

**Social Accountability and Accreditation
Impacting Health System Performance and Population Health**

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EXECUTIVE SUMMARY

Today's reality all over the world has shown a huge disparity in the quality, equity, relevance, partnership and efficiency in the provision of health services resulting in huge gap of health status in many societies across the globe, be it in the developed and the developing countries. A number of reasons have been discussed. One most important reason is the disconnected between medical schools and health profession education institutions with their ecosystem and community they are mandated to serve. The concept of social accountability endorsed by the WHO since 1995 has not really been embraced by medical and health profession education institutions and not yet supported by key policy makers and health managers in many regions and countries. A few case studies have proved that the concept of social accountability is feasible and manageable; and it eventually brings beneficial impact for the society in improving the health status. Existing guidelines and approaches could be used to accelerate the adoption of social accountability as long as key actors from international, national, institution and community levels are orchestrated congruently. A new paradigm in school's accreditation embracing social accountability concept could reinforce this venture.

Keywords: medical schools, social accountability, accreditation

Key Points:

- **Applicable to ministries of health and all health profession education schools**
- **Acknowledge that medical schools need to make this change as they are often the “blockers” of change.**
- **We need to adopt a moral compact that health is the fundamental human right, therefore multisectoral collaboration is a must.**

CONTEXT

Despite rapid advancement in medical science and technology coupled with fast progress in digital technology, according to World Health Organization (2011) over a billion people worldwide lack access to quality health services. This is due to a huge shortage, imbalanced skill mix, and uneven geographical distribution of professionally qualified health workers such as doctors, nurses and midwives. It is estimated that an additional 2.4 million doctors, nurses and midwives are needed worldwide (World Health Organization, 2013). This crisis has disastrous implications for the health and well-being of millions of people. Scaling up educational programmes to produce more doctors, nurses, midwives and other health professionals is clearly urgent and essential. However, increasing the number of graduates will not be enough. The shortage of professional health workers is compounded by the fact that often their skills, competencies, clinical experience, and expectations are often inappropriately matched to the health needs of much of the population they serve. Insufficient collaboration between the health and education sectors, as well as weak links between educational institutions and the health systems which employ graduates, often result in a mismatch between professional education and the realities of health service delivery including, but not limited to, public health emergencies and rapidly emerging global health issues. These factors limit the capacity of even highly-qualified personnel to improve health outcomes and respond to complex health challenges.

Global Consensus on Social Accountability in 2010 acknowledges this crisis summarized in the following statement:

“The 21st century presents medical schools with a different set of challenges: improving quality, equity, relevance and effectiveness in health care delivery; reducing the mis-match with societal priorities; redefining roles of health professionals and providing evidence of the impact on people’s health status.” (Global Consensus for Social Accountability of Medical Schools, 2010)

As early as 1978 when the Alma Ata Declaration was launched, concerns have been voiced out by world and national leaders to move toward primary health care which is critical to achieving Health for All by the year 2000 (WHO, 1978). However, after almost twenty years, rising inequity and poverty across the globe, political injustice, economic scarcity, food shortages, and unfavorable environments continue causing threats to the attainment of healthy lives and well-being.

In 1988, the World Federation of Medical Education (WFME) issued the Edinburgh Declaration on Medical Education that called for a closer link between medical education and health system. It acknowledged that “... *prior efforts to introduce greater social awareness into academic medical schools have not been notably successful*”. Two most relevant recommendations with the concept of social accountability are to ensure that that curriculum content reflects national and local health priorities and the availability of affordable resources, as well as to encourage and facilitate co-operation between the Ministries of Health, Ministries of Education, community health services and other relevant bodies in joint policy development, programme planning, implementation and review (WFME, 1988).

Being cognizant of this condition, in 1995 WHO introduced the concept of social accountability in its publication entitled “*Defining and measuring the social accountability of medical schools*”. Social accountability of medical schools was then defined as: “*the obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public*” (Boelen & Heck, 1995). This definition is based on the argument that a medical school has a social obligation to serve the community they are mandated. Therefore, there must be a closed alignment between medical education system and health system.

