World Health Organization

REGIONAL OFFICE FOR **Europe**

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Accountability for coordinated/ integrated health services delivery

Working Paper

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ABSTRACT

Accountability is an essential governance tool defining relationships, roles and responsibilities pertaining to the actors involved, ensuring that the resources necessary to perform those roles are available and that performance is measured and evaluated. This document explores how accountability can support coordinated/integrated health services delivery.

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Abbreviations

CEO	Chief executive officer
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes for Health Research
CIHSD	Coordinated/Integrated Health Services Delivery
CQC	Care Quality Commission
GAP	Global Accountability Framework
GP	General Practitioner
NHS	National health system
NICE	National Institute for Clinical Excellence
OECD	Organisation for Economic Co-operation and Development
PAM	Patient Activation Measure
POET	Personal outcomes evaluation tool
PROMs	Patient-reported outcome measures
WHO	World Health Organization

Preface

In 2012, Member States of the WHO European endorsed the European health policy *Health 2020*, recognizing health system strengthening as one of four priority action areas in setting out a course of action for achieving the Region's greatest health potential by year 2020[1].

The vision put forward by Health 2020 calls for people-centred health system. In doing so, it extends the same principles as first set out in the health for all and primary health care agenda, reorienting health systems to give priority to areas including disease prevention, continual quality improvement and integrated services delivery.

The importance weighted to health system strengthening is also made explicit globally in WHO's 12th General Programme of Work for the period between 2014 to 2019, with a priority technical cluster specifically concentrated on the organization of integrated services delivery as positioned in the interim global strategy for people-centred and integrated health services[2].

In line with these priorities, strategic entry points over the 2015-2020 period have been further delineated in two priority areas: (1) transforming health services to meet the health challenges of the 21st century and (2) moving towards universal coverage for a Europe free of catastrophic out-of-pocket payments[3].

This document contributes to taking the first of these priorities further. It is set in the context of developing an overarching Regional Framework for Action for Coordinated/Integrated Health Services Delivery. Launched in late-2013[4], the Framework aims to support Member States in transforming health services delivery by adopting a results-focused, action-oriented approach relying on health systems thinking to identify key entry points for taking action.

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[1] WHO Regional Office for Europe. (2012). Health 2020: A European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe.
[2] WHO. (2015). WHO global strategy on people-centred and integrated health services. Interim report. Geneva: World Health Organization.
[3] WHO Regional Office for Europe. (2015). Priorities for health system strengthening in the European Region 2015-2020: walking the talk on people centredness. Copenhagen: WHO Regional Office for Europe.
[4] WHO Regional Office for Europe. (2013). Strengthening people-centred health systems in the WHO European Region: a roadmap. Copenhagen: WHO Regional Office for Europe.

1. Accountability for CIHSD

Governance and accountability

The World Health Organization (WHO) has recognized the importance of governance for the responsible management of the well-being of the population and has included governance in its framework for strengthening health systems (Barbazza and Tello 2014, WHO 2008). Even though a consistent definition and measurement of governance is lacking, various authors stress the importance of governance as a critical instrument to strengthen public and institutional performance (Van Kersbergen and Van Waarden 2004, Chhotray and Stoker 2009) and accountability as one of its key levers for successful performance improvement (George 2003, Brinkerhoff 2004, Hammer et al. 2007, Lewis and Pettersson 2009).

In the WHO European Region, the adoption of the guiding policy framework, Health 2020, has prioritized improving leadership and participatory governance for health as one of two main strategic objectives towards improved health and well-being of populations. In doing so, whole-of-government and whole-of-society approaches have been called upon for equitable improvements in health (Kickbush and Gleicher, 2012) and are considered here as the necessary governance conditions to underpin coordinated/integrated health services delivery.

To this end, accountability is an essential governance tool. This is true to its characterization as "setting out a framework and making explicit the ways in which actors of the health system are expected to perform and interact" (Barbazza and Tello 2014, p7). By defining accountability relationships and the roles and responsibilities pertaining to the actors involved, ensuring that the resources necessary to perform those roles are available and that performance is measured and evaluated, overall accountability in the system can be strengthened and improved (Baez-Camargo 2011). These elements of accountability are referred to also in the literature as being crucial for successful implementation of CIHSD. Strengthening the coordination and integration of health services delivery requires strategic policy frameworks and top-down policy support is key to create sustainability for bottom-up, locally contextualised CIHSD initiatives (Borgonovi and Compagni 2013, Goodwin 2002, Kickbusch and Behrendt 2013, Kickbusch and Gleicher 2012, Maslin-Prothero and Bennion, 2010, Suter et al. 2009, Stein 2010, Williams and Sullivan 2009).

Figure 1. Scope of Intersectoral governance, system governance and accountability for CIHSD
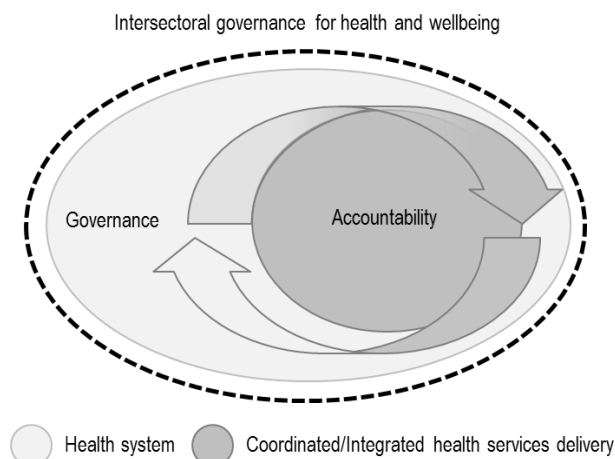
Source: Editor's own. Adapted from: WHO Regional Office for Europe. (Forthcoming). A concept note on health services delivery. Copenhagen: WHO Regional Office for Europe.

From the multiple functions pertaining to governance, this paper focuses on accountability for CIHSD.

Definition of accountability

Accountability means being answerable to someone for decisions and actions. Despite variations in definition and conceptualization of accountability (Brinkerhoff 2003, Deber 2014, Maybin et al. 2011), there are several common principles:

- Accountability in health services delivery is predicated on *relationships* between the ones making the decisions and those affected by them. (Ebrahim 2003, Fooks and Maslove 2004, Maybin et al. 2011).
- A *set of goals or objectives* must be defined including *clear explanation of roles and responsibilities* of each party in achieving the goals. (Denis 2014).
- The accountability relationship is governed by the *ability to measure and monitor* if these objectives or goals are being met. (Denis 2014, Morris and Zelmer 2005, Smith, Mossialos and Papanicolas 2008).

Failure to meet the goals and objectives will trigger consequences such as formal or informal sanctioning (e.g. negative publicity). Sanctions without enforcement diminish accountability and undermine the public's confidence in agencies and government. (Brinkerhoff 2004, George 2003)

Accountability can be difficult to achieve and failed or insufficient accountability often drives health system reform (Brinkerhoff 2004, Deber 2014, Ebrahim 2003, Maybin et al. 2011, Task Team 2013). On the other hand, focusing on accountability can increase our understanding of health system operations and lead to better system design (Brinkerhoff 2004).

