# Introduction: Accountability for Health Equity: Galvanising a Movement for Universal Health Coverage

## Erica Nelson, Gerald Bloom and Alex Shankland

**Abstract** This issue of the *IDS Bulletin* developed out of a workshop held at IDS, 19–21 July 2017, entitled 'Unpicking Power and Politics for Transformative Change: Towards Accountability for Health Equity'. We consider three thematic strands that emerged from the workshop. First, the nature of accountability politics 'in time' and the cyclical aspects of national and transnational accountability for health equity efforts. Second, the contested politics of 'naming' and measuring accountability, and the intersecting dimensions of marginalisation and exclusion that are missing from current debates. Third, the shifting nature of power in global health and new configurations of health actors, social contracts, and the role of technology in this new era. We conclude with a proposal for long-term approaches to the institutionalisation of accountability processes and the strategic galvanising of a broader range of partners to work towards Universal Health Coverage, as both a metric and a mechanism of achieving greater health equity.

**Keywords:** Universal Health Coverage, accountability, accountability politics, governance, health equity, health systems, institutionalisation, private sector, social accountability, global health history.

## 1 Introduction

On the fortieth anniversary of the Alma-Ata Declaration, otherwise known as the global commitment to achieve 'Health for All by the Year 2000', the stark reality is that substantial inequities of health persist. Tedros Adhanom, the recently appointed Director-General of the World Health Organization (WHO), has declared his intention to build a global movement to translate the revamped commitment to Universal Health Coverage (UHC) into reality by 2030 (United Nations General Assembly 2015; WHO 2018). In this new framing of primary health care, or Alma-Ata 2.0, the question of who is accountable, for what, and to whom, is wide open. From 19–21 July 2017, IDS hosted a workshop

on 'Unpicking Power and Politics for Transformative Change: Towards Accountability for Health Equity', with the aim of generating dialogue and mutual learning among activists, researchers, policymakers, and funders working towards more equitable health systems. Whether Universal Health Coverage – however so defined – is achieved by 2030 is explicitly tied to accountability for health equity efforts to create stronger institutions, legal frameworks, social contracts, and a deeper understanding of the relationships of power that enable or constrain the realisation of this goal. The renewed push for UHC, on the eve of celebrating 40 years since Alma-Ata, is the political context and historic moment within which this issue of the *IDS Bulletin* is published.

If we take the first decades of the twentieth century as a starting point for the development of transnational efforts to combat infectious disease, poor sanitation, poor nutrition, and inadequate public health education and infrastructure, why is it that nearly 100 years later, one's chance at a healthy life remains tightly tied to place, race, gender, ethnicity, religion, education, and economic status? This is not to suggest that inequalities in health are static (or even measured in the same way over time), but rather that 'avoidable' and 'unjust' differences in health by population subgroup persist in spite of decades of efforts to minimise them.[1] In light of these 'avoidable' and 'unjust' differences – which range across a broad spectrum of health indicators (WHO 2017) – what new accountability relationships might be established, or which existing institutions of accountability strengthened, to ensure that basic health entitlements and rights are realised? What does 'holding power to account' mean when it comes to achieving the aims of UHC and how can local, national, and global accountability for health equity initiatives come together as a movement for change? While much has been made of the potential for greater 'public accountability' of public and private not-for-profit institutions that deliver health services (Mulgan 2003), the participants in the IDS workshop spoke of a more complex intermingling of public and private health actors, diverse political landscapes, legal grey areas, and the dangers posed to those who would challenge hierarchies of power endemic to contemporary health systems.

The term 'accountability' when used without any sense of directionality or purpose is meaningless (O'Donnell 1998; McGee and Gaventa 2011; Halloran 2016; Fox 2016). Simply calling for 'more accountability' as the means to effect health systems-level change is not enough. However, accountability processes that target the systemic and structural drivers of inequity within health systems have the potential to shape a different future (Lodenstein *et al.* 2013; Hilber *et al.* 2016; Hernández *et al.* 2017), as do those that involve citizens directly as agents of change (Cornwall and Gaventa 2000). In July 2017, the Accountability for Health Equity Programme at IDS brought together engaged intellectuals, innovating activists, and pragmatic problem-solvers in the fields of health systems strengthening and good governance to debate these issues. As a normative stance and a convening approach, 'accountability for health

equity' places relationships of power at the centre of our understanding of how health systems function – or do not – for all parts of society. It goes a step beyond the call for disciplinary bridging in health systems scholarship on accountability (Van Belle and Mayhew 2016) and stakes a claim on a different kind of co-production and co-mobilisation of knowledge. In sparking discussion, the workshop sought to catalyse new thinking that would enable interlocking networks of change agents to push the accountability for health equity agenda forward in different political spaces, and at different political levels (local, regional, national, transnational). While the precise contours of this current drive towards Universal Health Coverage have yet to be defined (Rumbold *et al.* 2017), it is clear that accountability relationships will be key to determining just outcomes of health-care priority-setting processes and the realisation of health entitlements for all people.