Since then, a growing number of publications on social accountability have documented the evidence on how Social Accountability contributes to addressing the issues. The Global Consensus for Social Accountability of medical schools has identified the characteristics of a socially accountable medical school, namely: (i) responds to current and future health needs and challenges in society; (ii) reorients its education, research and service priorities accordingly; (iii) strengthens its governance and partnerships with other stakeholders; (iv) uses evaluation and accreditation to assess performance and impact (Global Consensus for Social Accountability of Medical Schools, 2010)

The concept of social accountability is grounded on four basic principles or values of the health system, namely: Relevance, Quality, Cost-effectiveness and Equity (Boelen & Heck 1995). Medical schools who develop and train medical doctors must ensure that the medical education programmes produce medical graduates who have relevant competencies needed to work in health services which eventually bring impact to the betterment of health system and improve population health (Boelen et al., 2016). Therefore, these values should underlie medical schools’ activities, namely education, research and service.

In its early publication, Boelen and Heck (1995) developed a Social Accountability Grid that can be used to evaluate to what extent a medical school moves toward social accountability. This Grid evaluates the values of social accountability in education, research and service for planning, doing and impacting. Boelen and Woollard (2009) developed the CPU model, which is an abbreviation of “Conceptualization, Production and Usability”. For each domain, a number of parameters are identified. The “*Conceptualization*” domain explores a medical school’s capacity to formulate explicitly the current and anticipated needs of society and its ability to respond. The “*Production*” domain explores the capacity to conduct educational, research and service activities consistent with identified needs and challenges. The “*Usability*” domain explores the capacity to make the most fruitful use of the school’s products as anticipated at the conceptualization stage. In 2010, “Global Consensus on Social Accountability of Medical Schools” (Global Consensus for Social Accountability of Medical Schools, 2010) offers 10 strategic directions which are elaborated into detailed actions which can be feasibly applied by medical schools. Further effort was elaborated

by Boelen and his colleagues (2012) in translating parameters in CPU model into specific indicators which are determined by medical schools themselves to assess progress toward social accountability (Boelen et al. 2012).

The following section explores several case studies representing success story on how a medical school has adopted social accountability principles and applied contextually.

CASE STUDIES

COUNTRY/MINISTRIES OF HEALTH

We provide two case studies to demonstrate the potential results when a country prioritizes the adoption and implementation of Social Accountability standards for all Medical Schools within a country. These represent a high sand a low resource nation—one with a long-established confederated structure with a new medical school and one with a new medical school established during a revolutionary development and establishment of a new confederated constitution. Given the diverse nature of academic health education institutions around the world, there are lessons to be learned from how national standards of accreditation and regularity mechanisms can develop, evolve and influence health and educational systems to co-develop responsive and accountable health systems that respond to priorities of the systems in which they are embedded.

Northern Ontario School of Medicine (Canada)

When Northern Ontario School of Medicine (NOSM) was established in 2006, principles of social accountability formed the foundation of its development. The planning, implementation and evaluation of the school's programs were conducted in close consultation with local authorities and communities. By thus *engaging* (not just consulting) with the broad range of populations in the region (including French minorities and Indigenous peoples) the policies, processes and structure of the school helped embed best choices to address the local needs. The medical education program is characterized by a longitudinal community immersion of students, learning in groups on real life health cases, tutoring by highly motivated staff to the school's mission (Strasser et al., 2013).

It is important to see NOSM as an example of iterative co-development of local innovation and national policy in a complex accreditation and regulatory environment. While there are unique features of the Canadian federation with primacy of Provincial management of the health and educational systems; this may have some bearing in many nations around the world as their own systems adapt to both evolutionary and revolutionary changes. In 2001 the national health ministry, in close engagement with national medical regulatory, educational and advocacy organizations produced a “white paper” of intended evolution towards social accountability (Cappon et al., 2001).

In the ensuing two decades this has developed into efforts at the undergraduate, postgraduate and CPD levels into concerted revisions of curricula and accreditation standards now fully

implemented with social accountability being a primary intent throughout. NOSM came into being during this time and as a new school could be explicitly developed in keeping with the evolving consensus. The existing 16 Canadian schools had differing challenges in “renovating” their institutions and the pathways and impacts will be published shortly.

NOSM has demonstrated significant impacts on the delivery of health services across the region served. A large majority (67%) of NOSM MD graduates choose specialty training in Family Medicine, and 30% enter other general specialties needed in the region (Strasser et al. 2013). More than 70% of those completing post-graduate medical training at NOSM remain in the region to practice and this figure rises to over 90% for those doing both MD and post-graduate training at NOSM (Boelen et al., 2016).