Accountability for CIHSD

Health is not the sole responsibility of the health system and health services are increasingly organized in decentralized structures responsible for resourcing, financing and delivering care (Barbazza and Tello, 2014, Kickbusch and Gleicher 2012). This means that within the context of CIHSD, accountability constitutes a complex web involving many actors across sectors (Canadian Healthcare Association 2004, Kickbusch and Behrendt 2013). Key players are different levels of government including the ministries (health, finance, social care, education), public and private service delivery organizations, regulatory bodies and agencies, service providers and the people/service recipients who are linked through networks of control, oversight, cooperation and reporting. Cross-sectoral service arrangements create ambiguous accountability relationships and potential conflicts as it is not always clear who is responsible for levels of service, quality and outcomes (Brinkerhoff 2004, Canadian Healthcare Association 2004, Deber 2014, Fooks and Maslove 2004, Kickbusch and Behrendt 2013, Maybin et al. 2011). Moreover, inter-organizational coordination and accountability is an ongoing challenge (Canadian Healthcare Association 2004). Thus, failed accountability has been a big impetus for change and health systems improvement (Brinkerhoff 2003, Flood and Archibald 2005). CIHSD requires an integrated view of accountability that acknowledges the multidimensional and complex relational nature of work (Ebrahim 2003).

From the people's perspective, using accountability mechanisms to enable CIHSD has two key strands (Flood and Archibald 2005):

- Firstly, there is the potential for public involvement in planning needs-based services that respond to people's priorities and preferences
- secondly, there is a key role for people in monitoring system quality and performance, including reporting on people's experiences in the health system.

Meaningful engagement in both strands of accountability requires clearly articulated structures and processes for engagement and high levels of transparency about the way people's perspectives are used to inform both planning and performance monitoring (Blagescu, de Las Casa, and Lloyd 2005, Health

Council Canada 2006, NHS Future Forum 2012). It is also important to remove barriers to patient and public involvement, strengthen incentives for promoting engagement and build capacity for people to self-manage health and wellbeing in collaboration with health professionals (WHO 2014).

Recently there have been efforts to revitalize the discussion and re-focus efforts on the wider range of roles and responsibilities that people can have in relation to health and care planning (Foot et al. 2014). This means moving accountability objectives beyond the identification of patient and public perspectives and towards a model where people are full co-creators of health and care processes and share some accountability with professionals and organizations (Hampson et al. 2013). A number of examples stem from England, where people's responsibilities and expectations of how they can contribute to effective and equitable health services delivery are being made more explicit. Expectations go beyond a healthy lifestyle but also focus on responsible and appropriate use of services, compliance with treatment regimens and respectful interactions with service providers (Foot et al. 2014).

2. Components of accountability for CIHSD

Analysing the literature, accountability may be subdivided into five components, which are relevant for establishing and scaling up CIHSD.

Legal accountability

Legal accountability needs to provide frameworks that enable joint planning, contracting and budgeting across sectors such as health and social services, or health and education (WHO 2012, Williams and Sullivan 2009). Policies need to clarify resources availability with a long-term view including funds for research and innovation for CIHSD. Furthermore, CIHSD requires new legal frameworks that clarify legal responsibility and liability in inter-professional teams. Some highlight the importance of increasing the efficiency of the allocation and spending of resources, supporting investment strategies based on a "value for money" philosophy (Task Team 2013).

Financial accountability

Financial accountability is the most commonly understood accountability component. It entails tracking and reporting on fund allocations, funds disbursement, and ethical use of resources (Brinkerhoff 2003, 2004, Deber 2014). CIHSD requires new approaches to resource sharing and the way services are paid for across sectors and along the continuum of care. Financial accountability frameworks need to provide incentives for progress, have a redistributive capacity, and support strategy implementation (Task Team 2013).

As such, both financial and legal accountability lie in the main responsibility of the legislative bodies on all levels.

Professional accountability

Professional accountability promotes service delivery according to legal, ethical and professional standards (Brinkerhoff 2003 and 2004, Deber 2014, Fooks and Maslove 2005). This is an accountability shared between service providers and public institutions such as professional bodies (Canadian Healthcare Association 2004), where the service providers can be subdivided into individual service providers and service delivery organizations:

- Individual service providers (e.g. health professionals, social service providers, etc.) are accountable for the individual quality of their work, the adherence to professional codes and standards as well as the commitment to continuous professional education (Department of Health 2009).

- Service delivery organizations (e.g. hospitals, primary care centres, social services) must ensure that service providers practice in a sound manner, maintain accountability and take responsibility for their practice. *Clinical governance* is an approach through which service delivery organizations establish accountability for continuously improving quality, creating an environment of clinical excellence and standards of care (Allen 2000, Department of Health 2009).
- Professional bodies (e.g. Chambers of Physicians, specialist/professional associations, national quality/standards organizations) are responsible for setting clinical and professional standards and for enforcing them; they have mechanisms for service users who would like to complain about individual professional conduct (Fooks and Maslove 2005).

One of the key components of CIHSD is the creation of inter-professional teams, which collaboratively plan, deliver and manage the services provided to the individual (Suter et al. 2009, Maslin-Prothero and Bennion 2010). This has implications for professional accountability. Frameworks for health professions outlining their roles and responsibilities, education and training, etc. may need to be revised to allow for expanded roles of providers and to set clear expectations about collaboration. Concerns about liability can be a barrier to working collaboratively (Deber and Baumann 2005, The Canadian Medical Protective Association 2006, Watson and Wong 2005), and to optimizing scopes of practice and models of care (Deber and Baumann 2005, Nelson et al. 2014).

The revision of roles for providers needs to be aligned with the (re-)organisation of providers and the management of delivery, so that they can meaningfully link across sectors and are enabled to collaborate through the support of appropriate organisational and institutional arrangements. These transformations should be evidence-based and supported by education and training opportunities for those involved. New methods of working within CIHSD call upon service providers to review the contribution they make to delivering services and consider how they may need to develop their roles to meet patients' needs (Scottish Executive Health Department 2005).

Professional bodies have a responsibility to advocate for new models of care that are patient- and family-centred since they provide better quality of care and to help the workforce acquire the right competencies to thrive in those new models (Johnson et al. 2008, Scottish Executive Health Department 2005). As such, they need to revise guidelines on professional education and training and collaborate with graduate and post-graduate education institutions to adapt curricula according to the demands set out by CIHSD.

Political accountability

Brinkerhoff (2003) argues that "[I]n principle, democratic governance systems and decentralization opens up the possibility of increased political accountability to the public, both through the political process and through administrative procedures that are more transparent and responsive" (p. 11). This is consistent with the philosophy of CIHSD and political accountability needs to be a core tenet of CIHSD.

Political accountability ensures that governments deliver on electoral promises, fulfill public trust, represent the public's interest and respond to societal needs and concerns (Brinkerhoff 2003). This ultimately leads to more informed, accountable and legitimate decision-making (Abelson and Gauvin 2006, Kickbusch and Behrendt 2013).

Provider organizations are mainly responsible for monitoring their performance against agreed upon standards and inform the government and the public on the system's performance (Brinkerhoff 2003 and 2004, Deber 2014). The government sets expectations for health system performance and reporting (Canadian Healthcare Association 2004). Some jurisdictions have implemented quality councils, Ombudsmen, accreditations organizations and other public institutions to monitor health system performance (Smith et al. 2012). Ongoing dialogue between diverse players such as politicians and operations leads/managers is important so everybody understands why things need to change and how. Where tensions exist, performance monitoring and the evidence it produces may serve as a tool to

highlight areas of deficiencies and create space for dialogue (Canadian Institute for Health Information [CIHI] 2013, Kickbusch and Gleicher 2012).

