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Health care systems must be transparent and fully accountable to achieve UHC.

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Abstract

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This essay characterizes transparency and accountability as evolving concepts, much like UHC itself, due to changing political, social and technological trends. It describes relevant features of transparency and accountability to explain why they are critical to the realization of UHC. After providing some examples of how transparency and accountability are used in the health care systems that promote UHC, it identifies areas requiring further analysis

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Introduction

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This essay characterizes transparency and accountability as evolving concepts, much like UHC itself, due to changing political, social and technological trends. It describes relevant features of transparency and accountability to explain why they are critical to the realization of UHC. After providing some examples of how transparency and accountability are used in the health care systems that promote UHC, it identifies areas requiring further analysis.

UHC, transparency, and accountability are evolving concepts

The way we discuss universal health coverage, transparency and accountability have all changed dramatically over the last hundred years. Most countries which enjoy UHC today justify their continued efforts and investments differently than when health care systems were first established. In countries as diverse as Japan, Germany, and Chile, access to health care was initially promoted as a way to strengthen the nation – both militarily and economically (Savedoff and Smith 2011). In most early industrializing nations, UHC schemes were promoted as a way for elites to coopt—or at least remove one source of conflict—between labor and capital. Furthermore, the powers of medicine were quite limited in the early 20th century, so that income-support (e.g., payments for medical leaves of absence and funeral costs) tended to be more financially significant in these early plans than reimbursements for medical costs.

Today, UHC is promoted internationally and in most countries very differently—with human rights assuming a central role alongside solidarity and financial protection. For example, a recent WHO report succinctly states: "Universal Health Coverage exists when all people receive the quality health services they need without suffering financial hardship" (WHO 2013).[1] In this view, public policy does not seek to improve the population's health as a *means* to something else, such as a healthy workforce or social stability, but rather as an *end* in itself. In many countries, this is so widely accepted that those who oppose government plans aimed at expanding health coverage to more people, for more services, and with greater financial protection (WHO 2010) do not contest this fundamental justification openly.[2] Rather they tend to dispute the efficacy of the mechanisms, institutions, and public policies that are adopted to achieve the aims of UHC or criticize it for being unaffordable.

As much as UHC has changed, so have conceptions of transparency and accountability in health care systems. In the early 20th century, health financing in most democratic countries was conducted by social insurance institutions. To the extent that these institutions addressed questions of transparency,

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[1] Most statements defining UHC tend to include access to good quality health care and protection from financial distress due to medical costs. Some key documents include WHA 2005; WHO 2010; "Universal Declaration of Human Rights, art. 25", 1948; UNGA 2012; and WHO/World Bank. 2013.

[2] The biggest exception to this is the United States which was expanding public health financing in line with other industrialized nations until the 1960s after which different political coalitions generally succeeded in obstructing progress by falsely equating universal health coverage reforms with totalitarian government policies.

it was defined narrowly in financial terms—fiduciary responsibilities in the management of funds. Given that most of these systems started as social insurance for formal sector workers, accountability was typically established by creating supervisory boards with representatives from government, employers' associations, and unions. This tri-partite structure is still championed by many people today as a route to UHC even when its basis – employment-related access to coverage – necessarily excludes large segments of the population (Savedoff 2004). In other cases, the public financing mechanism for UHC was given substantial autonomy (even constitutionally) with accountability restricted to the national accounting authorities and the courts (e.g. Costa Rica). Non-democratic countries that expanded access to health care rarely adopted any mechanisms of transparency; and accountability was usually exercised directly by the government or by a dominant party whose goals might have included universal access to care but only to the extent it supported and reinforced the ruling elite (e.g., the USSR).

Today, conceptions of transparency and accountability in health care systems are quite different. For one thing, they include much more than the integrity of financial management and address such issues as protection of human rights; equity in the distribution of resources; effectiveness in the provision of care; efficiency in the allocation and application of resources; relationships between payers, providers and suppliers; and dignified treatment of individuals. They are based on an inclusive notion of rights to health care that not only include citizens but also non-citizens and with special attention to marginalized groups. Furthermore, health care system transparency and accountability are being constructed within societies that are often democratic and participatory, with many communication channels between the people served by health care systems and the providers, policymakers, and administrators who manage them. In this way, transparency and accountability play important roles in political debates over the legitimacy of health care systems and their ability to progress toward UHC. Transparency and accountability mechanisms also provide the feedback for health system adjustments needed to achieve the UHC goals of better health, access to care, and financial protection.

Transparency and health care

Transparency is an essential feature for health care systems which aim to achieve UHC. Most of the information related to the financing, management, and provision of care should be publicly available by default. The only information that that has any justification for confidentiality is that which would violate individual rights to privacy or could lead to social stigma and harms.

A system, like health care, is transparent when information about its decisions, procedures, and activities are available to the public (Kim et al 2005; Vian 2010). The degree of transparency can vary considerably from being completely restricted through a continuum of openness that ultimately reaches unlimited and proactive dissemination.

Transparency is *restricted* when information is available only to representatives or political authorities but not to citizens. This is unfortunately a common characteristic of health care systems around the world in which even basic information like government spending on health care services is withheld from the public.

Transparency is *limited* when citizens have the right to information but must petition to obtain it—as with Freedom of Information laws—and when judges or other authorities have discretion to reject or approve such petitions. For example, even China has Open Government Information regulations which apply to all levels of government. Promulgated in 2008, the principle of citizens' right to know was

motivated, in part, by the government's loss of credibility over its secrecy during the SARS outbreak (Darch and Underwood 2010).

