PUBLIC ACCOUNTABILITY: UNDERSTANDING THROUGH THE ACCOUNTS OF OTHERS

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ABSTRACT

This work reconsiders the meanings attached to the concept of public accountability. While formally central to the constitution in the UK, its meaning is a contested one. After reviewing the literature, the work situates the concept of accountability in two case studies, each a discretionary service provided to vulnerable individuals. In this context, the research critically reviews the way in which the concept of accountability operates in practice, and particularly whether it meets the expressed needs of individuals and groups to whom the services are accountable.

The central arguments emerging from this work challenge the established meanings of the concept of accountability, ones associated with control, redress, responsibility and with blame. The formal accounts presented of each case study differed markedly from those presented by managers, frontline service providers, welfare rights advisers and user advocates. As such, these formal accounts were misleading, bearing little relationship to the experience of users.

Rather, the work suggests the need for a more reflexive, socialising model in which accountability is a means to understanding the nature of public services through the stories, the accounts, others tell of those services. The actions of public servants are better understood in the light of the experience of applicants or users. In this sense it is more concerned with dialogue than it is with mechanisms of control.

As such, this alternative conceptualisation of accountability presents both a challenge and an opportunity. Opening up a dialogue that genuinely includes the voices of vulnerable and excluded groups and that moves beyond the current language of blame and responsibility to embrace understanding requires a degree of political maturity and a cultural shift in the public sector. Yet, through such dialogue, there is the potential to better understand public services and, in consequence, raise standards. The work advocates the need to include the accounts of citizens in our understanding of public services and of the concept of accountability.

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LIST OF ABBREVIATIONS

A&E	Accident and Emergency
ASFO	Area Social Fund Officer
ASW	Approved Social Worker
BA	Benefits Agency
BL	Budgeting Loans
BMJ	*British Medical Journal*
C&AG	Comptroller and Auditor General
CCG	Community Care Grants
CHC	Community Health Council
CHI (or sometimes CHIMP)	Commission for Health Improvement
CL	Crisis Loans
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DHSS	Department of Health and Social Security
DSS	Department of Social Security
EGO	Extra-Governmental Organisation
GMC	General Medical Council
GP	General Practitioner
HAZ	Health Action Zone
HIMP (sometimes HIP)	Health Improvement Programme
HOTN	Health of the Nation
IRS	Independent Review Service
MHAC	Mental Health Act Commission
NAO	National Audit Office
NDPB	Non-Departmental Public Body
NHS	National Health Service
NHS-E	National Health Service Executive
NHS-ME	National Health Service Management Executive
NICE	National Institute for Clinical Excellence
PAC	Committee of Public Accounts
PI	Performance Indicator

PQ	Parliamentary Question
QUANGO	Quasi Autonomous Non-Governmental Organisation
RAWP	Resource Allocation Working Party
R&D	Research and Development
SFI	Social Fund Inspector
SFO	Social Fund Officer
SFRO	Social Fund Review Officer

CHAPTER ONE:
INTRODUCTION

The concept of accountability is brandished with increasing regularity, whether in political circles or in the press. Most frequently, it accompanies accusations that one election pledge or another has been broken; that decisions are not being properly presented to the elected representatives of the land; that public bodies are failing to provide adequate services; or when some corruption on the part of officials is exposed. As such, the concept of accountability is a malleable one. And at the same time, the examples indicate the central role it plays in our understanding of democracy and of government.

A matter of a decade ago, a debate arose around the concept of a 'democratic deficit' (see Stewart, 1992; Waldegrave, 1993). A proliferation of new forms of public bodies (such as National Health Service Trusts, Training and Enterprise Councils and Housing Associations), and of quasi-market relationships between funding and delivery agencies, provoked concerns that democratic accountability was being undermined. Performance league tables and the Citizen's Charter were not adequate substitutes for Parliamentary scrutiny and appeal tribunals. The merits of different concepts of the citizen and the nature of the relationship between individuals and the government underpinned this debate.

During the intervening years, questions of corruption, of sleaze and of accountability have remained headline topics (Committee of Public Accounts, 1994; Norton-Taylor, 1995; Scott, 1996a and 1996b; Leigh and Vulliamy, 1997; Committee on Standards in Public Life, 1995, 1996, 1997a and 1997b). These debates have found a parallel in the private sector's deliberations over corporate governance structures (Committee on the Financial Aspects of Corporate Governance, 1992; Study Group on Directors' Remuneration, 1995; Committee on Corporate Governance, 1998; Institute of Chartered Accountants in England and Wales, 1999). However, any review of the current literature on accountability presents a dry debate about mechanisms, whether for securing the resignation of offending ministers, for reporting performance or for securing individual redress (Weir and Hall, 1995; Weir and Hall (eds.), 1994; Barker,

Byrne and Veall, 1999; Public Service Committee, 1996a; Public Administration Committee, 1999). Lost in discussion of technicalities is the lofty purpose to which these contribute. Indeed, the mechanisms appear as afterthoughts, not as integral to the way in which politics and government is conducted. A central concept is treated as an *ex post* additional extra. This impression is confirmed by a brief glance at the most recent White Paper proposing the modernisation of government and of public services. While developing wide-ranging ideas, the paper also identified work still to be undertaken:

> 'We need an effective system of **incentives and levers** to put these principles [for inclusive and cross-cutting policy making] into practice and to tackle the barriers to more effective policy making. These may include new accountability arrangements, such as pooled budgets across Departments, cross-cutting performance measures and appraisal systems which reward team-working across traditional boundaries. We have asked the **Performance and Innovation Unit** (PIU) to examine the accountability and incentives framework and report its findings by the summer.' (Cabinet Office, 1999, p.18, emphasis in original)

Given that accountability is so central to political debate, to find it sidelined in the manner indicated in this extract is surprising. In transforming the manner in which services are delivered, one might expect to see some thought given to the arrangements for ensuring that those services deliver what is intended. Academics, working on the White Paper's key themes of 'holistic' or 'joined up' government, have identified accountability in complex networks as particularly problematic (Black, 2000; Perri 6, 1997; Rhodes, 1997; Wilkinson and Appelbee, 1999). Instead, accountability is relegated to a follow-on study, linked closely to incentive mechanisms, personnel appraisal systems and funding arrangements.

This work will seek to readdress the key ideas and debates that lie beneath concerns to improve 'incentives and levers'. In so doing, some of the tensions between the individual and the state will emerge. These tensions will highlight the narrowness of current concerns about accountability, further suggesting the need to recast the concept as a means to understanding increasingly complex patterns of public services.

Some Baggage

As will become clear to the reader, the work does not follow a simple path in any sense. For example, my reading of the literature has both informed, and been

informed by the selection of my case studies. This apparent paradox arises, largely, as a result of my previous experience in the public sector, a past that has included some engagement with a range of forms of accountability. In particular, I had some experience of the day-to-day operationalisation, as opposed to the theory, of parliamentary accountability mechanisms. In evidence to the Scott inquiry, Sir Michael Quinlan, a former Permanent Secretary at the Ministry of Defence, encapsulated the knowing civil servant's perspective when he stated:

> '1. Judgement on the propriety of answers given by Ministers in Parliament must have realistic regard to the underlying nature of the activity of seeking and giving information in that setting.
> '2. The activity can be viewed from a variety of angles. From one of these angles it is in a certain sense analogous to a game – not in the sense of being trivial or for entertainment, but in the sense that it is a competitive activity conducted, within rules, largely for a purpose different from that of its apparent form.
> '3. The form of the activity is to bring information into the public domain. But as between Government and Opposition that is not normally its key purpose. The prime purpose of Opposition members, because of the role which the Parliamentary context sets for them, is to give the Government a hard time; and the reactive purpose of the Government is to avoid having a hard time. The game is a tough one, played by determined people for high stakes; and it is humanly inevitable that each set of players will operate, within the rules, to maximise advantage or minimise disadvantage. The Opposition will seek to extract information which they can use to portray the Government in a bad light; and they will, within conventions looser than those binding the Government, feel free thereafter to exploit the information, if necessary selectively and tendentiously, to that end. The Government for its part will be reluctant to disclose information of a kind, or in a form, that will help the Opposition to do so.' (Scott, 1996a, Vol. I, Section D4.61, p.505)

This reality is reflected in elements of the academic literature. For example, Giddings quotes another senior civil servant, writing more than fifty years ago:

> 'It might be said cynically, but with some measure of truth, that the perfect reply to an embarrassing question in the House of Commons is one that is brief, appears to answer the question completely, if challenged can be proved to be accurate in every word, gives no opening for awkward "supplementaries", and discloses really nothing.' (Giddings, 1997, p.87)

My reading of the literature on accountability mechanisms is influenced by an understanding of the weaknesses I have observed in practice in dealing with, amongst other forms, parliamentary business, ministerial correspondence, Parliamentary Commissioner cases, annual reports and complaints. This experience at the sidelines of Sir Michael Quinlan's 'game' informs and shapes the presentation of the material in the coming chapters.

At the same time, the seven years I spent in the Department of Social Security has given me a detailed insight into public service delivery. The political science literature presents an image of benefit administration as simply and classically bureaucratic, posing few problems of accountability (e.g. Rhodes, 1996). As an image, this is a little simple, ignoring those aspects of policy where officials are required to exercise discretion (e.g. Donnison, 1982; Huby and Dix, 1992). Furthermore, while other services, such as the health service, are more clearly problematic, to characterise public services as simply bureaucratic is to ignore the discretion exercised by managers and staff throughout these organisations, discretion that may significantly affect the nature of the service provided and the experience of the individual seeking access to those services (Lipsky, 1980).

These personal experiences, of systems of accountability and of the delivery of public services, can be clearly seen in my discussion of the literature around accountability. They have also informed the manner in which I have conducted my research, and particularly the use of two case studies of services that might expose some of the hollowness of the political and academic discussions of accountability. These case studies share certain key characteristics that, both my experience and a reading of the literature suggest, present particular problems when discharging accountability. Both are of services, rather than public bodies, delivered within a national framework of law, rules and financial provision, but with a substantial degree of local flexibility and variation in process, output and outcome. The representation of such complex services, whether at a national or local level, and the means of challenging individual decisions will expose some of the flaws in accountability systems. They will also allow for some reflection on the integrity and robustness of current models of accountability, both in two specific contexts and more generally. A contrast will be drawn between the current positivist form of accounts, representing public services through financial statements, performance information and statistics, and the more complex accounts expressed by service providers, external experts and user advocates. This contrast will highlight the inarticulate nature of accountability, suggesting the need for a more rounded and balanced discourse between the state and citizens.

The first of the case studies I selected is of a service with which I have had some involvement in the past, the social security Social Fund. The second, of the commissioning of mental health services, further illustrates the problems, but with additional complications and different forms of accountability mechanisms. It might be suggested that the cases I have selected are atypical and that, on the whole, the weaknesses I highlight are not evident elsewhere. However, after twenty years of intensive reform, of privatisation, contracting out, market testing, quasi-markets and other initiatives, I would suggest that, in fact, variations and discretion are the norm in public service today, whether explicitly as a matter of policy, or inherently as a function of the management of services.