Public accountability

The political process and elections are important mechanisms for public accountability. However, for these mechanisms to be effective there has to be public engagement at all levels and appropriate structures to support information flow between decision-makers and different public involvement fora. George (2003) argued that accountability mechanisms should "ideally rely on participatory processes to support relationships that transform the terms of engagement and the actors themselves. This requires commitment to such processes by those in power and willingness to change" (p.9). In the context of the health system, public involvement serves four major functions (Health Council of Canada 2006):

- to ensure public accountability for the processes within and performance of the system;
- to improve the quality of information on population values, needs and preferences for health services delivery;
- to encourage public debate about the future direction of health services delivery; and
- to protect public interest.

In recent years, most health systems have introduced and strengthened processes for public involvement in all spheres. Examples are citizen panels to discuss service design and delivery (Canadian Institutes for Health Research [CIHR] 2013, Kickbusch and Behrendt 2013), the routine collection of patient-reported outcomes in care quality assessments or supporting public feedback on health services (Healthwatch England 2013). The public has also been engaged in governing bodies with a more direct oversight role (British Medical Association 2013, NHS England 2014). These strategies aim to increase public accountability by supporting people to become active participants in health services development and delivery. In addition to creating more responsive services, engagement can also help improve system transparency and build the trust needed to sustain relationships within and across health systems (Abelson and Gauvin 2004, NHS Future Forum 2012, Kickbusch and Behrendt 2013).

For almost two decades there have been attempts to improve public engagement with health systems in the hope that health care will better meet the public's needs and preferences (Foot et al. 2014). The emphasis has largely been on information sharing, power sharing, and building mutual respect and accountability (Abelson and Gauvin 2004, Flood and Archibald 2005, Health Council Canada 2012, NHS Future Forum 2012). Some of this shift has been attributed to increased consumerist attitudes and strengthening of the patient advocate voice (Foot et al. 2014). Most people want an opportunity to shape decisions about health and care and there is evidence to suggest that this can support better care planning, improved outcomes and reduce costs (Hampson et al. 2013). There are, however, challenges to moving the involvement and accountability agenda forward. For example, definitions, language, and strategies for public engagement vary and this can be off-putting to the public and to health service providers and planners (Foot et al. 2014).

Although public involvement has moved forward over the last two decades, some have argued that the current models of engagement tend to focus too much on discrete, higher-level deliberations. For example, discussions tend to focus on hospital closures at the expense of other important areas such as the design of care services or treatment preferences (Foot et al. 2014). These and other concerns about the historical limitations to power-sharing in health services have led to a shift in discourse towards collaboration instead of engagement or involvement. For example, in England the "people powered health care" literature characterizes people and professionals as co-producers of health (Hampson, Baeck, and Langford 2013) and makes their different, but equally important, roles explicit. The idea of a health pact between service providers and individuals changes the traditional allocation of responsibilities and accountabilities. It puts a new onus on people to get involved and take responsibility for their health and care at every level – from healthy living choices to giving feedback on services (Foot et al. 2014). It also addresses the fundamental changes in power relations needed between health system policy-makers, managers, service providers, and people to allow shared-decision making at all levels.

3. Roles and responsibilities in CIHSD accountability

Thus, there are at least five stakeholders that can be identified in accountability for CIHSD:

- *The government* plays a significant role in financial accountability pertaining to all areas of health service delivery. Specifically, government chooses the range of services based on the publics' needs and the mechanism to fund them; establishes legal and financial monitoring systems to support the delivery of care by a range of providers across sectors; and funds health research and innovation. Governments' responsibility for political accountability requires the development of processes and structures to engage and inform the public on all levels of the health system.

- *Individual service providers* are accountable towards their patients/the service users as well as to their organizations to provide high-quality care and complying with the professional and organizational standards and guidelines set up by the respective bodies.

- *Service delivery organizations* carry the main accountability for delivering safe, effective and efficient services across the continuum of care. To achieve this, service organizations have to adhere to guidelines and best practices, organize providers and develop structures and processes that support performance monitoring and improvement.

- They are supported by *professional and specialist bodies* that set out scope of practice regulations and professional competence requirements for their members to enable CIHSD. Furthermore, they need to develop guidelines that take into account CIHSD, identifying transitions, and defining roles and responsibilities.

- The *public* is getting an ever more active role in accountability, taking on rights and responsibilities for health services delivery, on the individual patient as well as the population level.

Table 1 summarizes the roles and responsibilities attributed to the stakeholders above identified according to the components of accountability for CIHSD. Other stakeholders, such as academic institutions, civil society bodies or independent public auditing or quality institutions may also play important roles in the country or local context and will need to be recognised accordingly, when contextualizing actions.

Table 1. Accountability for CIHSD stakeholders, their roles and responsibilities

	Legal accountability	Financial accountability	Professional accountability	Political accountability	Public accountability
Government	• Government accountable for defining the spectrum of services available • Government accountable for putting mechanisms in place (legislation, accrediting/monitoring bodies) for performance monitoring	• Government accountable for equitable distribution of funds to service organizations across the continuum of care; monitoring allocation of resources • Government accountable for funding mechanisms and compensation models that allow service delivery by a range of providers • Government accountable for funding research and innovation that support continuous performance improvement (including infrastructure such as data capturing systems, electronic health records etc.)	• Government responsible for health professions legislation • Government accountable for establishing a liability framework that supports services delivered by a range of providers across sectors • Government, service delivery organizations and professional bodies accountable for setting standards and performance targets	• Government accountable to represent public interest and respond to needs	• Government, professional bodies and service delivery organization accountable for mechanisms for the public to voice dissatisfaction with services received, lack of access

	Legal accountability	Financial accountability	Professional accountability	Political accountability	Public accountability
Service delivery organisations	• Service delivery organizations accountable for auditing services to safeguard from error • Service delivery organizations accountable for choosing a comprehensive set of services across the continuum of care; linking meaningfully across sectors and regulating the effectiveness and efficiency of services	• Service delivery organizations accountable for ensuring appropriate financial resources are in place (and are used ethically)	• Government, service delivery organizations and professional bodies accountable for formalizing evidence and its application in guidelines and standards • Service delivery organizations accountable for ensuring appropriate resources are in place (safe levels, appropriately skilled staff) • Service delivery organizations accountable for performance management of service providers • Service delivery organizations accountable for designing care pathways and personalizing standardized models of care to respond to individual needs • Service organizations accountable for fostering a culture of continuous learning and innovation	• Service delivery organizations accountable for structuring organizational and institutional arrangements and aligning referring and transitioning systems • Service delivery organizations accountable for meeting performance targets, quality outcomes and for reporting to Government	• Service delivery organizations accountable for adopting a population focus for the prioritization of needs • Some service delivery organizations may have a role in enabling patient/public advocacy to support people-centred service delivery • Service delivery organizations accountable for developing governance structures for the public to participate in performance monitoring (boards, councils) • Service delivery organizations accountable for reporting performance outcomes to the public in a way that is meaningful to the public

	Legal accountability	Financial accountability	Professional accountability	Political accountability	Public accountability
Professional bodies			- Government, service delivery organizations and professional bodies accountable for setting standards and performance targets - Professional bodies accountable for continuing competence of their members - Professional bodies accountable for establishing standards of practice for safe, competent and ethical care - Professional bodies accountable for guidelines on collaborative models of care - Professional bodies accountable for scope of practice regulation and interprofessional standards - Professional bodies accountable for monitoring provider competence		
	Legal accountability	Financial accountability	Professional accountability	Political accountability	Public accountability

Public	- People responsible for providing feedback through available engagement mechanisms - People responsible for providing feedback and participating in engagement opportunities - People should use available opportunities to shape the design of service models - People responsible for using available support to improve health knowledge, self-care, etc. - People accountable for using health services responsibly

4. Actions to strengthening accountability for CIHSD

The following examples outline which steps stakeholders may take in order to improve legal, financial, professional, political and public accountability. The actions are intended to illustrate the roles and responsibilities in practice and as such may need further contextualisation or reassignment to other stakeholders according to national specificities. They are merely illustrative and not exhaustive.

