Toward Social Accountability

The World Health Organization (WHO) describes social accountability as, 'the obligation [of physicians and medical institutions] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve' (Boelen & Heck 1995). For care to be socially accountable, it must be equitably accessible to everyone and responsive to patient, community, and population health needs (Buchman et al 2016).

The World Bank identifies four factors vital for any social accountability program. In this description "health care system" will be substituted for "state/government" and "community" for "citizens": (i) the opportunities for information exchange, dialogue and negotiation between communities and the health care system; (ii) the willingness and ability of communities to seek accountability in the health care system; (iii) the willingness and ability of health care systems and policy-makers to support constructive engagement with communities; and (iv) the broader environment that enables increased community engagement (such as the policy, legal and regulatory environment; the type of political system, the values and norms of society) (World Bank, 2002. Available from:http://www.worldbank.org/socialaccountability_sourcebook/PrintVersions/Health%2006.22.07.pdf)

Figure 1: The Benefits of Social Accountability

Below is an example of necessary collaborators to assure a socially accountable health system:

Literature on social accountability generally revolves around advocacy for vulnerable populations whose voice at the table is most likely to be dismissed. Critical to social accountability models such as the CARE Model, Equity Gauge and THEnet Model is an emphasis on the redistribution of power to assure the there is fair and effective inclusion and response to the needs and interests of underserved stakeholders (Sandhu et al, 2013).

To fully appreciate how to effectively engage and partner with community members, particularly vulnerable community partners, it is critically important to consider culturally and historically-embedded structures of power. Notably, the medical establishment is particularly notorious for being hierarchical. With this in mind, let us consider the construct developed by Dr. Camara Jones, President of the American Public Health Association, around racism. She describes three types of racism: institutionalized racism; personally mediated racism; and internalized racism (Jones, 2000). Vulnerable populations can certainly manifest in other "-isms" such as sexism, ableism, ageism, ruralism, etc. so let us expand Dr. Jones' construct to embrace concepts of power and privilege and frame our partnership with vulnerable

communities with an appreciation for: institutionalized inequity; individual bias; and internalized oppression**.**

In order to develop socially accountable metrics, we must assure that we we have considered issues of process and power in its initial framing, if we want to assure an authentically robust outcome. I propose application of concepts from the Equity and Empowerment Lens (Multnomah County Office of Diversity and Equity, 2014 https://multco.us/diversity-equity/equity-and-empowerment-lens).[1]

In reviewing, the five "P"s shown above, I will first articulate that our purpose is to eliminate health inequities through the central "issue" of a social accountability framework.

[1] Watch "Equity and Empowerment Lens: A tool to create equitable policies and programs" webinar https://www.youtube.com/watch?v=MvIbpGeBlqM)

Before addressing issues of people and place, we must first address process and power.

To begin the process consider an exercise at the forthcoming December Hands-On meeting that utilizes the collective wisdom and leadership of the six task force teams:
Task Force Areas

- Practice
- Workforce Education
- Technology
- Research
- Payment
- Engagement

Cross Tactic Team Health Disparities members would be interspersed in the above groups. Each team would work on the following questions around process and power:

- What barriers does your tactic team area encounter in making changes directly related to equity? (i.e., obligational, political, institutional climate (e.g. racism), emotional, legal, programmatic, managerial, financial, internal biases)
- How does your tactic team area engage the community in planning, decision-making, and evaluation?
- What policies, processes and social relationships meaningfully and intentionally *include c*ommunities most affected by inequities in your task force area?
- What policies, processes and social relationships contribute to the *exclusion* of communities most affected by inequities in your task force area?
- For policies and processes that exclude, what actions or strategies could build inclusion in your task force area?
- How does your tactic team area build community capacity and power in communities most affected by inequities?
- Who should be at the table for the Health Equity Summit to assure socially-responsive metrics are developed in your task force area?