EXECUTIVE SUMMARY

Increasingly, health services are delivered through mixed health systems in lower- and middle-income countries (LMICs). In many LMIC contexts, the private sector is an important source of health-related products and services for many people, including poor people and presents an important partner for universal health care (UHC). However, it will not self-regulate for UHC goals and requires stewardship. How accountable the health system is to citizens and consumers (which may include migrants and undocumented people) depends to a large extent on the degree of accountability between the public and private health sectors. In its place, a culture of mistrust and blame shifting may exist between sectors.

This paper considers accountability and its arrangements for health service delivery in the context of UHC. This work is intended to guide the efforts of the WHO Department for Health Systems Governance and Finance (HGF) and its Advisory Group on the Governance of the Private Sector for UHC. The paper drew on a short literature review, both academic and practice-oriented, on accountability and health service delivery. Primary data was collected through informant interviews with experts working on accountability, health sector governance and/or service delivery. The paper serves as an overview on the topic for WHO staff and member states; and as an input for the roadmap being prepared by the WHO expert committee on the private sector and service delivery.

Based on expert interviews, accountability gaps have been mapped to the following domains at a global level.

This is a discussion document commissioned by the World Health Organization and recommended by the Advisory Group on the Governance of the Private Sector to support the development of a WHO strategy.
Accountability gaps

- **Better diagnosis** - of the private sector and accountability environments in mixed health systems
- **Formalize and organize** – the private sector and sectoral engagement
- **Professionalism and ethics** - deepen conventions, norms and behaviors
- **Systems, not symptoms** – retool for systems level, retire tools that are inefficient or not effective
- **Data generation and use** – for correction, protection and empowerment

More detailed contextual diagnosis is needed at a country level to address accountability systems, and not just the symptoms of poor accountability. Irrespective of context, accountability cultures are needed. These require active entrepreneurs within global health and national health systems as well as the development of soft skills in negotiation, change management and good governance. Change is – or should be - a constant feature in efforts to strengthen accountability.

The following recommendations are put forth to the Advisory Group for consideration as part of the service delivery governance roadmap.

- Package learning and advice on how to design and implement accountability systems. Develop diagnostic tools for the private sector and accountability environments in mixed health systems.
- Support member states with the development of transformative accountability agendas, based upon social compacts between sectors, grounded in diagnosis and dialogue.
- Undertake research to understand the contextual factors that promote or hinder accountability environments in mixed health systems.

**INTRODUCTION**

Increasingly, health services are delivered through mixed health systems in LMICs (Patouillard, 2007). These systems, comprised of public and private sectors, are the product of interaction. While ‘sector’ is used to distinguish public from private orientation, in practice the private sector is less bounded and “generally large, poorly documented, and very heterogeneous” (Mackintosh, et al, 2016:1). It consists of both formal and informal providers ranging from drug shops to specialized hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Self-care interventions may also be cataloged as part of the private sector if models of self-care are provider-assisted and dependent on how the public sector interacts with or acknowledges these forms of care (WHO, 2019).

The private sector, in all its guises, may or may not be recognized by the public sector or included within its implementation network (Hellowell and O’Hanlon, 2018). However, private sector “economic and social patterning…is partly shaped by, and
interacts with, the organization and of the public sector in health care” (Mackintosh, et al, 2016:1). This can take a virtuous form, where competent health systems generate a “complementary, reasonable-quality private sector” (Mackintosh, et al, 2016:1); in contrast, the private sector may take on less scrupulous forms, if left unregulated. How accountable the health system is to citizens and consumers depends to a large extent on the degree of accountability between the public and private health sectors. In place of this, a culture of mistrust and ‘blame shifting’ may exist.

The private sector presents an important partner for UHC, if stewarded to do so. In many contexts, the private sector is an important source of health-related products and services for many people, including the poor (Patouillard, 2007; Grepin, 2014). However, the private sector will not self-regulate for these goals and requires stewardship as markets contain no mechanism for achieving equitable distribution – only non-market institutions can do this (Hellowell and O’Hanlon, 2018). This paper considers accountability and its arrangements for health service delivery in the context of Universal Health Care (UHC). This work is intended to guide the efforts of the WHO Department for Health Systems Governance and Finance (HGF) and its Advisory Group on the Governance of the Private Sector for UHC (herein referred to as the WHO Advisory Group). The paper serves as an overview on the topic for WHO staff and member states; and as an input for the roadmap being prepared by the WHO expert committee on the private sector and service delivery.

**METHODOLOGY**

This paper drew on secondary and primary data. Secondary data entailed a short literature review, both academic and practice-oriented, on accountability and health service delivery. Primary data was collected through informant interviews with experts working on accountability, health sector governance and/or service delivery. Interviews were conducted in October 2019. Annex 1 contains a list of experts interviewed. Where quoted, they have been referred to as “expert interview.”