Actions by the stewards

In order to strengthening legal accountability:

- Adapt legal frameworks to allow cross-sectoral and inter-professional collaboration.
- Implement compensation models that support collaboration between care providers within and across settings.
- Develop mechanisms (policies and legislation) that support a move away from single provider liability to shared/joint budgeting, pay for performance, accountable care organisations or similar

In order to strengthening financial accountability:

- Allocate funds equitably based on people's needs and spend according to ethical principles; create oversight mechanisms to ensure that intersectoral organizations have the capacity to deliver:
  - ✓ Minimize the divide between primary and secondary care as well as between health and social services. Differences in funding approaches and approaches to staffing and service provision make it difficult for collaborative practice to occur.
  - ✓ Create stronger incentives for service delivery organizations to collaborate to avoid fragmentation and duplication.
  - ✓ Use strategic budgeting to allocate resources based on evidence to achieve desired outcomes and targets.
- Designate research funds to address knowledge gaps including evaluation of the impact of integrated care on different populations.

Actions by service delivery organizations and stewards

In order to strengthening professional accountability:

- Develop clear and transparent performance standards; key measures should include all quality of care dimensions:
  - ✓ Develop accountability structures and processes to monitor performance and enable remedial action; this requires intersectoral committees that can negotiate priorities and desired targets.
  - ✓ Move to performance across the continuum and across organizations rather than a specific programme, hospital or service; this may require alignment of governance structures across the various health and social service providers to obtain shared interests and accountability in service delivery.
- Develop and adopt system-wide information technologies to share data and clinical records and foster collaboration including implementing an electronic integrated plan of care so providers and patients have timely access to up-to-date information.

- Implement post-licensure credentialing for continued competency development that will enable providers to work to scope and achieve inter-professional competence over the course of their career.

In order to strengthening political accountability:

- Create a range of structures to embed appropriate, timely engagement with people for a range of purposes in health service planning cycles (e.g., create Advisory Councils, service user groups, community panels for regular surveys and consultations; support people to have roles in governing bodies).

- Ensure engagement structures are resourced adequately so people have a meaningful opportunity to participate (e.g., adequate time, accessible space, access to appropriate information, knowledge and skills, backed by material or economic support).

In order to strengthening political and public accountability:

- Focus on the development of trust as part of reciprocal relationships that have both vertical (e.g., government to people) and horizontal connections (people to people). Set out reporting requirements for different levels in the health system (government, service delivery organizations).

- Embed the principle of shared decision-making (e.g. "nothing about me without me", National Voices 2014), while acknowledging the challenges of traditional power structures and relationships. To create meaningful accountability will require ongoing education and support to enhance people's capacity to engage with organizations (at various levels) and the receptor capacity of organizations (from Ministries to local services) to engage with people. Translate information so it's easy to understand and develop action plans to follow-up on information/recommendations.

- Make health systems answerable for public involvement by monitoring and reporting the extent of public engagement. This requires that public involvement be embedded in strategic documents and policies throughout the health system. Furthermore, it requires comparable metrics to appraise how well public involvement policies and activities are progressing across health service organizations and better methods for assessing the quality of relationships - a key aspect of meaningful public accountability.

Actions by providers

In order to strengthening professional accountability:

- Attend trainings and courses, which support continuous professional education.
- Adhere to the protocols and guidelines developed by professional associations and service provider organizations.
- Communicate adequately with other professionals, settings and patients, using appropriate language and communication channels.

Actions by the public

In order to strengthening political accountability:

- Demand accountability from government, service delivery organizations and providers by requesting information that is transparent and easy to understand. This can be achieved by working with advocacy groups to strengthen the public voice.

- Strengthen the public voice by engaging in the electoral process and casting ballots accordingly.

- Participate in political bodies, such as advisory boards and watchdog committees.

In order to strengthening public accountability:

- Participate in public involvement opportunities to voice their opinion and preferences for health services. This may include attending public health services planning forums and focus groups, joining patient advisory councils or participating in surveys on health and health services needs and preferences.

- Use existing mechanisms to flag health services quality and performance issues. Many constituencies have an ombudsman that responds to complaints of unfair treatment. Most professional bodies also have a mechanism for people to voice dissatisfaction with services received or lack of access.

- Understand and act in ways that support their health and wellbeing. Shifting towards a partnership role rather than a passive role is a culture shift. It means personal responsibilities in maintaining health must be taken seriously. This might include engaging in a healthy lifestyle, using finite health services responsibly, committing to medication and treatment regimes, or accepting that self-care is an important part of people-centred health services delivery.

To strengthen accountability for CIHSD support and education will be needed for all stakeholders. Government, professional bodies and service providers need to understand their roles and responsibilities and act accordingly. Equally, people need to take up their role as a partner in health, moving from their traditional role of merely recipient of health services.

5. Tools in accountability for CIHSD

Identifying appropriate tools and instruments to support accountability in CIHSD is an important consideration. In their paper on health governance, Barbazza and Tello (2014) included a review of tools that support governance. They state that "those in an oversight role must be equipped with applicable tools - instruments, mechanisms, measures - that exist to enable the governance function and steer the system toward defined goals" (p. 7). While governance is a broader construct than accountability, this statement is relevant for accountability and many of the tools that they identified would be useful from an accountability perspective. The authors acknowledge that despite the increasing interest in and literature on governance, there is a lack of studies on tools to support effective governance and evidence on the effectiveness of tools is scarce.

Vertical accountability relationships

Clear vertical accountability relationships typically exist between Government and service provider organizations. The accountability mechanisms between Government and the people have traditionally been unidirectional and vertical (Kickbusch and Behrendt 2013) with a focus on financial accountability and health systems performance. However, this does not capture the reciprocal nature of engagement as a mechanism for promoting accountability to the public. Accountability relationships between service provider organizations and service users or the public are typically vague. Service provider organizations have dual accountability relationships - up to the funders and down to service users - which can cause tension; this can be even more confounded if these organizations engage in advocacy. How strongly organizations feel accountable to the public partially depends on how strong the people's voice is.

Horizontal accountability relationships

Increasingly, accountability relationships in CIHSD also occur horizontally (Fooks and Maslove 2004, Kickbusch and Behrendt 2013, Michels and Meijer 2008, World Bank 2013). For example, governments can create public institutions that operate at arms-length and serve to monitor government activities on the public's behalf. Publically funded, these organizations have a responsibility to report to government on their own activities and use of funds, creating a horizontal, two-way accountability. At the same time, they are accountable to the public through a vertical relationship (Fooks and Maslove 2004), reporting both, on government activities as well as their own. Horizontal accountability relations are seen as important drivers of performance and accountability in decentralized governance (World Bank 2013). Specifically, horizontal associations can promote policy debate and continuity of policy. Public institutions such as quality councils and professional bodies have considerable power to influence and negotiate concerns (Kickbusch and Behrendt 2013; Michels and Meijer 2008, World Bank 2013). They are essential in helping different levels of government understand the importance of CIHSD while at the same time acting as a collective and coordinated voice for their members.