As a starting point for discussion and debate, we asked participants of the July workshop to set aside any preconceived notions on what accountability means in the fields in which they work, and be open to hearing about what it means to others (see note 2 for a short video by Sophie Marsden, Karine Gatellier and Sarah King that captures some of these reflections).[2] For example, if working on community-based social accountability interventions, we pushed for engagement with those working on accountability processes at national and transnational level, with the aim of achieving 'vertical integration' (Fox 2016). Or if working on accountability relationships within the sphere of formal political processes, we pushed for engagement with those working to improve accountability through legal frameworks, health systems management structures, or through informal challenges to hierarchies of power. We invited participants to reflect on the ways that new communications and data technologies, new forms of political organisation, new global health actors, new arrangements of public and private actors, new drugs and diseases, and new market influences have shifted the ground beneath our feet. The articles in this *IDS Bulletin* reflect the fact that while the desired outcome might be the same – *better health for all* – the proposed accountability strategies are as diverse as the contexts in which they developed.

One clear conclusion of this workshop: there is no universal language of accountability, nor is there a universalising framework capable of capturing the multiple and intersecting dimensions of power and decision-making that influence health outcomes. It is unproductive to flatten and make static the actors, institutions, legal frameworks, cultural norms, and market forces that influence the pathways that accountability travels, or to speculate on which pathway offers the most direct route to Universal Health Coverage. Crucial to moving beyond the empty rhetoric of accountability for 'improved health service delivery' or 'more resilient health systems' is a recognition that accountability processes are dynamic and should not be limited by tool-based approaches (Joshi and Houtzager 2012). Nor should our understanding of these processes be constrained by depoliticised metrics

of success or failure (Parkhurst 2016). The political and social nature of the relationships that determine who is held to account, for what, and to what end are temporally and contextually specific. They emerge and take shape according to a range of factors, only very few of which any given actor can control.

If we are to place accountability politics 'in time' (Pierson 2004), the big story at this historical juncture is that global leadership on health is up for grabs. While the language of Universal Health Coverage harkens back to Alma-Ata, the reality of our current global health landscape has substantially changed. To achieve 'better health for all' today requires innovative political strategies that acknowledge this greater diversity of actors and influences – from private philanthropic funding bodies such as the Bill & Melinda Gates Foundation, to the Chinese government's Belt and Road initiative (Gu *et al.* 2014; Husain 2017), to the limitations and possibilities for changed relationships of accountability opened up by new technologies (McGee *et al.* 2018). It also demands closer attention to the dimensions of marginalisation and exclusion that remain unresolved or misunderstood (Morgan *et al.* 2016). To tackle accountability failures requires determining the origins of the problem, and it is precisely this pinning-down of the 'who' in 'who is accountable?' that has become increasingly fraught (Bruen *et al.* 2014).

In this spirit, we have organised the *IDS Bulletin* around three principal themes that emerged from the workshop as needing deeper thinking and particular attention. First, how might our understanding of the relationships of power that mitigate health equity outcomes shift if we examine processes of change over longer time frames? Would such a shift in perspective help mobilise political will and commitment to long-term action? Second, what is at stake in the contested politics of 'naming' accountability and the epistemological battles over what types of evidence count in national-level and transnational health decision-making? Third, given the shifts in global power and new configurations of public and private health actors, what types of partnership and political action will be required to ensure functional accountability relationships, particularly where global goals such as UHC are concerned? These questions are explored both through text and, for the first time in *IDS Bulletin* history, through a selection of multimedia content online. This expansion into other forms of communication is explicitly aimed at galvanising larger numbers of people in a movement towards UHC and the linked agenda of accountability for health equity.

We conclude with a proposal for translating the globally accepted consensus on UHC into pragmatic strategies for change, stripping away any pretence that UHC is something 'technical' that can only be implemented if we have greater 'expertise'. Rather, we argue that if accountability relationships in health systems are substantially more complex, dynamic, and multi-sited than they once were (back in the days of Alma-Ata 1.0), the only way to galvanise a movement for greater health equity is through a similarly dynamic, multi-actor,

multi-level, and multi-sited approach. In short, a movement demands the coming together of perspectives, experiences, and knowledges that to this point have been largely stuck in silos. This *IDS Bulletin* is one small contribution to opening up the mutual dialogue and learning necessary to make this change.

## 2 The politics of health systems accountabilities in time

In 2000, IDS published an issue of the *IDS Bulletin* titled 'Accountability Through Participation: Developing Workable Partnership Models in the Health Sector', which explored the results of a workshop convened in 1999 to share experiences on the 'use of participatory approaches in enhancing accountability in the health sector' (Cornwall, Lucas and Pasteur 2000: 1). The introduction noted that, per the early work of Leonard (2000) and Bloom and Standing (2001), there was increased recognition that 'public health services in many low-income countries perform increasingly like an unregulated market' (Cornwall *et al.* 2000: 2). Furthermore, they argued, it was clear that the 'technical fix' approach, so common to biomedical health interventions in the global South, had 'singularly failed to meet the health needs of large sections of their populations.' (*ibid.*: 11).