**WHAT IS ACCOUNTABILITY, AND HOW DOES IT RELATE TO EFFORTS TO ACHIEVE UHC?**

There are various definitions of accountability in relation to the health sector. All share the principles of answerability (sometimes referred to as responsibility), liability and enforceability. In simple terms, accountability considers who is accountable to whom and for what - that ultimately “blame worthy individuals or organizations will be held accountable for their actions” (WHO, 2018). While this may appear straightforward, “there is confusion about what accountability is or isn’t, with many in the international health arena focused on social accountability...the soft outskirts of accountability” (Expert
There is also a tendency to view accountability as solely a health steward function, which may preclude recognition of oversight institutions that sit outside of traditional health systems. These include legislatures, supreme audit institutions, anti-corruption agencies and other bodies “charged with asking whether or not they [ministries of health] are in fact answerable, or calling them to account, for actions that they’ve taken” (Expert interview). This may also include actions not taken.

Within the health system, accountability is considered one of six sub-functions of stewardship (Box 1). Accountability, together with other sub-functions such as ‘tools for implementation’, seek to address “market failures common to health systems” as well as “potential public sector failure” (Travis, et al, 2002:4). The perception of failed or insufficient accountability may trigger other stewardship sub-functions, such as policy or organizational reform. Accountability, therefore, should not be looked at in isolation from other stewardship functions. Furthermore, an accountability lens may be helpful in generating a system-wide perspective on health sector reform as well as interconnections among individual improvement interventions (Brinkerhoff, 2003).

Stewardship encompasses the whole health system, including actors from the private and public sectors. National ministries of health are the “steward of stewards” (Travis, et al, 2002), in recognition that other arms of government, including devolved structures, have a role in stewarding the health system. Consumers may also seek services outside of the health system, such as through informal static, itinerant or digital dispensers of health products and services. These forms of care challenge traditional boundaries of health systems, precisely because they are often unbounded or unrecognized by stewards (self-care runs the risk of falling into this category).

There is no distinction by sector or actor in the outcomes of accountability. Health actors from both sectors should be accountable to the delivery of health care to improve or maintain health outcomes and avoid unnecessary or ineffective care; furthermore, as a normative system, the efforts of both sectors should establish a foundation of trust between consumer and health care provider, and be valued (Kruk, et al, 2018). These relations are characterized by asymmetries of power.

Box 1. Stewardship sub-functions

- Generation of intelligence
- Formulating strategic policy direction
- Ensuring tools for implementation: powers, incentives and sanctions
- Building coalitions / Building partnerships
- Ensuring a fit between policy objectives and organizational structure and culture
- Ensuring accountability

(Source: Travis, et al, 2002)

1Stewardship is sometimes more narrowly defined as governance and entails the wide range of functions carried out by governments as they seek to achieve national health policy objectives. [https://www.who.int/healthsystems/stewardship/en/](https://www.who.int/healthsystems/stewardship/en/) The stewardship sub-functions have been adopted by the WHO Advisory Group.
and information whereby consumers of health care services are reliant upon the professionalism and ethics of health actors and the institutions from which they seek care. In turn, health actors – from both sectors - must also trust the health system and may also suffer from asymmetries of power and information. In other words, they may not be empowered to act on their intent to improve or maintain health, to do no harm. Many governments are far from achieving these desired outcomes: only one-quarter of people in LMICs believe that their health systems work well, with poor-quality care a greater barrier to health outcomes than access (Kruk, et al, 2018).

Accountability may be further classified based on the ‘levers’ used to hold actors and organizations to account.

- Legal (or professional) accountability means that, as a professional, being able to accept accountability for one’s actions and being able to justify one’s actions: in other words, knowing when to and when not to do something (Cornock, 2014).
- Performance accountability concerns how the health system, or a health program delivers on its intentions based upon agreed-upon performance targets, in relation to services, outputs, and results (Brinkerhoff, 2003).
- Financial accountability refers to tracking and reporting on allocation, disbursement, and utilization of financial resources (Brinkerhoff, 2003); “the money trail helps to determine who is doing what to whom, when and how” (Hellowell and O’Hanlon, 2018).
- Social accountability refers to citizens’ efforts for meaningful collective engagement with public institutions in the provision of public goods (Joshi, 2017). This form of accountability seeks to empower and educate users to demand state obligated services, and support health-service actors to recognize and act on these demands (Joshi, 2017).
- Political/democratic accountability relates to 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” (Brinkerhoff, 2003: xi).

Accountability levers are reflective of the different forces that buttress an accountable environment. For example, ministries of health may seek to shape market forces so that these operate in the best interests of citizens.
and the health system. They also need to self-steward so government resources are optimized, and health actors, from both sectors, are empowered to deliver quality healthcare. Finally, democratic and political forces confer rights and obligations through the establishment of social and institutional arrangements for health, as part of the social contract with citizens. Ideally, governments through the political/democratic system would hold to account the performance of the whole market health system, and providers, both public and private, would be held to account for their performance in contributing to social goals (Expert interview). However, while a ‘forcefield quartet’ (Figure 1) of social/citizen, democratic/political, steward and market may suggest a clear accountability environment, in practice, there are “layered webs of accountability” (Brinkerhoff, 2003: xiii) within and between these forces. “It’s too simplistic to think of citizens only as part of civil society. Citizens are part of the state, as voters or recipients of government services. But citizens also play a role in the market as small producers and consumers” (Expert interview). Dual practice and provider moonlighting between the public and private sectors further blurs positions within an accountability environment.