Patan Academy of Health Sciences (PAHS) Nepal

In a fashion similar to NOSM but in a dramatically different context PAHS was conceived and established on the foundation of social accountability (Woollard, 2005). Over the course of PAH’s development, Nepal underwent a coup, a counter-coup, a revolution, the establishment of a republic with a new constitution creating a federated state with the health and educational policy and management largely devolved to provincial authority. Unlike Canada, where there were no private for-profit medical schools, Nepal underwent a virtual explosion of new for-profit schools, the vast majority of whose graduates left the country within two years. PAHS is a public school with an emphasis on the health of rural and lower caste populations whose health status was at dramatic negative variance to the populations in the Kathmandu Valley. A sophisticated admissions process, extensive use of self-directed and community engaged learning methods and the evolution of extensive web-based connections and distance learning has resulted in virtually all of the first 4 cohorts of graduates establishing service in needed areas within Nepal.

An extensive national review of medical education somewhat analogous to the Canadian experience has sought to change the accreditation and regulation of education in a more coherent national direction with greater commitment to quality improvement of all schools. During the 2015 earthquake disaster, PAHS became a beacon for disaster response and remains the paradigm of social accountable health education in Nepal (medical, nursing, public health and midwifery)

These two institutions briefly described here are examples of how national policies related to social accountability can both enable and be, themselves, shaped by innovations in health professional education. Accreditation systems become necessary but not sufficient factors in such attempts at systems transformation (Boelen et al., 2019). In both instances the model of the “pentagram partnerships” proved a useful lens for exploring the complex context needed for change and engaging the full range of partners required to actually make positive change. This is true at the scale of both the individual institutions and the broader systems level where the critical shortages and mismatch of professionals to needs are most acute.

MEDICAL INSTITUTIONS

Medical school of Tours, France. The medical school of Tours is one of the 35 medical schools in France. The dean and his team regularly invite representatives of all major health actors, from health authorities to citizens, of the Region (Region du Centre et du val de Loire) which counts for 3 million of inhabitants to attend meetings on the school premisses, addressing a straightforward question: “***What can and should the medical school do for you?***”. Each time, priority recommendations are made that engage all stakeholders and interim meetings are held to monitor progress in implementation of those recommendations. Again it is too early to predict whether this initiative will lead to improved coverage, create multi-professional health centers and contribute to greater equity and effectiveness in the health sector, but all ingredients are assembled to design an innovative and purposeful medical education program. Events such as the following are encouraging signs to that effect: the dean receiving a call from a village mayor to help establish a multi-professional health center with assistance of faculty and students; the regional health authority planning cooperative action to attract young graduates to settle in remote areas; health professional associations willing to review policies and practices for task shifting within multi-professional teams.

Medical school of the Fundacion HA Barceleo, Buenos Aeres, Argentina.

The medical school was founded in 1992 “***to serve health sciences and social values in the spirit of democracy, humanism and ethics***”. Very conscious of the living conditions affecting people's health status in the country, the leadership of the school made a strong commitment to social accountability principles. In 1998, the school created an academic health center in Santo Tome, a moderate size town in the province of Corrientes, close to the Argentina-Brazilian border. By this extension of the school far from the capital city in a low income community, a unique opportunity was given to faculty and students to be exposed to socio- economic and cultural determinants of health. Students were recruited from the community with plan to incite them to settle in their local environment when graduated. Strong relationships of the academic center with local health authorities and professionnals were weaved to address priority health problems.