A less restrictive form of transparency is *passive*—when authorities disclose unprocessed information to the public. Disclosing such information increases the system's transparency but, in practice, such information is only useful to trained or dedicated professionals. The International Budget Project is an example of an initiative that explicitly addresses this disconnect between the availability of information and the capacity of citizens to use it by providing training and institutional support to domestic civil society organizations.[3]

Finally, transparency can be *proactive* when institutions put resources into organizing, summarizing and interpreting their data for the public and reach out to citizens through mailings, social media, public hearings, and other forms of contact and communication. Transparency varies considerably across countries but—at least for government fiscal disclosures—it appears to be more open in countries with free and fair elections and where partisan competition in legislatures is relatively strong (Wehner and De Renzio 2013).

It is not a cliché to state that information is power. Transparency about health care system information is an exercise in redistributing power and as such can also be abused. If information becomes available in ways that only certain health sector actors can access or understand, then they can use and manipulate it in ways that harm the public's interests. By contrast, making information easily accessible, proactively disseminating it and providing it in understandable formats makes it much more likely that it will empower the broader population whose access to UHC is the primary goal. Given the impact of information on the distribution of power, it is likely that the degree of transparency in health systems is associated with each country's level of democratic participation.

Uruguay is among the world's more democratic nations, so it may not be surprising to find that it has been proactive in increasing transparency. Uruguay guarantees health care access through a mixed public-private system in which citizens choose their health care provider. Until recently, though, they had little access to information about health care quality collected by the government. In 2015, Uruguay launched a website called *A Tu Servicio* (At Your Service) that provides citizens with public data on health care providers to help them inform their choices. In collaboration with an NGO called DATA Uruguay, the Ministry of Health tested and adapted the site to make it more usable (Young et al 2016). This proactive transparency improves the health care system by giving citizens agency in their choices and by encouraging improvements in care by providers.

Sierra Leone lacks the open democratic institutions of Uruguay, but in the face of the Ebola crisis, it also proactively disclosed information to build trust and improve the effectiveness of the public response. OB Sisay, Director of the National Ebola Response Centre (NERC), expressly recognized that openness with data was insufficient. Rather, explanations of data needed to be disseminated through radio, TV, and town hall meetings in language that nonexperts could understand. Through weekly briefings, providing space for the press, quarterly financial reports, and openness about mistakes, the NERC gradually built the confidence necessary for engaging the population in ways that were critical to the campaign's success – encouraging reporting, cooperation with quarantines, and changes in burial practices. It also

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[3] See https://www.internationalbudget.org/ for more information about this initiative and its Open Budget Index (OBI); Wehner & De Renzio 2013 for research utilizing the OBI; and Ringold et al. 2012 for a discussion of how social accountability approaches need both information and opportunity to transform information into action.

facilitated better decision-making as well as deployment and management of health care and response resources (Sisay 2018; Young and Verhulst 2016).

In well-functioning health care systems, transparency is rich, diverse, and tightly linked to accountability mechanisms. For example, social insurance institutions in Chile and Estonia report extensively on financial revenues, allocations and expenditures to their boards, legislatures and government executives as well as in public reports and websites (Savedoff and Gottret 2008). Beyond that, each country also publicly shares data on health care utilization and increasingly seeks ways to measure and disclose service quality. Chile's AUGE reform not only required all insurers – public as well as private – to provide guaranteed services with explicit quality and timeliness standards but simultaneously informed citizens regarding what they could expect – and demand – of their health care providers and insurers (Missoni & Solimano 2010).

Most health care information should be openly available by default. The exceptions are related primarily to protecting human rights in terms of agency and privacy. In particular, health care systems that aim for UHC must respect the autonomy of patients, the autonomy of potential laboratory subjects and the privacy of individuals.

Respecting *individual autonomy* puts a limit on the authority, discretion and power of health care providers who have an obligation to obtain informed consent from patients before treating them. This requires assuring that the patient's consent is voluntary, that the patient has the capacity to authorize treatment, that relevant information has been disclosed, that the patient understands the disclosure and that the patient has explicitly decided to proceed with treatment before undergoing any procedure (Faden & Beauchamp 1986; del Carmen & Joffe 2005).

Medical research has brought tremendous improvements to health. But *transparency is also essential when conducting experiments with human subjects*. The Declaration of Helsinki explicitly states "The subjects [of research] must be volunteers and informed participants in the research project" (World Medical Association 2001). To be authentic, informed consent requires much more than a signature on a form; it requires that subjects understand the essential information about their participation. To achieve this, having a neutral educator explain the research one-on-one appears to be more effective than a variety of multimedia approaches (Flory & Emmanuel 2004). Others argue that testing subjects on their comprehension of a consent form should be routine (Fitzgerald et al. 2002).

