situations planning ministries, exercise oversight and control functions regarding line ministries and other executing agencies. Since many executing agencies contract with the private sector or with NGOs, these oversight and control functions extend to cover public procurement and contracting. Insurance fund agencies play a key role in financial accountability in health systems that pay providers for predetermined packages of basic services. Legislatures pass the budget law that becomes the basis for ministry spending targets, for which they are held accountable. Obviously, a critical issue for the viable functioning of financial accountability is the institutional capacity of the various public and private entities involved. For example, hospitals need to be able to account for the disposition of the funds they receive from various sources if they are to be granted higher degrees of autonomy.

3.2.2 Performance Accountability

Performance accountability refers to demonstrating and accounting for performance in light of agreed-upon performance targets. Its focus is on the services, outputs, and results of public agencies and programs. Performance accountability is linked to financial accountability in that the financial resources to be accounted for are intended to produce goods, services, and benefits for citizens, but it is distinct in that financial accountability's emphasis is on procedural compliance whereas performance accountability concentrates on results. For example, provider payment schemes that maximize efficiency, quality of care, equity, and consumer satisfaction demand strong financial and management information systems that can produce both financial and performance information. Performance accountability is connected to political/democratic accountability in that among the criteria for performance are responsiveness to citizens and achievement of service delivery targets that meet their needs and demands.

3.2.3 Political/Democratic Accountability

In essence, political/democratic accountability has to do with the institutions, procedures, and mechanisms that seek to ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns. The political process and elections are the main avenues for this type of accountability. In many countries, both developing and developed, health care issues often figure prominently in political campaigns. Building health facilities or providing affordable drugs can be attractive options for politicians in generating electoral support. Beyond elections, however, political/democratic accountability encompasses citizen expectations for how public officials act to formulate and implement policies, provide public goods and services, fulfill the public trust, and implement the social contract. Policy-making and service delivery relate to aggregating and representing citizens' interests, and responding to ongoing and emerging societal needs and concerns. A central concern here is the issue of equity. An important government responsibility is to remedy health care market failures both through regulation and resource allocation. Poor communities, rural

and urban, often suffer from lack of resources; even if government provides fiscal subsidies, facilities and caregivers are frequently scarce or nonexistent.

Political/democratic accountability also relates to building trust among citizens that government acts in accordance with agreed-upon standards of probity, ethics, integrity, and professional responsibility.³ These standards reflect national values and culture, and bring ethical, moral, and on occasion religious issues into the accountability equation at both agency and individual levels. For example, in some countries, caring for the sick is a religious duty, and in response health care providers feel an obligation to deliver services.

³ See Gilson (2003) on the role of trust and health systems.

4. Analytic Framework for Accountability and Health Systems

Applying the above classification of types of accountability to health services delivery will develop a clearer picture of what accountability issues emerge. These issues can then be assessed in terms of three purposes of accountability.⁴ The first purpose is to control the misuse and abuse of public resources and/or authority. This relates directly to financial accountability. The second is to provide assurance that resources are used and authority is exercised according to appropriate and legal procedures, professional standards, and societal values. This purpose applies to all three types of accountability. The third is to support and promote improved service delivery and management through feedback and learning; the focus here is primarily on performance accountability. These three purposes overlap to some extent, but in some cases pursuit of one can lead to conflicts with the other. Perhaps the most recognized tension is between accountability for control, with its focus on uncovering malfeasance and allocating “blame,” and accountability for improvement, which emphasizes discretion, embracing error as a source of learning, and positive incentives.

There are numerous challenges to achieving these accountability purposes in the health sector, as noted by a variety of observers. Among these are the following: First, health services are characterized by strong asymmetries among service providers, users, and oversight bodies in terms of information, expertise, and access to services. Regarding information, central oversight bodies can experience difficulties in monitoring provider performance since providers often control the necessary information (see, for example, Millar and McKevitt 2000). Concerning expertise, for example, service users “may be ignorant of treatments and medicines that could harm them, and thus need some form of protection” (Shaw 1999: 12). Regarding access, providers can exercise significant gatekeeper power, for example, determining who receives what care, despite official procedures. Health service users, especially the poor, are in a weak position to confront this power.

Second, there are often divergences between public and private interests and incentives, which can constrain efforts to increase accountability (see Bennett et al. 1997). For example, Shaw (1999: 12) notes that,

The public and private sector can be sharply distinguished in terms of the speed by which client feedback can affect production, performance, and job tenure. When services are underprovided or of poor quality in the public domain, negative client feedback often takes considerable time, through public opinion polls, media coverage, and eventual changes in political candidates and platforms via the voting process. All this implies a lagged process whereby public administration officials may be misinformed about client demands for some time.

⁴ The following discussion of purposes draws upon Aucoin and Heintzman (2000).

Because at least some components of the health system are likely to remain in the public sector regardless of the ambitiousness of privatization, feedback for accountability can never be as efficient as a fully private model.