Within what was described at the time as a 'rapidly changing, dynamic, complex world', the authors promoted health system accountability at the local level, through greater community involvement in decision-making, resource allocation, and monitoring and evaluation. They warned, however, against the dangers of co-optation of accountability processes by powerful actors seeking to maintain the status quo, and of the potentially distorting effect of participatory accountability interventions if issues of marginalisation and social exclusion were ignored. Since that time, the speed of change has accelerated, the levels of complexity have increased, and the accountability challenges have become ever more glaring.

Travelling further back in time, we find within the literature supporting decentralised primary health-care services and broad-reaching sanitation, hygiene, and public health campaigns, similarly unresolved tensions between disease-specific interventions aimed at preventing epidemics and approaches to community health for meeting local needs and concerns (Packard 2016). It is telling that in meta-level historical reviews of the indicators dominant in international public health, now 'global health', the question of how to measure 'equity' – with the exception of a brief moment of attention in the run-up to Alma-Ata in 1978 – does not appear in transnational compilations of health indicators until the 2000s (Gorsky and Sirrs 2017: 370). What this history tells us is that if one drew a line connecting the creation of the International Sanitary Bureau (in 1902) (Fee and Brown 2002) to the launch of Africa CDC – Africa Centres for Disease Control and Prevention (in January 2017) (Nkengasong, Maiyegun and Moeti 2017) it would not be straight, and it would not track ever upwards towards more equitable health systems.

Yet, 40 years on from the first attempt at 'health for all', the promise of what might be achieved through global consensus remains compelling. It is clear from what we now know about accountability failures that the shapers and makers of functioning health systems are not limited to those individuals and institutions signed on to transnational global agreements. It bears emphasising that this long-standing effort to promote greater equity of health service delivery, of health education, of access to medicines, and of quality of care, is largely rooted in local and national politics, although bilateral donors and the dominant multilateral agencies have also been influential (Cornwall and Shankland 2008; George 2009; George *et al.* 2016; Lodenstein *et al.* 2013).

The temporal specificities of political change and the challenge of continuous engagement with accountability issues are threads that run the length of this *IDS Bulletin*. However, they are dealt with most explicitly in the first three articles and video content. To begin, Walter Flores and Alison Hernández describe what they call 'cycles of accountability' in their work with the Centro de Estudios para Equidad y Gobernanza en Sistemas de Salud (CEGSS) in Guatemala. Confronting inequities of power between public health service providers and members of rural indigenous communities could not be achieved through short-term, quick-fix, technical approaches. Rather, over a decade of effort, CEGSS came to understand its work as part of a longitudinal process of change in a country scarred by civil war, and in particular, the targeted violence and persecution of indigenous communities. Instead of seeking linear progress in improving the accountability of public health services, CEGSS now frames its efforts to improve indigenous health in Guatemala as a continuous returning-to and revisiting-of barriers to change. They approach strategic decision-making in line with the dynamic nature of the change they seek. The CEGSS case study challenges the notion of a straight route to the institutionalisation of accountability mechanisms for improved health service delivery.

In a photo story titled *Enabling Community Action for Maternal Health* (see Introduction to Multimedia, this *IDS Bulletin*) we hear Vaishali Zararia describe the long-term social accountability work done by a group of non-governmental organisations (NGOs) – SAHAJ, ANANDI, and KSSS – in Gujarat, India. Through a visual depiction of the material realities of this process, Zararia, Renu Khanna and Sophie Marsden's video captures both the challenges and possibilities for improved accountability relationships at the local level. Similar to the process described by Flores and Hernández, this photo story shows that the key to increased citizen and health worker engagement, and the mobilisation of local people to improve maternal health services, required dialogue at multiple levels of the health system, and an adaptive, cyclical approach to change.

In a second article that takes the 'long view', Jose Dias and Tassiana Tomé analyse the results of a recent Community Scorecard

intervention in Mozambique through the lens of political promises made by the post-independence revolutionary party Frelimo, as well as the legacy of the Portuguese colonial state. This 'practice-based reflection' asks whether the promise of social accountability to remedy the inadequacies of state-run health services has become distorted over time, increasingly placing the onus for improvement of health services on those who use them (versus those responsible for their delivery). In a sense, Dias' piece sits at the other end of the spectrum from the participatory accountability approaches envisioned in the 2000 issue of the *IDS Bulletin*. Two decades on, the case of Mozambique and the transfer of roles and responsibilities for public health system functioning from state to citizen, suggests that the original meaning of 'social accountability' is at risk of being lost. This case study raises fundamental questions about the potentially distorting effects of tool-based accountability approaches at the point of service delivery.