Ateneo de Zamboanga School of Medicine

In The Philippines, the highly disadvantaged populations in the big island of Mindanao led to the creation of a medical school in Zamboanga. The graduates would return to their villages or small towns of origin where health facilities were rare and health indicators poor. From the early start, the Dean and faculty maintain strong links with local public and health authorities and initiated an educational program totally dedicated to respond to local pressing health needs, using the catchment area as a main source of learning opportunities, addressing the various health determinants and implementing effective pedagogical approaches. Two decades later, after consistently implementing a social accountable education program, the school estimates that it contributed to decrease the infant mortality rates by 90% and to retain 80% of their graduates in

local underserved areas, which a great deal would have migrated otherwise either to the capital city or abroad (Cristobal & Worley, 2012). The Philippines, like many LMIC countries, in the crisis situation of health human resources outlined by the WHO has been subject to the establishment of many private, for-profit health professional schools—many of very low quality producing graduates for elsewhere. The Atteneo de Zaboanga school this serves as a shining example of an alternative, locally focused approach that, together with a well developed laddering program, has proven successful in drawing future professionals from the population in need and providing opportunities for relevant education and engaged service. This provides a replicable model for the rest of the country in shifting away from profit driven irrelevance to increasing self sufficiency in appropriate health professionals.

The Tunis Medical School

The Tunis medical school has been established for 50 years after the French model under the former colonial ruler. A considerable leap toward social accountability was eventually achieved in 2011 and 2012 at time of the “arab spring revolution”. The four medical schools unanimously decided, in close concertation with the Ministries of Health and Higher Education, to address one of the main causes of the national unrest. The flagrant disparity in well being between populations living on the coast and those living inland has long existed. This led each school to commit extending its services to the entire population. In case of the Tunis medical school, the leadership and faculty members facilitated a national societal dialog with representatives of several health actors including civil society to reform the health system toward greater equity and effectiveness. In practice, the school passed an agreement with the health authorities to serve the northern part of the country and its two millions of inhabitants. The school made a special commitment to improve the performance of the first level of care, enlarge health services coverage and prioritize the development of family medicine education program (Boelen, 2016).

Chulalongkorn Faculty of Medicine Thailand

In 1978, Chulalongkorn University started a parallel program called MESRAP. This program aims at increasing medical graduates and decrease maldistribution by recruiting students from rural areas, conducting their clinical training in rural hospitals and health centres, after graduation sending them back to work in rural communities. The curriculum was designed specifically to produce community doctors and is known as a community-oriented curriculum. Input from the community was drawn on in curriculum development. Suggestions were gathered from community leaders, data were obtained from local and national health problems. In 1997, there were 453 living MESRAP graduates, 388 were working in rural areas and 65 were pursuing further studies. Using Social Accountability grid, a systematic review was conducted and found that social responsiveness is outstanding in the educational domain, fair in the research domain, and good in the service domain. The key success were the leadership of the dean, the participation and loyalty of the staff of the institution, and the missions of the medical school and Chulalongkorn Memorial Hospital (Sirisup, 1999)

Faculty of Medicine Suez Canal University

The Faculty of Medicine Suez Canal University (FoMSU) has the autonomy to organize its health service activities as optimally as possible. Since its establishment in 1978, the school has had a well-planned community program including teaching, research and service taking into consideration the community needs. The school implements required priority health programs in collaboration with the Ministry of Health. In the period before job assignment in the faculty, which is six months at least, the MOH distributes all medical graduates to the PHC centers as an obligatory period of service. It remains a challenge to have a majority of faculty accepting to work in PHC centers as they regard this as a job for MOH physicians. Despite the fact that the school has an excellent reputation in health delivery in the five governorates it serves, the true impact on community health has not yet been measured (Hosny et al., 2015)

CASE STUDY ANALYSIS/FINDINGS

Based on the six social parameters of the Social Obligation Scale, i.e 1) social needs identified; 2) institutional objectives; 3) educational programmes; 4) quality of graduates; 5) focus of evaluation; and 6) assessors, a medical school might be at the stage of social responsibility, then social responsiveness, eventually social accountability, (Boelen et al., 2016). The above cases are all at the stage of approaching social accountability, although in one parameter – impact to population – FoMSU acknowledged that a systematic evaluation had not been done yet. With regards to barriers and enablers, in line with the results from (Leigh-Hunt et al., 2015), six factors are identified that can be barriers or enablers, namely external factors, institutional system and staff, research priorities, design and delivery, student selection and values, curriculum design and deliveries, implementation and evaluation. All the above cases have managed to overcome barriers and gained enablers. Ultimately, it is proven that social accountability requires support from national authorities, political and academic partners, including accrediting bodies (Boelen et al., 2016)

Table 1. Social obligation scale.