Third, institutional capacity gaps often constrain or undermine efforts to increase accountability for all three purposes. The inability of health facilities to track and report on budgets, collection of fees, pharmaceutical purchases and supply inventories, vehicles and equipment, and so on limits possibilities for accountability for control and assurance purposes. It results in waste in the health system and can create fertile ground for corruption. Further, weak capacity to exercise oversight of facility and practitioner performance hampers efforts at accountability for the purpose of performance improvement. This capacity gap is aggravated by the difficulty in isolating the contributions of various health system actors to achieving performance goals.

Table 1 presents illustrative health system issues associated with the three types of accountability: financial, performance, and political/democratic. It then identifies the dominant purposes of accountability associated with these issues: controlling abuse, assuring conformity with standards and norms, and supporting improved performance/learning. This creates a framework for categorizing and taking stock of health system reforms in terms of accountability.

Table 1. Accountability Types, Purposes, and Health Service Delivery

Type of Accountability	Illustrative Health Service Delivery Issues	Dominant Purposes of Accountability
Financial	Cost accounting/budgeting for: Personnel Operations Pharmaceuticals/supplies Definition of basic benefits packages Contract oversight	<ul style="list-style-type: none"> ▲ Control and assurance are dominant. ▲ Focus is on compliance with prescribed input and procedural standards; cost control; resource efficiency measures; elimination of waste, fraud, and corruption.
Performance	Patient involvement in medical decision-making Quality of care Service provider behavior Regulation by professional bodies Contracting out	<ul style="list-style-type: none"> ▲ Assurance and improvement/learning are dominant. ▲ Assurance purpose emphasizes adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and values; and quality of care standards and audits. ▲ Improvement/learning purpose focuses on benchmarking, standard setting, quality management, operations research, monitoring and evaluation.
Political/democratic	Service delivery equity/fairness Transparency Responsiveness to citizens Service user trust Dispute resolution	<ul style="list-style-type: none"> ▲ Control and assurance purposes are emphasized. ▲ Control relates to citizen/voter satisfaction, use of taxpayer funds, addressing market failure and distribution of services (disadvantaged populations). ▲ Assurance focuses on principal-agent dynamics for oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values.

5. Role of Health Sector Actors in Accountability

To address accountability and health systems, it is critical to identify and assess the various roles that health sector actors play. Two questions emerge regarding health sector actors with a role in accountability relationships. First, who is accountable? In other words, which actors in the health system are answerable for their actions and behaviors, and are subject to accountability sanctions? Second, to whom are they accountable? That is, which actors have the power, authority, and right to ask for answers and explanations, to engage with the accountable parties in discussion of those answers and explanations, and to impose and enforce sanctions?

5.1 Health Service Users/Patients

Although health care beneficiaries and patients are central to service delivery, traditionally, health systems have not accorded them much of a role in accountability. As noted above, information and expertise asymmetries and the gatekeeper power of health care providers have limited health services users' ability to obtain and evaluate health services information. These limitations make it difficult for beneficiaries and patients to demand accountability, or to impose sanctions. In principle, democratic governance systems and decentralization open up the possibility of increased political accountability to the citizenry, both through the political process and through administrative procedures that are more transparent and responsive. Health care issues often figure prominently on political platforms, and thus to the extent that politicians make good on their electoral promises, beneficiaries may exercise some indirect sanctions on the health system via the ballot box. However, social, economic, and political factors are important in that differential access to power and influence plays an important role in determining which health service users politicians will listen to and in shaping which ones governments are more or less accountable to. In modern democracies, access to the legal system is an essential element in power and influence for accountability, where patients can pursue malpractice suits as a means to hold health providers accountable.

Many health system reforms seek to strengthen the role of health service users and patients in accountability, particularly for purposes of assurance (e.g., meeting standards) and of improving performance. The creation of health care markets through privatization and new provider payment schemes, which characterizes reforms in the United States and Commonwealth countries (Appleby 1999) as well as developing nations (Bennet et al. 1997, Shaw 1999), seeks to transform service users into customers. Customers can hold service providers accountable by exercising their options for either voice (expressing preferences, complaining) or exit (choosing another provider), thereby imposing sanctions that influence providers' incentives (Paul 1992). Similarly, efforts to increase users' participation at the community level also aim to expand the role they play in accountability relationships by transforming them from passive recipients of services to active, engaged shapers of policies and services, and in cases where the health system decentralizes and devolves some service

delivery functions to communities themselves, turning them into service co-producers and partners.⁵ Focus groups and client satisfaction surveys are some of the mechanisms that can be used to obtain the views of service users.

5.2 Ministry of Health

Clearly a country's ministry of health (MOH) is a central actor in accountability relationships, both in terms of holding health care providers accountable, and being accountable to other branches of government, and indirectly to citizens. The MOH can exercise oversight of a significant number of other actors: public sector health care providers at various levels (central, regional, local); private sector health care providers through regulatory monitoring and enforcement; budget, logistics, facility, and equipment management units; purchasing and contracting entities; policy, planning, regulatory, and quality assurance functions; and so on. This broad oversight mandate is in most cases accompanied by strong sanctions: the ability to hire, fire, and promote; the right to award or abrogate contracts; and the authority to set and enforce policy, regulatory, and performance standards. In many countries, the ability of the MOH to fulfill this mandate is limited, and thus health system reforms often focus on strengthening or building the organizational systems and procedures needed for the MOH to exercise its accountability functions effectively, and on devolving functions best fulfilled by other actors—in particular, separating payment from provision of services. For example, the WHO's concept of stewardship identifies ensuring accountability as one of the key domains for successful health systems and a major responsibility of the MOH as the primary policymaker and overseer of the health system (Travis et al. 2002).