In *Holding a Health System to Account: Voices from Mozambique*, produced by Denise Namburete and Erica Nelson (see Introduction to Multimedia, this *IDS Bulletin*), we hear directly from health service users and providers in the Mozambican capital city of Maputo on current accountability gaps and challenges. Filmed as part of the Vozes Desiguais/Unequal Voices Economic and Social Research Council–Department for International Development (ESRC–DFID)-funded research project on the politics of accountability within multi-level health systems in Brazil and Mozambique, these interviews capture the frustration and injustice of health inequities as they are experienced in day-to-day life. Common problems such as unacceptably long waiting times, frequent drug stock-outs, and illicit charges for public health service delivery are described by residents of Maputo. This documentary explores what strategies are possible to ensure that these issues are comprehensively dealt with by those with the power to remedy them. In a country such as Mozambique, with a post-independence history of national health system creation and the promise made to achieve 'health for all', what would health management strategies and an enabling policy environment need to look like to have more meaningful accountability on health user rights and entitlements?

Jeevan Raj Sharma, Rekha Khatri and Ian Harper adopt a social history approach to understanding the dynamics of interlinked networks of actors within and beyond Nepal's Ministry of Health in the adoption of misoprostol for postpartum haemorrhage. Through close analysis of the relationships of a constellation of state and non-state actors involved in the debate over misoprostol use, they question the accountability of bilateral donors, international non-governmental organisations (INGOs), and consultancy firms to Nepalese health service users when it comes to matters of national-level health policy. One result of the proliferation of global health actors beginning in the 1990s, as evidenced in this case study of INGO and bilateral aid agency involvement in Nepal's health sector, is that accountability relationships become dispersed across dense and complex networks of actors.

### 3 The politics of naming accountabilities: 'accountability to whom, by whom, and for what?'

It is clear that the promise of greater accountability has the potential to both mobilise communities and advocates of health equity, as well as the potential to be subsumed into depoliticised discourses that maintain the status quo. The act of naming relationships of power, of bringing them into the light, is one step towards transforming them. It is important, then as now, to be clear about what accountability relationships people seek to change (Gaventa 2002). Part of the challenge of applying accountability approaches to improving health equity is that it demands a complex adaptive systems way of thinking, planning, and acting (Paina and Peters 2012), and this is where the meaning of accountability can become muddled. On the one hand, the relatively new field of Health Policy and Systems Research has championed interdisciplinary approaches to understand what drives and shapes health outcomes within the complex social and political worlds in which health services are delivered and health policies defined (Sheik *et al.* 2011; Gilson *et al.* 2011). On the other, the fields of good governance and accountability studies have shifted away from linear thinking on the relationship between citizen and state, and encouraged a more holistic understanding of social contracts and accountability bargains (Joshi 2014; Fox and Halloran, with Levy, Aceron and van Zyl 2016; Halloran 2016). Neither field has fully addressed the complex accountability landscape of health systems in many low- and middle-income countries, where private market actors are intertwined with government-sponsored health services at multiple levels (Leonard *et al.* 2013; Bloom *et al.* 2014).

At the IDS workshop in July there was fierce debate over what constitutes 'pro-equity accountability' in practice. As a starting point to a productive conversation, we need some shared terms and understandings. Bridging the themes of 'health systems and accountability mechanisms: the long view', and that of 'the politics of naming accountabilities', is Jonathan Fox's piece on 'The Political Construction of Accountability Keywords'. In the vein of Cornwall's challenge to unpick development 'buzzwords and fuzzwords' (2007), Fox calls for a creative reappraisal of the existing terms used in the English language to describe the multiple actions and objectives encompassed by the term 'accountability'. Fox revisits the diversity of concepts that emerged to challenge inadequate, corrupt, and/or poorly performing public services long before the word 'accountability' became codified by the World Bank (World Bank 2003). His article includes examples from Mexico, Pakistan, the Philippines, and Guatemala. He questions the tendency of some within the contemporary field of 'accountability studies' and those designing accountability interventions towards 'linguistic determinism'; that is, the inability to conceive of a richness of accountability meanings in those languages and cultures where the word has no direct translation. He suggests two possibilities for better communicating a public accountability agenda: (1) to open up the discourse to include terms and phrases already used in popular culture and 'repurpose' them; and (2) to create a new language of public accountability that has the capacity to 'go viral'.

In Linda Waldman, Sally Theobald and Rosemary Morgan's piece (this *IDS Bulletin*), they call attention to the relative absence of gender and intersectionality analyses within accountability for health equity debates. For example, within the 'Brinkerhoff Matrix', a tool used to catalogue distinct levels of power, influence, and responsiveness within a public health system, the multidimensional ways that people might negotiate and be subjected to hierarchies of gender, race, ethnicity (to name a few possibilities) are flattened out and rendered invisible (Brinkerhoff 2004). Health systems, the authors remind us, are themselves 'gendered structures', and gender itself is only 'one dimension of oppression, marginalisation, and inequality'. To truly address health inequities, they argue, we must first understand the interdependent nature of empowerment and accountability. Without empowerment of marginalised and vulnerable groups there can be no true accountability for health equity, and vice versa. What is lacking at present are new tools and indicators that would enable health systems researchers to grapple with the 'full range and complexity of gender and accountability'.