All accountability forces need to be marshalled to achieve UHC. Marshalling necessitates stewardship, of both governmental and non-state actors, by establishing, promoting and supporting accountable relationships between actors (Howlett and Ramesh, 2014). However, while the World Bank and the WHO have identified governmental accountability as a pillar of UHC, accountability frameworks are often developed with only the public sector in mind (IAP, 2018). Additionally, non-state accountability actors may operate on one force, applying tools that respond to or marshal that force, without considering the wider accountability environment. As acknowledged through expert interviews, government and non-state actors are not always looking at accountability systemically, “often times it’s kind of plugging holes where we see problems” (Expert interview). There has also been a tendency to see private sector accountability as different to the public sector as, with government, “there are accountability relationships that people can understand and follow” (Expert interview). However, for accountability to work, standards and systems should be universal, supported through incentive regimes (via financing and regulation) that align private sector goals with social goals (Expert interview). Addressing one force of accountability, such as social accountability, should be viewed as complementary to, and not a substitute for, other forms of accountability (Kruk, 2018).

Taking a normative stance, the purpose of accountability should be to protect, correct and empower (as a counter frame to ‘answerability, liability and enforceability’). Foremost, regulation should protect consumers from unnecessary, ineffective or harmful care (Kruk, 2018). It should
facilitate access to quality care and optimize population and individual health outcomes. It should also ensure that the user experience of accessing care is a positive one as this fosters “confidence in the system, trust in health workers, and appropriate care uptake” (Kruk, 2018: e1201). Accountable care should also protect health workers, ensuring that they operate from safe care settings and are motivated through decent working conditions. Accountability should correct, both processes and systems of healthcare delivery, so that this is optimized (financial, performance and legal aspects of care). Finally, accountability should empower systems and health actors deliver quality services through the establishment of incentives and sanctions that “orchestrate and modulate” positive change (Hellowell and O’Hanlon, 2018).

“It’s really about getting those incentives, rules and regulations in place to have a win-win for all actors across the board and really align all incentives towards public health goals. So, that it’s in people’s interest, whether you’re making a profit or not, to contribute to public health goals” (Expert interview).

ROLE OF DIFFERENT ACTORS IN ACCOUNTABILITY

Private sector patterns and public sector authority have a bearing on accountability roles. The role of government as health steward and service provider is reflected in the ‘patterns and dynamics’ of the private sector. These are described in Table 1 and are based on the typologies of Mackintosh et al (2016).²

Table 1. Patterns of private and public sector health systems

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<tr>
<th>Accelerating private sector.</th>
<th>Complementary private sector.</th>
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<td>A deteriorating public sector accelerates growth of the private sector, both formal and informal providers as consumers lose trust in the public health system and “take their chances” with the private sector. The health system is characterized by poor quality and poor health outcomes as well as low entry costs into the market.</td>
<td>The role of the private sector is shaped by the role of the public sector. Strong government investment in the public sector and stewardship of health system creates complementary patterns of care, characterized by high(er) quality and good health outcomes. Entry into the market is regulated.</td>
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²Mackintosh et al define a fifth health system described as a “highly commercialised public sector under-going reform” however this is not widely prevalent and only China is given as an example.
In contexts where the government is not stewarding the private sector – or predominant parts of the private sector – it will be difficult to ascribe a role for private sector accountability to social goals. Rather, the private sector will have other forms of accountability (e.g. to consumers) but in a context of asymmetric information, these are unlikely to function optimally. Similarly, in contexts where there is weak stewardship and poor accountability within the public sector, it will be difficult for the government to demand accountability from the private sector. In contexts where citizens cannot mobilize or express voice, they will not be able to apply “countervailing power” (Joshi, 2017) on either the market or the state. An expert respondent equated an accountable environment with ‘herd immunity’, in which a sufficiently high proportion of health actors [both public and private] are answerable for their actions and held to account. If not, as in the case of an unchecked private sector and eroded public authority, unaccountable environments may prevail. “[Health] systems work because a large set of actors within these systems follow basic norms, basic professional norms, ethical norms. And so, if everybody stops doing that, these systems actually can’t cope” (Expert interview). What may be a realistic role in one setting may not be feasible in another and signal more broadly, the demise of a “system” and the legitimacy of government as steward. “Our starting point tends to be that the government has legitimacy as the steward of the health system because it is to some degree accountable to the population and you see that varies tremendously between different jurisdictions, different country settings. In some cases, you could say that is simply not the case, and nowhere is it the case that accountability is perfect” (Expert interview).

Private providers within these very mixed health systems can be stewarded for public health goals. To do so, requires an understanding of “key health characteristics, including the pattern of stratification of private sector use, the scale and accessibility of public provision, and the extent of
reliance of the poor on out-of-pocket payment” (Mackintosh, 2016: 8). Health systems that are inequitable and of poor or highly stratified quality, signal a weak accountability environment, “it is evident that where incentive and accountability regimes do not favor equitable, cost effective delivery of healthcare, we don’t tend to find equitable, cost effective health care” (Expert interview). Furthermore, evidence of a large, fragmented, unregulated private sector “may create an impossible accountability context” (Expert interview). For the private sector to play a role in public health goals, such as UHC, the structure of the market needs to be recognized, formalized and organized, “when fragmented, it’s just about impossible to do anything” (Expert interview). In these contexts, the role of professional associations as a representative-based trust mechanism, remain largely underutilized and may compensate for other forms of accountability (Bloom, et al, 2008).

