Assessing and enhancing health stakeholders' impact on people's health using a social accountability conceptual framework

Charles Boelen[1], Paul Grand'Maison[2], Somaya Hosny[3], and Karen Flegg[4]

[1]MD, DPH, MSc, International consultant in health systems and workforce, former Coordinator of WHO Human Resources for Health., France
[2]MD, MSc, Emeritus Professor and Associate Professor, Department of Family Medicine and Emergency Medicine, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Sherbrooke, Canada
[3]MD, PhD, MHPE, Former Dean, Professor, Department of Physiology, Faculty of Medicine, Suez Canal University, Ismailia. Egypt
[4]MBBS, MIPH, President of WONCA, Asssociate Professor, Rural Clinical School, Australian National University, Canberra, Australia

Abstract

There is a growing worldwide concern about the capacity of health systems to effectively address both current and future health needs and challenges faced by societies and individuals. The key players in this context, referred to here as "health stakeholders", must reconsider how they can enhance their response to health needs in society. This paper introduces a conceptual framework grounded on principles of social accountability that is designed to help stakeholders critically assess their contributions. The framework supports the alignment of stakeholder missions and actions with evolving social needs and enables the evaluation of their impact on population health and well-being.

The uniqueness of this framework lies in its starting point: it prioritizes relevant broad features of health in a society rather than beginning with the stakeholder itself and its conferred mandate. This shift in focus enhances the relevance and effectiveness of the dynamic interplay between health in society and various stakeholder roles. The three-gradients stepwise approach of social accountability put forward encourages and guides each stakeholder through a progressive and continuous journey of quality improvement, moving through three stages of awareness, transformation and measurable impact.

The application of this framework offers health stakeholders an opportunity to update and develop more relevant quality indicators and accreditation standards at the institutional level. The presented example of medical schools can be extended and applied to other stakeholders. The framework should enable all of them to assess their contribution to health, identify pathways for improvement and strengthen their social accountability. Avenues for further research and development projects are identified.

Keywords: Social accountability, Assessment, Health stakeholders, Accreditation standards.

Date submitted: 1-March-2025

Email: Paul Grand'Maison (paul.grandmaison@usherbrooke.ca)

Citation: Grand'Maison P, Boelen C, Hosny S, and Flegg K. Assessing and enhancing health stakeholders' impact on people's health using a social accountability conceptual framework. Educ Health 2025;38:166-175

Online access: www.educationforhealthjournal.org
DOI: 10.62694/efh.2025.236

Published by The Network: Towards Unity for Health

Introduction

Health systems worldwide face significant challenges in addressing the priority health needs of citizens and communities. Despite decades of efforts, many health systems still fall short in meeting these needs, leaving gaps in access, coverage, relevance, efficiency, equity, and quality of care. These shortcomings are often exacerbated by the rapidly changing landscape of health determinants influenced by demographic, educational, economic, cultural, political, environmental and climate factors. Health systems are constantly challenged to better align their strategies, practices and services with changing or emerging needs and priorities in any given society.

By applying principles of social accountability, a better alignment of stakeholders' actions as a

response to priority health needs and challenges can be expected. This paper proposes a conceptual framework grounded in the concept of social accountability as a pathway to assess and enhance stakeholders' impact on health in a society, providing a structured approach to drive systemic change to improve health systems and thus people's health.

Health systems and their stakeholders

Health systems consist of all the people, institutions, and actions aiming to promote, restore, and maintain health.[1] Health stakeholders such as policymakers, health administrators, health professionals, academics and their institutions, plus communities, occupy a unique position in any health system to respond to health needs as confirmed in the last progress report of the United Nations Sustainable Development Goals initiative.[2]

Persistent inefficiencies within health systems frequently result from a gap between health needs and stakeholders' actions. They also result from a failure to convince stakeholders to be less preoccupied by their internal agendas and to work together around a unity of vision. At their best, health systems should function as interconnected networks, leveraging synergetic expertise, resources and actions of various stakeholders to achieve shared goals based on people's priority health needs.[3] (Figure 1).