Fatima Lamishi Adamu, Zainab Abdul Moukarim, and Nasiru Sa'adu Fakai draw from their experience working on the UK aid–DFID-funded Women for Health programme in Northern Nigeria to explore gendered and spatial dimensions of social accountability. In this article, Adamu *et al.* describe a health worker crisis in five states that has resulted in dramatic inequities of maternal health quality of care and service availability. In seeking to address this front-line health worker shortage, they discuss the challenges to implementing an educational programme aimed at preparing young women from affected communities for future studies in midwifery and nursing. What they found was that gendered social norms created substantial barriers to the success of the programme, with the demands of husbands and male family members often taking precedence over the demands of training and capacity building. Adamu *et al.* point out the limitations of community-based accountability approaches that treat 'the community' in simplistic terms. They encourage those working on social accountability to be aware of, and to be prepared to challenge, relationships of power beyond the clinic–community dyad that impact on health inequities.

In a recent analysis of views on accountability among primary health-care government officials in Nigeria, George *et al.* (2016) argue that seeking to 'spark, support and steer change', rather than seeking 'social equity' might be a more effective strategy for engaging with health decision makers. If accountability interventions are designed to further burden the least powerful actors in a health system (namely, front-line community health workers) they will fail. However, if they are designed in a way that acknowledges both the complexity and multidimensionality of marginalisation and difference, *and* they are designed in a way that recognises the long-term, often cyclical nature of positive change, they have the potential to engender greater equity and meaningful relationships of accountability.

## 4 The shifting nature of power in global health: new actors, new partnerships, and a new global consensus

There are a number of reasons for the growing interest in ways to strengthen mechanisms for accountability in the health sector. As we have already established, the history of holding power to account within national-level health systems and at the transnational level is not in itself new. However, the particular dimensions of contemporary accountability relationships in an increasingly diffuse and complex landscape of health actors offers fresh challenges. In the last several decades, many countries have experienced rapid and sustained economic growth, which has been associated with changing patterns of inequality in income and health (Marmot 2007). At the same time, changes in technologies of communication and data-gathering have led to increased awareness of problems with access to health services within countries, as well as in comparisons of efficacy and quality between countries (though, it bears repeating, the existence of comparative transnational health indicators goes back to the early 1920s). This spread of communication and knowledge on service gaps and 'accountability failures', together with increased pressure on bilateral and multilateral donor agencies to show 'value for money', has contributed to rising expectations and pressure on governments to improve health system performance.

Alongside this increased use of certain types of metrics to establish the parameters of health 'success' or 'failure', the last three decades have been dominated by the flood of funding and transnational action targeting the HIV/AIDS 'epidemic' (such as it was originally known), and the post-Millennium Development Goals, the sector-specific, and vertically organised health responses to malaria, tuberculosis (and HIV/AIDS). More recently, global health actors and institutions have focused efforts on the perceived threat of an influenza pandemic, the spread of resistance to antibiotics, and the glaring health systems failures made evident by the Ebola epidemic in 2014–16. Each of these events and issues has contributed to an increased awareness of how health systems failures at local levels have impacts that spread beyond local spaces, and how the prioritisation of resources and funding at national and transnational level can create distortions in health system functioning that travel back down to the level of local clinics, pharmacies, and health posts.

Brazil is often touted as an exemplar of late twentieth-century universal health system creation. Currently, the Sistema Único de Saúde (or SUS) is used by close to 65 per cent of the population. In an article by Vera Schattan Coelho we learn that to meet the needs of the population in São Paulo, Brazil's largest city, the municipal government has outsourced some primary health-care services to private not-for-profit organisations. She demonstrates that this outsourcing, in combination with political competition at the municipal level, formed the backdrop to a reduction in health disparities and inequalities. This story offers hope that new models of collaboration and partnership for health service delivery, together with high levels of political engagement and a holding to account of political actors, could have real impact on reducing health disparities across all sectors of a given population.

Within the context of pluralistic health markets in India, Abhay Shukla, Abhijit More, and Shweta Marathe (this *IDS Bulletin*) explore the kinds of regulatory partnership that could provide effective stewardship and greater accountability of private sector actors. Shukla *et al*. draw attention to the lack of evidence on the quality of services provided by the non-state sector, despite the fact that they provide the majority of all health services in India. They also challenge received wisdom that health professions are self-regulating, noting that in India a wide range of medical associations (at both state and national level) have failed to protect public interest over self-interest (Peters and Muraleedharan 2008). In response to these failures of accountability, they describe how they developed an alliance of citizens and socially responsible medical professionals in Maharashtra State, in effect creating a multi-pronged movement aimed at strengthening institutional arrangements for influencing the performance of private health-care providers.

In the last article of this *IDS Bulletin*, we move from the national to the transnational and take our considerations of accountability global. Emma Michelle Taylor and James Smith consider the politicised creation of the term 'neglected tropical diseases' (NTDs) and its salience to current debates on global health priorities, investment, and collective responsibility. They suggest that the NTDs have the potential to function as 'proxies of progress', given that the 17 diseases included under this shared banner can only be eliminated through multi-sectoral action, sustained commitment to improved primary health-care services and health infrastructure, and public–private partnerships to achieve vector control and mass drug administration. If within this framing of NTDs as 'proxy indicators', there was a push to collect disaggregated NTD data (by sex, age, place, race, or ethnicity where possible), it would be possible to begin unpicking the dynamics that shape health inequity among the most marginalised populations, and offer a starting point for identifying accountability failures where they exist.