Formal and informal roles, sometimes conceptualized as horizontal and vertical accountability, are necessary parts of an accountability environment. Horizontal accountability relates to institutional checks and balances, the “capacity of state institutions to check abuses by other public agencies and branches of government, or the requirement for agencies to report sideways” (World Bank, 2019: 1). Vertical accountability relates to the public or citizens’ ability to enforce standards of good performance on officials; this may be through enlisting horizontal accountability institutions (World Bank, 2019:2), such as Ombuds offices and parliamentary committees. The public – sometimes referred to as the third sector - can wield pressure “that comes from outside of formal institutions and include…a lot of informal mechanisms that put pressure on the formal accountability system” (Expert interview). Reliance on informal pressure is not “evidence of a broken system, it’s evidence of a functioning system” (Expert interview). However, over-reliance on one form of accountability over the other is unlikely to be effective and is more likely to be reflective of weak role execution, in which ‘checks and balances’ are circumvented (or to continue with the analogy, the herd is not immune).

Prevailing conventions and norms also play a role in how accountability roles are understood and executed. Accountability roles are reflective of social institutions and how the social contract operates within a given society. Simply put, some societies may be more conditioned to follow the rules, while others may be more conditioned to circumnavigate the rules. “There is a different cultural expectation in which you are going to comply with laws regardless of whether those laws are seen as legitimate. Some of it’s quite fundamental in terms of the way the social contract operates within society” (Expert interview). While all healthcare workers are conditioned to uphold the high standards and ethical behaviors exacted from the profession, when people don’t feel valued, are overworked or underpaid, “people look
for opportunities to justify breaking those norms” (Expert interview). Professional behaviors may also be countered by personal gain/gaming. Both situations can create a system in which basically “regular people do bad things…it may even be a system in which good people do bad things” (Expert interview). Systems can reproduce bad behaviors over time, to an extent that these become the prevailing conventions and norms. Given this, there is need to consider the temporality of accountability and not a snapshot, “because what has been going on has been eroding the capacity of the public sector to regulate the private sector for years and years and years” (Expert interview).

KEY ACCOUNTABILITY STRATEGIES

Accountability strategies can be categorized in three ways: government-directed, self-instituted and citizen-led (IAP, 2018). These strategies operate within the force-field of social/citizen, democratic/political, steward and market. Strategies require government to set “the rules of engagement and assert stewardship muscle” (Expert interview). This cannot be left to the market or to citizens. Simply put, governments must govern, set rules about “who gets what, where, when, and how” as well as the “symbolic resources that are the basis of legitimacy” (Lasswell, 1958 in Howlett and Ramesh, 2014).

- Government sets (or should set) the vision about what good care should look like, through the establishment of normative frameworks and guidelines for standards of care, access to care and the financing of care. This may be done as part of UHC and existing “openings at the political level” afforded through UHC. These openings provide opportunity to establish or reset the “social compact” (Expert interview). Government also needs to set the framework and tempo for progressive realization of UHC ambitions, “the how”. More than slogans, this should be underpinned by legislation, regulations and judicial normative oversight that reinforce the social compact, reduce abuse and assure compliance with procedures and standards. It is the responsibility of government to align the interests of the private sector, through regulation of their actions and behaviors, with the best interests of citizens and the state (LWV, 2011).

- Markets respond to the direction, tempo and rules of government. They perform better when there are rules that are reinforced, as this creates some element of predictability and uniformity within the market. “Everyone should know what they are working for...business hates uncertainty” (Expert interview). Government-direction determines the shape of the private sector in relation to who operates, how they operate, who is reached, what is offered and how it is offered. In the absence of a normative framework
and stewardship “muscle”, the private sector may self-institute organization into the market as a means of engaging government or reinforcing its legitimacy (or the legitimate parts of the market). Examples of this include voluntary membership in healthcare federations or professional associations as well as self-imposed peer review and benchmarking. While well intentioned, it is recognized that these forms are not enough on their own as they lack validation by independent sources (IAP, 2018).

- **Citizen-led strategies** may include the use of media as censure, civic action as redress, and consumer education and choice, in which citizens seek out information and quality health care – be it public or privately provided. Ombuds offices may be called upon by citizens to investigate and resolve complaints and their maladministration. Civil society and NGOs may work with citizens to formalize mechanisms for redress through the introduction of fora and tools that facilitate interaction between community members and health care providers as a means of exerting communal pressure on the system (examples include social audits and scorecards). However, often these approaches do not percolate upwards and remain peripheral to the “inner workings” of health systems (Expert interview).