Tools for legal accountability

Legal approaches are often chosen to enforce accountability in health services delivery (Fooks and Maslove 2004). They tend to enable control rather than cooperation (Barbazza and Tello 2014). Many countries have *health care acts or similar legislation*. They can set out objectives, professional and institutional standards but also speak to resource allocation, public engagement and participation in decision making and monitoring and evaluation. However, the challenge is enforceability of the principles set out in these laws as they are typically interpreted within a bigger context and are not necessarily binding (Ries and Caulfield 2004).

Medical malpractice law is another accountability tool that acts as a deterrent to poor care and enforces standards of care (Ries and Caulfield 2004). Some authors have pointed to the tension between balancing

market forces and regulation and have noted the many regulatory and medico-legal barriers for inter-professional practice (Deber 2014).

Some of the newer, more innovative legal and regulatory mechanisms are *Patient Charters* or *care guarantees* that outline specific expectations for the patients (e.g. wait times) and patient rights when dealing with providers. Examples are the Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care 2008), or the NHS Choice Framework (Department of Health 2014). Charters or care guarantees may add some clarity for those negotiating health systems. There is some debate about their effectiveness as accountability mechanism if the processes for redress or remedial actions are unclear or insufficient to bring about change (Collier 2010, Fooks and Maslove 2004, Ries and Caulfield 2004).

Tools for financial accountability

Financial mechanisms are critical to CIHSD, in particular financial tools that support shared service delivery across teams and sectors. Current fee for service models are a well-recognized barrier to service integration and new funding and payment models, such as *pay for performance* or *provider incentives* may effect or hinder changes in practice (Deber 2014). However, the evidence on the effectiveness of provider incentives is mixed and there have been few significant impacts noted (Christianson et al. 2007, Flodgren et al. 2011, Mukhi, Barnsley, and Deber 2014). The authors of the Cochrane review also noted the poor quality of the evidence (Flodgren et al. 2011). Many financial tools are combined with quality improvement initiatives, which make it difficult to isolate the effect of financial incentives (Christianson et al. 2007). Other tools focus on *activity-based funding*, which has been instituted in some hospitals (Deber 2014), or *service agreements* (Kromm et al. 2014). Many service agreements are not aligned at the different levels (e.g. ministry-level agreements, hospital service agreements, quality improvement agreements), which may jeopardize the overall success (Kromm et al. 2014). A recent study found that expenditure-based accountability tools may carry a number of unintended consequences that can be positive (such as focus on quality) but also negative (such as shifting care time away from clients, focus on inappropriate performance indicators, hindering innovation) (Steele Gray et al. 2014).

Overall, there is limited evidence that financial tools are effective in changing the service delivery patterns and improve quality of care (Christianson et al. 2007). Some authors go a step further and state that various incentives, premiums and compensation models are insufficient to hold parties accountable for their activities (Mukhi et al. 2014). Newer tools focus on *results-based accountability* as part of a contracting framework between government and health service providers. The New Zealand Government uses this tool to create an increased focus on outcomes in government contracting (Friedman 2014).

Tools for professional and organizational standards

Accountability tools that focus on *professional standards* are mainly directed to health services providers and their professional bodies (Zelisko et al. 2014). *Professional regulatory bodies* are responsible to set and enforce standards of behaviours. Since behaviours are difficult to measure, there is a high reliance on *professional stewardship* (Deber 2014, Zelisko et al. 2014). For example, professionals are typically responsible for self- reporting on *continuing education requirements* and are expected to adhere to professional standards and *codes of conduct* with little direct monitoring. Regress mechanisms exist for the service user in the form of *public complaints mechanisms* such as Ombudsmen. Typically, *Ombudsmen* have jurisdiction to investigate administrative matters. But while the *Ombudsman* provides the public with an avenue of complaint, the Ombudsman's power is generally limited to making recommendations (Ries and Caulfield 2004). Professional bodies control the ongoing *licensing* of health professionals and deal with malpractice complaints through disciplinary hearings (Zelisko et al. 2014). They also deal with conflict of interest issues that may affect care provided to a client (Zelisko et al. 2014).

More formal mechanisms are *national accreditation programmes* that exist in many countries and other forms of audit and feedback. For example, Canada has the Accreditation Canada Qmenten accreditation programme run by an independent not-for profit organization (Mitchell, Nicklin, and Macdonald 2014). Accreditation is not mandatory in all sectors and jurisdictions. The programme supports service delivery organizations across the continuum of care to improve health services delivery with focus on safety, client-centred services, access and continuity of services. In England, the Care Quality Commission, an independent regulator of health and social services, inspects and publishes reports on quality measures (Care Quality Commission 2013 and 2014). Their themed inspections are targeted at specific standards, sectors and types of care. The effectiveness of accreditation, audit and feedback is not established. For example, the Qmenten programme claims that it has been effective in promoting accountability through benchmarking and reporting back to organizations (Mitchell et al. 2014). However, a Cochrane review found that the effects of audit and feedback on professional behaviour vary considerably and are related to baseline performance and the type and frequency of feedback given (Ivers et al. 2012).

Tools for political accountability

Public governance is an important aspect of CIHSD. Typical examples of public governance tools are *advisory boards* and *advisory councils*. These structures serve to hold governments and other interest groups such as the medical profession to account in their responsiveness to the values, needs and interests of the public (Flood and Archibald 2005). In the United Kingdom, the Health and Social Care Act places a legal duty on decision-makers in the NHS to involve and consult patients and the public in the planning and development of health services and in making decisions that affect the way those services operate (Health and Social Care Act 2012). The National Institute for Clinical Excellence (NICE) in the United Kingdom has created a *Citizens Council* and a *Patient Involvement Unit* that issues regular reports to NICE on public concerns about issues on which the Institute proposes to publish guidelines (Flood and Archibald 2005).

The role the public plays on advisory committees, councils and boards is inconsistent and accountability relationships are not always clear (Fooks and Maslove 2004). Also, there is mixed evidence on the effectiveness of these mechanisms to enhance accountability to the public. As Flood and Archibald (2005) conclude *"The fact that there is more of an apparent role for citizen governors in any particular jurisdiction does not tell us whether these initiatives have resulted in decisions that are more attuned to local values or, overall, better decision-making. There is very little empirical work done in this area and thus it is hard to conclude what works and what doesn't. (p. 39)."*

Tools for public accountability

Public accountability tools can be grouped into two categories:

> *Tools to support public reporting on performance*
> Public reporting mechanisms are directed towards potential users to inform them on decisions and actions, the performance of the health system and help them make decisions on service use (Deber 2014, Fooks and Maslove 2004, Morris and Zelmer 2005, Smith et al. 2008). A mix of *reporting on population health status, financial and clinical outcomes, service volume and performance* has been recommended (Fooks and Maslove 2004). Official bodies such as *quality health councils* are often involved in collecting information and making it publically available (Deber 2014, Morris and Zelmer 2005). However, careful consideration needs to be given to the make-up and role of such councils. One example is the Canada Health Council, which was implemented based on the recommendation of an expert committee report on the state of the Canadian health system. But, stacked with political appointees and representatives, it faced an up-hill battle to earn the trust and credibility it needed to make a difference and to satisfy the publics' demands for greater accountability (Flood and Archibald 2005). It was eventually disbanded in

2014. In England, the Care Quality Commission fills a similar role by posting inspection reports on their public website (Care Quality Commission 2013).