### 5 Conclusion: naming the moment to shape the future
At the July workshop, Jonathan Fox reflected on a practice common among civil society activists in Latin America in the 1970s and 1980s – '*análisis de coyuntura*' or 'analysing the conjuncture' for political analysis and action. By naming the precise political, social, and economic contours of this moment,[3] we can anchor future action in a recognition of all that has come before. The aim of this *IDS Bulletin* has been to provide a space for the exploration of the moment we are living; a moment in which many long-standing barriers to achieving 'health for all' under the current rubric of Universal Health Coverage remain solidly in place (Rumbold *et al.* 2017). At the same time, major changes to national and global power structures, alongside rapid technological and social change, open up the possibility of innovating accountability practices and processes in ways that favour greater health equity.

We do not yet have a road map for how to best join up accountability efforts at distinct levels of decision-making and influence in health

systems, nor do we fully understand how to wrestle with the accountability gaps created by new market actors (including tech actors) and changes in how we communicate. We are missing tools and indicators that would enable us to identify the influence of relationships of power, not only between levels of health systems organisation, but within them and within the communities they serve. We do not yet have a network-of-networks that joins pro-equity accountability efforts in distinct corners of the globe. We do not yet know what might be possible in terms of challenging stasis and entrenched hierarchies in global health if a true movement for Universal Health Coverage is formed.

Right now, many governments are facing increased demands to meet existing health needs and tackle health inequities. Fears about the next pandemic remain high. At the same time, the emergence of new powers and their search for global leadership roles has created a different set of possibilities for transformational change. New transnational ethical norms within health must reflect this political reality and the uneven balance of power (Bloom and MacGregor, forthcoming). Within this context of complexity and dynamic, shifting political power, a simple framework for accountability will not suffice. Instead, priority must be given to mutual learning and mutual respect between different stakeholders, different levels of health systems decision-making, different cultural norms, and understandings of health entitlements and rights.

Much of the current focus on accountability has been on monitoring the use of externally provided finance to health services (within a value-for-money framework). This can be seen as meeting the needs of an outside agency, and in support of accountability relationships that travel from top to bottom (with the least powerful actors within the system held to account, such as front-line community health workers). The discussions at the July workshop, together with the arguments put forward in this *IDS Bulletin*, are contributing to a different kind of dialogue on the political challenges to accountability. These challenges are not limited to poorly-functioning or corrupt ministries of health or quality-of-care issues in remote health posts, but rather include a much broader range of health systems actors. The new WHO Director-General has said that he hopes to stimulate a movement for Universal Health Coverage. The aim of the July workshop, this *IDS Bulletin*, and all future action connected to the Accountability for Health Equity Programme at IDS is to galvanise our networks in support of Universal Health Coverage, and through the aims of UHC, engender more functional relationships of accountability and greater health equity. It is our hope that in another 20 years' time, when the next set of *IDS Bulletin* authors reflect on what was written in 2018, they will be able to document real progress and transformational change in the health sector.

**Notes**

1 WHO defines 'health inequity' as a 'normative concept, defined as the avoidable and/or unjust differences in health between population subgroups. Statements about health inequity involve a judgement about what is deemed to be right, fair or acceptable in a society' (2015: 5).
2 www.youtube.com/watch?time_continue=1&v=ZFWoVvOFfBA.
3 This methodology of 'naming the moment' was first developed within the popular education movement in Latin America. See, for example: www.catalystcentre.ca/wp-content/uploads/Naming_the_Moment_Manual.pdf.

**References**

Bloom, G. and MacGregor, H. (forthcoming) 'Global Development, Public Health and Ethics', in *Oxford Handbook of Public Health Ethics*

Bloom, G. and Standing, H. (2001) *Pluralism and Marketisation in the Health Sector: Meeting Health Needs in Contexts of Social Change in Low and Middle Income Countries*, IDS Working Paper 136, Brighton: IDS

Bloom, G.; Wilkinson, A.; Standing, H. and Lucas, H. (2014) *Engaging with Health Markets in Low- and Middle-Income Countries*, IDS Working Paper 443, Brighton: IDS, www.ids.ac.uk/publication/engaging-with-health-markets-in-low-and-middle-income-countries (accessed 6 March 2018)

Brinkerhoff, D.W. (2004) 'Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance', *Health Policy and Planning* 19.6: 371–79, doi:10.1093/heapol/czh052 (accessed May 2017)

Bruen, C.; Brugha, R.; Kageni, A. and Wafula, F. (2014) 'A Concept in Flux: Questioning Accountability in the Context of Global Health Cooperation', *Globalization and Health* 10.1: 73, doi:10.1186/s12992-014-0073-9 (accessed 6 March 2018)