	Responsibility	Responsiveness	Accountability
1: Social needs identified	Implicitly	Explicitly	Anticipatively
2: Institutional objectives	Defined by faculty	Inspired from data	Defined with society
3: Educational programs	Community-oriented	Community-based	Contextualized
4: Quality of graduates	«Good» practitioners	Meeting criteria of professionalism	Health system change agents
5: Focus of evaluation	Process	Outcome	Impact
6: Assessors	Internal	External	Health partners

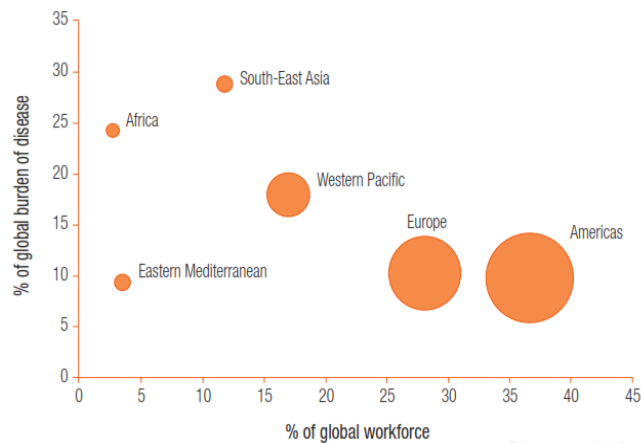
(Boelen et al., 2012)

SCALING SOCIAL ACCOUNTABILITY CHALLENGES

Despite the fact that social accountability for medical schools have been echoed for almost four decades, the adoption and implementation of social accountability continues to be a high level of resistance from many medical schools. One of the key issues for this is the poor coordination and organisational collaboration between the education system and the health ministries in many countries. Medical schools are usually under jurisdiction of Ministry of Higher Education, whilst the health system is under the authorities of Ministries of Health with separate budget schema. Medical, nursing and midwifery and other schools frequently do not operate in synergy with Ministries of Health who will eventually deploy their graduates. With a structural disconnection so profound historically and politically, it is little surprise that these institutions often produce health professionals who are ill-suited to meet the needs of their country's health system.

According to WHO Report in 2006, there is a global shortage of health professionals and is most severe in low and middle income countries. As an example, and as depicted in Figure 2, overall, sub-Saharan Africa has a total professional health workforce of approximately 1 per 1000 people — the lowest ratio of any region in the world. Yet the burden of disease in the region is among the highest. At the country level, shortages are made more acute by uneven distribution across the population. In many countries the majority of professional health workers are practising in towns and cities, rather than in rural and underserved areas. Poor working conditions and low pay also make it hard to retain qualified health professionals in service to hard-to-reach populations and many choose to emigrate to more attractive jobs in more developed countries. Brain drain of medical doctors is still a common phenomena these days. Some countries are unable to recruit the graduates they have educated since new doctors, nurses, midwives and other health professionals cannot be deployed without sufficient budgetary resources to hire and support them (WHO, 2011).

Figure 1. Distribution of the health workforce by level of health expenditure and burden of disease, by WHO region



(World Health Organization, 2006)

No matter how many individuals are educated and deployed, medical doctors and other health professionals cannot impact population health issues unless the disconnect between the health workforce and social care workforce is addressed. Focusing on improving the quality of education alone might have a moderate impact on population health. WHO guidelines on ‘Transforming and Scaling up Health Professionals’ Education and Training’ (2013) calls for new approaches in health professions’ education, namely social accountability. This new approach takes the education institutions away from its fragmented traditional focus to shift to looking at the education as a complex system involving the whole institution and its surrounding stakeholders. The factors preventing Medical Schools to adopt and implement Social Accountability can be attributed to accreditation systems, recruitment of students, out-migration of health care workers, and economics.

Accreditation Systems and Rankings

Not all countries have established accreditation system for medical education programmes. Regulatory mechanisms designed to ensure the quality of education, such as accreditation, are rarely standardized and are often weak and inconsistently applied, especially in the case of private sector institutions. Excellence of educational institutions is generally not associated with how well students are prepared to address their context-specific population health needs (WHO, 2011). Currently, many universities are pursuing university ranking and international accreditation; having international recognition as their vision is seen more prestigious rather than focusing on meeting the needs of the population. This is worsen by the fact that standards as the basis for accreditation are usually grounded on the quantative measures of input and product. ‘Conceptualization’ and ‘Usability’ as figured out in the CPU model by Boelen and Woollard

(2009) are not yet taken into consideration. The institution and programme assessment is currently based on the peer-review concept, which has prohibited the involvement of assessors representing the health system and the public.