Accountability strategies often enlist a range of tools and tactics. These are directed at different accountability levers and towards different accountability actors. Table 2 provides a non-exhaustive list of tools. Some tools are ubiquitous across LMICs, such as many

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<th>ACCOUNTABILITY LEVERS</th>
<th>TOOLS</th>
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<tr>
<td>Legal</td>
<td>Professional codes of conduct, registration in professional associations, accreditation, licensing and certification, legislation</td>
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<tr>
<td>Performance</td>
<td>National compacts, programmatic commitments and targets, annual reports, league tables, peer benchmarking, policies, standards, guidelines, steering committees or task forces, surveys, health management information systems, maternal death surveillance and response (MDSR) systems</td>
</tr>
<tr>
<td>Financial</td>
<td>Budgets and workplans, performance-based contracts, vouchers, public expenditure reviews, budget execution reports</td>
</tr>
<tr>
<td>Social</td>
<td>Media, social media, digital technologies, scorecards, social audits, feedback mechanisms, Ombuds office, health committees, health councils, participatory budgeting, budget literacy, citizen-generated data, surveys</td>
</tr>
<tr>
<td>Political/democratic</td>
<td>Elections, electoral platforms (i.e. UHC), service and patient rights’ charters, public participation, legislation, judicial review</td>
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Table 2. Accountability tools
of the listed performance and financial management tools. However, these have largely been developed for and applied to the public sector; as health systems have become more mixed, and governments have less control over or proximity to service delivery, these mechanisms have become less effective (Expert interview). Increasingly there has been more attention to strategic purchasing and the use of formal contracts as a “vehicle for reconstructing norms and ethics” however it is important to understand the nature of existing social contracts on which formal contracting is grafted (Bloom, et al 2008:2082). In some instances, there may be deliberate intention to out-source tools, for example, when governments contract-out accreditation to a third-party administrator (which will operate within an accountability framework set by government).

Some of the newer accountability ‘tools and tactics’ may not be set or recognized by government. In some instances, tools and tactics may be introduced through civil society actors, such as NGOs. Increasingly, these may operate in the digital space, through social media, or bespoke apps, designed to elicit information and feedback, from providers and consumers. It is sometimes unclear to whom and for whom these tools of trade serve. While it is acknowledged that many countries need to catch up on regulating the private sector after years of its largely unregulated growth (IAP, 2018), there is also a case to be made for catching up with novel tools of technology. These examples serve to reinforce that new technologies present both opportunities and risks for accountability environments and that the ‘tools and tactics’ of accountability require stewardship.

Accountability tools should be considered in aggregate, as part of integrated strategies. They should be grounded in contextual realities and work politically (Haloran, 2015). Accountability tools that work in one context may not in another. They may be technically sound, derived from best practice, have form, but lack substance. This is sometimes referred to as “isomorphic mimicry”, where governments adopt the form of functioning accountability mechanisms while failing to perform their actual functions (Andrews et al., 2012 in Haloran, 2015). Necessary elements

Box 2. Elements to strengthen accountability

- Analysis and mapping of accountability systems, and their underlying power dynamics
- Strategies that emphasize integrated approaches, both vertically and horizontally
- Strategic use of varied and complementary tactics
- Embedding learning and adaptation in organizational approaches
- Politically informed practice, that focuses on addressing and shifting power relations that underpin accountability

(Source: B. Haloran, 2015)
to strengthen accountability based on “emerging insights about more successful experiences” pick up on these issues as well as the importance of learning and adaptation (Box 2). Examples of accountability tools are considered singly for the purposes of illustration in Panel 1.

**Accountability strategies should work in concert, orchestrated and modulated by government.** Strategies based on a single tool or approach, and isolated from other efforts, do not work (Fox, 2014; Gaventa & McGee, 2013; in Haloran, 2015). Whether this is construed as vertical or horizontal, top down or bottom up, government is the central player – either potentially or actually – whether it chooses to play that role or not (Howlett and Ramesh, 2014). Within the context of mixed health systems, ideally governments set the accountability framework for health service delivery “where you have packages of regulatory and financing tools” (Expert interview). Simultaneously you have bottom up – citizen-led accountability “where patients are looking to serve their own best interests by seeking out information and seeking out the best providers that can best meet their needs” (Expert interview). Within a mixed health system, this combination “ought to lead to a situation in which we can be reasonably confident that high quality goods and services will be delivered” (Expert interview). This approach seeks to mobilize citizen-led sanctions as a counterweight to government mechanisms, through the exercise of voice (expressing preferences, complaining) or exit (choosing another provider) (Paul, 1992 in Brinkerhoff, 2003). However, in practice, exit may not be possible when there is lack of alternative provider for example and voice may favor the more articulate/vocal. Governments may also engage citizens and providers as shapers of policies and services, and in devolved contexts as service co-producers and partners (Paul, 1992 in Brinkerhoff, 2003). Interaction between actors and sectors, and a stake in the process, may improve compliance, “major policy decisions in any country should not be made without coordination, consultation with those who end up having to implement and those who have a stake in the matter” (Expert interview). While integrated strategies have produced more accountable health care environments, these remain more of a promise than effective practice in many LMIC contexts.

**ACCOUNTABILITY GAPS**

Based on expert interviews, the following accountability gaps have been mapped at a global level. More detailed contextual diagnosis is needed at a country level to address accountability systems, and not just the symptoms of poor accountability. Irrespective of context, accountability cultures are needed. These require “active entrepreneurs” within global health and national health systems as well as the development of soft skills in negotiation, change management and good governance. Change is – or should be - a constant feature in efforts...
to strengthen accountability (Haloran, 2015).