Cornwall, A. (2007) 'Buzzwords and Fuzzwords: Deconstructing Development Discourse', *Development in Practice* 17.4–5: 471–84

Cornwall, A. and Gaventa, J. (2000) 'From Users and Choosers to Makers and Shapers: Repositioning Participation in Social Policy', *IDS Bulletin* 31.4: 50–62, doi:10.1111/j.1759-5436.2000.mp31004006.x (accessed June 2017)

Cornwall, A. and Shankland, A. (2008) 'Engaging Citizens: Lessons from Building Brazil's National Health System', *Social Science & Medicine* 66.10: 2173–84

Cornwall, A.; Lucas, H. and Pasteur, K. (2000) 'Introduction: Accountability Through Participation: Developing Workable Partnership Models in the Health Sector', *IDS Bulletin* 31.1: 1–13, doi:10.1111/j.1759-5436.2000.mp31001001.x (accessed June 2017)

Fee, E. and Brown, T.M. (2002) '100 Years of the Pan American Health Organization', *American Journal of Public Health* 92.12: 1888–89

Fox, J. (2016) *Scaling Accountability through Vertically Integrated Civil Society Policy Monitoring and Advocacy*, Making All Voices Count Working Paper, Brighton: IDS

Fox, J. and Halloran, B. with Levy, A.; Aceron, J. and van Zyl, A. (2016) *Connecting the Dots for Accountability: Civil Society Policy Monitoring and Advocacy Strategies*, London: Transparency and Accountability Initiative/School of International Service/American University/International Budget Partnership/Government Watch/SIMLab

Gaventa, J. (2002) 'Exploring Citizenship, Participation and Accountability', *IDS Bulletin* 33.2: 1–14, http://bulletin.ids.ac.uk/idsbo/issue/view/84 (accessed 6 March 2018)

George, A.S. (2009) ' "By Papers and Pens, You Can Only Do So Much": Views about Accountability and Human Resource Management from Indian Government Health Administrators and Workers', *International Journal of Health Planning and Management* 24.3: 205–24, doi:10.1002/hpm.986 (accessed May 2017)

George, A.S.; Erchick, D.J.; Zubairu, M.M.; Barau, I.Y. and Wonodi, C. (2016) 'Sparking, Supporting and Steering Change: Grounding an Accountability Framework with Viewpoints from Nigerian Routine Immunization and Primary Health Care Government Officials', *Health Policy and Planning* 31.9: 1326–32, doi:10.1093/heapol/czw057 (accessed July 2017)

Gilson, L. *et al.* (2011) 'Building the Field of Health Policy and Systems Research: Social Science Matters', *PLoS Medicine* 8.8: e1001079, doi:10.1371/journal.pmed.1001079 (accessed June 2017)

Gorsky, M. and Sirrs, C. (2017) 'World Health by Place: The Politics of International Health System Metrics, 1924–c. 2010', *Journal of Global History* 12.3: 361–85

Gu, J.; Li, X.; Bloom, G. and Zhang, X. (2014) 'Introduction: China and International Development: Challenges and Opportunities', *IDS Bulletin* 45.4: 1–5, http://dx.doi.org/10.1111/1759-5436.12088 (accessed 6 March 2018)

Halloran, B. (2016) *Accountability Ecosystems: Directions of Accountability and Points of Engagement*, Making All Voices Count Research Briefing, Brighton: IDS, https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/11739/RB_ManilaBgnd_Accountability_final.pdf (accessed 6 March 2018)

Hernández, A.; Ruano, A.L.; Marchal, B.; San Sebastián, M. and Flores, W. (2017) 'Engaging with Complexity to Improve the Health of Indigenous People: A Call for the Use of Systems Thinking to Tackle Health Inequity', *International Journal for Equity in Health* 16.26: 26–30

Hilber, A.M. *et al.* (2016) 'Strengthening Accountability for Improved Maternal and Newborn Health: A Mapping of Studies in Sub-Saharan Africa', *International Journal of Gynecology & Obstetrics* 135.3: 345–57

Husain, L. (2017) *China's Increasing Global Health Engagement*, Hove: Itad, www.itad.com/knowledge-products/chinas-increasing-global-health-engagement/ (accessed 6 March 2018)

Joshi, A. (2014) 'Reading the Local Context: A Causal Chain Approach to Social Accountability', *IDS Bulletin* 45.5: 23–35, doi:10.1111/1759-5436.12101 (accessed July 2017)

Joshi, A. and Houtzager, P.P. (2012) 'Widgets or Watchdogs?: Conceptual Explorations in Social Accountability', *Public Management Review* 14.2: 145–62, https://doi.org/10.1080/14719037.2012.657837 (accessed June 2017)

Leonard, D.K. (ed.) (2000) *Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues*, Basingstoke: Macmillan Press

Leonard, D.K.; Bloom, G.; Hanson, K.; O'Farrell, J. and Spicer, N. (2013) 'Institutional Solutions to the Asymmetric Information Problem in Health and Development Services for the Poor', *World Development* 48 (August): 71–87, doi:10.1016/j.worlddev.2013.04.003 (accessed May 2017)