I have expressed these influences openly in part to explain the shape taken by the research. For example, the literature review is informed by my own experience. A declaration of this background might also explain and clarify some of my methods, the interviewees selected and perhaps, at times, the line of my questioning.

If my approach was influenced by past experience, the thinking presented in this work developed during the course of the research. My early reading focused upon the main public administration and political science accountability literature. This reading informed the selection of the two case studies that formed the focus of the fieldwork. While conducting my interviews, I began to explore the literature associated with the Social Fund and with mental health. These opened up different images of accountability. In parts of the social psychology and critical accounting literatures is presented the idea of accountability as a relationship. While I came to this material during the course of the fieldwork, it resonated with the themes I was already uncovering and influenced the later work, particularly that on mental health.

The Structure

Having said that no simple progression from literature to question to method to findings can be distilled from my research, it will be helpful to the reader to set out the broad structure of the remainder of this work. In the following chapter, the literature on accountability is reviewed at some length. In doing so, I have endeavoured to present the main arguments surrounding the 'democratic deficit'. These arguments form the background to our understanding of the roles, strengths

and weaknesses of the range of accountability mechanisms and the way in which they apply to different types of organisation. In closing, the chapter outlines the current state of the debate about accountability, introducing a critical theme that questions our understanding of accountability and which will inform the approach to the research. Chapter three describes the approach to the research, the selection of case studies and the development of the programme of interviews. Chapter four introduces a further body of literature specific to the two case studies. In each case, I intend to provide the reader with a good grounding in the policy framework and management of each case study, describing the form that accountability takes in each case.

Chapters five through eight present a discussion of the material gathered in the course of the research. Chapter five, through the accounts of service providers and managers, suggests the need for a more sophisticated understanding of the nature of discretion and of the role of front-line workers in shaping each of the case studies. Chapter six seeks to further complicate our understanding by presenting the views and accounts of user advocates and welfare rights advisers. From the accounts presented in these two chapters emerges a more rounded view of the case studies. Chapter seven contrasts these accounts with the information presented in formal accounts of the case studies. While interviewees were almost universally critical of current forms of accountability, few had given a great deal of thought to alternatives. Chapter eight discusses these thoughts. Finally, chapter nine both reflects on and seeks to develop some of the ideas picked up and developed throughout the work.

CHAPTER TWO:
THE POLITICS OF ACCOUNTABILITY

Introduction to the Literature

The literature on accountability, surveyed in this chapter, is extensive. At the outset in 1996, the key debate focused upon arguments about a 'democratic deficit' (Stewart, 1992). This provided a starting point for my review, leading on to two further themes: the range of accountability mechanisms, to be found in the public administration and public law literature; and debates about the forms of organisation emerging from public service reforms. These two strands embrace the majority of the literature and are drawn together in a further body of literature emerging from the Democratic Audit. The themes identified in this material shaped the selection of the two case studies, for each of which, further background reading was undertaken (outlined in Chapter 4). During the course of the fieldwork, first on the Social Fund and subsequently on mental health services, not only did the inadequacies of these main debates became apparent but different perspectives also emerged. Thinking along similar lines, but drawing on different disciplines, I began to explore current themes in the critical accounting, psychology and learning organisation literatures.

This route map explains the development of my understanding of accountability and, in part, the structure of this chapter. Debate about accountability has, in recent years particularly, generated a great deal of heat while not always throwing any light on those aspects of public sector activity conducted in the penumbra. Like much else, responsibility for the interest recently shown in accountability can be placed largely at the door of the New Right's influence on government, not just in the UK but around the world. Indeed, debates about accountability go to the very heart of controversies about the nature and legitimate extent of the state, the merits of hierarchies and markets as coordinating devices, and the means by which state activity is best supervised and controlled.

I shall endeavour to examine the main themes of these debates, before going on to survey the literature concerning accountability. This literature, as indicated above, treats the two broad approaches separately: the first focuses upon accounts of the

means of holding public organisations to account (e.g. politically, financially), detailing the operation, strengths and weaknesses of each; the second examines particular organisations or types of organisation (e.g. the NHS or executive agencies), examining the means by which they are held to account. This represents a crude schema, but it is a useful means of understanding the approaches to accountability in the literature to date.

While these issues form the bulk of my review of the literature, a further approach to the subject begins to emerge. Based on a recognition of the weaknesses of much of the literature in reaching an understanding of accountability, some have pointed to the need to appreciate the specifics and complexities of public services. Playing with our understanding of accounts, they begin to describe a form of accountability as much about listening as about reporting.

Theoretical Background

It is, at times, misleading and unhelpful to juxtapose recent theoretical challenges from the New Right to a preceding traditional consensus, not least because they do not separately represent coherent bodies of thought. Under the heading of New Right exist public choice theorists and economists of the Austrian school, their opponents consisting of a range of theorists placing greater emphasis on collective political judgements. Nevertheless, in a brief presentation of the debate about the nature and legitimate role of the state, and the means of influencing its actions and behaviour, the broad headings of New Right and Modern Social Democratic will serve some purpose.

Legitimate Role of the State

At base, there is a fundamental debate about the nature and role of the state vis-à-vis the market. To the right of the political spectrum, and associated with Austrian economists such as von Hayek, the state represents a fundamental threat to the operation of the market and to individual freedoms. The minimal state's legitimate role is very limited:

> 'The state's prime task is to define and protect individuals' property rights and the means by which property rights are traded.' (Levacic, 1993, p.49)

Beyond this, the extension of state activity into regulation or the provision of goods on a collective basis has precipitated a crisis, both political and moral:

> 'Welfare state policies encourage dependence amongst the recipients of services or transfer payments. Yet they simultaneously involve coercion both of their "beneficiaries" and of those taxpayers forced to meet the costs of intervention.' (Dunleavy and O'Leary, 1987, p.133)

For neo-classical economists, the state's purpose is wider than this minimal role. The tendency of the market to fail, for competition to be imperfect, requires intervention to stimulate or simulate competition. Market failures also necessitate the extension of the state into the regulation and provision of public goods that benefit all, whether directly or indirectly. For socialists, the welfare state performs a similar function, but has been won by the struggles of the working class rather than being a gift from caring capital (Hill, 1990).

Co-ordinating Devices – Markets and Hierarchies

An aspect of the debate about the legitimate role of the state is the effectiveness of hierarchies as a means of coordinating the actions of individuals. For the New Right, markets combine efficiency and freedom:

> 'Markets coordinate the diverse and often conflicting plans of individuals without any single body having to reach and enforce agreement between participants. This, in von Hayek's view, underpins the superiority of the market because it coordinates while permitting and even promoting individual choice and freedom. In contrast, state hierarchy as a coordinating device is a deliberate and planned social order.' (Levacic, 1993, pp.41-2)

Bureaucracies, the epitome of hierarchical organisations, are characterised by continuous organisation of official functions bound by rules, specified spheres of competence, use of technical rules or norms, separation of the office holder from ownership of the means of production, and the maintenance of records (Weber, 1993, pp.107-8). For Weber, bureaucratic hierarchy is an ideal type, the most efficient model for performing and ordering tasks, particularly those tasks requiring repetitive action to be taken in a uniform fashion on a number of cases. Indeed, the use of bureaucracy as a coordinating device is not limited to the public sector, but is also a feature of the performance of routine, particularly administrative, tasks in the private sector (Mitchell, 1993). Weber, nevertheless, recognised the inherent tendencies

within bureaucracy to expand, to stifle initiative, to become inflexible, and to be insensitive.

Controlling Bureaucracies

Criticism of bureaucracy is, then, not the preoccupation of either the right or left. The tendency of bureaucracies to develop autonomously, to become ossified, and to disregard the individual is acknowledged across the political spectrum. For Weber, this tendency to autonomy requires charismatic figures to 'invigorate stagnant political systems' (Mommsen, 1989, p.46) and to exert political control over the actions of the bureaucracy.

For the New Right, the tendency of bureaucrats to 'budget-maximise' derives from rational choices:

> 'As a general rule, a bureaucrat will find that his possibilities for promotion increase, his power, influence and public respect improve, and even the physical conditions of his office improve, if the bureaucracy in which he works expands.' (Tullock, 1993, p.112)

Bureaucracies are, inherently, inefficient. They have a dynamic of their own which, like the economy, can be understood and predicted:

> 'William Niskanen suggests that bureaucrats will maximise their budgets, because a higher budget will:
> 1. provide more jobs for bureaucrats and therefore improve promotion prospects;
> 2. tend to strengthen the demand for services making the department easier to run;
> 3. improve prestige and patronage opportunities;
> 4. generally provide more chances to deliver funds to private interests and goals.' (Dowding, 1993, p.247)

These bureaucratic tendencies align well with those of politicians. Both have an interest in offering more services, in the case of the politician, to improve their prospects of re-election. It is rare for politicians to seek to curb a service that, once in existence, begins to acquire immortality (Dunleavy and O'Leary, 1987).

The solution, it is argued, is to introduce market or quasi-market forces to bureaucracies, to break the situation where the market for services is monopolistic and/or monopsonistic. Whether through contracting out or internal markets, competition for contracts or for customers, the tendency of bureaucracies to serve their own interests will be broken:

'If the bureaucracy is one whose purpose is to serve the public directly, there will be no market pressure to ensure consumer satisfaction; its customers or clients cannot vote with their feet and take their custom elsewhere. In the absence of any such external sanctions or incentives, the tendency will be for a bureaucracy to serve the convenience of those who work within it, rather than the customer for whose benefit it supposedly exists.' (Beetham, 1996, p.25)

Accountability and the State

Debate about accountability cannot be divorced from these wider discussions of the nature of the public sector, its appropriate functions and extent, and the means of controlling its actions. Figure 2.1 broadly summarises and characterises the conflicting perspectives. The degree to which the concepts affect an understanding of accountability is clear. The consequent approaches are outlined in the next section.

Figure 2.1

Competing Perspectives

	Modern Social Democratic	New Right
Philosophy	Democratic	Economic liberalism
Coordinating Mechanism	Hierarchy	Markets
Decision-makers	Citizens	Consumers
Service Availability	Access	Choice
Control Systems	Rights	Exit

Understanding Accountability

In simple dictionary terms, we might understand accountability to mean liability to give an account or responsibility for actions. The questions for what, to who, and how automatically arise, and the technical considerations begin. None of these questions, however, address the purpose of accountability. Why an account is required, to what end, and what being accountable entails are the questions determining the characteristics to be derived from any meaning.