Gaps have been mapped against the following domains:
- Diagnosis - of the private sector and accountability environments in mixed health systems
- Formalize and organize – the private sector and sectoral engagement
- Professionalism and ethics - deepen conventions, norms and behaviors
- Systems, not symptoms – retool for systems level, retire tools that are inefficient or not effective
- Data generation and use – for correction, protection and empowerment

Better diagnosis – of the private sector and accountability environments in mixed health systems

As previously illustrated in Table 1, there is a complementary effect between sectors; this can be virtuous, where competency and accountability in the public sector beget competency and accountability in the private sector. This “ying-yang” effect led by government and shaped by accountability forces, can not be left to the happenstance of the market. Understanding the private-public mix in mixed health systems therefore is important, as “…the blanket acceptance that the private sector is always better, always more innovative is really, really impoverishing our ability to look beyond and to see nuances in what the private sector is” (Expert interview). Better contextual diagnosis of the private sector can be used to determine appropriate roles for private providers within the context of UHC and direct stewardship muscle to better shape markets for health. To do this, information is key to describing, measuring, and classifying the private sector. Several LMIC countries have started to diagnose the private sector but it needs to be taken an analytical step further to inform understanding of accountability environments. This form of diagnosis and analysis can be used to clarify chains of accountability, shorten chains to make feedback on performance more direct and timelier, and/or ‘power’ chains by increasing incentives for responsive performance (Brinkerhoff, 2003). It is foundational to other forms of accountability intervention and what is feasible in a given context. Tools from the Managing Markets for Health (MM4H) address accountability within the context of market reform and can guide diagnosis.

Formalize and organize – the private sector and sectoral engagement

Atomized relationships within the private sector divide up accountability relationships and loosen accountability chains. This may contribute to the aforementioned “impossible accountability environment.” It is premised that only if the private sector is organized/consolidated and engagement formalized, can it be stewarded for UHC. Supporting private SME actors to engage within the health system milieu is particularly needed so that they get a “fair shake” and can participate in UHC schemes.
As suggested by an expert respondent, there is need for “much more face time” to force “everyone to get together and talk even if they don’t want to”. Even if mechanisms are tokenistic at first, when used, they can evolve into more meaningful forums, “it’s still better to talk rather than not talk even if you feel like you’re not being heard” (Expert interview). Foundational to engagement is the development of a “common language and social compact”, founded in political commitment that health care quality matters (Kruk, et al, 2018). This foundation can be used to build better accountability tools, such as contracting so that these meet the needs of government, providers and citizens, “…how can we make sure that services provided under the contract reach our joint public health goals without putting a private sector entity in a disadvantage and in a way that they’re not able to have the funds needed to function?” (Expert interview). To do this, there is need to develop government soft skills of dialogue and negotiation, “the skills that we need in 21st century ministries of health” (Expert interview).

Professionalism and ethics - deepen conventions, norms and behaviors

Government should set standards (or support professional associations to do so), provide a compelling vision and rules of engagement for UHC that evoke the professionalism and ethics of the health sector. Rather than starting with gaps, “start with what you have in order to get what you have not”, by identifying examples of good, positive norms and rewarding, sharing and expanding them (Expert interview, quoting Moses Coady). To build cultures of accountability within the “DNA” of health systems, the role of quality improvement teams, professional associations, and peer benchmarking could be harnessed, and may be “far more effective at changing norms than demand driven citizen accountability” (Expert interview). There is opportunity to learn from practice, “about what policy makers or client governments do to establish effective professional associations that can champion the development and institutionalization of professional conventions, norms, behaviors and ethics” (Expert interview). This gap was also identified in the Lancet Commission on Quality, “health workers and their professional associations must redouble efforts to maintain and enforce high standards of practice to earn and keep the public’s trust” (Kruk, et al, 2018: e1242).

Systems, not symptoms – retool for systems level, retire tools that are inefficient or not effective

There is need to reorient donor funded work around accountability to focus more on systems, and less on symptoms. This body of work, often implemented by NGOs within the social accountability sphere, has contributed to a proliferation of micro-level efforts (Kruk, et al, 2018). These may drain resources and shift attention from investment in system-wide strategies and their implementation. Systemic efforts may require re-tooling or,
more likely, optimization of existing tools, and their institutionalization. As noted, calls for “more accountability” are often related to changing the focus and purpose of accountability, rather than simply to do “more of the same” (Romzek 2000 in Brinkerhoff, 2003). This may require greater intentionality to accountability by design within new or existing systems, programs and policies. These efforts should seek to apply the same accountability levers to the public and private sectors over the long-term, as these “take time, can be disruptive initially, but eventually start to function” (Expert interview).

Data generation and use – for correction, protection and empowerment

Irrespective of accountability strategy, tool or tactic, all require data. Only with the right data, of the right quality, used in the right way, can there be an accountable environment that protects, corrects and empowers, that is answerable, liable and enforceable. However, often there is a data lacuna when it comes to the private sector, with even basic information on the nature and number of private sector entities and their capacities, scarce (Kruk, et al, 2018). While there is more data available in the public sector often these are “incoherent…rarely actually used…and there’s usually too much information for anyone to absorb” (Expert interview). Even when data of the right quality is available, it may not be used for accountability due to “gaps in governance and coordination, resources and monitoring systems” that hinder analysis or action (Kruk, et al, 2018). In recognition of the data lacunae and “know-do” gap, there has been a call for fewer, but better, measures of health system quality for use at national and subnational levels (Kruk, et al, 2018). This information should be available to public and private sector actors as well as the general public, in a digestible form, using key metrics that matter, such as “health outcomes, people’s confidence in the system, system competence, and user experience along with measures of financial protection and equity” (Kruk, et al, 2018: e1197).