Full transparency in health care systems could disclose *sensitive information about individuals* which is considered private. Health care systems are increasingly gathering data about individuals, including employment, financial contributions, service utilization, and diagnostic results. Furthermore, as health care systems become more complex, this information is shared among an ever-wider range of actors involved in providing, managing, or paying for health care services. The ease of accessing such data is increasing with the shift toward digital records and interoperable databases. Such data can be misused by employers or insurers to discriminate against people with particular medical conditions, abused by criminals seeking to exploit or scam individuals, and be a cause for social exclusion for those with stigmatized conditions. Whether from the perspective of a right to privacy or a consequentialist argument, health care systems need to respect the privacy of such information.[4] Nevertheless, they also

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[4]Legislation protecting citizens with regard to personal information can be found in EU Directive no. 95/46/EC of 24 Oct. 1995 and the British Data Protection Act of 1998, covering information that is commonly managed by health care providers and insurers such as physical and mental health, race, ethnicity, and sexual activity. However, such

must balance this confidentiality against the potential benefits from disclosing such information to researchers, health care providers or other individuals (Sadan 2001).

Transparency is essential to achieving UHC and all information should be treated as public by default, with exceptions only for specific kinds of information whose disclosure would violate privacy or would lead to harm (Kenny and Karver 2012). Personal health data is a large and easily distinguished class of information managed by health systems whose disclosure should be restricted. Nevertheless, health systems are full of information related to payments, premiums, prices, incomes, research data and the like which must be publicly accessible if a health system is to be held accountable for its performance and individuals are to be held accountable for their conduct.

Accountability and health care

Every social system is implicitly accountable for something, but not always for its ostensible purpose. Most people would view health care systems as a means to improving health or providing financial protection from high medical costs. Nevertheless, health care systems also generate employment, incomes, sales, opportunities for patronage and favors, and sources of prestige and power. Thus, achieving UHC requires not only that health care systems become more accountable, but that they become primarily accountable for achieving the goals of UHC.

Accountability requires that decisions, actions and procedures are subject to review and sanction by someone with adequate interest and authority to assure there are consequences in relation to performance. In other words, accountability comprises answerability and enforceability (Brinkerhoff and Bossert 2014; Brinkerhoff et al. 2017; Greer et al. 2016; WHO 2014; World Bank 2004). Systems as complex as health care involve multiple accountability relationships—with actors as diverse as physicians, government, private insurers, employers, hospitals, professional associations, courts, and patients among others (Emanuel and Emanuel 1996). Furthermore, accountability is impossible without some form of transparency – if not to the public at large, at least toward authorities with oversight and responsibility.

Three principle domains of accountability are rights, finances and performance.[5] *Respecting and promoting rights* is a central element of health care system accountability. At one extreme, governments need to be accountable for achieving the goals of UHC, namely equitable access to quality care without financial hardship. But medical personnel must also be accountable for protecting individuals' rights to autonomy and dignity; and people managing health data must be accountable for protecting privacy. Health insurers' or payers' actions are accountable for protecting the rights to equitable non-discriminatory treatment and access to care.

Financial resources are another key domain of accountability in health care systems. Regardless of whether funds are generated by prepaid premiums or different kinds of taxes, the people entrusted

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legislation allows disclosure to authorities in the event of police investigations or matters of national security. (Darch & Underwood 2010, p. 104).

[5] Emanuel and Emanuel 1996 propose six domains: legal and ethical conduct; financial performance; adequacy of access; public health promotion; community benefit; and professional competence. The first two roughly correspond to rights and finance, while the latter ones represent ways to disaggregate performance.

with collection, management and spending of those funds must be accountable to someone for properly applying them. In fragmented health systems, people managing funds are primarily accountable to the particular agency or firm for which they work or the clients they serve. However, in a UHC system, government is more broadly accountable for assuring the integrity of the use of financial resources overall.

Finally, actors throughout the health care system are *accountable for their performance*. Performance itself has many different facets. For health care facilities, this primarily involves the quality of care and treatment but can also include responsible use of resources and properly selecting the most appropriate services for an individual or community. For suppliers and pharmaceutical companies, performance is primarily associated with providing good quality equipment, supplies and medications. However, they also are accountable for producing, marketing and selling their products in ways that do not harm the public or the capacity of the health care system to reach its UHC goals. Insurers are accountable for prudent financial management, of course, but also for efficiently processing claims, being open about their claims policies, and achieving value for money.

Societies have numerous models for assuring accountability. These include institutional and procedural approaches; political mechanisms; social norms and participatory exercises; markets; and professional standards.[6] *Institutional and procedural approaches* are among the easiest to describe because they are typically laid out in legal, regulatory or procedural documents. Financial accountability is frequently elaborated in financial control procedures, internal and external audits, public disclosure requirements, and reports to governing bodies – with people who break the rules facing consequences that range from warnings, fines and dismissal to criminal prosecution. Anti-corruption mechanisms like whistleblower protections, detection systems (e.g. random audits), investigative units, and hotlines to receive complaints are additional tools for assuring integrity and holding individuals and institutions accountable. With regard to rights and performance, institutions often establish grievance procedures, investigative processes, and rules for referring abuses to authorities for sanctions like losing licenses or criminal prosecution if warranted. Therefore, health care systems need to encompass a wide range of these institutional mechanisms to assure accountability.

Political models of accountability rely on a society's delegation of power to governments and public authorities. Political accountability encompasses almost any form by which social power is used to assure rights are protected, public funds are managed properly, and performance is appropriate. In modern democracies, political accountability is exercised through a mix of formal elections, opportunities for petition and access to representatives, and public hearings and legislative deliberation. Political accountability operates at the broadest level to assure that a health care system is achieving its UHC goals, but it can also provide alternative channels of redress for specific instances when institutional channels are ineffective.