Modern Social Democratic Approaches

Those studies that endeavour to identify the purpose of accountability confront early problems. For Simey, accountability is more than reporting, being fundamental to the political system:

'...accountability is not a mechanism or a routine but a principle. More than that, it is a principle which serves a specific purpose. In a democracy, that purpose is

to provide the basis for the relationship between society and its members, between those who govern and those who consent to be governed.' (Simey, 1985, p.20)

What this might mean in practice she sets out in quasi-contractual terms:

'It must be open and fair. It must be efficient and effective. And there must be sanctions and safeguards which ensure the rights and duties of all concerned in the "contract" to which it relates are adequately upheld.' (*ibid.*, p.24)

Oliver (1991), in similar fashion, details aspects related closely to the meaning of accountability:

'Accountability is therefore closely related to responsibility, transparency, answerability and responsiveness, and these terms are often used interchangeably.' (Oliver, 1991, p.22)

Key to her approach to the subject, however, is the use of accountability as a check upon the unrestrained exercise of power:

'Decision makers must be obliged to justify their acts and not be allowed to rely on claims that their rightness is to be assumed.' *(ibid.*, p.22)

Oliver and Simey present the meaning of accountability in terms of control and legitimacy, suggesting a variety of similes equally problematic in their definition. The concept is integral to the political process and relates to power relationships and the openness of the executive.

Stewart bases accountability in the unique features of the public domain:

'Such powers are only justified if those who exercise them are answerable to them [citizens]. The powers, it can be argued, do not belong to those who exercise them, but belong to citizens on whose behalf they are exercised. That relationship is only justified if there is accountability.' (Stewart, 1992, p.4)

The powers and purposes of the public sector are derived from an organising principle unlike other sectors of society. It is based upon 'public discourse leading to collective choice based upon public consent' (Ranson and Stewart, 1994, p.88) and:

'In the arena of public discourse the judgement of public action cannot be limited to the concerns of those for whom the service is provided or based only on the achievement of the immediate purposes for which the service is provided.' (*ibid.*, p.89)

Accountability is not simply a control mechanism, but a principle upon which the organisation of public services must be founded:

'The organising principle of public discourse leading to collective action requires ready access to arenas for those who have problems to raise, actions to contest,

> aspirations to express, issues to pursue and comments to make. The effectiveness of these arenas depends upon undistorted discourse which in turn requires the free flow of information in the public domain, so that choices may be tested by debate and discussion, and by pressure and protest should they be required.' (*ibid.*, p.93)

Fundamental to this principle is the concept of the citizen as being an 'individual-as-a-member-of' (*ibid.*, p.60) a wider public. For Stewart, accountability relates to consent, public choices and informed discourse.

New Right Approaches

However, such an approach is challenged by the New Right:

> 'The key point ... is not whether those who run our public services are elected, but whether they are producer-responsive or consumer-responsive. Services are not necessarily made to respond to the public simply by giving citizens a democratic voice, and a distant and diffuse one at that, in their make-up. They *can* be made responsive by giving the public choices, or by instituting mechanisms which build in publicly approved standards and redress when they are not attained.' (Waldegrave, 1993, p.13, emphasis in original)

For the New Right, elected representatives on the boards of public services are likely to be 'captured' by producer interests (Pirie, 1991, p.6). Consumer interests are consequently not expressed. For Pirie, the recent public service reforms have been based on three assumptions:

> 'They are that the citizen is entitled to receive some level of service in return for the taxpayer funds used to finance it; that the citizen is entitled to know what that level of service is; and that he or she is entitled to some form of redress if that level is not attained.' (*ibid.*, p.8)

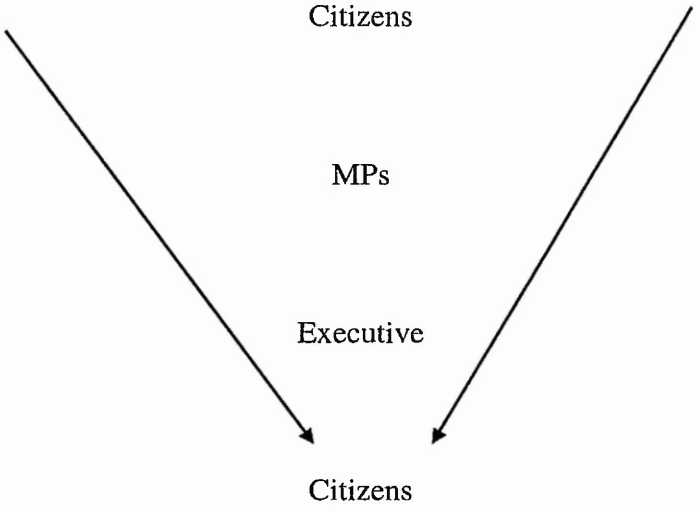
This is, for Pirie and the New Right, the meaning of accountability both in theoretical and practical terms, and clearly expresses the twin pressures that separately might effectively constrain the public services - the taxpayer and the consumer.

Overview

These arguments, then, are the battleground over which much of the discussion of accountability takes place. They reflect differing views of the nature and role of the state and the means of overseeing and controlling its operations. To those espousing more traditional views of accountability, it represents a system of control in which the state accounts to citizens for its use of delegated powers (see Figure 2.2). The reintroduction of the citizen at the bottom of this diagram is fundamental to a traditional understanding of accountability. The state only exercises legitimate

Figure 2.2

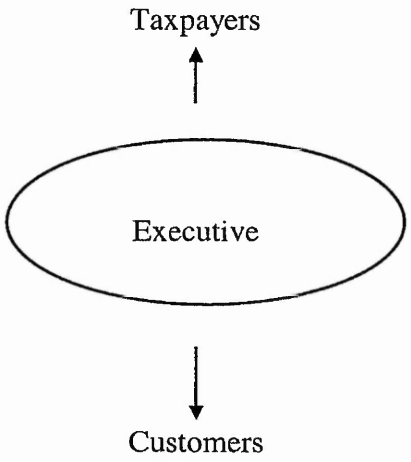
Accountability – Modern Social Democratic



authority over citizens to the extent that the powers used are delegated by the very same citizens. Choices are exercised in a political arena, through debate amongst all citizens and are then applicable to all citizens. In reality, the model presents the image of a passive citizen, exercising choices periodically through the ballot box and challenging services through tribunals or other formal mechanisms. The ways in which dialogue might extend beyond these very limited and sporadic forms are not developed except to emphasise the role of elected representatives.

Figure 2.3

Accountability - New Right



For the New Right, the state is accountable in the same way as any other enterprise (see Figure 2.3). Account is given to shareholders (taxpayers), while customers (service users) influence the quality of goods in the way they exercise their choices in a market place. In giving account, this removes all reference to policy choices at a collective level. Taxpayers seek to minimise their costs while users seek to maximise the services. Often, the taxpayer is also a customer of a service. Where this is not the case, complications and conflicts of interest emerge in this model. The citizen does not feature.

The debate on these themes has become heated as a consequence of the New Right influences on government policy throughout the 1980s and 1990s. Their impact upon accountability is evident in reforms such as privatisation, market testing, and internal markets as well as the abolition of some state functions.

Accountability Mechanisms

The various mechanisms used to secure the accountability of public services fall into two broad types. These broad approaches apply whichever view one might take of the nature of the state and of accountability: the first, accountability 'upwards' to citizens as a whole and, more specifically, their representatives in Parliament, for the policy and financial regime within which services are provided; the second, accountability 'downwards' to the individual citizen, now more usually referred to as a customer of public services, through the courts or other less formal channels. However, the emphasis placed on the mechanisms reflects the changing political climate and the theoretical debate already outlined (see Figure 2.4).

In accounting 'upwards', to citizens, traditional approaches emphasise political mechanisms of elections, discourse and debate leading to collective choices. The New Right, while not rejecting political mechanisms, have placed a greater emphasis on accounting to taxpayers, the control of costs, the promotion of value for money and the shedding of functions, whether through abolition or privatisation. In accounting 'upwards', emphasis has shifted from *what* services are provided towards the *cost* of any services provided.

In accounting 'downwards', to individual citizens, traditional approaches emphasise rights and entitlements defined following (in theory) public discourse and political choices. The New Right has moved the emphasis towards exercising rights in a market place.

Figure 2.4

Accountability - Preferred Mechanisms

	Modern Social Democratic	New Right
'Upwards'	Political	Financial/Performance
'Downwards'	Legal	Consumerist

The next section of this chapter will examine the literature concerning each of these mechanisms in turn, detailing the role, the strengths and the weaknesses of each.

Political Accountability

At the heart of the British system is the doctrine of ministerial accountability and responsibility. Stated simply, by the Chancellor of the Duchy of Lancaster, this consists of:

> '...a clear democratic line of accountability which runs from the electorate through MPs to the Government which commands the confidence of a majority of those MPs in Parliament. The duly constituted Government - whatever its political complexion - is assisted by the civil service which is permanent and politically impartial. Hence, Ministers are accountable to Parliament; civil servants are accountable to Ministers.' (cited in Public Service Committee, 1996a, p.xviii)

Radcliffe (1991) identifies three aspects to this doctrine: explanatory accountability; amendatory accountability; and the requirement that a minister resign for serious failings. Ministers may be called upon to explain their actions and those of the department and officials under their charge. Whether this applies to policy or to the action taken in a specific case, there is a requirement that ministers respond to such queries. They may also be called upon to correct actions where they have been shown to be incorrect or injurious. Through correspondence with ministers, parliamentary questions, debates or through select committees, ministers may be required to give an account of their actions and those of their officials.

It is with respect to Radcliffe's third aspect, the securing of resignations where serious errors occur, that substantial debate has arisen. In part this is a political concern about the conduct of ministers (Scott, 1996a and 1996b; Norton-Taylor, 1995; Leigh and Vulliamy, 1997). However, concern also surrounds the increasing evidence of policy failure (Dunleavy, 1995; Butler *et al.*, 1994), of legislative weaknesses (Hansard Society Commission on the Legislative Process, 1993; Foster and Plowden, 1996), and of administrative incompetence (Parliamentary Commissioner for Administration, 1993; Committee of Public Accounts, 1994; Social Security Select Committee, 1993a and 1993b). Through all but a few crises and scandals, ministers have resolutely refused to tender their resignations and Parliament has failed to hold ministers to account in the specific sense of securing resignation:

> 'While ministers pay "lip-service" to adherence to cherished constitutional values, there seems to have been a considerable weakening of commitment to, and devaluation of the structure and operation of, Parliamentary accountability.' (O'Toole and Jordan, 1995, p.118)

Concern about the reluctance of ministers to take responsibility for the actions of their officials is increasing and has been linked to the separation of the policy activities of government departments, with which ministers are closely associated, from the administrative aspects, from which ministers distance themselves. Since 1988, following the Ibbs report (Efficiency Unit, 1988), administrative functions, associated with the implementation of policy and not its development, have been hived off and arms-length agencies formed, known as Next Steps agencies. There were, at 1st April 1999, 107 such agencies employing 77% of all civil servants (Cabinet Office, 2000, p.6). For these significant areas of activity, ministers have passed responsibility to

agency chief executives who are now responsible for responding to MPs' enquiries, a source of dispute in itself (Kaufman, 1992; Flynn, 1997). They also take responsibility for answering before select committees on administrative matters. However, there is concern that, since their evidence will be covered by Osmotherly Rules, detailing issues for which civil servants cannot answer before select committees, in the same way as other civil servants' evidence, ministers will be able to avoid responsibility for the consequences of their decisions. More specifically, this reflects a widespread belief that there is no clear distinction between policy and operations (Greer, 1994; Lewis, 1997):

> 'The question remains, however, where does policy end and administration begin? It is a question which gives considerable scope for ministers to pick and choose what they are going to be accountable for, yet at the same time retain the control they so desire.' (O'Toole and Jordan, 1995, p.136)

For Dowding, such concerns have always been based on a false premise. That ministers, in some bygone golden era, resigned when their civil servants made serious mistakes has been 'empirically demolished' (Dowding, 1995, p.178). Harrow and Gillett (1994) have also demonstrated that, in fact, the weaknesses revealed by the Committee of Public Accounts (1994) do not relate to new organisations, in the way that has been assumed, but to more traditional forms of public organisation.