The efforts of a single stakeholder are unlikely to produce sustainable outcomes unless other key stakeholders engage in similarly aligned actions and coordinated activities, and unless their interventions are mutually reinforcing.

It is strongly recommended that national policymakers actively invite and encourage all major health stakeholders to undertake an essential introspective process on how they could better respond to priority health needs within the society they serve. They should also provide them with appropriate incentives, material, organizational guidance and strategic support, both nationally and regionally, to have them envision and implement *meaningful* reforms and efficient partnerships within their respective territories.

This paper proposes a conceptual framework as a platform for health stakeholders to assess their respective roles, align their efforts and actions with health priorities, and to work collaboratively. In doing so, they may be challenged to go beyond their traditional working realms.

Defining Social Accountability in Health

Social accountability in health is broadly defined as the commitment to identify and respond to health priorities and needs in a society to be served by all stakeholders, and to ensure that actions yield meaningful outcomes.

Derived from the WHO's initial definition of the social accountability of medical schools[4] and after numerous consultations and experiences from the field, a more comprehensive definition has been suggested by the International Francophone Network for Social Accountability in Health (RIFRESS) resting on three key pillars[5] (Figure 2).

Figure 1: The partnership pentagram

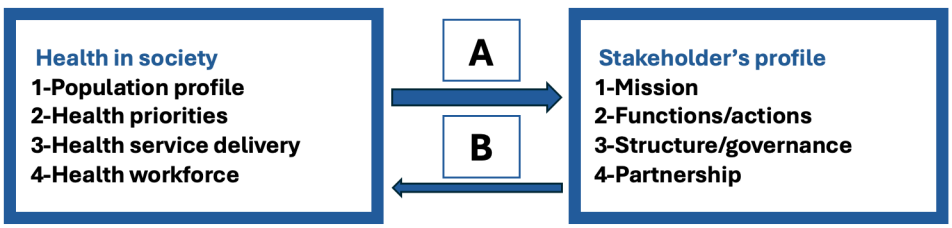
The first pillar emphasizes a systemic and problem-solving approach encompassing identification of health needs, transformations to address them effectively and sustainably, and subsequent follow up for outcomes and impact. The second pillar highlights four health system core values—equity, quality, relevance, and cost-effectiveness, as essential and interrelated beacons for guiding stakeholders' missions. The third pillar underscores the necessity of strong partnerships, recognizing that no single actor can address complex health challenges in isolation.

A social accountability grounded conceptual framework: a quest for pertinent assessment.

At the heart of social accountability in health is the relationship between society in general and its stakeholders in health. This relationship is dynamic and reciprocal. On one hand, society exists with decisions to make on protecting and improving people's health. On the other hand, stakeholders exist with their invested mandates. An innovative feature of this framework is its emphasis on the most relevant features of health in society as the primary entry point, rather than beginning with the

Figure 2: Social accountability in health (RIFRESS)

Figure 3: The interplay between health in society and stakeholder's profile



profile and characteristics of any given stakeholder. This leads to a more comprehensive understanding of the full spectrum of health needs in society, and of the possible required stakeholders' actions, as well as the dynamic interplay between the two. Even though Figure 3 illustrates a reciprocal relationship, vector A should conduct the flow. "Health in Society" is the first component of the framework. It focuses on broad features for health: population profile, health policies and priorities, service delivery systems and workforce.