Much consideration has been given to *performance measurement* which is seen as a key tool for quality improvement, policy setting and resource allocation (Eddy 1998, Forster and Van Walraven 2012, Smith et al. 2008, Smith et al. 2012). The feasibility and value of health system performance measurements has been well established and public reporting of performance data has become an enduring feature in many health systems (Morris and Zelmer 2005, Forster and Van Walraven 2012, Smith et al. 2012). Some innovative *dashboards* have emerged such as the one used by the Department of Health in Vermont, USA. It allows the public to easily track the health status of Vermont residents through more than 100 goals in 21 focus areas (http://www.healthvermont.gov/hv2020/). This real-time dashboard presents measures, indicators and trends and helps to keep the Vermont government accountable in their health strategy. Similarly, the Canadian Institute for Health Information (CIHC) has developed an interactive website that allows the public to review performance data and health system spending (http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001).

Despite the growing popularity of performance measures many challenges remain including the question of what to measure and the inadequacy of available data (Anell and Glengaard 2014, Eddy 1998, Forster and Van Walraven 2012, Steele Gray et al. 2014, Kraetschmer et al. 2014, Morris and Zelmer 2005, Smith et al. 2008, WHO 2008). Often, the focus is on what can be measured rather than what is meaningful. This can have unintended consequences such as misdirected behaviours or data collection bias (Forster and Van Walraven 2012, Smith et al. 2008). The WHO (2010) and the OECD (2006) have both developed indicator handbooks to guide discussions on what indicators to measure and how. The Health Metrics Network under the auspices of WHO has also developed a framework and standards for country health information systems (WHO 2008). This document serves as a guide for how to collect, report and use health information and discusses the technical requirements of data systems. The challenges of using performance indicators to incentivise health care providers has been highlighted (Anell and Glengaard 2014, Forster and Van Walraven 2012, Smith et al. 2008) but this has been touted as a promising area (Smith et al. 2008). It is not always clear if performance reporting leads to quality improvement (Eddy 1998, Forster and Van Walraven 2012, Kraetschmer et al. 2014) as accountability mechanisms that would prompt action might be lacking (Smith et al. 2008, Smith et al. 2012).

There are also questions on what the public uptake is on publically reported information. Some authors have suggested that the public seems to like *public report cards* and has a reasonable awareness of health system performance issues. On the other hand, the impact of public reporting on consumer choice may be modest as choice may be constrained by other factors. (Morris and Zelmer 2005) Health literacy may be an issue and more consideration should be given to the presentation of performance data (Morris and Zelmer 2005, Smith et al. 2008). Overall, there seems to be little doubt though that public reporting is essential and can enhance accountability (Eddy 1998, Fooks and Maslove 2004, Forster and Van Walraven 2012, Morris and Zelmer 2005, Smith et al. 2008).

Public involvement tools
An increasing emphasis in CIHSD has been put on the role of the public and giving the public a voice in health matters. The literature reflects a move away from ideas around simple participation towards public involvement with the goal to build strong relationships through trust (Abelson and Gauvin 2004, CIHR 2012, Fooks and Maslove 2004). This is not about consulting the public on health reforms - public engagement ensures that the needs and interests of the public are more fully understood and that patient knowledge is taken into account in health decision-making and policy choices (Flood and Archibald 2005, Fooks and Maslove 2004, Foot et al. 2014). Deliberative methods such as *public panels, juries, deliberative polls, scenario workshops and consensus conferences* gained popularity during the 2000s (Abelson and Gauvin 2004, Flood and Archibald 2005) and ideas around engagement have continued to evolve. The CIHR case

book (2013) describes a range of strategies that have been used for public engagement with the goal to share successful strategies with a broader audience. The King's Fund also has a useful reading list and information resources on methods of public involvement in health services, with some information on monitoring/accountability processes (King's Fund 2014).

There is some evidence that as one-time events, such activities make no real contribution to relationship building but may satisfy answerability criteria. Longer-term or regular events have more potential to create relationships and lead to real change and action. Some mechanisms are thus being institutionalized. Examples are the HealthWatch forum in England (Healthwatch 2013), embedding public representatives in Health and Well Being Boards (Department of Health 2013) or the Care Quality Commission's new "experts by experience" members of inspection teams (Care Quality Commission 2014). Evidence of impact of these various engagement strategies is still required. There are some successful examples from Denmark where the Danish Board of Technology has used an engagement process to create institutional dialogue between the public, experts and public officials including in areas of health (Abelson and Gauvin 2004). The Canadian Institutes of Health Research (CIHR) has developed a framework for public engagement around corporate strategic plans, research priority setting and governance structures (CIHR 2012). The case studies captured in the CIHR report (2013) highlight the importance of ongoing communication and knowledge translation. The need for using multiple methods of engagement and outreach has also been stressed (CIHR 2012, National Voices 2014).

In the United Kingdom, programmes such as People Powered Health (Nesta 2013) argue that culture change, system change and the development of appropriate accountability methods and tools are fundamental to the shift towards people-centred health systems. Although there are gaps in the methods used to collect information to support people-centred accountability, there are examples of tools and processes evolving. For example, in the case of *personal budgets* for health and social services, a national evaluation of the pilot projects in over 60 primary care trusts showed favourable results with positive user feedback. Current work focuses on developing a personal outcomes evaluation tool (POET 2014) for routine evaluation of user experience (http://www.in-control.org.uk/what-we-do/poet-%C2%A9-personal-outcomes-evaluation-tool.aspx). The tool aims to assess the impact of budget control on the lives of individuals and families and is being administered annually. Impact assessment tools for public involvement in health services research are garnering interest as the demand for an evidence base to back different types of engagement strategies grow (Popay and Collins 2014) and have relevance to the evaluation of impact of public engagement on health system transformation, most obviously in terms of their theoretical and conceptual base, but also in terms of specific measurement metrics.

Table 2. Overview of selected Accountability tools for CIHSD

Tool for Accountability in CIHSD	Description
Vermont's Performance Dashboard http://www.healthvermont.gov/hv2020/	The Healthy Vermonters Toolkit/Performance Dashboard is an online tool used to track progress in real time for improving population health indicators (such as smoking rates) and programme performance measures (such as the number of registrants with the Vermont Quit Network). It uses concepts from *Results Based Accountability* and a visual results scorecard to summarize health information in a way that is accessible for health providers, other community stakeholders and the general public. The performance dashboard is linked to the Vermont health plan (Healthy Vermonters 2020). Data can be viewed on maps and as trends by county, health department district office area, and hospital service area.
Canadian Institute of Health	CIHI has compiled an interactive, searchable database of health information that