AREAS FOR THE ADVISORY COMMITTEE TO CONSIDER AS PART OF THE ROADMAP ON SERVICE DELIVERY GOVERNANCE

The promise of UHC will not be achieved without more accountable health systems. These require foundational relationships between public and private sector actors as well as citizens and consumers of health services. While stewardship muscle is needed, strategies that leverage other accountability forces and reinforce accountable relationships are equally needed. UHC schemes offer opportunity for ministries of health to redesign accountability into health systems and close data and know-do gaps.

Areas for the committee to consider have been derived from the
accountability mapping and expert interviews and set out an agenda for the service delivery governance roadmap.

• **Provide normative guidance for accountability systems.** Package learning and advice on how to design and implement accountability systems. Develop diagnostic tools for the private sector and accountability environments in mixed health systems (this may include the development of an accountability module in the MM4H course).

• **Support member states to apply normative guidance for accountability systems.** Support member states with the development of transformative accountability agendas and change management practices. This should be based upon social compacts between sectors, grounded in good diagnosis and constructive dialogue.

• **Address knowledge lacunas.** Undertake research to understand the contextual factors that promote or hinder accountability environments in mixed health systems. Questions to consider include:
  - **How can accountable environments be strengthened in contexts of weak stewardship and an unregulated private sector?** How can improved diagnostics and data be used to manage markets for health?
  - **How can prevailing conventions and norms be reoriented to uphold accountable environments?** How do we professionalize and reinforce good behaviors and underlying incentive structures?
  - **How can we build stewardship muscle that can adapt and flex to the market and direct change?** How do we develop the soft skills of dialogue and negotiation between sectors?
  - **What challenges and opportunities do novel service delivery models, such as digital health and self-care, pose for stewardship and accountability environments?**
  - **How can good practices be shared and diffused between and within accountability actors and contexts?**
Panel 1. Examples of accountability tools, what works and what does not

Regulation is a critical - non-negotiable - mechanism for health service accountability. Regulation entails a “spectrum of rules, procedures, laws, decrees, codes of conduct, standards” that guide a health system (Travis, et al, 2002). These require active stewardship. Active stewardship entails analysis on whether appropriate tools and rules exist, are used, and are contributing to health system goals (Travis, et al, 2002). There are several ways to approach an effective regulatory framework. There is also an argument to be made of doing less, well, in line with the Pareto principle, by focusing on the vital few (20%) to get 80% of the result. This may entail regulation of common market failures to address asymmetric information between patient and provider, or provider and purchaser. It may also focus on the ease in which private sector enters and exists the market. Another approach may be to focus health system goals, and address problems of behavioral alignment of actors towards those goals (Travis, et al, 2002). Governments need to strike the right balance between too much and too little regulation (IAP, 2018), since over-regulation may reduce compliance and depress private sector engagement.

Discretionary use of regulatory tools may result in their being wielded unaccountably by regulatory actors. Tools may be applied more rigidly in the private sector as compared to the public sector, or with different cadres of private provider, based on qualification, age, gender, location and facility type. In particular, the small to medium enterprise (SME) private sector, entailing nurse and midwife run maternity homes and clinics for example, may be discriminated against, “probably many of them don’t get a fair shake because health systems are plagued with cronyism and the closer to the ground and the less power and influence you have, the less of a fair shake you’re going to get” (Expert interview). SME providers often have greater congruence with public health goals as they offer primary health care and serve poorer, more rural communities, in many contexts. However, these providers may experience the greatest barriers to participation in government UHC schemes (Suchman, et al, 2018; Appleford, 2019).

Purchasing levers may offer opportunity for reinforcing regulation and organization within the health system. Tracking the flow of funds is considered one of the most reliable mechanisms to monitor performance as well as ensure accountability (Salamon, 2002 in Hellowell and O’Hanlon, 2018). UHC schemes allow government to redefine its role as purchaser of services and develop its capacity for contracting the private sector. This has several advantages over direct public sector provision: contracted providers may be held to a higher level of accountability, as governments are likely to be more objective in evaluating the work of contracted providers than in evaluating their own
A contract allows the government to shift its role from the provision of health care to the tasks of stewardship, such as financing health care, monitoring provider performance and consumer protection. This shift from passive to more strategic purchasing entails the “continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom” (RESYST, 2014). It is viewed as a means of improving quality and efficiency, however, poor targeting, inadequate use of evidence, and fragmented financing may continue to reduce the efficiency of such investments (Lie, et al, 2015). This is not immutable and is likely to improve over time as stewards gain skills in strategic purchasing.