Political accountability is often linked with institutional accountability, as when a national health insurance institution is required to report regularly to parliament and when its budget and policy decisions are subject to review by the legislative or executive branches. For example, Estonia has a national health insurer (EHIF) which reports directly to parliament and publishes a "balanced scorecard," making it particularly responsive to visible indicators like wait times (Savedoff and Gottret 2008).

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[6] Emanuel and Emanuel 1996 pose three models of accountability: professional, economic, and political. Brinkerhoff et al 2017 have categories of vertical and horizontal accountability in the realms of democratic, performance and financial accountability.

Similarly, Chile's national health insurer is directly accountable to the Ministry of Health and the Comptroller's office, but also reports to the President and Congress. As a result, popular dissatisfaction with performance can be channeled to elected officials and play a role in electoral campaigns (Savedoff and Gottret 2008). In Nordic countries, local or regional governments tend to have significant responsibility for managing local health care services and consequently concerns over of health care can play a significant role in elections at this level (Magnussen et al 2009).

Social models of accountability rely on citizens, patients and civil society groups to promote rights, financial integrity, and good performance. While political accountability mechanisms operate by way of governmental institutions, social accountability involves citizens or patients bringing their concerns or problems directly to service providers, insurers, or suppliers. Social accountability is also exercised less directly but sometimes more powerfully through norms and standards of behavior. Particularly in small communities, social accountability can affect performance through non-institutional channels associated with culture or affinity (Tsai 2007).

Markets can also be an accountability mechanism in cases where goods or services are supplied through competitive markets, so long as transactions are also frequent and quality is easily observed. Under these conditions, suppliers who perform poorly or charge excessive prices will be pressured to improve or be forced into bankruptcy when purchasers shift toward better performing and cheaper competitors. However, due to many features of health care services, they are not easily transacted in markets. These features include asymmetric information between medical professionals and patients, adverse selection in private insurance markets, and thin markets. Thus, only a subset of standardized supplies and services are easily held accountable through competitive markets. Countries which make greater use of competitive pressures to assure accountability in more complex health care system services do so with extensive public sector regulation. For example, Colombia, Chile, and the Netherlands use competitive private insurance markets to achieve UHC; however, their success relies on tightly regulating the benefit packages, pricing and conditions of competition in the market.

While market accountability is less prominent in health care systems than other parts of society, *professional accountability is more common* due to the historical role physicians played in the emergence of modern health care systems. In the professional model of accountability, health professionals are answerable to their colleagues – often through formal associations – and to their patients – by asserting to act in the patient's best interest. Professional accountability has formal elements, as when associations are responsible for accrediting or licensing physicians or facilities; however, professional accountability is also exercised informally through interactions among physicians at conferences, hospitals, and other venues where standards of conduct and care are disseminated, reviewed, and upheld. In this way, physicians are both regulators of their peers and regulated by their peers. Professional accountability also applies to other actors in UHC systems – such as researchers, lawyers, or politicians – who are expected to exercise their professional expertise to serve the best interests of society and not to profit at the expense of the public good.

In a system as complex as health care, no single model of accountability will be adequate. Rather different accountability models should be encouraged to operate in the appropriate spheres and designed to be compatible with those operating in other spheres (Emanuel and Emanuel 1996). For example, professional accountability may be the most salient check on professional-patient relationships; yet professionals who work for hospitals or firms will also be subject to institutional forms of accountability. In instances when these mechanisms fail, legal action by investigators or courts may be required. Depending on the structure of a health system, medical facilities or health insurers may be

held accountable through market mechanisms; but usually institutional and political forms of accountability are more significant.

Accountability is essential to achieving UHC and needs to be assured through different modes that interact coherently and functionally, but also without overburdening the system with excessive costs, reporting requirements, or oversight that becomes an obstacle to innovation or appropriate care. Redundancy is not in itself a bad thing as long as it is part of a mix of accountability mechanisms that assure the health care system's resilience without hindering its ability to achieve other goals.

Why do transparency and accountability matter?

Transparency and Accountability are key to achieving UHC because they are essential to: the exercise of rights; establishing trust in the health care system; and (under certain conditions) to instrumentally improving the performance of the health care system.

Transparency and accountability are sometimes advanced as rights themselves. In the last hundred years, the advancement of democratic principles and particular national and international laws often establish transparency and accountability as a right of all citizens. The most visible manifestations of this view, in the case of transparency, are Freedom of Information Laws and, in the case of accountability, the powers of political representation and legal recourse to courts. In the specific case of health care systems, the same general rights of citizens to information about the decisions, actions and procedures of public institutions apply, along with their ability to hold public officials accountable through elections, petitions, and judicial action.

Transparency and accountability play a central role in establishing trust in a health care system. The scale of public effort required to design, implement and govern a health care system makes it a fundamentally political process in all modern nations. That being the case, no health care system has been established or preserved without broad trust in its principles, procedures, and performance. Transparency and accountability build trust by giving citizens familiarity with the criteria and procedures for decision-making. This, in turn, can educate the public and lead to acceptance of decisions that might otherwise be opposed if they are less well understood.

The existence of effective accountability mechanisms gives citizens confidence that they can influence or even override decisions with which they disagree (WHO 2014; Daniels & Sabin 2008). The role of transparency and accountability in promoting the legitimacy of public policy is well illustrated by debates over the Oregon Medicaid program, which at one point sought to prioritize health benefits purely on cost-effectiveness criteria but was forced to accommodate other priority-setting principles as a result of public political action (Jacobs and Oberlander 1999; Glassman et al. 2017).