As an entity that is by constitutional or statutory design part of the public sector, the MOH does not simply demand accountability, but is itself subject to a web of accountability requirements. The minister serves at the pleasure of the government in power, and in Westminster-style democracies is directly accountable to the parliament, and indirectly accountable to the public. Health system reforms that increase the MOH's accountability to external stakeholders include such things as: citizen charters (patients' bill of rights); increased transparency of various types of information on budgets, services, regulations, levels of performance, and achievement of targets; increased participation of consumer groups in MOH policy and planning bodies; and decentralization to bring MOH officials and service users in closer contact.

5.3 Agencies of Restraint and Enforcement

This category of actor includes the array of state entities that make up the institutional structure of checks and balances for all three types of accountability (financial, performance, and political/democratic). Among these entities are, for example: anti-corruption agencies, supreme audit institutions, constitutional courts, ombudsman offices, and law enforcement agencies (see Schedler 1999). These agencies need to function together to have impact, e.g., enforcement backed up by the power of an impartial judiciary. However, they are also linked to citizens in that a) they derive some of their power from the weight of public opinion, b) the information they make public informs citizens regarding agency performance or abuses, and c) they may rely to some degree upon citizen input to identify cases of performance failure or financial malfeasance. In health systems, such

⁵ See the various articles in Cornwall et al. (2000) for examples of community partnerships where increasing accountability through participation is an explicit objective.

agencies play a role in addressing issues of financial control, for example, corruption in the form of illegal trafficking in pharmaceuticals, extracting bribes to provide health care, skimming from user fee receipts, and so on. They also can play a role in accountability for performance in working with standard-setting entities, hearing complaints, or investigating and prosecuting allegations of malpractice, although this latter role is relatively minor in most developing countries. In Scotland the following agencies work together to review and report on performance, and to assure accountability: Audit Scotland, the Clinical Standards Board for Scotland, the Royal Colleges, the Scottish Health Advisor Service, and the Clinical Negligence and Other Risks Indemnity Scheme (Government of Scotland 2001). Similar entities can be found in some developing and transitioning countries.

5.4 Funding Agencies

Funding agencies are an important set of actors in health system accountability. In most developing countries the finance ministry provides sectoral entities with annual budget envelopes, which are usually arrived at through a budget forecasting and negotiation process. Funds are then disbursed against those targets (on a quarterly or monthly basis). Disbursements require the MOH to report on and account for funds spent, and in some cases, to make adjustments in forward spending plans.

In health systems where payment and provision are separate, and providers are reimbursed for services based on a capitation or other formula, the insurance fund agency becomes a key actor in accountability relationships. While the most obvious accountability role insurance funds play relates to financial control, these funds can strongly influence accountability for quality of care and other standards (assurance purposes), and performance accountability through the design and implementation of provider payment systems. These payment systems create incentives both for patients and providers that can have important impacts on health system performance and the achievement of health outcomes and equity (Maceira 1998). For example, in Thailand in 1990, a compulsory social insurance scheme put in place a system of main contractors (hospitals) and sub-contractors that led to increased competition among contractors and pushed contracting hospitals to introduce utilization reviews and monitoring of patient complaints. These changes led the contracting hospitals to be more accountable for performance and patient satisfaction (Yip et al. 2001).

Insurance fund agencies are themselves subject to accountability demands. Depending upon how they receive their funding, these agencies are answerable to finance ministries and courts of accounts, or in some cases to legislatures, boards of directors, or other oversight entities. They have a basic fiduciary responsibility to account for the monies they receive and disburse, but to the extent that the information systems they employ include data on service utilization patterns and so on, they may report on performance measures as well.

5.5 Parliament

Legislatures can play a role in health system accountability by virtue of their place in administrative chains of political/democratic accountability. This type of accountability flows from the MOH to the cabinet and the parliament, and through parliament, whose members are the duly elected representatives of the people, to the citizenry. This chain's links consist of the obligations of the minister to provide answers and explain administrative decisions; provide an accounting of the MOH's resource utilization, activities, and achievements; investigate and remedy deficiencies and problems; and, if required, resign. Legislatures can also play a role in issues of performance accountability, quality of care, and so on via oversight committees and hearings. To the extent that

health care issues figure on the political agenda, parliamentarians are more likely to engage in discussion and debate that can affect health systems and accountability. For example, public dissatisfaction in Western industrialized countries with managed care has provoked political debate on the tensions health care providers face between financial accountability to funders and the “bottom line,” and accountability to patients for quality care.