In evidence to the Scott Inquiry, Sir Robin Butler, the former Cabinet Secretary, drew a distinction between responsibility and accountability:

> 'There is a further point. Sir Robin Butler, both in evidence to the Inquiry and in evidence to the 1994 Treasury and Civil Service Select Committee, has drawn a distinction between Ministerial "accountability" and Ministerial "responsibility". Ministerial "accountability" is a constitutional burden that rests on the shoulders of Ministers and cannot be set aside. It does not necessarily, however, require blame to be accepted by a Minister in whose department some blameworthy error or failure has occurred. A Minister should not be held to blame or required to accept personal criticism unless he has some personal responsibility for or some personal involvement in what has occurred. The kernel of Sir Robin's point, I think, is that the conduct of government has become so complex and the need for Ministerial delegation of responsibilities to and reliance on the advice of officials has become so inevitable as to render unreal the attaching of blame to a Minister simply because something has gone wrong in the department of which he is in charge. For my part, I find it difficult to disagree.' (Scott, 1996a, Vol. IV, para. K.15, pp.1805-6)

This restatement of the nature of accountability has, however, provoked strong reaction from some, notably Graham Mather MEP in evidence to the Public Service Select Committee:

> 'The problem with this approach is not just that it does violence to constitutional texts. The problem is that its practical effect is to diminish Ministerial responsibility without increasing official responsibility.' (Public Service Committee, 1996a, p.122)

Nevertheless, the focus of debate about political accountability tends to be on the relative strengths of ministers vis-à-vis the House of Commons. In this contest, the position of departmentally related select committees is widely acknowledged as of crucial importance in influencing the policy and actions of the executive (Liaison Committee, 1997, 2000a and 2000b; Public Service Committee, 1996a, 1996b, and 1997; Drewry, 1989a; Giddings, 1989) though they have taken a more limited role in financial supervision (Flegmann, 1986, p.66). The reports produced by these committees carry weight in part because of their thoroughness but also because of their cross-party nature. Committee membership reflects the balance of forces in the House of Commons and their chairmen will strive to achieve unanimity in a report.

However, the desire for unanimity in select committees clearly demonstrates the weakness of Parliament as a means of securing accountability. The 'Rossi doctrine', so named after the chair of the Environment Select Committee, in 1985 declared that committees should concentrate on 'areas of public concern where the political parties had not defined their attitudes and in which it appeared that ministers had not much time to investigate in depth for themselves' (cited in Drewry, 1989b, p.406). This reflected a desire for unanimity, rather than controversy, and had the consequence that the committee did not consider issues in which the government was interested or which might be controversial, notably the Poll Tax (Butler *et al.*, 1994). This represents a failure even to attempt to hold government to account.

In a more recent investigation, and one that strove to take-on a controversial issue, the Trade and Industry Select Committee sought to investigate the 'Supergun' affair and allegations of government involvement in illegal arms exports. However, the investigation was frustrated at every turn:

> 'The Trade and Industry Select Committee report was inadequate for at least three reasons: it split along party lines; it came only weeks before the 1992 general election and the issues it raised were therefore even more politically controversial than they would otherwise have been; and most importantly for our purposes the committee was denied access to evidence from four key sources that did appear before the Scott inquiry.' (Tomkins, 1996, p.482)

Fundamentally, and as outlined in the government's response to the Public Service Committee (Public Service Committee, 1996b), it is for Parliament to determine the extent of ministerial responsibility:

> 'If failures occur or errors are made, it is for Parliament to consider whether the Minister is personally responsible and, if so, what constitutes an appropriate sanction. Where, however, Parliament decides a Minister is not personally responsible, it will rightly expect an account from the Minister of what steps have been taken to correct the error and prevent recurrence, including reporting (which may be on a confidential basis) on any disciplinary action.' (*ibid.*, p.v)

The decision of Parliament can only be expressed in a vote subject to majorities in the normal way and, as a consequence, the ability of Parliament to secure resignations is severely constrained by party political considerations.

Financial Accountability

Party majorities also, even particularly, dominate debates on government finances. Centred around the Budget and public expenditure forecasts, so clearly are the lines drawn that debate is more a formality:

> 'So automatic has this approval become that the fiction of Supply Days for approving departmental activities has been dropped and renamed Opposition Days to signify the set-piece partisan debates that take place between Government and Opposition on any and everything other than finances. When even the British constitution drops a fiction, it is a telling sign.' (Heclo and Wildavsky, 1981, pp.243-4)

Efforts have been made to improve the information presented to Parliament and the public on the financial performance of government. Departmental reports, produced at the end of each financial year, summarise performance against financial and service targets and present forecasts and future objectives (Likierman and Taylor, 1990, 1991 and 1992). However, there is little evidence that these reports are used either on the floor of the House or in committees.

The principal agent of Parliament in controlling public expenditure is the Committee of Public Accounts (often also referred to as the Public Accounts Committee or PAC):

> 'The enviable reputation of the PAC as the one select committee before which even the most exalted permanent secretary can be made to tremble rests upon two crucial factors which do not apply to other select committees. First, the PAC alone has the benefit of the highly expert and authoritative reports of the Comptroller and Auditor General... the other advantage, which is that the Treasury sees to it that the Committee of Public Accounts' recommendations are implemented by the Departments.' (Drewry, 1989a, p.157)

It is the role of the Comptroller and Auditor General (C&AG) that gives the Committee of Public Accounts its particular significance. The C&AG is an officer of Parliament, supported by the National Audit Office (NAO), responsible for auditing the accounts of government departments and many other public bodies. These audits are not limited to the accuracy of the accounts, but include examination of the 'regularity and propriety of government expenditure, addressing the risks to financial control and accountability' (NAO, 1996a, p.3). In addition to these financial audits, the NAO undertakes value for money audits of 'the economy, efficiency and effectiveness of programmes, projects and activities' (*ibid.*, p.4). Substantially more intrusive than private sector audits, this work is intended to both assure Parliament that the monies voted are being spent as intended, and also that they are being spent to best effect, providing evidence where this is not so. Critical reports from the NAO provide not only ammunition for the PAC, but also headlines for the national press. With this expert backing, and partly because financial accountability is seen as 'a neutral, technical exercise' (Day and Klein, 1987, p.8), the PAC exercises significant authority in its scrutiny of government finances.

While the NAO broadly covers central government and conducts value for money studies in the Health Service and other bodies, the Audit Commission (or the Accounts Commission in Scotland) performs similar audits of Health Service bodies and local authorities. Stewart and others have remarked that the Audit Commission, while it may publish certain material, is itself accountable to the Secretary of State for the Environment and, as such, is not entirely independent of the executive, nor does it report to a body such as the PAC.

There are, however, some further concerns about the state of public sector audit. The first is that not all public services are audited by either the NAO or the Audit Commission, though the Conservative government undertook to allow the NAO sight of all the accounts (Committee of Standards in Public Life, 1995; Cabinet Office, 1997a). However, this only takes the form of guidance at present. The second is that the increasing involvement of private firms in delivering public services may present obstacles not just for access to the contractor's accounts but also the ability of Parliament to consider the value being achieved with monies voted. There have been calls from the NAO and Audit Commission to be given powers similar to the European Court of Auditors which is empowered to follow public money wherever it goes (cited in Cabinet Office, 1997a, Annex E).

Furthermore, there are some who criticise the role and authority of auditors. Agency chief executives have not always been impressed by the quality of auditors and the burden value for money audits impose upon public bodies (Judge, Hogwood and McVicar, 1997; Hogwood, Judge and McVicar, 1998). A former finance director of the Prison Service suggested that the politics behind one particular audit was such that the conclusions reached were erroneous (Landers, 1999).

A more serious critique is one that questions the purpose of audit and the burgeoning role it plays in modern society:

> '... how can a practice whose benefits are being privately questioned as never before nevertheless come to occupy such an important role in public policy? Have alternatives to audit really become so unthinkable? Can we no longer think of accountability without elaborately detailed policing mechanisms?' (Power, 1994, p.1)

Audit, a form of discipline and control, has displaced other forms of accountability. Power suggests a number of problems with the current understanding of audit. In fact, it has a more limited application than is sometimes attributed to it, and its legitimising effect is greater than is warranted:

> 'The danger is that it is now more important to an organisation's legitimacy that it is seen to be audited than that there is any real substance to the audit.' (*ibid.*, p.16)

Furthermore, audit is invulnerable to failure and, in this respect, shares features common to similar forms of inspection. Following the failure of auditors to detect

and expose irregularities in the Maxwell and BCCI collapses, discussion focused on the need for *more* audit, rather than to question the value of audit.

In fact, Power suggests, audit has a different purpose, that of reconciling contradictory pressures between the need to decentralise and devolve while retaining control:

> 'The great attraction of audit and accounting practices is that they appear to reconcile these centrifugal and centripetal forces better than available alternatives. The consequence is a displacement in terms of government discourse, from service-specific values of teaching, care and so on to more abstract financial and quantitative categories.' (*ibid.*, p.16)

Financial data is more commonly seen as concrete and certain. Paradoxically, Power suggests it is abstract in that it does not relate to the specifics of any particular service. As such, financial accountability is much less about revealing what is happening and more concerned with the control of those actions by the use of accounting and audit as forms of discipline. Indeed, audit is partial, *ex post* and limited in the learning it allows. It is remarkable that a discipline of control should have adopted a name, the origins of which are to hear, to listen.

The Role of the Media

Before proceeding to consider the accountability mechanisms operating 'downwards', to the citizen, it will be useful to briefly reflect on the role of the media. The panoply of reports, accounts, debates and parliamentary questions are actually read by relatively few people. In communicating the information to a wider audience, the media plays a significant part. Without examining the issue in great depth, two central points emerge: government seeks to use the media to get a positive message across; and the media picks news items to report according to their own interests. This is not to say that the end result is deliberately misleading. Rather, from amongst a vast range of reports and information, politicians will steer the media to those items most favourable to them. At the same time, the media select items that are likely to interest their readership or viewers. If the media has a role to play in holding the executive accountable, we must at the very least accept that it will do so in a distorted manner (Keane, 1991; Curran and Seaton, 1997). The role of the press in picking-up and publicising the reports of the NAO has already been noted above. In contrast to the government's financial accounts, of which they audit hundreds, the fifty value for

money studies receive the bulk of the attention. This is in part because they are more accessible to the layperson, but also because they often tell tales of incompetence and waste, making for good headlines. The influence of the media was even felt at the committee hearing (Landers, 1999). If, then, the mechanisms of political and financial accountability are weak in themselves, the channel through which the information is communicated to the majority also distorts the messages.