Information (CIHC) health system performance indicators http://yourhealthsystem.cihi.ca/	allows anyone to compare health system performance at national, provincial/territorial, regional and facility levels. There are 37 in-depth indicators and 15 in-brief indicators. Indicators can be searched by topic area (access, person-centredness, safety, appropriateness and effectiveness, health status and social determinants). The indicator library contains definitions and methodologies for 60 indicators as well as links to the actual data. The library has embedded search and filter functions.
NHS England guide to transforming participation in health care for commissioners http://www.england.nhs.uk/2013/09/25/trans-part/	The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006. NHS England has produced guidance that focuses and supports commissioners in meeting two legal duties to enable: • patients and carers to participate in planning, managing and making decisions about their care and treatment through the services they commission • the effective participation of the public in the commissioning process itself, so that services reflect the needs of local people. The guide includes resources to support the design of services, recommendations on levers and incentives to promote participation in standard contracts and administer sanctions (local and national), commissioning guidance, and by setting targets for data collection to monitor progress and providing tools to measure different elements of participation, for example: • National Inpatient Survey http://www.nhssurveys.org/Filestore/documents/IP12_Core_Questionnaire_v11.pdf • GP Patient Survey https://gp-patient.co.uk/ • Health Literacy Scale for Europe: http://www.maastrichtuniversity.nl/web/Institutes/FHML/CAPHRI/DepartmentsCAPHRI/InternationalHealth/ResearchINTHEALTH/Projects/HealthLiteracyHLSEU/HealthLiteracyHLSEU.htm • PROMS: http://www.hscic.gov.uk/proms
New tools for assessing engagement and co-production of health – e.g., POET (personal budget outcome evaluation tool)	Nesta and the Innovation unit are advocating bottom-up redesign of monitoring and outcome assessment as a mechanism to drive change. The seemingly unbreakable link between what is measured and what is valued means that for the People Powered Health approach to flourish, a wider range of measures need to be explored and captured in evaluating the impact of provision. POET is less medically driven and more focused on meaningful goals and capacity for people and communities e.g., patient reported outcomes that are broader than the current model and focus on confidence and control over own health, behaviour change and lifestyle, measure of quality social networks and social support. Wider measures could also look at satisfaction with equal and effective relationships, level of patient engagement using tool like the Patient Activation Measure (PAM), assessment of levels of participation. http://www.thinklocalactpersonal.org.uk/_library/POETSummaryFINAL.pdf http://www.nesta.org.uk/publications/people-powered-commissioning-embedding-innovation-practice http://www.nesta.org.uk/publications/co-production-catalogue http://www.nesta.org.uk/project/people-powered-health
Citizen report card surveys: Washington DC, World Bank	Citizen surveys are a mechanism to promote civil engagement and demand-side accountability, and empower individuals to express their views to government bodies. The surveys were originally developed in Bangalore, India, but have been widely applied. They allow citizens to contribute to oversight and regulation and therefore aim to improve the quality and integrity of public services. http://www.worldbank.org/socialaccountability_sourcebook/Resources/pub4.html
Ottawa patient decision aids	Decision aids are tools that aim to help people become involved in decision making by making explicit the decision that needs to be made, providing

http://decisionaid.ohri.ca/index.html	information about the options and outcomes, and by clarifying personal values. They are designed to complement, rather than replace, counseling from a health practitioner. As well as a series of tools for patients to use, the Ottawa Hospitals Research Institute websites identifies evaluation measures http://decisionaid.ohri.ca/eval.html and provides links to other sources of support and guidance.

In some countries, independent institutions have been given the legal mandate to accredit, monitor and audit the performance of service delivery organisations and the health system in general. Two examples of such institutions and how they employ some of the tools described above are given in table 3.

Table 3. Examples of accreditation and quality assurance institutions

Accreditation and Quality Assurance institutions	Description
Accreditation Canada conducts regular inspections, rates progress and sets targets http://www.accreditation.ca/	Accreditation requires organizations to identify what they do well and where they could do better, and make improvements based on the results. Organizations that meet the required standards are given accreditation (along with levels of distinction). Accreditation is based on a continuous cycle of inspection and improvement. Peer reviewers (surveyors) typically visit every four years and test for compliance with Required Organizational Practices and set deadlines for evidence improvement to be submitted. http://www.accreditation.ca/sites/default/files/rop-handbook-2015-en.pdf The accreditation process and inspection involves education about the accreditation process, surveys of staff and clients, survey feedback, on-site visits, inspection findings and required actions.
Care Quality Commission (CQC, England) sets national standards for quality and safety, inspects services and monitors data on performance against national standards, takes action (including enforcement) http://www.cqc.org.uk/	The CQC conducts a mixture of announced and unannounced inspections of health and social care providers at least once a year to monitor performance against national standards. The CQC also monitors performance through data analysis and other checks and has the power to take action, including enforcement, if services are found to be below standard. Data from local groups, people who use services, other stakeholders and the care provider are collated before inspection visits. During inspections a range of evidence is gathered to assess whether a service is: *safe, effective, caring, responsive, and well-led.* This includes interviews, focus groups and observations with staff, service users, and senior management. Inspection reports rate the quality of care being provided and hold quality summits with care providers, local partners and the local HealthWatch group. Inspection reports are published on the CQC website and may be shared with media where reports find "Outstanding" or "Inadequate" care, where and what enforcement action is required, or if a prosecution results. The CQC inspection teams now include an "Expert by Experience" member, who is someone with experience of using services. CQC also has formal relationships with local HealthWatch groups and other stakeholders.

Table 4 summarizes a selection of tools that have been identified in the literature to support different accountability components.

Table 4. Summary of Accountability tools for CIHSD

	Legal approaches	Financial approaches	Professional standards	Political Accountability	Public Accountability	
					Public reporting	Public involvement
Definition	Legislation, statues and regulations, contracts and agreements to set standards and to guarantee the public rights and complaints mechanism	Financial mechanism that enable appropriate resource spending	Mechanisms to ensure professional standards are uphold	The public acts in the role of governor of institutions and agencies to provide oversight for accountability purposes.	Public provision of information on decisions and actions related to health services delivery, funding and policy directions	Involvement of the public in setting policy direction and making decisions on health care
Examples	• Health Acts, Rules, procedures, decrees • Medical malpractice law • Charters of rights and responsibilities • Care guarantees	• Pay for performance agreements • Financial incentives • Activity-based funding • Service agreements • Results-based accountability • Integrated budgets and accounting • Resource pooling • Rewards and sanctions • Audits	• Professional standards • Regulatory bodies • Continuing education requirements • Codes of conduct • Public complaints mechanisms • Ombudsman • Licensing/certification • Accreditation • Common workforce training curricula	• Advisory and appeal boards, bodies established under statues, regulations or ministerial orders • Citizen advisory committees, citizen juries • Watchdog committees (facility boards, health authority, ombudsman, parliamentary committees)	• Publically available information on performance of health system • Publically available budgetary and financial information • Quality health councils • Dashboards • Citizen report cards • Benchmarking	• Deliberative methods (deliberative poll, scenario workshops, consensus conferences) • Open meetings, public workshops • National health forums • Satisfaction surveys • Personal budgets • Electoral process •

Adapted from Fooks and Maslove 2004, Barbazza and Tello 2014.

6. Development and assessment frameworks for CIHSD accountability

Accountability for CIHSD involves different processes for the different stakeholders. Some authors have noted that the monitoring of accountability is the least developed element of health system governance (Smith et al. 2012) but others have also noted that the providers alone cannot drive people-centred health systems (WHO 2014). As patients, communities and diverse organizations evolve their roles as partners for health, appropriate tools and mechanisms for diverse forms of accountability must be developed.

The following needs to be considered when tracking and reporting on performance in CIHSD:

- What standards to agree upon and how to measure them is a critical question that will require careful negotiation between the different entities involved. Having comparable standards across organizations and sectors is imperative.
- It is important to ascertain that the different organizations have the capacity to measure and monitor against the agreed upon standards. This requires adequate infrastructure, in particular data capturing systems that need to be funded.
- While performance reporting has increased over the past years, the information is not always easily accessible and meaningful to the public. There is a need to package information in a way that the public understands how the system is performing and what the quality of services is. Information presented properly can increase the public's sense of ownership of health services (George, 2003).
- Performance accountability mechanisms need to include structures and processes to act upon information. This includes identification of who is responsible for remedial action if targets are being missed. Solutions to address insufficiencies need to be based on best practice evidence.