A fragmented private sector limits engagement with the public sector and the effectiveness of market-directed accountability mechanisms. As the literature and expert respondents noted, a large, fragmented private sector can create an impossible accountability environment; some of these were described in Table 1 and included scenarios of an accelerating, tiered or socially stratified private sector. Public-private collaboration for UHC and better “market shaping” requires organization of providers and formalization of engagement mechanisms. For example, government can orchestrate the shape of the market through mechanisms such as accreditation, licensing and certification, as a means of ensuring minimum entry requirements (in terms of qualifications, infrastructure, etc.). These are often pre-requisites for private sector participation in UHC schemes, such as national health insurance or results-based financing initiatives. In some contexts, private providers may organize themselves, as a means of engaging with and shaping government policy and purchasing initiatives. An organized sector and formalized engagement may create an environment where there is better understanding of policy intent, its acceptance and implementation in practice (Hellowell and O’Hanlon, 2018). Formal communication channels may also act as mitigation mechanisms for managing conflicts and troubleshooting problems as they arise (Hellowell and O’Hanlon, 2018). In contrast, informal channels may not offer recourse for either party and may suffer from elite capture and cronyism (Expert interview).

Accountability mechanisms at service delivery level may not induce systems level changes. There is a tendency for social accountability mechanisms, to operate at the service delivery level, with no horizontal accountability ‘systems’ anchor to regulation or purchasing mechanisms. While social accountability has its roots in citizen activism in response to a lack of political accountability, increasingly these approaches may take the form of non-confrontational ‘widgets’ (examples are included in Table 2) as opposed to organic political processes (Joshi, 2017). This may be considered another example of isomorphic mimicry, or form over substance. The evidence suggests that success in social accountability has been “limited, local, and not always sustainable largely due to the prevalence of tool based, apolitical, and decontextualized approaches over strategic ones” (Joshi, 2017:162).
Singular interventions may attract their own accountability problems through elite capture. Examples include health committees and health councils, which may “reinforce local discriminatory structures or local power structures where the marginalized still get left behind locally and where the local elite basically just get more power” (Expert interview). Service delivery deficits may also be reflective of accountability ‘problems’ being devolved from higher to lower levels of the system. It may result in “squeezing the balloon” (Haloran, 2015), where local authorities blame other actors, arms of government or the private sector and thus avoid responsibility. This reinforces the importance of strategic use of varied and complementary tools and tactics, based on understanding of vertical and horizontal lines of accountability.

**Political slogans the and use of accountability tools apolitically may belie poor accountability environments.** Maternal mortality is considered a highly politicized indicator of the performance of health systems within and between countries and is reflective of gender equality and women’s status more generally. Redress has prompted political attention and slogans - *no mother should die while giving birth* – in many LMIC contexts. The WHO and other international organizations have promoted maternal death surveillance and response (MDSR) as a tool to increase accountability for maternal health in high burden maternal mortality contexts. This tool builds from the three-delay model: delay in seeking care; delay in reaching a health facility; and, delay in receiving appropriate care at a health facility. Both MDSR and the three-delays model are intended to guide accountable action to improve the quality of pregnancy and birth care.

The ‘practiced norms’ of the MDSR however, may reflect a lack of trust between health actors and unclear accountability environments. Health worker and managers may fear legal accountability for maternal deaths through implementation of MDSR, a performance accountability tool. A study by Melberg et la (2019) showed that accountability fears, in this instance personal and political, strongly influenced MDSR reporting practices as well as clinical care decisions (accountability to women and communities was not mentioned). Health workers and their managers resorted to minimizing the number of maternal deaths recorded, with only 10% of the expected number of deaths reported (Melberg, 2019). They also deflected responsibility for adverse outcomes to the first and second delays – decisions to seek and reach care – as well as infrastructural factors beyond their control (Melberg, 2019). Fear of reprisal from the ‘political hierarchy’ and higher levels of the health system pervaded decisions to refer patients, so that their deaths would be attributed to other facilities or ambulatory care (Melberg, 2019). For the aggrieved, recourse to judicial review was mentioned but not acted upon. The study concluded that while political commitment is needed for the implementation of maternal health policy and a MDSR system, the broader political culture influences practiced norms of implementation, and ultimately effectiveness to protect, correct and empower health actors.³

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³Of interest, the study was well received by a professional association, which provided feedback and an opportunity to present study findings as part of their annual conference, suggesting professional interest in remedy.
## ANNEX 1

### EXPERT INTERVIEWS

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ABOUT THE PROJECT

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Additional documents in this series include the following:

- International Organizations and the Engagement of Private Healthcare Providers
- Measuring the Size of the Private Sector: Metrics and Recommendations
- Principles for Engaging the Private Sector in Universal Health Coverage
- Private Sector Utilization: Insights from Standard Survey Data
- Engaging the Private Health Sector to Advance Universal Health Coverage: WHO Eastern Mediterranean Region Case Study

The Advisory Group on the Governance of the Private Sector for UHC was convened in February of 2019 to act as an advisory body to the WHO about developing and implementing governance and regulatory arrangements for managing private sector service delivery for UHC. The group was formed with the primary goal of providing advice and recommendations on the regulation and engagement with the private sector in the context of the WHO GPW goal of 1 billion more people benefiting from Universal Health Coverage, and in particular outcome 1.1.4 of this goal – “Countries enabled to ensure effective health governance”. Members of the Advisory Group include: Dr. Gerald Bloom, Mr. Luke Boddam-Whetham, Ms. Nikki Charman, Dr. Mostafa Hunter, Mrs. Robinah Kaitiritimba, Dr. Dominic Montagu, Dr. Samwel Ogillo, Ms. Barbara O’Hanlon, Dr. Madhukar Pai, Dr. Venkat Raman, and Dr. Tryphine Zulu.

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