Judicial and Quasi-judicial Accountability

For the individual citizen, rules and the law are the principle routes available to control and hold the executive to account. To a large degree, those decisions made by the state that might directly affect individuals are subject to appeal to independent tribunals. These tribunals operate under the supervision of the Council on Tribunals and the Lord Chancellor's Department. Rules covering appointments and appeal board membership are clear and well supervised. Indeed, the role and independence of these tribunals has not been seriously challenged, though public awareness of rights to appeal and the operation of tribunals have been investigated with a view to improvement (Ogus and Wikeley, 1995).

There are, however, key omissions in the pattern of tribunal coverage, notably the absence of independent appeal against decisions on Housing Benefit claims and Social Fund applications. While, in the case of the Social Fund, the review arrangements are conducted by an Independent Review Service for the Social Fund (Ogus and Wikeley, 1995) that is statutorily independent, Housing Benefits are subject to review by boards consisting of local councillors:

> 'Housing Benefit review boards cannot be regarded as an independent appeals mechanism, and research has shown that they compare poorly with social security appeal tribunals in terms of their procedures.'(Council on Tribunals, 1994, p.27)

Other exceptions cover those aspects subject to professional review, principally medical questions requiring expert assessment of the competence of doctors and others. Until recently, the arrangements for appeal to the General Medical Council (GMC) against the clinical judgement of a professional have not seriously been challenged. However, a number of recent cases, such as the Bristol Royal Infirmary inquiry, have questioned the competence and impartiality of the profession in policing itself. Furthermore, it is not clearly accountable to the public for the actions it takes,

though account is given to the Secretary of State for Health (Kennedy and Grubb, 1994).

The field of social security is, additionally, covered by regular and quasi-independent reviews of the accuracy of decisions made, their compliance with laws, and the adequacy of the training provided to staff involved in adjudicating upon claims. The Chief Adjudication Officer and Chief Child Support Officer, in reality the same person, are supported by the Central Adjudication Service and provide guidance material for Adjudication Officers in addition to reviewing the standards of decision-making. The Independent Review Service for the Social Fund, in addition to carrying out the duties of independent review, outlined above, oversees the quality of decisions made by Social Fund Officers. Reporting on these standards to the Secretary of State and to Parliament, these reviews of standards provide a significant insight into the operation of the benefit system (Chief Adjudication Officer, 1997; Ogus and Wikeley, 1995; Social Fund Commissioner, 1999).

Decisions not covered by the appeal routes described may be subject to judicial review. Though limited in their scope, judicial reviews of the legality of the decisions and actions of public bodies have increased dramatically in recent years. Some have suggested this is in response to increasing failure, though it may be related to an increased awareness on the part of rights groups.

Finally, and covering only issues not subject to any independent review by the courts and tribunals, the Parliamentary Commissioner for Administration, the Health Service Commissioner, and various other ombudsmen, provide further avenues for independent redress. With powers to demand sight of all documentation relating to an individual's case, the ombudsmen are in a position to examine all aspects of the process and of the treatment meted out to an individual. Birkinshaw (1985) details six headings under which cases might be classified according to the ombudsman's findings: assorted errors and oversights; failure to inform or explain; inaccurate or misleading information; misapplication of departmental rules; peremptory behaviour on the part of an official; and unjustifiable delay.

The inquiries of ombudsmen are, however, limited to maladministration:

> 'His task is not to question the content of legality, but to ensure administrative propriety within a given framework of legality.' (*ibid.*, p.136)

The ombudsman 'should not give his opinion that he would have exercised the discretion differently' (Stacey, 1978, p.134). Additionally, access to ombudsmen is restricted to those referred on by their MPs, or councillors in the case of the Commissioner for Local Administration covering local authorities. Indeed, Stacey has suggested the ombudsmen be seen more as an administrative audit than as a significant channel for aggrieved citizens. One former minister has gone further, suggesting the ombudsman represents little more than a safety valve:

> 'This is often a convenient way out for the MP. Some constituents will not take "no" for an answer.... When it comes to genuine grievances, however, the Ombudsman has always seemed to me something of an irrelevance. The MP should himself be able to obtain redress. The Ombudsman, by contrast, often seems hidebound by Whitehall's own rules. If they have been observed, he is satisfied, even if the rules make no obvious sense. If they have been flouted, the Whitehall department will receive a drubbing - even when common sense suggests that the citizen has been fairly treated.' (Bruce-Gardyne, 1986, pp.145-6)

This comment hints at the existence of less formal routes of redress. Beyond appeals on the grounds covered by tribunals and the GMC, and operating particularly in respect of decisions not subject to independent review, government departments and agencies operate a plethora of internal complaint and review mechanisms. Principle amongst these is the handling of MP's correspondence, whether channelled through local offices, hospitals or other facilities, or through ministers. Since the formation of agencies, a significant number of enquiries from MPs have been directed to agency chief executives (Public Service Committee, 1996a). Because of the potential for cases raised through these channels to become political issues, public servants treat them with particular care.

It would appear that these various means of challenging the decisions of public bodies represent a comprehensive package, covering all eventualities. Their efficacy, however, depends among other things upon their accessibility, scope and objectives, the availability of assistance in their use, whether financial, legal or technical, and the speed with which they operate. That they are all *ex post* is clear, but where those decisions significantly affect the lives of individual citizens, such as is the case in

welfare services, the speedy redress of errors and grievances may be as important as the fact that redress is available.

Consumerist Accountability

Rayner scrutinies and the Financial Management Initiative were early measures taken by the governments of Margaret Thatcher to control the administrative costs of the civil service. The one examined programmes and areas of expenditure to derive efficiencies. The other allocated budgetary responsibilities to management at all levels in the bureaucracy. Emphasis was switched from 'control of activity to the control of performance: from regularity to output, from retrospective to prospective accountability' (Day and Klein, 1987, p.44). Outputs and outcomes have increasingly become the yardstick for performance measurements.

The role of the contract as a means both of delivering a service and of giving account has increased significantly in central government since the publication of the White Paper *Competing for Quality* (Her Majesty's Treasury, 1991a). It brought the local authority experience of compulsory competitive tendering to the civil service in the form of market testing and contracting out. At the same time, the formation of executive agencies introduced framework documents that specified, in quasi-contractual terms, the respective responsibilities of department and agency. Finally, and most prominently, the formation of the internal market in the health service brought contracting to patient care.

These changes have been introduced as part of, and together with, the Citizen's Charter reforms (Cabinet Office, 1991), whose most prominent feature is the publication of the standards and the service quality which individual consumers are entitled to expect of public services.

In theory, the Citizen's Charter, by specifying what is required of the contractor (whether a private or public sector contractor), opens up government to scrutiny and allows the identification of responsibility for failings. Ultimately, the intention is to introduce to the public sector the same pressures that drive the private sector to be efficient - competition for custom:

> 'The Citizen's Charter, if it is to be effective, must imitate in some sense the rights which people have as customers in a competitive market.' (Pirie, 1991, p.7)

In many services this has proved difficult, requiring choice to be exercised by the authorities responsible for awarding contracts. Commentators (Deakin, 1994a; Pollitt, 1994) have characterised the government's vision as one of the 'heroic lone consumer' (Pollitt, 1994, p.11) empowered and a bureaucracy decentralised, fragmented and responsive to citizens. Reality, he suggests, is rather different:

> 'The standards which are crucial to the entire enterprise are to be set by managers, who are advised to *consult* consumers but are in no way obliged to comply with their wishes.' (*ibid.*, p.11, emphasis in original)

But, even where an individual has the option of 'exit', there are serious questions as to whether this constitutes accountability:

> 'To say one has fulfilled one's contract can be to deny responsibility rather than to accept it.' (Stewart, 1992, p.10)

Nor is it clear that the qualitative measures to be detailed in the various Charters represent any more than management information on volumes of work and speed of throughput:

> 'The accountability in question turns out to be strongly led by consideration of financial efficiency, and by cost-related numerical performance targets.' (Freeland, 1994, p.102)

The degree to which charter targets align with internal management targets and those reported to Parliament will also have a bearing on the power exercised by the consumer. Where there is no alignment, the priority that public services will give to management targets affecting resources and their own career may work to the detriment of the charter targets and of the consumer (NAO, 1997).

Perhaps more serious is the criticism which brings the debate full circle, to the very heart of the meaning of accountability:

> 'Consumer accountability can undermine the ability of government to provide services efficiently and effectively if it subordinates the general public interest to the interests of consumers.' (Oliver, 1991, p.26)

Stewart (1992) argues that the Citizen's Charter reforms, in giving choices to individuals, undermines collective decision-making in public policy:

> 'In the public domain many services are provided not to meet demand, but to meet need and as a result the management task is the management of rationing,

> which necessarily involves public accountability not market accountability, since the denial of a service to a particular customer will be the fulfilment of a public choice.' (*ibid.*, p.9)

The organising principle of the market, competition, is by its nature irrational and, taken to extremes, counter-productive (Hirschman, 1970), while the nature of the public domain is that of rational and collective choice and decisions. A citizen has, and can have, no right of 'exit' from the public domain.

Overview

Considerations of accountability that take the approach of analysing the operation and scope of types of mechanism, of whatever kind, will tend to conclude that accountability could go further. It is inevitable that the public services might be more accountable from any individual viewpoint. The value of these means of securing accountability are, however, not easily judged in isolation either from other mechanisms or from consideration of the organisations to which they are applied. Indeed, there is a tendency to segregate them without addressing their role in the round. This weakness in the first, mechanistic approach to accountability is, to some extent, remedied in the second, organisational approach.

Accountability of Organisations

The second major approach to the consideration of accountability is to identify an organisation, or organisational type, and consider the application of the various accountability mechanisms to that body. This approach has been particularly pursued in recent years with the proliferation of types of public organisations, including next steps agencies, NHS Trusts, Training and Enterprise Councils and Grant Maintained Schools, as well as the introduction of private contractors to many areas of public service. However, it is not a new concern. Sir Philip Holland led a hunt for the QUANGO in the late 1970s, a search he continues to this day with the Adam Smith Institute (Holland, 1994).

There are several weaknesses with a generic organisational approach. The principle weakness is that public bodies with the same organisational characteristics undertake widely differing functions. It is the contention of both Conservative and Labour

governments that accountability and governance structures have been tailored, in recent years, to best suit the requirements of each public body:

> 'The Government believes that the differences between these bodies, which are tailored to the particular activities they perform and which Parliament has accepted, argue against imposing a single structure on them.' (Cabinet Office, 1996a, p.3)

While the imposition of a single uniform type is not at issue, the extent to which the main organisational types are tailored to the 'particular activities' is doubtful. The degree to which there is any coherent approach to matching organisations to particular activities becomes clear after a brief survey.