Lodenstein, E.; Dieleman, M.; Gerretsen, B. and Broerse, J.E.W. (2013) 'A Realist Synthesis of the Effect of Social Accountability Interventions on Health Service Providers' and Policymakers' Responsiveness', *Systematic Reviews* 2.1: 98–107, doi:10.1186/2046-4053-2-98 (accessed May 2017)

Marmot, M. (2007) 'Achieving Health Equity: From Root Causes to Fair Outcomes', *The Lancet* 370.9593: 1153–63

McGee, R. and Gaventa, J. (2011) *Shifting Power? Assessing the Impact of Transparency and Accountability Initiatives*, IDS Working Paper 383, Brighton: IDS, www.ids.ac.uk/files/dmfile/Wp383.pdf (accessed 6 March 2018)

McGee, R. with Edwards, D.; Anderson, C.; Hudson, H. and Feruglio, F. (2018) *Appropriating Technology for Accountability: Messages from Making All Voices Count*, Making All Voices Count Research Report, Brighton: IDS, https://opendocs.ids.ac.uk/opendocs/bitstream/handle/123456789/13452/RR_Synth_Online_final.pdf (accessed February 2018)

Morgan, R. *et al.* (2016) 'How to Do (or Not to Do)… Gender Analysis in Health Systems Research', *Health Policy and Planning* 31.8: 1069–78, doi:10.1093/heapol/czw037 (accessed 6 March 2018)

Mulgan, R. (2003) *Holding Power to Account: Accountability in Modern Democracies*, Basingstoke: Palgrave Macmillan

Nkengasong, J.N.; Maiyegun, O. and Moeti, M. (2017) 'Establishing the Africa Centres for Disease Control and Prevention: Responding to Africa's Health Threats', *The Lancet* 5.3: e246–e247, https://doi.org/10.1016/S2214-109X(17)30025-6 (accessed 6 April 2018)

O'Donnell, G.A. (1998) 'Horizontal Accountability in New Democracies', *Journal of Democracy* 9.3: 112–26

Packard, R.M. (2016) *A History of Global Health: Interventions into the Lives of Other People*, Baltimore MD: Johns Hopkins University Press

Paina, L. and Peters, D.H. (2012) 'Understanding Pathways for Scaling Up Health Services through the Lens of Complex Adaptive Systems', *Health Policy and Planning* 27.5: 365–73, https://doi.org/10.1093/heapol/czr054 (accessed 21 March 2018)

Parkhurst, J. (2016) *The Politics of Evidence: From Evidence-Based Policy to the Good Governance of Evidence*, London: Routledge, www.tandfebooks.com/doi/book/10.4324/9781315675008 (accessed August 2017)

Peters, D.H. and Muraleedharan, V.R. (2008) 'Regulating India's Health Services: To What End? What Future?', *Social Science & Medicine* 66.10: 2133–44

Pierson, P. (ed.) (2004) *Politics in Time: History, Institutions, and Social Analysis*, Princeton NJ: Princeton University Press

Rumbold, B. *et al.* (2017) 'Universal Health Coverage, Priority Setting, and the Human Right to Health', *The Lancet* 390.10095: 712–14, https://doi.org/10.1016/S0140-6736(17)30931-5 (accessed July 2017)

Sheikh, K. *et al.* (2011) 'Building the Field of Health Policy and Systems Research: Framing the Questions', *PLoS Medicine* 8.8: e1001073, doi:10.1371/journal.pmed.1001073 (accessed May 2017)

United Nations General Assembly (2015) *Resolution Adopted by the General Assembly on 25 September 2015. Transforming Our World: The 2030 Agenda for Sustainable Development*, www.un.org/ga/search/view_doc/asp?symbol=A/RES/70/1&Lang=E (accessed January 2018)

Van Belle, S. and Mayhew, S.H. (2016) 'What Can We Learn on Public Accountability from Non-Health Disciplines: A Meta-Narrative Review', *BMJ Open* 6.7: e010425, doi:10.1136/bmjopen-2015-010425 (accessed June 2017)

WHO (2018) *WHO Director-General Addresses the Executive Board*, Geneva: World Health Organization, www.who.int/dg/speeches/2018/142-executive-board/en/ (accessed February 2018)

WHO (2017) *National Health Inequality Monitoring: A Step-by-Step Manual*, Geneva: World Health Organization, http://apps.who.int/iris/bitstream/10665/255652/1/9789241512183-eng.pdf?ua=1 (accessed May 2017)

WHO (2015) *State of Inequality: Reproductive, Maternal, Newborn and Child Health*, Geneva: World Health Organization, http://apps.who.int/iris/bitstream/10665/164590/1/9789241564908_eng.pdf?ua=1&ua=1 (accessed July 2017)

World Bank (2003) *World Development Report 2004: Making Services Work for Poor People*, Washington DC: World Bank/Oxford University Press