5.6 Local Government Officials

In decentralized governance systems, local authorities often have some responsibility for health services, either direct service provision, financing, or both (Mills 1994). Particularly in terms of decentralized health care financing, local governments are often key intermediaries between central authorities and local citizens, which can result in accountability tensions. Since most local governments’ tax base is dependent upon land and property taxes, which put limits on how much additional revenues can be raised, they depend upon central government transfers for health spending. The mixed funding can put local officials in the difficult position of being accountable to the center for planning and budgeting according to standardized norms and procedures and to local constituents for meeting their preferences and expectations.

A well-known example of successful health program collaboration between a central health agency and local governments is the case of the Health Agent Program in the state of Ceará in Brazil (Tendler 1997). In this program, the Ceará health department set and monitored hiring standards for community health workers, who were hired by the local municipalities to work with communities on preventive health. Success derived in part from the fact that

The state raised the community’s hopes about what to expect from its government, and then educated them precisely about what workers, supervisors, and mayors should be doing. This turned the community...into informed public monitors...consistent with...user-driven accountability (Tendler 1997: 43).

Another success factor identified was the emergence of trust and respect between the health workers and the community as the health workers became embedded in the community. As a result the health workers went above and beyond the job requirements to respond to community needs and desires.

5.7 Non-governmental Organizations

Non-governmental actors play an increasingly important role in health sector accountability. The reasons for this are varied: the rise in contracting out for health services delivery, increased numbers of public-private partnerships, and NGO participation in policy networks (see Cornwall et al. 2000). When NGOs are engaged in service delivery, the major focus is on financial and performance accountability. Cross-sectoral service delivery arrangements create ambiguities and possible conflicts for accountability since it is often not clear which actors are ultimately responsible for level of service, quality, and outcomes (see Edwards and Hulme 1996, Leazes 1997). A key source of ambiguity has to do with whether NGOs should be more accountable to the funders of services (that is, to government), or more accountable to service users (citizens). When NGOs are engaged in representing their constituents/members interests via watchdog activities, or lobbying and advocacy, then democratic/political accountability comes to the fore. This raises questions regarding the extent of representativeness and legitimacy of these actors vis à vis their constituents/members, and the legitimacy of their actions as perceived by government. It also introduces confusion into

accountability relationships because often NGOs simultaneously deliver services through grants or contracts with public agencies and engage in advocacy on behalf of constituents and service recipients.

Financial accountability issues can emerge within NGOs to the extent that they have responsibility for managing their members' money. For example, in community-based health insurance (CBHI) schemes, local communities collect funds, which are managed by local non-governmental insurance organizations that are then answerable to community members for the management of those funds, as well as to public health officials. The existence of strong accountability relationships reinforced by social norms and community values is a well-recognized factor in the success of CBHI (Schneider et al. 2001).

As a large amount of experience and analysis has shown, the extent to which public agencies are accountable to citizens depends, among other factors, upon how citizens are organized to exercise voice and advocacy. Without sufficient aggregation, individual citizens are unlikely to be in a position to push for accountability when health systems may be disinclined to be responsive. Thus, the role of civil society and NGOs comes to the fore, along with issues of their breadth, depth, representativeness, and capacity. The role of NGOs extends beyond interest aggregation and advocacy, though this is certainly an important one, which has received a lot of attention. NGOs are also critical for providing information on, and demystification of, health policies, regulations, and responsibilities so that citizens can become knowledgeable consumers of health services, as well as informed voters. As discussed above, the complexity and specialized technical content of medical and health issues are barriers to citizens' exercise of intelligent accountability, and NGOs can be critical to overcoming them. Here, NGOs often collaborate with the media to disseminate their message. Indeed, an active press is key to both generating and disseminating the information necessary for citizens to hold public health officials and agencies accountable.

5.8 Health Councils and Hospital Boards

These types of advisory and oversight bodies are a growing category of actor in health system governance and accountability. They are often the product of decentralization and privatization strategies and efforts to increase responsiveness of health facilities. Although the specifics vary by health system, councils and boards are constituted as statutory bodies with distinct legal identities. Councils, whether at district, provincial, country, or municipal levels, tend to have supervisory authority over boards, and thus become links in the accountability chain upwards to health ministries/departments and to legislatures.

Boards have responsibility for individual hospitals, undertaking strategic planning, providing fiduciary stewardship, monitoring performance and the achievement of targets, ensuring quality standards, appointing and appraising senior management, and engaging in constituency and community outreach. Boards are usually comprised of elected members, in general a mix of health care professionals, private businesspersons, and community representatives. In some cases certain categories of members can be appointed. The composition of the membership is an important variable in board effectiveness. Many health reforms seek to increase the number and role of nonprofessionals and community members on boards to expand representativeness and responsiveness (see, for example, NPPHCN 1998). Thus boards can have a key role in political/democratic accountability as well as financial and performance accountability.