The national higher education system has a profound effect on how a medical school is managed. In most countries, medical schools are subsystem of university systems. They must follow the academic regulation of their respective university, as well as national policy and regulation from the Ministry of Higher Education. Currently, especially in developing countries, Ministries of Higher Education have pushed universities to increase their researches and publication capacities so as to increase their ranking – nationally and internationally. Schools and faculties are geared towards conducting breakthrough researches. Academic promotions are tied in with the number of publication in reputable international journals.

The political dynamic might imperil the good intention to provide health services relevant to the need of the population. There are countries who has more centralized government where all health policies are decided at the national level. The local governments must comply with the national health policies. In this situation, the district health offices might be less sensitive to respond and tackle local health needs. In countries where health policies are decentralized, the political parties who win the local government election, could have other priorities other than health.

Recruitment of Students

The recruitment of students is seen in that providing health services in primary health is not the priority of universities and potential medical candidates from rural or underserved areas are not prioritized. As an example, in Pakistan, the proportion of the population receiving services in primary care centres is 85% with only 1% of the population's health care needs being met at the tertiary level. The pattern is similar in many other countries, yet the deployment of the professional health workforce fails to reflect the way service delivery is organized. Less than 9% of graduates from medical schools in sub-Saharan Africa are practicing in rural public general practice. This is partly because, providing health services in primary health care is not the concern of the universities. Mostly, the medical students spend their clinical years in tertiary and secondary teaching hospitals. Other challenges relate to the suitability of the students who are recruited into the health professions. The concentration of opportunities in urban and specialist settings also influences the types of students that are recruited. Potential candidates from rural or underserved areas face numerous disincentives including travel, accommodation and lack of familiarity with an environment so far from home (WHO, 2011).

Out-Migration of Health Care Workers

The issue of out-migration of health care workers from developed to developing countries further compounds long-standing intra-country disparities between urban centres and rural environs. In general, rural areas have lower availability and quality of local health facilities with inadequate staffing. Further, it is often more difficult to gain access to health services due to distance,

transportation, road infrastructure, and geographical factors (Salafsky et al., 2005). Ensuring that health care workers, including medical doctors, opt to serve their own country in the most needed areas requires both professional and national commitments that prioritize the country's health needs. While some of these commitments may be regulatory, the most effective ones will be a combination of inspiring service and providing the infrastructure whereby recent graduates can do their highest and best work. It is likely that a large percentage of the outmigration of trained health professionals relates less to economic advancement and more to frustration at seeing suffering that they might help but lacking resources to use their skills in that effort.

Economics

University autonomy is one pillar in higher education management that has been adopted by many countries. In developed countries, autonomous university means delegating government powers to university to manage their own affairs. Universities become self regulating institutions in order to improve their efficiency and their relevance. However, in many developing countries, university autonomy means giving authorities to public universities to generate income due to decreasing government funding for public universities. This has pushed universities to become entrepreneurial universities, academic staffs are pushed to do researches that will have economic value from commercialization of research results. University autonomy in itself has little meaning, it has to be coupled with the University vision and mission.

Boelen et al (2016) has further identified a number of economic barriers. The greatest barrier is the traditional manner in which institutions are incentivized to behave. Preventive health programme receives lowest priority of budget and is poorly rewarded. Practicing primary and collaborative care lacks sufficient prestige. Community engagement with other stakeholders and sectors in society is a slow process in which few faculty have skills or are allowed sufficient time for investment. Professions tend to be self-regulated and can be challenged to what extent they prioritize serving to the people with the greatest health needs (Boelen et al., 2016)

CALL TO ACTION

From the public administration perspective, social accountability is defined as *a form of accountability that emerges through actions by citizens and civil society organization aimed at holding the state to account, as well as efforts by government and other actors (media, private sector, donors) to support these action* (UNDP, 2010). It is important to emphasize that social accountability is the operationalization of a number of key principles which are at the heart of the democratic governance and human-right based approach to development. States are legally responsible for commitment they have made under international human rights treaties and their own national legislation. Right-holders are entitled to hold them to account for these obligations and can use a wide array of formal and informal measures to do so (UNDP, 2010)