Transparency and accountability can also be an instrument for improving UHC performance. Transparency and accountability create opportunities for discovery and feedback which can improve the performance of a UHC system by improving the responsiveness of medical facilities to patients' needs, by increasing efficiency, and by limiting corruption. The asymmetry of information between governments and citizens can protect the powerful from responding to those they govern. In this way, greater transparency and accountability makes abuses less likely and increase the chances that social needs will be satisfied (Stiglitz 2002).

But unlike their role in promoting rights or trust, the instrumental value of transparency and accountability varies significantly across contexts and performance measures. For example, the participation of representatives in governing bodies of mandatory health insurance institutions might be valued intrinsically, but comparing countries, it appears to have little practical effect on either equity or efficiency of those institutions (Savedoff and Gottret 2008). Furthermore, social insurance schemes with tri-partite governance perform no better and possibly worse than those provided by or paid for by the public sector directly (Savedoff 2004, Wagstaff 2010).

As another example, transparency and accountability are often posed as effective tools for preventing corruption, yet evidence of this impact is often mixed. In particular, transparency and accountability mechanisms are unlikely to reduce corruption without complementary institutions or norms which support professional integrity and provide real consequences for corrupt behaviors (di Tella and Savedoff 2000). Still, transparency and accountability mechanisms are important to health care system performance and can be viewed as preconditions for other forms of social, political, and financial feedback to be effective.

How have countries promoted transparency and accountability?

Countries have experimented with a wide variety of mechanisms to promote transparency and accountability in their health care systems. They have passed laws, established procedures, and published information to make health care system decisions more transparent and to hold providers, suppliers, insurers, and officials accountable for their actions. They have created institutions to promote ethical conduct, monitor performance, investigate malfeasance, and judge infractions. Yet, it is impossible to judge the effectiveness of each these actions for promoting UHC in isolation. Rather, the effectiveness and impact of transparency and accountability reforms depend critically on the coherence of these reforms with other elements of the health system and with a country's governance more broadly.

This section will describe a range of specific transparency and accountability interventions or institutions which countries have used to progress toward UHC. But these should not be considered to be a menu of separable items. Rather, they only work if they work together to encourage feedback and adaptation in the direction of better health care services, quality, accessibility and financial protection. The importance of this coherence can be best understood when analyzing the situation facing any particular person in the health care system. Regardless of a person's role in the health care system (e.g., service provider, purchaser, insurer, regulator), accountability means little without information on which to judge whether responsibilities are being met. Conversely, information alone is not much use unless some form of accountability leads to action in response to that information. In general, improving transparency and accountability is likely to promote UHC when those who are being held accountable have the authority, the information, and the motivation to respond to demands. For example, providing data and information to health care decision makers is unlikely to have much impact if they lack the authority to reallocate resources, manage staff, or the motivation to improve performance (Savedoff 2011).[7]

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[7] "Making Social Services Work" (World Bank 2004) makes a similar case within the framing of principal-agency models by emphasizing five features of accountability: delegation, finance, performance, information about performance, and enforceability.

The main actors involved in health care systems are citizens, providers, and government. The relationships between these actors provide a useful way to categorize transparency and accountability mechanisms (World Bank 2004). This categorization is obviously a simplification. For example, the government "actor" is really a multiple set of actors – different ministries, subnational authorities, parastatal institutions – but the mechanisms by which citizens hold them accountable bear similarities. This simple set of categories doesn't necessarily include important groups like insurers or pharmaceutical companies, yet many of the reporting and accountability mechanisms described here can be applied to these entities as well.

Citizens holding government accountable. Citizens hold government accountable in health care systems in many ways, including through information, elections, lawsuits, participation in hearings, and social campaigns.

Health care systems typically generate information for management of health care services, but rarely in terms of the systems' overall outcomes and only partially in terms of the disclosures necessary for citizens to hold governments accountable. For example, one study found that health care systems in 22 out of 26 countries surveyed tracked health care utilization by enrollees; but only 14 had the equivalent of a Freedom of Information law (Cotlear et al. 2015). It is common to find that initiatives aimed at increasing access to information are necessary but not sufficient conditions for affecting access to care or other health system goals (Fung et al 2007). In India, initial efforts to "name and shame" bureaucrats who failed to provide services like health care looked promising, but were ultimately ineffective due to an unsupportive context; by contrast, civil action in South Africa was more successful at improving social service access due to stronger traditions of grass-roots mobilization (Calland and Bentley 2013).

Open government initiatives seek to make information routinely accessible to the public, increasingly through the use of modern communications technologies. However, it is worth remembering that conventional channels of open government are also valuable; for example, in Guinea the Health Ministry is required to conduct press briefings, which are televised and broadcast on the radio. Interventions utilizing new technologies have mixed results in terms of improving health care services, including efforts to have beneficiaries report via cell phones (U-Bridge in Kenya) or providing open information through web portals (*A Tu Servicio* in Uruguay) (Brinkerhoff et al. 2017).

Information on public contracts merits attention since health care systems typically involve large amounts of public funding – whether raised through general or payroll taxation – to contract insurance, health care providers, or employ people to provide services directly. Recent work calling for governments to "Publish What You Buy" argues that such transparency can improve the quality of government investment decision-making, improve the quality and reduce the costs of tender and bid processes, and improve contracted services. These benefits far exceed the costs of making information public (CGD 2014).[8]

It is well established that disclosure of most health system information should be the norm, not the exception. Given the experience with freedom of information laws in places like Colombia, the United Kingdom, and Victoria (Australia), it appears that once these disclosures are mandated – overriding traditional reticence to publish contracts – the worries about confidentiality and trade secrets turn out

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[8] See also the publications and activities of the Open Contracting Partnership at https://www.open-contracting.org/why-open-contracting/

to be chimeras. In fact, the benefits of disclosure through publishing contracts may be particularly valuable in countries with weak governance (Kenny and Karver 2012).