The development and assessment of accountability frameworks has to deal with multiple challenges, including existing institutions, structures and cultures, which add to the already complex concept. Assessing how well accountability mechanisms already work and where further actions are necessary thus starts with mapping the stakeholders and their relationships. These accountability frameworks need to take into account national specificities and need to be contextualised. (Baez-Camargo 2011) However, learning from other countries and examples may help in finding appropriate solutions and many comprehensive frameworks have been developed in the last years.

In Table 5 examples of overarching accountability frameworks are provided with the potential to support the design of accountability systems and existing tools for monitoring progress over time. Examples of emerging assessment tools that broaden performance monitoring and accountability away from traditional clinical/health system targets and towards people-centred goals are also identified.

Table 5. Selected examples of frameworks to support accountability development and assessment

Pathways to Accountability II – revised Global Accountability Framework (GAP)

Pathways to Accountability: The GAP Framework was originally developed as part of the Global Accountability Project at the One World Trust as a tool to facilitate improved accountability (Blagescu, de Las Casa and Lloyd 2005). It focused on common factors to improve accountability and incorporated four dimensions and self-check lists in the following areas: transparency, participation, evaluation, and complaint and response mechanisms. In 2011 a revised version of the framework -The Pathway to Accountability II - was published (Hammer et al. 2011). The framework is intended for practical use and supports capacity building and system development. As well as lists of key indicators for transparency, participation, evaluation and complaints the revised version acknowledges the complexity and cross-cutting, inter-sectoral approach that is needed. It has introduced a graded scoring system, quality management system indicator, and additional indicators within the dimensions. It is being widely used in WHO initiatives to support global accountability assessments across health systems. http://www.oneworldtrust.org/globalaccountability/pathways

WHO Building Blocks for health system performance assessment

The Building Blocks Framework (WHO 2010) focuses on six building blocks (i.e. service delivery, health workforce, health information systems, access to essential medicines, financing, leadership and governance) and potential indicators. This allows some degree of standardization to enable comparison within and between countries, while trying to avoid creating a blueprint that cannot be adapted to different contexts. Each section of the Handbook outlines the importance of the building block, its dimensions, and possible sources of data, their strengths and weaknesses, and recommendations for key indicators.

Building Blocks of Health System Information and Leadership/Governance are regarded as cross cutting. The challenges of health system data quality as a foundation for accountability are addressed, and links to the Health Metrics Network standards for information systems components and data management are referenced. http://www.who.int/healthmetrics/documents/hmn_framework200803.pdf

The Leadership and Governance Building block places an emphasis on accountability: "Accountability is an intrinsic aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organizations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services" (p. 86). Indicators are broadly grouped into two groups: rule-based or outcome-based. The handbook primarily focuses on the outcome-based indicators, which are assessed using routine data, facility surveys and public expenditure reviews of client assessments. http://www.who.int/healthinfo/systems/monitoring/en/

Results-based accountability framework

Results based accountability (http://resultsaccountability.com/about/what-is-results-based-accountability/) is a framework developed by the Fiscal Policy Studies Institute and Mark Friedman (2014) that is used by organizations to improve their performance. It involves "turn the curve" thinking - reverse-engineering solutions to problems by identifying desired outcomes and working back towards appropriate mechanisms and processes to achieve those ends, along with the data required to track performance. It focuses on three key questions: How much did we do? How well did we do it? Is anyone better off? It has been widely applied in social and community programs, but is also being used in a range of health contexts (see, for example applications in New Zealand http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/results-based-accountability/ or Washington http://www.wcmhs.org/outcomes-and-rba.htm).

In addition to providing guidance and training to support local result-based accountability implementation, tools such as the Results Scorecard (http://resultsscorecard.com/features/scoreboard/) are used to support reporting and accountability.

Table 6. Cont'd. Selected examples of frameworks to support accountability development and assessment

Health Data Navigator

The Health Data Navigator is an interactive platform for researchers, policy makers, and health professionals to access health data. It contains information on European health systems of Austria, Estonia, Finland, France, Germany, Israel, Luxembourg and the United Kingdom. It contains information and links to support health system performance measurement, including a list of international frameworks that can be adapted to national settings (http://www.healthdatanavigator.eu/performance/frameworks), methods for performance measurement (http://www.healthdatanavigator.eu/performance/methods), and a toolkit to promote generic standards for conceptualizing performance assessment and relevant data sources for comparative evaluations under the OECD health care quality indicators (Kelley and Hurst 2006) domains of quality, efficiency and access. (http://www.healthdatanavigator.eu/HDN_Toolkit_Final.pdf)

Accountability cycle – A resource manual for achieving health system accountability 2009: Getting there together

Manitoba, Canada developed a resource manual to achieve accountability (Manitoba Health 2012). The manual complements the Accountability Framework for the Health System in Manitoba (Manitoba Health 2009) and promotes ongoing, sustainable accountability practices and quality improvement. The accountability cycle moves through an iterative process of setting expectation – measure, monitor, report – and evaluation and feedback. The Framework includes a distinction between different levels (governance, strategic direction, management and operational) and each section contains useful questions, check lists and definitions to help stakeholders work through the process. https://www.gov.mb.ca/health/rha/docs/ahsa2009.pdf

Delivering for Patients - The 2014/15 Accountability Framework for NHS trust boards

The Framework (NHS England 2014) sets out the policies and processes which govern the relationship between the Trust Development Authority and NHS Trust Boards. It outlines an approach to working with NHS trusts for oversight and escalation and provision of support for improvement and sustainability. There is a commitment to maintaining local accountability within a "one model" approach. It aligns with the Care Quality Commission regime for assessing the quality of services (caring, effective, responsive, safe, and well-led).

The Framework is supported by a series of other documents at http://www.ntda.nhs.uk/blog/2014/03/31/af2014/. These include a metrics framework, guidance on oversight and escalation model (indicators and scoring), and NHS Trust Board monthly self-certification requirements.

Improving Impact – Do accountability mechanisms deliver results?

The authors developed a framework on how to asses accountability based on the Humanitarian Accountable Partnership standards (Christian Aid 2013). The objective of the research was to generate evidence that well-functioning accountability structures and processes enhance program quality in terms of their relevance, effectiveness, efficiency and sustainability. They tested the framework in a number of case studies and highlight examples in which ways accountability mechanisms contribute to high quality programmes. The framework can be adopted by program planners and decision-makers to strengthen accountability in their programmes. http://www.alnap.org/resource/8388

7. Final Remarks

In summary, there is a vast range of tools and mechanism that can be used to enhance accountability for CIHSD. While accountability mechanisms for performance monitoring and reporting or for financial accountability are well established, others are still emerging. There is currently a strong push for tools to strengthen public engagement at different levels and innovative strategies have emerged. The type of tools and mechanisms to use is very much contextual and depends on the goals to be achieved and existing health systems structures (Deber 2014). Barbazza and Tello (2014) organized tools according to how they enable control, coordination, collaboration and communication – along this continuum, the tools and mechanisms become more informal and less enforceable. Given the different accountability domains and actors, finding the appropriate mix and balance of tools that can lead to the desired results remains the key role of stewards calling for more rigorous evidence on the effectiveness of accountability tools and mechanisms.

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