Executive Agencies

Formed following the Ibbs report (Efficiency Unit, 1988), executive agencies now undertake the majority of routine delivery and administrative functions formerly performed as part of monolithic central government departments. The publication of framework documents, business and strategic plans, annual reports and charters have provided more information than ever before on the internal machinery of departments and allow responsibility to be more easily attributed (Waldegrave, 1993). As outlined above, however, concern has been voiced as to the extent to which the separation of roles actually clarifies responsibility or rather allows responsibility to be passed on.

These concerns are in practice, however, expressed in relation to a small number of agencies where particular problems have resulted in a high political profile - these include the Prison Service, the Child Support Agency and the Benefits Agency. The majority of agencies have excited little interest from MPs. A Public Service Committee investigation of ministerial accountability and responsibility cited the numbers of MP's enquiries addressed to each agency, figures which illustrate the variation in profile. Numerous agencies received less than ten letters in both 1994 and 1995. A number received thousands in both 1994 and 1995, including Customs and Excise (4,969 and 4,914), the Employment Service (1,156 and 1,306), the Prison Service (1,569 and 2,564), the Benefits Agency (21,411 and 2,689) and the Child Support Agency (9,092 and 5,554) (Public Service Committee, 1996a, pp.xlviii-xlix).

A glance at the list of agencies suggests that it is scarcely reasonable to consider agency status as being tailored to any particular need, as the government contend. Nor is it wholly reasonable to suggest that agency status is itself a problem when it may only be so for a small number of high profile bodies. Identification of where the problems may arise has been undertaken since the formation of agencies.

The first major review of the operation of agencies, undertaken by the Efficiency Unit (1991), classified agencies according to 'the nature of the relationship with the sponsor Department and the skills needed to manage it, the most important characteristic being the status of the Agency's business relative to the overall functions of the Department' (*ibid.*, p.22). In effect, then, they were intent upon identifying the nature of accountability mechanisms between a parent Department and its arms-length agencies. The four types identified were:

- **mainstream agencies** - agencies which are fundamental to the mainstream policy and operations of their Departments;
- **regulatory and other statutory agencies** - agencies which execute, in a highly delegated way, statutory (usually regulatory) functions derived from the main aims of the Department;
- **specialist services and the customer-contractor relationship** - agencies which provide services to Departments (or other Agencies) using particular specialist skills; and
- **peripheral agencies** - agencies which are not linked to any of the main aims of a Department but none the less report to its Minister. (*ibid.*, pp.22-5)

Without hint of irony, the Efficiency Unit described a key point, in relation to mainstream agencies, as being the need to 'ensure that the Agency makes its full contribution to policy formulation in the Department and to prevent any artificial divide growing up between policy and execution' (*ibid.*, p.23). Such concerns mirror those of MPs, and others, about artificial divisions of responsibility and accountability as a consequence of government reforms.

The degree to which agencies represent a tailored approach to the organisation of government functions is also suggested by the annual review of agencies (Cabinet Office, 1997b) which groups them according to a different typology:

'The agencies are grouped as follows:

- Service to the Public;
- Departmental Services;
- Research Establishments;
- Regulatory Functions; and
- Former Agencies

Within each of these broad groupings, agencies are brought together by the nature of their business or their type of operation, so as to make the comparative data more accessible and more helpful.' (*ibid.*, p.xi)

These typologies are not exclusive, one relating to a form of relationship, another to function. In that they do not align with other classifications, it is not clear that agencies are 'tailored' in a meaningful manner. Rather, a vast array of roles, services and functions is encompassed, raising concerns about the extent to which thought has been given to the impact this might have on accountability.

Non-Departmental Public Bodies (NDPBs)

Sometimes called Quasi-Autonomous Non-Government Organisations (QUANGOs) or Extra-Governmental Organisations (EGOs), the term, in fact, encompasses a plethora of organisations with widely differing functions and constitutions. It is not easy to define an NDPB, as is witnessed by the industry associated with attempts to do so (Davis (ed.), 1996; Ridley and Wilson (eds.), 1995; Weir and Hall (eds.), 1994). Even having defined what one might mean, given that scarcely any of these bodies, whether they be advisory bodies, tribunals or regulators, has an identical framework for operation, there is immense variety within the definition, whichever one may be using. The government, in its annual review (Cabinet Office, 1996b), has loosely defined four types of NDPB based upon a crude functional analysis. These types are: executive bodies; advisory bodies; tribunals, whether with licensing or appeal functions; and others. Of particular note is that 'other' includes NHS bodies of all types.

Dismissing any consideration that these might represent attempts to tailor organisations to meet functions, Lord Nolan commented, with reference to audit arrangements:

'There may be good reasons for maintaining differences in the audit regimes for different public bodies, but the current variation seems to be the result of the introduction of measures on an *ad hoc* basis.' (Committee of Standards in Public Life, 1995, p.90)

Each NDPB, even those with apparently similar functions, varies in requirements with regard to annual reporting, the openness of their proceedings and their legal status vis-à-vis the executive (Cabinet Office, 1996b). In response to this, and subsequent suggestions that a more coherent approach be taken, the government has explained that the legislative burden of such changes would be too great (Cabinet Office, 1997a, p.61).

Also worthy of remark is that while some regulatory functions are carried out by next steps agencies, such as the Medicines Control Agency, others are conducted by NDPBs, for example the Occupational Pensions Regulatory Authority, while still others are undertaken by bodies whose position is opaque at best, including the Bank of England and other financial regulators. Reviews, then, of NDPBs, QUANGOs or EGOs present similar problems to those of agencies in that they do not represent useful classifications of types of public body.

The Health Service

The concept that the government has created a coherent approach to the arrangement of functions with a view to securing the most appropriate accountability mechanisms is a more defensible proposition in some key areas of the public service. These include Health Service bodies, Training and Enterprise Councils, Grant Maintained Schools and other organisations formerly influenced, in part at least, by local democracy.

The organisational approach to the study of accountability is useful in reaching an understanding of health authorities and NHS Trusts. While much criticised, the governance of NHS Trusts and health authorities is tailored to the service they provide, though there is debate as to whether the tailor intended that they be accountable. Indeed, accountability issues in the NHS have been the subject of numerous studies (Bruce and McConnel, 1995; Commission on Representing the Public Interest in the Health Service, 1999 and 2000; Day and Klein, 1987; Davis and Daly, 1999; Insight Management Consulting, 1996; Jenkins, 1996; Lewis and Longley, 1992; Rolfe, Holden and Lawes, 1998; Simey, 1985; Wall, 1996; Weir and Hall, 1995; Weir and Hall (eds.), 1994). This interest is, to a large extent, due to the impact of reforms upon the service. The distancing of ministers from operational

matters resulting from the formation of the NHS Management Executive, the introduction of the internal market and new regimes for financing services, and debates over the openness with which health authorities and Trusts conduct their business have ensured that accountability remains at the centre of discussions about the NHS. The removal of locally elected councillors from health authority boards as part of these reforms has been a major focus of argument about the 'democratic deficit'.

Waldegrave, in his defence of the government's record of reform (Waldegrave, 1993), referred at length to the health services. The division between purchaser and provider has, for him, clarified management responsibility at the very lowest levels of the service. He asserts that the publication of strategic purchasing plans, allowing debate about priorities, and performance targets and reports for individual local hospitals have increased public debate and accountability:

> 'So here, too, we can see how much substance there really is behind the democratic deficit theory. The old theory was represented by the Nye Bevan doctrine: "if a bedpan is dropped in the National Health Service the Minister will get to hear of it". This theory of ultimate accountability remains, but now there is some chance of identifying the actual bedpan droppers.' (*ibid.*, p.13)

Various objections have been raised to the reforms of the NHS. A common theme amongst them is the appointment of individuals to the boards of Trusts, the lack of registers of interest and other such means of ensuring the suitability of individuals and their actions, and other technical questions (Weir and Hall (eds.), 1994). Essentially, the appointment of directors and of boards raised concerns about political control:

> 'Both in the case of health authorities and of the new Hospital Trusts, there could no longer be any doubt about their exclusive accountability to the Secretary of State: the reforms represented the ultimate logic of Nye Bevan's principle that health authority members were the "creatures" of the Minister.' (Klein, 1995, pp.197-8)

But more fundamental are questions as to the means of incorporating local needs and priorities in the market mechanisms:

> 'With the separation of purchasers from providers, the old hierarchical structures of the NHS no longer work as a means of control and supervision. In their stead are contracts that are fed by specifications for services. But how do such specifications incorporate citizen's as well as patient's rights?' (Wall, 1996, p.75)

At the heart of this issue is rationing. In addressing this, there is no ideal model to return to, in which democratic representatives significantly influenced priorities in the interests of the local populace. The rationing function was performed by waiting lists, and management consisted of raising or lowering these lists more or less quickly. While recent reforms have brought rationing to the fore, making it a more overt and conscious decision, debate has moved on to the means by which this process might reflect priorities locally and nationally.

As a tool for achieving accountability, the internal market represents little more than a means of achieving efficiencies, and there is dispute even here, and not of reaching policy choices:

> 'Resource allocation formulae are not a substitute for policy. It will always be possible for those at equal risk to receive other than equal access to health services as a result of local policy decisions.' (British Medical Association cited in Health Select Committee, 1995, Vol. 2, p.169)

Essentially, priorities are public and political choices. They cannot be taken behind closed doors, as happened previously, nor can they be left to customers to influence.

The significant issue for accountability of the NHS is not the appointment of individuals and the outside interests they may bring to the posts, or their liability to surcharge. These issues are common to many public bodies exciting considerably less interest (Weir and Hall, 1995; Weir and Hall (eds.), 1994). It is the decisions they are taking which lie at the heart of the problem. Market mechanisms, designed to tame the 'topsy' factor (Waldegrave, 1993) of health expenditure, are forming the basis of rationing choices and providing an inequitable service across the country. It is the nature of the *functions* performed in the Health Service that present the particular problems of accountability. There is no mechanism that might easily reconcile the pressures of equality, local responsiveness and rationing in the Health Service.

Understanding accountability, then, based upon an analysis of structures, obscures the differences between public *services*, placing dissimilar functions in the same categories and failing to identify those where concerns are, or are likely to be, more acute.

An Emergent Normative Model

In recent years, a further pattern has emerged in thinking around accountability. An alternative to Social Democratic and New Right models, the normative approach pays little regard to the ideological issues behind the debates of the past. Instead, it has become common to seek to apply every mechanism to every public body in a uniform, undifferentiated manner.

Beetham (1994) has detailed the problems with defining the word 'democracy'. He points out that any single definition will be subjective, in part because it will not reflect alternative cultural approaches to democracy, and in part because it will state the conclusion an individual wishes to reach. Such problems also afflict the definition of accountability. Instead, he argues that the words must be accepted as political concepts rather than as words with precise definitions.