Citizens can hold government accountable through legal action in courts. In fact, numerous countries have adopted a right to health in their constitutions, while most others have established rights to health care or insurance in legislation. This mechanism has been used effectively in many countries to force governments to provide services or address inequities in health care coverage. However, where citizens have differential resources and access to the courts, the effects on equity and efficiency can also be problematic for UHC goals. For example, companies have frequently sponsored individuals to legally challenge health policies aimed at protecting the government from reimbursing unproven or ineffective treatments in order to get their products or services included in national health plans. In other cases, court orders to provide costly treatments effectively countermand legislative or executive decisions that seek to establish more equitable allocative priorities in the public health budget (Backman et al. 2008; Gauri and Brinks 2008; Cotlear et al. 2015).

Elections are a central aspect of accountability in democracies, though the limitations on choice among candidates relative to the large number of issues addressed by government representatives means it is often difficult to hold politicians accountable except in the broadest terms. Elections may be more effective in cases where health system responsibilities are the main role played by a particular level of government or an elected representative, which is more likely in health care systems which decentralize responsibilities to subnational authorities. For example, the introduction of electronic voting in Brazil appears to have increased the number of valid votes cast by poorer citizens, which is associated with electing politicians who allocated more attention or resources to services, greater provision of maternal and infant health care services, and better health outcomes among the poor (Fujiwara 2015). Other studies of decentralization have found that the electoral process can lead to better performance, but only in particular circumstances, as when local governments or districts have critical elements of authority, information, and resources with which to manage services (Eckardt 2008).

Citizens can also hold providers accountable. Citizens hold health care providers accountable in different ways, including through participation in oversight committees, public hearings and social audits, community monitoring, report cards and complaint mechanisms.

Participation in committees that oversee health facilities or districts are one way citizens can have the authority and information to demand equitable access to quality health care. Bolivia's *Ley de Participación Social* created opportunities for citizens to participate in such boards for local hospitals. One study found citizen participation in these hospital boards, when they were active, resulted in fewer demands by personnel for informal payments and lower prices paid for supplies – effectively restricting opportunities for corruption (Gray-Molina 2000). Kenya created Health Facility Management Committees (HFMCs) to oversee the use and allocation of funds based on community priorities with some success, though lack of information and complaint mechanisms may have limited its impact (Cotlear et al. 2015, p. 180). Other similar settings for citizens to participate in oversight of the health care system include citizen's juries, panels, consensus conferences, deliberative polling and town meetings (WHO 2014).

Community Report Cards are a formal process by which citizens survey, review, assess and provide feedback to providers. They seek to motivate improved performance by using social pressures and reshaping the status and power between citizens and provider. They were first used in Bangalore, India by the Public Affairs Centre and showed considerable impact on the delivery of social services and a

decline in corruption. But other experiences have had limited impact, partly because citizens rate providers on factors which are visible to them, such as waiting times, and not on factors they find difficulty to assess, such as appropriate medical diagnosis (Joshi 2013).

Community monitoring involves training citizens to observe, identify and report health care provider performance to higher authorities, the media, or civil society groups. The Uganda Debt Network (UDN) successfully used community monitors to identify poor construction in health posts and sometimes triggered official investigations into corruption (Renzio et al., 2006). In Uganda, encouraging citizens to monitor providers led to lower absenteeism, shorter waiting times and higher utilization of health care services and better health outcomes (Björkman and Svensson 2009). But citizen monitoring has its limits; for example, citizen monitoring of road projects in Indonesia had little impact relative to government audits (Olken, 2007).

Public hearings and social audits are additional tools for bringing attention to poor performance or discrepancies in expenditures. India has had several initiatives documented in this regard with the NGO *Mazdoor Kisaan Shakti Sangathana* (MKSS) gathering information about budgets and expenditures and verifying them in meetings where officials, politicians, providers and workers are all present. India's Right to Health movement has also used public hearings to expose inequities in health care access and advocate for change, though little impact has been documented (Duggal 2005). Such approaches are still worth exploring because they have been used successfully to expose corruption in other sectors (Joshi 2013).

Governments can hold providers accountable. Governments have multiple instruments for holding public officials and providers accountable in health care systems, including formal legislative oversight, regulatory enforcement, consumer protection agencies, performance-based budgeting, and internal and external financial audits.

Health care systems are diverse when it comes to how they are organized and how government can hold providers (and insurers) accountable. Even systems which have successfully reached a level of UHC are diverse – some are almost entirely publicly financed and delivered; others are highly regulated but rely on private and non-profit actors to manage funds and service delivery. For example, Costa Rica's single national health insurer, the *Caja Costarricense de Seguro Social,* collects payroll contributions and directly provides health care to most of the population with substantial autonomy (established in the constitution) and relatively weak oversight by the executive, legislative and judicial branches of government (Savedoff and Gottret 2008). By contrast, Thailand has three major public insurance schemes which hold providers financially accountable for service delivery; the insurance schemes themselves are accountable, in turn, to different branches of government. Thailand's Civil Servant Medical Benefit scheme is managed by the Comptroller General under the Finance Ministry; the Social Security Scheme is managed by a social security office within the Ministry of Labor; and the Universal Coverage Scheme (UCS) is managed by the National Health Security Office, an agency supervised by the Public Health Minister and accountable to a 30-member National Health Security Board that includes five civil society representatives. In systems that have competing health insurers, multiple authorities often regulate, determine or negotiate premiums, benefit packages, fees for service providers, and quality standards. These authorities may be part of the executive branch (e.g. the Chilean Ministry of Health) or autonomous boards (e.g., the Dutch Health care Authority – NZA).