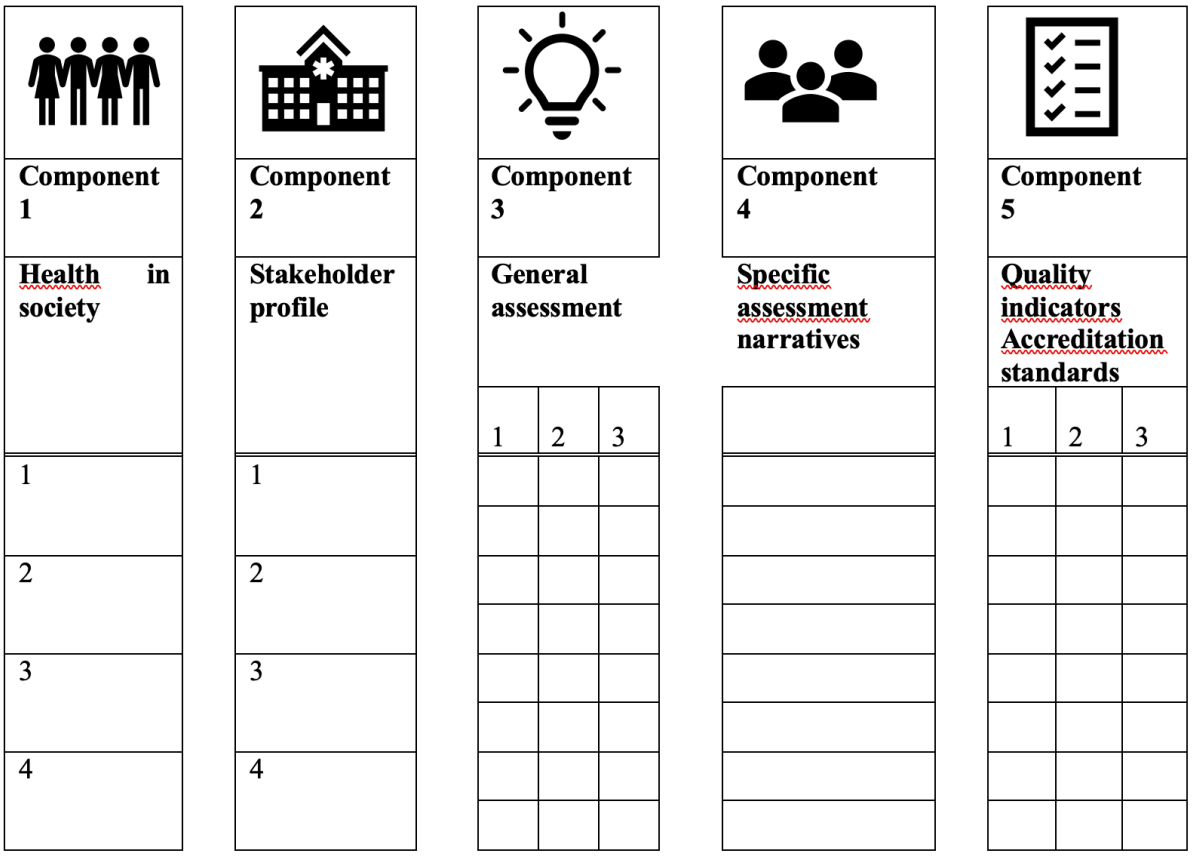
"Stakeholder Profile" is the second component of the framework. It focusses on stakeholders' mission, functions and actions, structure and governance, as well as partnerships.

Even though each society, and each stakeholder, has their own unique features, the content of component 1 and component 2 presented here is a relevant skeletal outline. This outline works to characterize any society concerned with the health of its people, as well as to depict the general status of any stakeholder, (being a governmental decision-maker, a health administrator, an academic institution, an association or group of professionals, and a community). The number and precision of sections and subsections of component 1 and component 2 may vary depending on_the regional or national

Table 1: Component 1. Health in society.