He, nevertheless, details various indices that might be used as indicators of the democratic health of a society. One of three key headings under which these are presented is 'open and accountable government', the other two being 'free and fair elections' and 'civil and political rights' (*ibid.*, p.30). In assessing the extent to which a society might be considered open and accountable, a series of questions to be addressed are listed. In so far as these questions define the meaning Beetham attaches to accountability, they are worth quoting (questions 1-5 referring to free and fair elections):

> '6) How systematic and open to public scrutiny are the procedures for government consultation of public opinion and of relevant interests in the formation and implementation of policy and legislation?
> 7) How accessible are elected politicians to approach by their electors, and how effectively do they represent constituents' interests?
> 8) How effective and open to scrutiny is the control exercised by elected politicians over the non-elected personnel and organs of the state?
> 9) How extensive are the powers of parliament to oversee legislation and public expenditure, and to scrutinise the executive; and how effectively are they exercised in practice?
> 10) How accessible to the public is information about what the government does, and about the effects of its policies, and how independent is it of the government's own information machine?
> 11) How publicly accountable are elected representatives for their private interests and sources of income that are relevant to the performance of their public office, and the process of election to it?

12) How far are the courts able to ensure that the executive obeys the rule of law; and how effective are their procedures for ensuring that all public institutions and officials are subject to the rule of law in the performance of their functions?
13) How independent is the judiciary from the executive, and from all forms of interference; and how far is the administration of law subject to effective public scrutiny?
14) How readily can a citizen gain access to the courts, ombudsman or tribunals for redress in the event of maladministration or the failure of government or public bodies to meet their legal responsibilities; and how effective are the means of redress available?
15) How far are appointments and promotions within public institutions subject to equal opportunities procedures, and do conditions of service infringe employees' civil rights?
16) How far do the arrangements for government below the level of the central state satisfy popular requirements of accessibility and responsiveness?
17) To what extent does sub-central government have the powers to carry out its responsibilities in accordance with the wishes of its own electorate, and without interference from the centre?
18) How far does any supra-national level of government meet the criteria of popular control and political equality, whether through national parliaments or through representative institutions of its own?' (*ibid.*, p.37)

The extent to which these questions reflect Beetham's concerns is clear, not least from the inclusion of questions that assume the merits of 'sub-central' government. At the same time, any 'audit' using these principles could only be highly subjective. While Beetham acknowledges this, and accepts that an audit based on these questions will be 'necessarily evaluative and judgmental' (*ibid.*, p.36), he nevertheless claims such an audit might have value as a means of self-assessment, not directly comparable with other societies.

Later work, as part of the same Democratic Audit, has further revealed the nature of the assumptions underlying the work. In their investigation of QUANGOs, the Democratic Audit (Weir and Hall, 1995; Weir and Hall (eds.), 1994; Weir and Beetham, 1998; Barker, Byrne and Veall, 1999) have focused upon the extent to which these bodies are subject to the same rigorous controls of openness and probity as apply in local government. Evaluating the accountability of what they define as Extra-Governmental Organisations, Weir and Hall proceed to compare their governance with the various external controls and reporting requirements placed upon local government. Again, accountability is defined against a standard, in this case that of the local government model, and, in effect, a similar string of questions is developed to those of Beetham.

These investigations illustrate the weakness associated with much current work on accountability. The debate becomes one of subjective definition rather than an attempt to understand the purpose of holding public services to account. It is much easier to define actions that are unaccountable than those that are accountable. The outcome of such approaches is to suggest that mechanisms should be strengthened and applied more consistently across agencies (e.g. Elcock, 1998; Davis and Daly, 1999). With more teeth, extant mechanisms might fulfil our requirements. At one and the same time, a 'belt-and-braces' approach has prompted some grumblings about an overload, even a pathology associated with accountability (Judge, Hogwood and McVicar, 1997; Hogwood, Judge and McVicar, 1998).

This approach seems to carry some weight in current thinking in the Labour party, shaping their approach to the reform of public governance structures (Cabinet Office, 1997c and 1998; Public Administration Committee, 1999). Representing, at the same time, consumerist and collective models of accountability, subjects much contested a decade ago, the theoretical underpinnings of accountability are now confused and in need of clarification (Rowe, 1999a and 1999b).

Problematising Accounts

The weaknesses of mechanistic, organisational and normative approaches to the study of accountability might be addressed by an alternative approach. While bringing together accountability mechanisms as they operate in concert, such an approach might avoid the tendency to treat dissimilar bodies in the same way. Day and Klein argue that accountability, particularly where most problematic, must entail agreed language and standards, agreement being a process rather than a definable answer:

> 'It is a social and political process. It is about perceptions and power. It can therefore be expected to vary in different contexts, depending on the nature of the policy arena and the power of the different organisational actors.' (Day and Klein, 1987, p.2)

This understanding contrasts with the simple definition of accountability, meaning liability to give an account or responsibility for actions. The defining characteristics of public services, the unique characteristics of each function and programme might

be identified as a means to defining the what, to whom, how and, more importantly, why of accountability.

Turning to critical accounting disciplines, this specificity is taken further. In recent years, a number of studies have highlighted the role of accounting and auditing in shaping understandings of organisations, of performance and of accountability (Miller and O'Leary, 1987; Power, 1996). Others have suggested that, after recent reforms and the introduction of private sector models to the public services, accountability is becoming a 'contested issue' (Cochrane, 1993, p.48), suggesting the need to stretch our understanding of accounts and accountability (Ezzamel and Willmott, 1993; Goddard and Powell, 1994).

The accounts currently presented of organisations are more concerned with internal ordering and control than with informing others about an organisation's performance. If accepted as only one way of understanding an organisation, accounts emerge as a much more limited technology:

> 'If, however, one treats the picture given in Accounts merely as an image, rather than as reality, then the inevitably partial, selective and potentially distorted nature of the image must be recognised.' (Roberts and Scapens, 1985, p.454)

Criticising the accounting profession from a political science perspective, Nelson argues for the place of 'narration and acknowledgement', for stories and context, in accounting practices (Nelson, 1993).

Developing an alternative conception of accountability, and of accounts, Munro (1996) suggests the employment of the concepts in a wider framework, one of explaining (accounting for) actions, a lens through which our own actions are to be understood. Willmott, discussing accountability (and accounting) in the public sector identifies the same tendencies that have emerged in the review presented above:

> 'Many commentaries on accountability are preoccupied with the description, classification and analysis of the components and workings of accountability structures and systems.' (Willmott, 1996, p.24)

Accountability is not something to be considered in such a mechanistic fashion but in a more dynamic form:

> 'In other words, Garfinkel [1967] highlights the pervasive nature of accountability practices through which human beings render the world, including themselves,

> 'observable-and-reportable' in those ways that are commonsensical to other members who share this way of accomplishing a common sense world. For Garfinkel, as for other analysts influenced by phenomenological forms of analysis (or accountability), the world exists only in the ways that we account for it: the social world is, in this sense, "an endless, on-going, contingent accomplishment".' (*ibid.*, p.27)

Accountability is a form of dialogue, of presenting oneself to others, and at the same time of understanding the world:

> 'The sense of being a discrete, autonomous individual is not innate but, rather, is learned, or socially constructed, through processes of social interaction in which it is regarded as normal to become an object to oneself. To repeat, this process of representing human experience as the responsibility of a centre of consciousness (usually located in the brain, and often likened to the novice rider of an unruly, passionate horse) is not "direct or immediate". Rather, it is slowly acquired as the infant identifies with the way that others relate to him (or her) as an object of their experience – a process of identification that is facilitated by the sense in which others appear as discrete objects, or individuals to the infant.' (*ibid.*, p.34)

We understand ourselves through the accounts others give of us:

> 'Thus an individual's initial sense of self emerges through an internalisation first of the attitudes of particular others, which is then stabilised against a generalised sense of others' expectations.' (Roberts, 1996, p.43)

This represents a very different understanding of accountability to those most commonly deployed in the literature. Instead of being a means of reporting ones' own actions to others, it is the means by which, in listening to the reports of others, we understand our own actions and our selves:

> 'Accountability in confronting self with the attitudes of others comes thereby both to address, confirm and shape the self.' (*ibid.*, p.44)

This image, of accountability as a way of forming one's own identity, finds echoes in the writings of psychologists. Laing and Esterson (1970) described the influence of the actions and statements of others, and particularly family members, upon the perceptions diagnosed schizophrenics have of themselves (see chapter four for a further discussion).

Roberts (1991) contrasts hierarchical forms of accountability with socialising ones. Hierarchical forms separate particular actions from others, subjecting them to scrutiny and control (see also Miller and O'Leary, 1987). Socialising forms, instead, place

actions in a wider context as a means of understanding those actions in terms of their impact and relationship with others:

> 'The process of hierarchical accountability is one in which we are kept anxiously preoccupied with securing self in relation to the objective standards of expected utility that accounting advertises and imposes. These standards are "taken over" and become the lens through which we judge ourselves, and compare ourselves with others. By contrast, in writing of a socialising form of accountability one can suggest the possibility of a form of talk where others are encountered directly.' (Roberts, 1991, pp.362-3)

He understands accountability as a relationship in which people encounter each other. Encounters might include verbal and non-verbal forms of communication, much as described by Goffman:

> 'Knowing that the individual is likely to present himself in a light that is favourable to him, the others may divide what they witness into two parts: a part that is relatively easy for the individual to manipulate at will, being chiefly his verbal assertions, and a part in regard to which he seems to have little concern or control, being chiefly derived from the expressions he gives off.' (1971, p.18)

Using imagery drawn from theatrical performances, Goffman talks of the roles people play, with more or less conviction and more or less convincingly, in encounters with others. Paying attention to the non-verbal, as well as verbal, performances reveals more of the person, the actor. In the same way, users might look as much at the behaviour as at the language of public service organisations in forming their impressions of those services.

Drawing on these threads, an accountable public service might begin to take on some of the characteristics and forms associated with learning organisations. Senge (1993) identified the need for 'systems thinking' as a new discipline, placing the actions of an organisation in a wider context and seeking to understand the consequences of those actions. Pedler, Burgoyne and Boydell (1991) identify further elements that resonate with the arguments of Roberts and Willmott: boundary workers as environmental scanners; informating; and formative accounting. They describe organisations structured to learn about their actions from the environment in which they operate, using that information to learn and develop. In the public sector, such ideas have been introduced through concepts of quality, and particularly total quality management (Morgan and Potter, 1995). But they go further, presenting a challenge to politicians also. Opening up the concept of accountability to include different

accounts, ones that might contradict current accounts, requires a degree of maturity in political discourse. Understanding the impact of policies and services through the accounts of users, as well as those of politicians and managers, presents a challenge to simple measures of success and failure.

In contrast to both the Modern Social Democratic and New Right models of accountability, Roberts and Willmott present the users and citizens in a more active role. They are not simply passive voters with access to tribunals, nor are they depicted as exercising choices in a form of marketplace. Rather they are intimately engaged in the process of understanding and shaping public services through their very engagement with those services.