5.9 Professional Associations

Particularly in health care, associations have an important role in accountability for assurance and performance improvement purposes. The medical profession has a long history of self-accountability through the Hippocratic tradition, standard setting, peer review, and accreditation. Professional associations, as definers and guarantors of effective medical practice, have an implied contract with society to hold their members accountable (see Cruess and Cruess 2000). To a certain extent, accountability relies upon shared values of technical expertise and altruistic commitment to provide quality care to assure that standards are being met and outcomes achieved. Because of the logistical difficulties of monitoring service delivery and the specialized knowledge required to assess quality, professional associations advocate for self-policing, arguing for trust in professional codes and in training and accreditation standards (see Emmanuel and Emmanuel 1996, Gilson 2003). For example, the nursing profession has a long history of self-monitoring for accountability and community service. In health systems in the United States and OECD nations, the state and professional associations collaborate in licensing health care providers. The state provides the legitimizing and legal basis for licensure, but the licensing body is under the control of the leadership of professional associations. In developing countries, professional associations' capacity to fulfill these roles is relatively limited, though growing in some countries.

5.10 Unions

In many countries, civil service unions and/or public health worker unions—doctors, nurses, etc.—are important actors with roles in accountability. In some cases they seek to fulfill functions similar to professional associations related to standard-setting. They often serve as a countervailing source of power vis à vis the MOH, challenging ministry rules and oversight. Related to performance accountability, unions tend to be a force for preserving the status quo and limiting accountability, frequently resisting efforts to increase monitoring, tie rewards to levels of performance, or involve community groups in oversight. For example in Zambia, the 1995 Health Services Act empowered hospital boards to hire and fire staff and to establish performance-based staff appraisal systems. The civil service union opposed these accountability measures and threatened a nationwide strike to shut down the health system, which caused the government to amend the 1995 Act in 1997 to limit the autonomy of boards regarding personnel decisions (Chilumbwa et al. 1999). Another example comes from Venezuela, where the power of labor unions is such that “[l]abor negotiations in the health sector have become a perverse and almost ritualized exercise between unequal forces” (Jaén and Paravisini 2001: 62-63). Unions are powerful stakeholders whose interests need to be taken into consideration for many health reforms to succeed. While often concerned with maintaining their autonomy and privileges, unions can potentially be engaged as allies when reformers can demonstrate the positive side of change.

5.11 Health Care Providers

Health care providers are, of course, key actors in health systems accountability. A major distinction can be made between individual providers (e.g., doctors, nurses, community health workers) and organizations or facilities that provide services (e.g., hospitals, family group practices, local health centers). Another important distinction is between public and private-sector providers. Providers are subject to a wide range of accountability demands from the other actors identified here. For individual providers, the organizations in which they operate create the immediate context for accountability where organizational procedures, rules, routines, and hierarchical relationships shape

the pressures and sanctions that hold providers to account and influence their behaviors. Beyond their immediate organizational settings, individual providers face accountability pressures from professional associations and licensing bodies to meet and maintain standards and values, from community groups to respond to their needs, and from individual patients to provide quality care. Organizations/facilities face similar accountability pressures, many of which are codified in regulatory frameworks that specify financing arrangements and reporting requirements, performance and quality targets and standards, and outcome/impact measures. Provider payment schemes, for example, establish both financial and performance accountability stipulations.

Public versus private (including NGO) providers confront some differences in accountability demands, although health system reforms that create public-sector markets for service delivery have narrowed those differences, subjecting public providers to hard budget constraints and performance targets. A major difference has to do with responsibility for service delivery to poor and underserved populations. Public health providers are, by and large, charged with the care of the poor and the indigent, and with offering services in areas, both rural and urban, where private providers are unavailable. In some cases, NGO providers also fill this niche (see above).

5.12 International Donors

Finally, there is a category of accountability actor that extends beyond national boundaries. Governments are also accountable to the international donor community, where, particularly for the multilateral development agencies, accountability is a core aspect of grants and loans, formalized in conditionalities. Donors fund health system reform efforts in developing countries to a large degree, and the reform components set targets that grantee/borrower governments become accountable for. Thus, pressures for health system accountability arise from the International Monetary Fund, World Bank, WHO, and various bilateral agencies such as USAID.

6. Accountability Strengthening Strategies

It is important to note that intervention designs and strategies for health-sector reform and system strengthening tend not to use accountability as the organizing theme. Rather, they focus on one or another aspect of health system reform, and treat accountability (if mentioned at all) as a secondary or corollary dimension. For example, there is a large body of literature on community participation in health services reform and delivery, some of which notes that among the rationales for, and results of, community participation is increased targeting of services on community needs and more accountability (see, for example, Cornwall et al. 2000). Another topic area where accountability issues are mentioned concerns health system governance and institutional structures: for example, national, district, and local health councils; hospital boards; medical review boards and professional certification bodies; decentralization; and so on (see, for example, Savage et al. 1997, NPPHCN 1998, Mills 1994, Gershberg 1998). In the health economics and financing literature, as noted above, accountability implications can be identified in the context of analyses of health care markets, principal-agent issues arising from information asymmetries, public-private mix, demand-driven services and user fees, priority-setting, and separation of payment from provision.⁶ Accountability also figures, sometimes implicitly, sometimes explicitly in the quality assurance/quality improvement literature.⁷

Because accountability is a common thread in health systems and in a variety of reform interventions, a focus on accountability can lead to an increased understanding of health system operations, better reform design and implementation, as well as increased integration of accountability into the system. A systemic view of accountability acknowledges and highlights the interdependencies among health actors. The following discussion of accountability-strengthening strategies illustrates a range of intervention options and targets the connections among them.