1. **POPULATION PROFILE**
   - 1.1. Populations and territories to be served.
   - 1.2. Demographic, geographic, socioeconomic, cultural, and ethnic characteristics.
   - 1.3. Epidemiological profile of prevalent diseases and health risks.
   - 1.4. Identified priority health issues.
   - 1.5. Other context-specific considerations.
2. **HEALTH POLICIES AND PRIORITIES**
   - 2.1. Responding to priority health needs.
   - 2.2. Affordable healthcare for all.
   - 2.3. Primary healthcare as the foundation of health services, complementarity across all levels of care.
   - 2.4. Commitment to reducing disparities and iniquities in health caused by health determinants.
   - 2.5. Balance among quality, equity, relevance, and cost-effectiveness.
   - 2.6. Collaboration and partnership among stakeholders.
   - 2.7. Other context-specific considerations.
3. **HEALTH SERVICE DELIVERY**
   - 3.1. Accessible care and services.
   - 3.2. Comprehensive health services at the primary care level.
   - 3.3. Context-sensitive and person-centered care.
   - 3.4. Coordination and integration of health services and interventions within a territory.
   - 3.5. Services for disadvantaged or underserved groups and individuals tailored to their needs.
   - 3.6. Structures linking individual and population health.
   - 3.7. Cross-sectoral, multidisciplinary, and inter-professional approaches.
   - 3.8. Exploration of effective models for delivering health services.
   - 3.9. Other context-specific considerations.
4. **HEALTH WORKFORCE**
   - 4.1. Quality, quantity, diversity, and complementarity of health professionals.
   - 4.2. Competencies and practice activities aligned with the needs of population and territories.
   - 4.3. Competencies agreed upon by stakeholders.
   - 4.4. Collaboration and coordination within multi-professional teams.
   - 4.5. Distribution of health professionals in areas they are most needed.
   - 4.6. Working conditions that promote optimal health workforce performance and motivation.
   - 4.7. Other context-specific considerations.

Figure 4: A conceptual framework grounded on social accountability to derive quality indicators and accreditation standards for health stakeholders



Component 1. Broad features of health in society.
Component 2. Functions and structure of a stakeholder.
Component 3. Levels of evidence a stakeholder contributes to health in society.
Component 4. Narratives collected to document the observed level of evidence.
Component 5. Depository of indicators/standards.

context. An expanded version of component 1, Health in Society is presented in Table 1 as an example.

The whole conceptual framework includes three more components and is illustrated in its entirety in Figure 4.

Any stakeholder is invited to observe the unique interactions between Health in Society issues and its own profile. Analyzing this interplay allows an initial assessment (component 3) of the stakeholder's response to priority health needs and its contribution to health. The assessment is categorized into three levels considering the intermediate nuances of social accountability.[6] The three levels are as follows:

- Level 1: Awareness. This level illustrates evidence that the stakeholder is well aware of health issues and needs in society,
- Level 2: Transformation. This level illustrates evidence that the stakeholder takes appropriate action and reorients its resources accordingly, resulting in tangible and sustainable transformations to meet priority health issues listed in component 1.
- Level 3: Impact. This level illustrates evidence that transformations are monitored and are likely to produce expected outcomes and have an impact on people's health in the short, medium and long term. As a single stakeholder may not have the capacity by itself to meet all of the society 's health needs, a strong partnership with other key stakeholders, at all levels, is essential.

The three-gradient stepwise approach offers (at least) two advantages. Firstly, it recognizes that what a stakeholder has so far achieved, and how modest it may appear, is a step in the right direction giving confidence to pursue its efforts and actions. Secondly, it inspires the development of indicators and measurement tools for each gradient of social accountability, offering stakeholders directions for further evolutionary steps to become more socially accountable.

The fourth component of the framework is an invitation to its users to elaborate narratives detailing the observed evidence for one of the three levels attributed.

Out of the analysis made throughout the first four components, component 5 evolves as a depository of formal indicators and measurement tools reflecting one of the three levels of social accountability. Accreditation organizations should find it useful to translate such indicators as standards.

The distinctive features of this conceptual framework are summarized here. It puts upfront Health in Society issues as its primary entry point. It considers all the missions and functions of any stakeholder, instead of limiting itself to one of them. It emphasizes the progressive nature of the path to greater social accountability. It stresses the identification of quality indicators, or standards, matched to these three gradients.

It points out that these indicators could (and should) be adopted, and adapted to their context, by accreditation organizations as standards—what should lead to and warrant long term movement and effect. It highlights partnerships without which no sustainable impact can occur. Authors argue that without taking into account all these features and their complementarity, changes and effective results would be more limited and fragile.

How the framework provides hints to design relevant indicators of progress. The case of medical schools and underserved populations.

The authors decided to make medical schools an example in order to apply the proposed conceptual framework, for both some objective and subjective reasons. To our knowledge, medical schools form a stakeholder group that has had the longest acquaintance with the concept of social accountability, being urged over the years to embrace its principles[7,8,9] and to consider them in their accreditation standards and processes.[10,11,12] It is also the stakeholder that authors know best, while their experience with others is limited.