Social accountability can enhance development outcomes and progress towards the achievement of human development overall by strengthening the links between government and citizens to (UNDP, 2010):

- Improve the focus of public service delivery
- Monitor government performance and foster responsive governance
- Emphasize the needs of vulnerable groups in policy formulation and implementation
- Facilitate effective links between the citizens and local governments in the context of decentralization
- Empower marginalized groups traditionally excluded from policy processes

As a fundamental human right, it is the responsibility of every government to ensure that universal access for health care is guaranteed. Good health and well-being is one of the Sustainable Development Goals.

What is needed is a radical transformation that puts population health needs at the centre of health professional education and positions health outcomes as a crucial component by which the educational process is assessed. To achieve this transformation, isolated improvements in educational institutions or narrowly defined health sector reforms will not be enough. While the expansion of health professional schools may serve to increase the quantity of professional health workers, expansion alone will not meet the equally important objectives of improving the quality and relevance of the health workforce. Without the active engagement of real people, with passion and commitment, it often proves impossible to change established norms. Yet social movements rarely succeed without appropriate technical instruments that can help convert aspirations into practical action on the ground.

WHO in 2013 issued a Guidelines on “*Transformative scaling up of health professionals’ education and training*” which is defined as the sustainable expansion and reform of health professionals’ education and training to *increase the **quantity, quality and relevance** of health professionals, and in so doing strengthen the country health systems and improve population health outcomes* (World Health Organization, 2013). The three strategies to put the principles of social accountability into action are: (i) demonstrate excellence and advantage to the medical schools, (ii) involve stakeholders to build the vision, and (iii) to lobby both nationally and globally (Boelen et al., 2016). Two other strategies are major cultural transformation within health professional education and changes in the structure and outcomes of medical education and practice. To move from intention to action, academic administrators, affiliated hospital and health centres, members of accreditation governing bodies need to commit to social accountability through leadership development, organizational capacity building, and programmatic governance (Ventres et al., 2018).

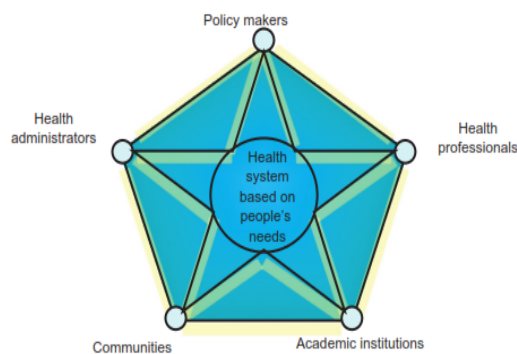
We can conclude that globally social accountability for medical schools is accepted as philosophy, norms, principles and vehicle to improve the health system which bears universal coverage, relevance, and equity. The following are recommendations stemming from the above position.

POLICY RECOMMENDATIONS

These policy recommendations are based upon steering the global community toward a balance between individual and communal interests. They are not based upon a revolution of the existing structures, but rather an evolution to meet the demands of a changing world.

They are framed within the existing guidelines constructed by leading figures and organizations internationally. The CPU Model (Conceptualization-Production-Usability) provides parameters which can be used to gauge the degree of socially accountable medical schools (Boelen & Woollard, 2009). Global Concensus for Social Accountability of Medical Schools (GCSA, 2010) proposes ten strategic guidances to become socially accountable. The AMEE Guide (Boelen et al., 2016) on Producing a Socially Accountable Medical School provides a deeper understanding of social accountability concepts and advices on how to overcome barriers and resistance to change based on fruitful examples from three medical schools in improving the health status of their community. The Partnership Pentagram provides a framework for developing the health system based on people's needs by involving principal stakeholders, namely policy makers, health profession, academic institutions, communities and health managers as depicted in Figure 2. This Partnership Pentagram could be applied in all levels – from local, regional, provincial and national.

Figure 2. Relationship building partnership pentagram



(Boelen, 2000)

Internationally

International partners have a key role to play in supporting country-led strategies for reform and helping to facilitate the engagement of many stakeholders. Global political leadership and the

commitment of international policy-makers responsible for priority health programmes and education programmes will be crucial to success.