6.1 Mapping Accountability Linkages

Table 2 offers an assessment matrix to map accountability linkages and to examine actors' interactions. The table tracks the patterns of answerability and sanctions in terms of which actors are in a position to demand information and impose sanctions, and which actors are charged with supplying information and are subject to sanctions. The table can indicate situations where there are either too few or too many accountability linkages. Too few linkages can open the door to corruption, lack of responsiveness, poor quality services, and evasion of responsibility on the part of health service providers. On the other hand, too many linkages, particularly if they are distant or attenuated connections, can limit the effectiveness of accountability. When many actors, along with their differing interests, are involved, health service provision risks not being sufficiently accountable to

⁶ See, for example, the various chapters in Janovsky (1995). Numerous PHR documents cover these topics; see, for example, the list of applied research reports available at <www.PHRproject.com>.

⁷ See, for example, the materials developed by the USAID-funded Quality Assurance Project (<www.qaproject.org>).

anyone. There is no universally “correct” number of accountability linkages. How many linkages are appropriate will, to an important extent, be situation-specific, and will depend upon the quality, not simply the number, of connections.

Table 2. Health Sector Actors Accountability Matrix

Health Sector Actors		Demand information, impose sanctions												
		Health service users/patients	MOH	Agencies of restraint	Funding agencies	Parliament	Local govt officials	NGOs	Hospital boards	Health councils	Professional associations	Unions	Health care providers	International donors
Supply information, respond to sanctions	Health service users/patients	→												
	MOH		→											
	Agencies of restraint			→										
	Funding agencies				→									
	Parliament					→								
	Local govt officials						→							
	NGOs							→						
	Hospital boards								→					
	Health councils									→				
	Professional associations										→			
	Unions											→		
	Health care providers												→	
	International donors													→

Code:

Capacity to supply information and respond to sanctions: Weak →, Medium ⇄, Strong →

Capacity to demand information and impose sanctions: Weak ↓, Medium ⇄, Strong ↓

As the code for the table indicates, these supply and demand linkages can be rated as strong, medium, or weak. The downward arrows indicate capacity to demand information and impose sanctions. The horizontal arrows show capacity to supply information and respond to sanctions. Each box in the table may contain two arrows. Effective accountability systems will exhibit a high number of boxes with both downward and horizontal arrows, indicating that demand for information is adequately met by supply. For example, systems with a preponderance of downward arrows without corresponding horizontal ones suggest several possible problems: mistargeted accountability demand, inadequate response capacity, and/or disagreements over appropriate linkages.

These ratings seek to capture information on the capacity of the various actors to fulfill their accountability roles, the pattern of accountability relationships, and the relative strength or weakness

of the accountability chains that connect them. For example, health ministries may have a legal mandate for budgetary oversight of public health facilities' expenditure and collection of user fees, but in many countries their ability to exercise that accountability function is substantially limited (Russell et al. 1999). For a particular country, the matrix can be customized by including the specific array of actors in each of the categories, and/or by tracing the linkages for different types of accountability, e.g., financial versus service delivery performance.

The next steps include identification of problems/issues related to answerability and sanctions, and of which type(s) of accountability (financial, service delivery performance, political/democratic) is (are) involved. The mapping exercise informs appraisal of actors' capacity to fulfill accountability roles, helps to pinpoint gaps, and feeds into setting purposes and targets. When undertaken as a team effort, the mapping exercise can also serve to support the process dimension of achieving change targets. It can forge consensus among reform team members, as well as point to who else needs to be involved. Strategy implementation will depend upon tapping the shared interests of various actors to build coalitions, commitment, and mutual understanding. Clarifying actors' connections, capacities, and interests is a key input for developing strategies to strengthen accountability.

6.2 Developing Accountability-Enhancing Strategies

Accountability-enhancing strategies can be arrayed around the three accountability purposes discussed above: reducing abuse, assurance of compliance with procedures and standards, and improving performance/learning. In practice, efforts to increase accountability are likely to include more than one of these purposes.

6.2.1 Reducing Abuse

Reducing abuse is arguably both the "default" strategy and a pillar supporting the other two purposes; it focuses on containment of fraud, misuse, and corruption. It is a default strategy in the sense that if reformers do nothing else to address accountability gaps, at a minimum health sector resources need to be protected from corruption. It is a pillar for compliance with standards and performance improvement because without the basic levels of accountability that combat abuse it is impossible to distinguish between active efforts to engage in corrupt practices from management/operational systems weaknesses that contribute to health system inefficiency and ineffectiveness.⁸ In addition, if levels of corruption are high and corrupt practices are embedded in a country, they undermine efforts to achieve/maintain quality standards and increase accountability for service delivery performance.