Table 2 presents a detailed profile for a medical school addressing component 2. Elements of this profile are derived from procedure manuals of best-known accreditation systems. Worth noting are some included functions going further than educational functions, and less frequently put forward, such as population to be served, governance, contribution to health services, research, partnership.

An example of how the structured approach of this conceptual framework could be used for a hypothetical medical school is presented in the following paragraphs. Its relative simplicity is intended to ensure that the utilization of the framework is well understood. No matter how simple it may appear, the example covers all the distinctive features of the framework presented in the preceding section, including the consideration of the three missions of medical schools: education, research and services. Its simplicity, and at the same time its comprehensiveness, should facilitate readers to derive lessons from it.

In this example, the user initially identifies one priority issue of health in society, and analyzes how the medical school aligns different elements of its profile to better respond to it. From this analysis, the user assigns a level of social accountability and supports his or her assignment by mentioning relevant narratives. Finally, he or she suggests hints for accreditation standards, respectively, to the three levels of social accountability.

Table 2: Component 2: Medical Schools´ Profile (Functions and Structure).

1. **POPULATION AND TERRITORIES TO BE SERVED**
   - 1.1. Identification of the population(s) and regions/territories to be served.
   - 1.2. Identification of priority health determinants and needs of populations and territories.
   - 1.3. Identification of one or more designated territory or population with specific needs requiring targeted interventions.
   - 1.4. Consideration of the specific features and characteristics of the identified populations and territories.
2. **MISSION OF THE MEDICAL SCHOOL**
   - 2.1. Commitment to addressing priority health needs.
3. **LEADERSHIP, GOVERNANCE, AND ADMINISTRATION**
   - 3.1. Leadership committed to addressing priority health needs.
   - 3.2. A strategic development plan shaped by the principles of social accountability.
   - 3.3. Governance structures involving faculty, administrators, students, and health partners in strategic planning, development, execution and evaluation.
4. **SELECTION OF STUDENTS**
   - 4.1. Characteristics of the student body versus population social and geographic diversity.
5. **CURRICULUM**
   - 5.1. Competencies designed to enable students to effectively address populations priority health needs.
   - 5.2. Learning on biological, social and environmental determinants of health.
   - 5.3. Consideration of health inequities that plague vulnerable and underserved populations.
   - 5.4. The interplay between population and individual health.
   - 5.5. Training for all levels of care including primary care and in underserved areas.
   - *5.6.* Multi-professional education and collaborative teamwork.
6. **FACULTY**
   - 6.1. Faculty composition representative of the diversity of the population.
   - 6.2. Faculty development programs on social accountability and issues aligned with the strategic plan.
   - 6.3. Recognition and rewards for faculty contributions to the school's strategic goals.
7. **RESEARCH**
   - 7.1. Community-based research projects with active student participation.
   - 7.2. A balanced research agenda addressing biomedical, clinical, and psychosocial issues aligned with societal needs.
8. **CONTRIBUTION TO HEALTH SERVICES**
   - 8.1. Contribution to primary healthcare and its coordination with higher levels of care.
   - 8.2. Engagement, experimentation, development and study of innovative models of health services delivery.
9. **PARTNERSHIP**
   - 9.1. Partnerships with key health stakeholders within the territory (ies).
   - 9.2. Consultation and collaboration with health partners to develop, implement, and monitor the school's strategic plan and related actions.

Example of a hypothetical school

1. Health in Society issues.
Services for disadvantaged or underserved populations tailored to their needs. (Item 3.5 in Table 1)

2. Medical school profile.
Contribution to health services. (Item 8 in table 2)

3. General assessment.
Level 3. Impact

4. Specific assessment narratives.
Students complete training activities with these populations. Faculty offer clinical services to them responding to their evolving needs. Researchers conduct work with and for these populations.