Explicitly clarifying responsibilities is important to holding individuals and organizations accountable, regardless of the health system's structure. Some of the key responsibilities entail defining what health

care will be available to the population, by whom and at what cost. Countries are increasingly defining explicit Health Benefit Packages to establish the set of services to which citizens will be entitled. Transparency in the process by which these benefit packages are selected – by whom and according to what criteria – is essential to public acceptance of the implied limitations or explicit priorities. For financial intermediaries, the definition of these benefit packages and any rules regarding exceptions, are critical if they are going to be able to set premiums to assure solvency or work within their budgets (Glassman et al 2017). Benefit packages are explicitly defined by 21 countries out of 25 surveyed in one research project; those with benefit packages included Argentina, Brazil, Georgia, India, and Mexico, but not Costa Rica, India's NRHM or Tunisia (Cotlear et al., p. 170).

Management contracts between different levels of government or government and providers are another way to make responsibilities explicit. In Argentina's Plan Nacer, the national government has successfully expanded coverage by giving Provinces subsidies to insure and provide care for specific populations under explicit annual performance agreements (Gertler, et al. 2014). But clarifying roles is not sufficient. For example, Costa Rican reforms introduced hospital management contracts with clear annual performance goals but failed to significantly improve performance (Garcia-Prado and Chawla 2006).

Coherent decision-making requires that actors be held accountable for the decisions over which they have authority. In many countries, legislative action establishes service mandates on health agencies without necessarily providing adequate funding. This leaves the health agencies accountable for providing services for which they may not be equipped. For example, the Republic of Korea and Mexico have had difficulty maintaining the solvency of their respective social insurance institutions and have periodically resorted to unprogrammed subsidies from general revenues to keep these institutions afloat. By contrast, Estonia explicitly recognizes that legislative action has financial implications for the Estonian Health Insurance Fund (EHIF) by establishing two reserve accounts – one for EHIF to handle the normal commercial risk associated with managing health insurance and a second for use by the legislature in the event that it alters premiums or service mandates over which the EHIF has no control. In this way, Estonia acknowledges that the EHIF can manage risks within the context of legislative action – and reveals the costs of legislative action to the public record (Savedoff and Gottret 2008).

Finally, governments hold providers accountable by exerting their regulatory authority. The government affects health care providers even with general regulations that are not specific to the health care sector, such as those involved with enforcing contracts, prohibiting discrimination, assuring consumer product safety, and mandating financial reporting. But governments also frequently establish regulatory authorities with responsibilities specific to the health sector for functions like assuring the quality of drugs (e.g. the United States Food & Drug Administration), setting prices or premiums (e.g., the Social Security Administration in France or the National Health Insurance Corporation in South Korea), and approving new technologies and medications for coverage (e.g., the United Kingdom's NICE).

The accountability relationships between government, providers, and citizens are the significant in health care systems that reach UHC. However, two other prominent accountability mechanisms are also present and significant in successful health care systems, namely competition among health care providers and professional accreditation.

Market competition creates a form of accountability among providers or suppliers who flourish or fail to the extent that they can attract clients. The earlier discussion on how citizens hold health care providers accountable emphasized the role of "voice" – in which citizens elicit responses by expressing their

appreciation or concerns. By contrast, market competition works through "exit" – citizens requiring health services reward some providers over others by choosing the ones they will seek out for care or insurance coverage (Hirschman 1970). Market competition is an active part of almost all health care systems, though it is often restricted to particular categories of services and products and is almost always highly regulated.

At the broadest level, some countries – including Chile, Colombia, the Netherlands, and Switzerland – encourage competition among health insurers – but under strict regulations which address benefit packages, premiums, and ability to reject applicants, among others (Sekhri and Savedoff 2006). Medications and medical supplies are often sold in markets that have varying degrees of competitiveness, depending on the character of the goods and services and government regulations regarding intellectual property. The ability of market competition to hold pharmaceutical companies accountable for the quality and cost of their products is particularly weak in contexts where few companies supply these products. Even after patent protections expire, competition among producers of medications is often compromised by the preferences of purchasers for branded generics which lead to conditions of monopolistic competition and its attendant inefficiencies.

In systems that allow patients to choose their providers, competition plays a role; however, it is often limited by patients' inability to distinguish providers on performance related to medical care quality – relying instead on more visible factors like responsiveness, waiting times, and appearance of physical infrastructure. Still, competition among providers has in many cases increased accountability, responsiveness and quality of care – even for poor populations in developing countries – though the full implications vary significantly across context (Berlan and Shiffman 2012; Das et al. 2016).