Corruption is increasingly recognized as a problem for the health sector (Di Tella and Savedoff 2001, Vian 2002). Areas where increased accountability can help combat abuse include: contracting procedures, both for facilities construction and for service provision; pharmaceuticals purchasing, distribution, and prescription; collection and management of user fees; personnel management and informal activity of health workers, e.g., side payments, moonlighting, absenteeism. For example, in Chile, reform of pharmaceutical procurement increased accountability and transparency through the application of an electronic bidding system, decentralization of purchasing, and institutional

⁸ Lee et al. (n.d.) discuss the need to differentiate between waste and corruption problems in their paper on family planning programs in developing countries. Cohen and Montoya (2001) also make this point regarding pharmaceutical procurement.

restructuring of the previously centralized drug-purchasing agency. Corruption was reduced and the cost-effectiveness of pharmaceutical purchases increased (Cohen and Montoya 2001).

6.2.2 Assuring Compliance with Procedures and Standards

Accountability strategies that target compliance with procedures and standards involve regulation, oversight, monitoring and reporting requirements on the answerability side. Sources of sanctions include the country's legal framework and judicial system, administrative rules and operating procedures, markets and quasi-markets, professional norms and ethics, licensing and accreditation, and sociocultural values. For example in Egypt, the procedures developed for contracting with the Family Health Fund included incentives and sanctions through capitation payments and performance-based reimbursements that reward decreased patient waiting time and delivery of preventive care.⁹ Community participation in monitoring of service delivery is an often-used strategy to assure compliance with standards and to increase grassroots accountability. Pakistan's Family Health Project set up village health committees in Sindh Province, and in several villages the committees created "accountability/vigilance" committees to oversee the finances and operations of rural health facilities and report on problems (Khuwaja 2000).

Accountability for compliance faces the challenge of determining what the procedures and standards should be. At one end of the spectrum are legally and administratively established procedures that are relatively straightforward, particularly for financial accountability. Toward the other end of the spectrum are procedures and standards that require specialized technical expertise both to establish and to monitor, for example, quality of care standards. Issues here include the appropriateness of standards, capacity for standard setting and monitoring, and differing performance criteria among various stakeholders. Concerning the latter issue, the U.S. state of Oregon's effort to involve citizens in dialogue on prioritizing Medicaid health services is an example of setting standards in a way that marries technical expertise with service user perspectives on health priorities (Office of Technology Assessment 1992). Citizen input came from a telephone survey that provided weighted scores of various functional limitations and health states/symptoms, 12 public hearings where citizens groups and health care providers gave testimony, and 47 community meetings organized by an NGO to solicit perspectives on health and wellness values and preferences.¹⁰ In developing countries, similar, though less elaborate, forms of community participation involve the poor in setting standards and fixing priorities (see Cornwall et al. 2000).

6.2.3 Improving Performance/Learning

Accountability strategies intended to improve performance and promote learning often include the following elements: clarifying chains of accountability to determine more precisely who is responsible for what, shortening the chains to make feedback on performance more direct and more timely, and/or making the chains more powerful to increase incentives for responsive performance (e.g., the discipline of the market). There are many examples of these kinds of strategies, such as

⁹ See the descriptions and analyses of Egypt's health sector reform and PHR's technical assistance activities at <www.phrproject.com/country/egypt.htm>.

¹⁰ See Chapter 3 of Office of Technology Assessment (1992) for a detailed description of the process and methodology used to arrive at the list of 709 prioritized health services. Medicaid coverage was initially set to cover the first 587 conditions and associated treatments on the list.

increasing hospital autonomy so that facility performance is more directly tied to the actions of hospital managers. Patients' bills of rights and agency charters exemplify measures to specify provider responsibilities and performance expectations (e.g., Government of Scotland 2001). Various provider payment schemes seek to create monetary incentives for better performance and responsiveness to clients.

A major tension related to performance-focused accountability is the pull between allowing actors some degree of discretion to determine the best way to reach performance goals versus requiring actors to follow predetermined rules and modalities. For example, a study of the Irish health system found that service providers tended to reject the notion that they were accountable for performance outcomes, and managers as agents charged by the state with enforcement "are reluctant to regulate and evaluate professional service providers" (Millar and McKevitt 2000: 293).

Several methodological issues arise in thinking about performance-improving accountability strategies. One has to do with the setting of performance targets and their measurement. In general, these tasks are easier for service delivery, such as health care facilities, than for organizations, such as health ministries, whose outputs are policy-related and less tangible. It is also easier for service users to assess performance directly and to hold agencies accountable when the service provided is straightforward and concrete. As noted above, health service users may lack appropriate knowledge and expertise to determine service quality. Another issue has to do with shared accountability and attribution of responsibility (e.g., Barrados et al. 2000). For services and activities that cut across several government agencies or involve public-private partnerships, how to determine who has done what, and thus to ensure accountability is often unclear. For example, when health service delivery is contracted out to the private sector and/or NGOs, what happens to the locus of accountability? Besides interdependence in producing performance, there is also the question of how to deal with environmental factors beyond the control of individual organizations that may affect performance.