- Curate a policy and system change course composed of workshops, symposiums, expert consultations and community of practices for local change agents as one mechanism to support them to find simple options for action in their volatile, uncertain, complex, and ambiguous worlds.
- Construct, collaboratively with global thought leaders, a policy and system toolbox for local change agents.
- Publically recognize academic institutions as the global health leaders who are leading their respective universities/institutes toward Social Accountability standards.

Nationally

National governments need to enact a medical education legislation to achieve greater alignment between educational institutions and health service delivery. There must be far greater cooperation and coordination between the education and health sectors at many levels. Closer working relationships must be established between ministries of education and health as well as other relevant ministries such as finance and labour. Mobilizing multisectoral and multi ministerial level can only be done through legislation. All issues relating to social accountability are drafted and incorporated in the legislation, such as multisectoral collaboration, social accountability of medical schools, health equity, population-based health system, reforming accreditation system to include redefinition of excellence, aligning financial incentives to support social accountable goals, tools to assess short-term and long-term impact of medical education. The presence of such national legislation could sustain institutional initiatives and endeavour in moving towards socially accountable medical and health profession schools.

National governments need to establish a national authority to regulate medical education and practice. Once medical education legislation is enacted, there must be a national authority across ministries who is mandated to coordinate the execution of medical education legislation. This authorized agency could adopt the concept of collaborative governance as defined by Ansell and Gash (2008):

“A governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets”. (Ansell & Gash, 2008)

Hence, the members of medical regulatory governing bodies comprises of representatives from ministry of education, ministry of health, ministry of finance, ministry of internal affairs, professional organizations, medical schools association, general practitioner and specialist, colleges, community organization, and other stakeholders. This medical regulatory body is a melting pot of all stakeholders in medical education, health services and public as reflected in the Partnership Pentagonam (see Figure 2). The remits of this agency could be to facilitate the dialogues

among multiple stakeholders and to decree related rules and regulation derived from the national legislation based on participatory decision making process. This agency could develop instruments and toolkits to monitor the implementation of socially accountable medical education legislation.

Locally: Institutional and Community

There is a need to consider the concept of social accountability as an essential source of the inspiration in elaborating a strategy for the future development of the institution. For this to happen, there must be a driving force, which is not seen as threatening to a traditional leadership. For instance, the institution may decide to setup a think tank whose mission is to make an initial inventory of actions already taken by the institution which are relevant to social accountability and explore ways to initiate new and more committing ones. Practically, an internationally developed toolkit could help establishing such a think tank with clear terms of reference and advice of how it should link to the governing bodies of the institution. National medical regulations could be an external driving force to accelerate the institutional efforts. One valuable toolkit that could be used has been developed by the International Federation of Medical Students' Association in collaboration with TheNet. This toolkit aspires students to take action to move towards socially accountable medical schools (IFMSA, 2017).

It has been comprehended that the concept of social accountability of medical and health profession education is a complex system as it tries to bring together various systems and subsystems into harmonious actions to improve people's health. The appreciative inquiry approach which has been developed as a philosophy and an orientation to change the human system (Macpherson, 2015) could be used by the institutions and community in initiating changes towards social accountability. The appreciative inquiry attends to the positive core of relationships and organizations which is encapsulated into 4 D cycle process, namely Discovery, Dream, Design, and Destiny (Watkins & Stavros, 2009).

Conclusion

We have learned that today's reality all over the world has shown a huge disparity in the quality, equity, relevance, partnership and efficiency in the provision of health services resulting in huge gap of health status in many societies across the globe, be it in the developed and the developing countries. A number of reasons have been discussed. One most important reason is the disconnected between medical schools and health profession education institutions with their ecosystem and community they are mandated to serve. The concept of social accountability endorsed by the WHO since 1995 has not really been embraced by medical and health profession education institutions and not yet supported by key policy makers and health managers in many regions and countries. A few case studies have proved that the concept of social accountability is feasible and manageable; and it eventually brings beneficial impact for the society in improving the health status. We need to expand the adoption of social accountability in order to achieve the

ultimate goal of social justice. We can start from the international community, country level, institutions and community. If the key actors from each levels are orchestrated congruently, social accountability implementation could be accelerated. A new paradigm in school's accreditation embracing social accountability concept could reinforce this venture.

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