5. Possible hints for accreditation standards.
**Level 1 of SA: Awareness. The school targets specific disadvantaged or underserved populations in its territory and identifies their priority health needs.*

**Level 2 of SA: Transformation. Faculty members develop and offer innovative need-oriented services to disadvantaged or underserved populations at first level of care. Medical students offer services to these populations through a clinical rotation that has been confirmed as mandatory by program leaders.*

**Level 3 of SA: Impact. Partnering with public health, practicing professionals and patients coming from underserved populations, faculty members complete research projects on disadvantaged or underserved populations. One such project may be to assesses the impact of the aforementioned transformations on the health services offered to the targeted populations, as well as their impact on students' attitudes towards providing services to similar populations in their future careers.*

In building their own collection of standards, accreditation organizations would also benefit from consulting documents that propose indicators of social accountability from which standards can be derived.[8,10,13,14,15,16] Applying these are likely to bring a change of their constituents' ethics for better health in society.

Health stakeholders acting towards social accountability as a benchmark of excellence.

Although the framework was initially developed with medical schools in mind and exemplified with them, its principles are broadly applicable to other health stakeholders, such as a regional health authority, a district hospital, a health centre, a health-related social service, a health practitioner, and other academic institutions. They all share a common responsibility: to address priority health challenges of the society they serve. They can all benefit from adopting social accountability as a guide to improving their contribution.

What follows are examples where such a trend is notable, even if we can hope for other developments.

The Canadian CanMEDS competency framework highlights the physicians' roles. It confirms the necessary commitment to society and the responsibility to address community health needs; it promotes system-level change and advocacy for health.[17] By further incorporating social accountability principles, CanMEDS reinforces the practice standards of physicians and other health professionals, as well as their ethics, regarding their response to the health care needs of the population.

The CPTS ("Communautés professionnelles territoriales de santé") in France are networks of physicians and other health professionals who work together in a community centre offering services to a defined population in a specific geographical area.[18] Designed to deliver a combination of health promotion, preventive and curative care services, they focus on access to care and better healthcare pathways for patients. They may benefit from the framework described here by appraising the need for better outreach services for disadvantaged populations, and for increasing coordination and partnerships with key stakeholders in the area for optimal fulfilment of their goal.

The CIVIS alliance, a network of European universities, may consider the framework as a tool to strengthen their multi-disciplinary approaches in education and research, and their wish to engage with communities to work on social changes that would improve people's wellbeing.[19]

Puting forward social accountability in health as a benchmark of excellence will have a ripple effect on all health sector stakeholders and their engagement for better health.

Conclusion and perspectives

As societies and health systems around the world face significant political, economic, cultural, and environmental changes that affect health and shape priority needs, it is essential that each stakeholder, whether operating at the national, regional, or local level, takes responsibility and embraces its ethical obligation to enhance its contribution to maintaining, and improving, the health of all its citizens.

The proposed conceptual framework, grounded in social accountability, is a practical and structured tool to sharpen consciousness for reflection, reform, innovation, engagement and continuous improvement that should ultimately benefit all citizens and their societies. It is hoped that the following expectations of the development of this framework will be reached:

First, that it would be used as a suitable instrument to support health stakeholders to go beyond good intentions and their present stance and move towards more practical and measurable

achievements to better people's health in the societies they serve.
Second, that health stakeholders monitor, in an effective way, their position in this venture as a basis for further continuous progress. Third, that the accreditation organizations of the different groups of stakeholders include, in their indicators of quality standards, that they are designed under the lens of social accountability.

Following are a few recommended actions:

National authorities should facilitate and support national, regional and local activities, both within and among groups of different stakeholders, to critically review their adhesion to social accountability principles and to envisage institutional changes in the scenarios in which they would work as partners in a given territory.

Information and capacity-building initiatives linked to the potential of the social accountability concept and principles to bring institutional transformative reforms for better responses to health care needs, should be made widely available to audiences of health leaders and stakeholders.

International studies examining the usefulness of the conceptual framework presented here should be undertaken, in order to provide valuable insights on best ways to proceed to enhance social accountability of health stakeholders, considering the specificity of their context and their openness.
Accreditation bodies of health stakeholders should be consulted on their views regarding the potential offered by the concept of social accountability as a strategy to upgrade their standards for a better response of their members to the priority health needs of the people they serve.

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