6.3 Accountability Targets

Accountability-enhancing strategies can select targets at three different levels: the health system, the facility, and/or the individual health service provider. System-level interventions would include national health reforms, for example, that reinforce and/or modify the regulatory framework, or that reassign functions among health sector actors, for example, establishing contracting for service delivery, separating payment from provision, or decentralization of pharmaceutical procurement. The introduction of market mechanisms and contracting models is a primary example of an intervention targeted at the system level.

Contracting models seek to address all three accountability-enhancing purposes. The transparent market framework for resource allocation helps to curb abuse and provides incentives for meeting prescribed procedures and standards. The introduction of competition-based private-sector incentives builds in motivation to improve performance. The specification of roles, responsibilities, and outputs that characterize contracting is an important facilitator of increased accountability (England 2000). However, it is important to note the gap between theory and practice in realizing the accountability and service delivery benefits of contracting (McPake and Mills 2000). The stewardship notion seeks to inject social and political values, especially attention to equitable distribution of services, into market mechanisms that use efficiency and effectiveness as the major accountability metric (see Saltman and Ferroussier-Davis 2000).

Accountability strategies for all three levels depend upon the availability of information. This is an area where government has a primary role; one of the hallmarks of democratic governance is information availability and transparency. Data on health needs, health status, health system resource use, and performance need to be available to stakeholders if accountability relationships are to be more than pro forma or empty exercises in oversight (see Bloom 2000). Thus governments' willingness and ability to generate and disseminate these categories of information are important variables. In this sense the degree of political/democratic accountability, which strongly influences that willingness and availability, is part of the enabling environment for health sector accountability enhancement.

At the facility level, development or strengthening of information systems are important accountability-enhancing interventions. These can include strengthening of financial management, patient tracking and case management, and procurement systems. For example, in Albania, lack of individualized patient charts, poor medical records, inadequate documentation, and insufficient information flows are significant impediments to increasing clinical quality assurance and performance accountability. Other, complementary interventions encompass new organizational mechanisms such as the village accountability/vigilance committees that monitor rural health facilities in Sindh Province in Pakistan (Khuwaja 2000), or the expansion of hospital boards in Capetown, South Africa to involve community representatives in hospital management (NPPHCN 1998). Providing greater autonomy to individual facilities, facility accreditation, and facility-based contracting are additional examples of interventions that can increase accountability. All of these tighten the feedback link between the actions of facility managers and outcomes. For example, in Rwanda, community-based health funds build accountability to local communities through the contracts that local health facilities sign with community councils. Capitation payments direct facility managers' attention to patient satisfaction and service quality (Schneider et al. 2001).

For individual service providers, reward and salary structures, employment status, plus staff supervision and reporting can have important impacts on accountability. The organizational setting in which providers function strongly conditions individual provider behaviors related to accountability. A study in Peru, for example, found significant differences among doctor absenteeism, propensity to perform unnecessary procedures, and performance accountability in hospitals managed by the ministry of health, the social security administration, and private facilities (Alcázar and Andrade 2001). In addition, as noted previously, attitudinal factors and professional norms and ethical or religious values can influence the extent to which individual health service providers feel accountable for the care they offer. Particularly where clients have limited power and voice to articulate their needs and demands, the likelihood of accountability to these weaker stakeholders remains low (see Bloom 2000). As Mills notes, "the quality and responsiveness to user needs of peripheral health services are likely to be crucially dependent on whether some sense of accountability of health workers to local people can be put in place" (2000: 511).

7. Conclusions

Increasing accountability is a key element in a wide variety of reforms, from government-wide anti-corruption campaigns, to national-level health system reform programs, to decentralized health service delivery at the local level, and community-based health funds. One of the main reasons why this range is so broad relates to the interconnections among the various types and purposes of accountability (see Table 1). Financial accountability quickly leads to performance issues, and these two combined have implications for political/democratic accountability. Accountability to curb abuse underlies accountability for purposes of adhering to standards and of improving performance.

As this paper has demonstrated, the accountability landscape is filled with a broad array of actors with multiple connections; in some cases these actors are both accountable to one set of actors while simultaneously exercising accountability with regard to another set (see Table 2). These connections create layered webs of accountability with varying degrees of autonomy and sources of control/oversight. For example, public providers, health ministries, finance ministries, parliamentary health committees, insurance agencies, and hospital boards are often linked. This leads to intervention strategy issues, such as the advantages or disadvantages of strengthening different nodes in the web. For instance, efforts to increase the power and autonomy of hospital boards to exercise expanded oversight may not be effective if the health minister is not subject to political accountability and can dismiss board members who displease him/her with impunity.

While the framework and analytic tools presented here cannot provide the specifics of answers for an individual reform effort, they can assist reformers to consider accountability from a systemic perspective and to be aware of the multiple connections involved. Such mapping and analysis can respond to calls for attention to “how best to regulate, supervise and monitor both public and private sector providers and how best to encourage them to act in the broader public interest” (Mills 1998: 511). Field application and fine-tuning of these tools can lead to sharper observations regarding accountability enhancement and its role in health sector operations and reform efforts.

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