Another accountability mechanism is professional accreditation which is common in fields – such as medicine – where standards of performance and quality are difficult to summarize in a few objective indicators. Instead, an external actor like a professional association, a non-profit entity, or a public authority, undertakes periodic reviews of organizations or facilities to assess whether they meet with certain minimal standards or to rank them on different criteria. Typically, the criteria for accreditation are developed through consultation with experts in the particular field. For health care organizations, such criteria can include reviewing its mission, governance, and management systems, as well as the factors that are presumed to directly affect service quality, such as available equipment and physical infrastructure, conditions of hygiene, clinical practices, and risk and safety standards.

The consequences of such reviews will vary across systems – in some cases failure to be accredited will limit an organization's participation in particular programs. For example, Guatemala only contracts non-governmental organizations to provide health care if they are accredited by Health Area Offices; German physicians must be accredited to participate in the social health insurance system. In other cases, publication of accreditation rankings has been promoted as a way to encourage people to choose better quality organizations – though there is little evidence to date that such mechanisms make much of a difference. Rather, when accreditation has an impact, it is usually because professionals in the organization undergoing accreditation exert themselves to meet standards out of genuine concern for betterment or, along with this, motivation to preserve their professional status in the eyes of their peers (Cotlear et al 2015; Vian 2010).

What more do we need to know?

Health systems are complex and adaptive systems (Sturmberg et al 2012). It is impossible to find the "right" design for a health system that establishes transparency and accountability for achieving universal access to quality care without financial hardship. Rather, as in the past, progress toward UHC is likely to involve periods of experimentation and adaptation punctuated by moments of significant reform (Savedoff and Smith 2011). Improving transparency & accountability in UHC systems therefore needs to proceed on two different tracks: one related to learning and adaptation; the other related to politics and advocacy. Research can play a role in helping countries adopt approaches to transparency and accountability by informing both of these tracks in relation to rights, legitimacy and impact.

First, transparency and accountability are clearly essential to assuring that human rights are respected; but which approaches are most effective in realizing this goal? For adaptive learning, countries need to share their documentation and institutional arrangements for assuring transparency – such as the texts and deliberative processes behind freedom of access laws and procedures; data management and handling of confidentiality and privacy concerns; technical and social reviews of health benefit packages; and indicators for measuring health care utilization and quality. The same kinds of information sharing will be useful in those moments when new governments or political movements successfully push their countries toward UHC.

Second, we need to know how transparency and accountability can best establish and sustain trust in the health care system. The goals of health care systems have changed dramatically since the time – over a 100 years ago – when the dislocations associated with industrialization and efforts to establish nation-states dominated politics. Today, governments face competing pressures to assure access to individual health care services (e.g., surgeries and cancer treatments), effective provision of public health services (e.g., epidemiological surveillance and emergency responses), and equitable distribution of resources, all within limited budgets. It is difficult for governments to address these tradeoffs in a way that inspires trust when strong demands for individual health services are highly salient and the impact on costs and public health are relatively invisible. Thus, we need to study and share information about how transparency and accountability can inspire confidence and trust in the public institutions that make the difficult decisions regarding benefit packages, funding, and allocations across diseases and health system functions. This may include analyzing the institutional arrangements, procedures, participatory mechanisms and the ways that technical information are used to inform decisions. It should also include social research into the character of public and political debate to understand how different forms and content of social discourse affect support and trust in the health care system.

Finally, despite a rich literature on how transparency and accountability mechanisms affect a health care system's performance, we will never have strong simple recommendations that apply to every country because institutions and contexts are so varied. This is why experimentation and learning in each country is key. But this country by country learning process will proceed more quickly and effectively if it is informed by studying and sharing experiences across countries. Thus, the most useful research will look at how transparency and accountability mechanisms promote progress toward UHC by documenting and evaluating different health system institutions, the provision of information to the public, accountability mechanisms for providers, regulatory approaches to promoting efficient supply markets, and innovations in public administration and contracting.

Conclusions

UHC itself is a goal based on certain principles of equity, accessibility, and financial protection that will continue to evolve along with social and political institutions and the institutions and technologies of

medicine and public health. Similarly, transparency and accountability can be understood as principles that are realized through a range of institutions and mechanisms that must change and adapt to the political, social and technological context. Regardless of how they vary across countries or change over time, transparency and accountability will remain an essential part of the health systems that aim for UHC because they are critical to realizing human rights, establishing trust, and providing effective and equitable health care services at an acceptable social cost.

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Annex: Ten Precepts for UHC (Version February 2018)

Precept One
Universal is universal: the commitment to Universal Health Care must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of social exclusion or discrimination.

Precept Two
The commitment to UHC entails equally a commitment to economic growth, equitable and sustainable development, and the rule of law.

Precept Three
The journey towards UHC must start with a candid and rigorous assessment of a country's existing health system and a medium- and long-term plan to achieve it.

Precept Four
UHC requires compulsory participation, comprehensive pool funding, subsidization and consolidation of the entire system.

Precept Five
UHC financing must be public. UHC ideally must be financed by general taxation rather than either compulsory – or even worse, voluntary – social health insurance. Out of pocket payments for health should be out of the question as a primary source of financing.

Precept Six
UHC must contribute to fostering in the economy more and better paid jobs, not informal and precarious ones.

Precept Seven
The UHC's delivery system must be maximally effective – medically, economically and administratively.

Precept Eight
The UHC system must provide the right care by relying on high-value, not low value, health interventions and curbing both medical underuse and overuse.

Precept Nine
UHC must have first and foremost the right human resources.

Precept Ten
The UHC system must be transparent and fully accountable