Accounts and Stories: A Cautionary Note

In discussing accountability, this work will begin to use the term 'account' in an increasingly ambiguous manner. When introducing the case studies, upon which the work focuses, the formal accountability systems will be introduced. These are the 'accounts' public bodies present of their own actions. In this sense, the term 'account' encompasses both formal financial statements and other images, such as annual reports, statements presented to Parliament and responses to individual complaints. These will be contrasted with other 'accounts' of those same services given by people with different experiences of the services summarised in annual reports etc. Referring to this variety of sources using the one word, 'account', may appear confusing at times. Indeed, it is intended to be so. The reader may be forced, from time to time, to pause and consider the nature of the 'account' being presented. And in pausing, I hope the reader will reflect on the partiality (whether biased or incomplete) of the 'accounts' in question.

CHAPTER THREE:
AN ACCOUNT OF THE RESEARCH

If my experience as a civil servant predisposed me to be critical of the conventional literature on accountability, my review of the literature has confirmed the need for a critical examination of the concept. The description and analysis of mechanisms, and the consideration of the application of these to specific organisations does not allow for such a critical reappraisal of accountability. Rather, this work will describe a study of the way in which specific services, that is the actual actions of public servants, are held up to public scrutiny. Whether these accounts of actions correspond with the experience of recipients or represent accurate accounts forms the fundamental problem that the remainder of the work addresses.

To pursue this question, and in similar fashion to some work on broadcasting undertaken by Mitchell and Blumler (1994), the research seeks to examine the content, the functioning of accountability, rather than the form and the ideal that dominates investigations to date. The research is grounded in the experience and seeks to gain some understanding of the operation, the dynamic of accountability from the perspective not just of those giving the account, but also of those to whom that account is given. This approach will begin to reveal whether accountability systems, as they currently function, are reasonable in what they describe and provide the checks and balances intended. Further, it will address the adequacy of those accounts and checks, the extent to which they meet the expressed needs of users.

Just as my approach to accountability is to question the current positivist approach to accounts in favour of a more complex, subjective conception, so my approach to the research is an interpretative one drawing on material from two case studies (Yin, 1994). In many respects, the approach to the research might be considered to be a 'grounded theory' one (Glaser and Strauss, 1967; Strauss and Corbin, 1990). In my development of the research material and findings, I have used an iterative approach, categorising and re-categorising as my thinking has developed. However, I could not claim to have come to the subject without some preconceptions. Indeed, I have sought to openly declare the baggage with which I began the research.

Rather, in seeking to understand the differing perceptions of participants and stakeholders, to contrast written accounts with the accounts of the experiences of others, I have sought to interpret the meanings and understandings presented to me. Openly bringing my experience and prejudices to the research and to the work of interpreting the evidence gathered, I intend to not only critique the current form of accountability but also to point to a different model. In this sense, the work itself represents a different form of account, of accountability for the selected case studies.

A combination of archival material and face-to-face interviews has been employed. The approach has been to collect reports and data that provide accounts of public services and to compare these both with the services they describe and with the experience and needs of those to whom the account is given. To capture these differing viewpoints, a range of stakeholders has been identified. These include those defining and delivering services, that is policy officials, managers and front-line service providers, and those to whom accounts are given, such as Members of Parliament, campaigning and lobbying organisations, expert and academic observers, and bodies supporting and representing individuals in their dealings with public services. The approach recognises that accounts will be partial, but together will allow a critical re-examination of the adequacy of the forms of accountability in practice. By contrasting the accounts of different managers and service providers, and by further contrasting these with a range of accounts given by observers and user representatives, a more nuanced image of the case studies will emerge.

Selected Case Studies

The case studies were selected after a review of organisational and functional types that sought to identify those aspects of public functions that might prove problematic in terms of accountability.

Political Sensitivity

The first, and perhaps obvious, characteristic that impacts on an understanding of the accountability of public functions is the extent to which the activity is politically sensitive:

> 'In the last resort, political control and delegation of authority do not mix. Individual responsibility for management in any area may therefore be possible only in reverse proportion to the level of interest in that area shown by Parliament.' (Royal Institute of Public Administration, 1982, p.39).

Indeed, precisely for which activities Ministers should take direct responsibility and why is at the heart of the issue. In that respect, political sensitivity is not always a useful point in that any issue has the potential to become a subject of interest to Parliament. However, the classification of agencies cited above (Efficiency Unit, 1991, pp.22-25), describing the relationship between agencies and their parent departments, provides a more useful basis for considering the issue. Those agencies, and by extension functions, closely associated with the purpose and objectives of ministers are likely to be those where delegation and operation will be of intense interest to citizens. It also reflects the concerns expressed by MPs (Kaufman, 1992; Flynn, 1997; see also Lewis, 1997; Judge, Hogwood and McVicar, 1997; Hogwood, Judge and McVicar, 1998).

Complexity

Probably the key dimension affecting accountability is the nature and purpose of the service itself. The degree to which the product or purpose of a function is heterogeneous or complex, involving various actors, will affect the extent to which policy intentions are easily translated into action and to which outcomes can be anticipated and predicted. Where a service is provided in tandem with external agents, through networks of providers, accountability will become problematic (Rhodes, 1997; Lovell and Hand, 1999; Cope and Goodship, 1999).

The extent to which the relationship between inputs and outputs can be defined, and outcomes specified affects the degree to which the accountability of a service may be reduced to numerical performance indicators and to which it will be open to contractual arrangements (Carter, Klein and Day, 1992). Additionally, and in so far as there is real choice available, consumer (often the 'purchasing' body) preference, as a mechanism for securing accountability, is appropriate in some respects. Finally, the degree to which a service is specified in the form of rights and entitlements will impact upon the degree to which legal sanctions might apply.

Bureaucratic systems, bound by rules, do perform functions, at least in theory, as specified and in a uniform manner:

> 'The more bureaucratic government is and the more removed the experience of ordinary people is from any actual exercise of power, the more likely it is that the system will be considered formally legitimate unless it embarks on policies which deviate from normal expectations to a very great extent.' (Mommsen, 1989, p.48)

Where services are not closely defined, and particularly where rationing and discretion are applied, they will prove particularly intractable.

Service Deliverers

Of particular interest are the characteristics of service deliverers, their professional status and the extent to which their actions are capable of definition. These characteristics are closely related to Lipsky's (1980) 'street-level bureaucracies', services in which public servants exercise substantial discretion in the handling of individual cases and, thus, make and shape policy through their actions and decisions. This group has been defined as 'public service workers who interact with citizens in the course of their jobs, and who have substantial discretion in the execution of their work' (*ibid.*, p.3). The decisions are immediate and personal, affecting the life choices of individuals and not easily open to proscription by rules and regulations. As such, street-level bureaucracies give account to two groups - agency preferences as expressed by rules and performance indicators; and client claims as presented to them. This is the tension inherent in the dual nature of citizenship.

Presenting even more complex issues of accountability are professionals. Harrison and Pollitt (1994) suggest that there are three views of the role of professionals:

- patients, as ignorant consumers, need to be able to trust clinicians, who in turn must therefore be independent;
- professionalism is a means of evading managerialism through self-regulation; and
- professionals make hard decisions that might otherwise be politically embarrassing.

They suggest that the latter two are dressed in the language of the first, but each model of the role of professions suggests dilemmas in holding the services they provide accountable. Day and Klein locate the problems of accountability in the Health Service, and in similar organisations such as the police force, in the role of

professionals within it:

> 'The growth of professionalism and expertise has led to the privatisation of accountability, in so far as professionals and experts claim that only their peers can judge their conduct and performance. Furthermore, as the systems of service delivery have become more complex, so it has become more difficult to assign responsibility.' (Day and Klein, 1987, p.1)

The problems of controlling and accounting for the actions of those directly responsible for delivering services have been the subject of a range of studies (Hudson, 1993; Hill and Bramley, 1986; Lipsky, 1980).

The Recipient

The nature of the beneficiaries, recipients or users of public services will also affect accountability. Whether a service is provided to institutions or to individuals; whether their involvement is voluntary or compulsory; and the extent to which a public service requires certain behavioural patterns of the subjects will affect the degree to which a service is intrusive and provocative, and thus more likely to be challenged. The more vulnerable, isolated and dependent the recipient/user of a public service, the more problematic accountability might be expected to become.

The Choice

A large number of public services might fit readily into these categories. Two services were selected, both in their own way controversial, complex and provided to vulnerable individuals. As such, they may represent atypical, even extreme, examples of public services, but these are precisely the services that will expose the formal systems of accountability to a rigorous examination.

From my own experience within the Department of Social Security, I was familiar with the first case study, the Social Fund. This service is characterised by several key features that could be expected to throw some light on the themes emerging from my reading of the literature. The Social Fund is a national service, delivered locally through a network of offices, each of which has a limited fund available from which to provide cash assistance to some of the most vulnerable in society. Thus, the service could be expected to vary from office to office and from case to case, raising questions of consistency, equity and effectiveness. The case study could be expected

to reveal the way in which accountability mechanisms actually function and whether they are adequate, from the perspective of key stakeholders.

The Health Service case study was selected as an example of a service demonstrating some of the same characteristics (cash limited; local provision within a national service) as the Social Fund, but having some key distinguishing features of interest to the study. Discretion is exercised in a more complex framework of institutional and professional providers, making it both more overt and at the same time more obscure. Further, the form of accountability is different and, at the same time, has been the focus of more controversy. As such, the Health Service case study could be expected to provide differing perspectives on the central issues of interest to the research.

It was necessary, given the breadth of services delivered by the NHS, to narrow this case study further. The commissioning of mental health services will form the focus of the second case study. While presenting problems common to the NHS as a whole, mental health services are further complicated by the particularly vulnerable position of the service users, individuals who can be deprived of their liberty or subjected to other forms of compulsory treatment. In addition, there is an array of professions and institutions directly concerned with the delivery of the service, each with competing interests, perspectives and views as to the nature, cause and best means of treating mental health needs. In this respect, mental health services represent a most testing study of forms of accountability. How do services account for their actions when dealing with people they deem to have a reduced capacity to care for or represent themselves?

Further case studies, notably of local authority social service functions, were considered. The key reason for limiting the study to the two identified above was practical. Each case involved a large number of interviews with a range of stakeholders. An additional case study would have been unmanageable given this approach.

The Evidence

In both case studies, a range of material has been gathered. Initially, this consisted of written statements of policy and procedures, reports and financial accounts,

Parliamentary records and copies of audit and other evaluations of each service. This reading, together with a thorough reading of the academic literature, allowed a description of the policy field and the means by which each service is delivered, managed and held accountable. This description is presented in the following chapter.

Policy Officials

With this understanding beginning to form, I arranged interviews with senior policy officials in the Department of Social Security, Benefits Agency and NHS Executive. Officials interviewed fulfilled a range of functions, including finance, statistics, legal and parliamentary work, in addition to direct responsibility for policy formulation and advice. In this, I was assisted by the National Audit Office, initial contact in each of the organisations being with officers responsible for liaison with the NAO. When interviewing officials, this association with the NAO had positive and negative aspects. Cooperation was readily offered, but I had to handle some suspicion that my material might appear in a future value for money audit, or in some other way inform the work of the NAO. I made every effort to assure individuals that there was no other agenda, emphasising that the work was unconnected to any value for money study and was sanctioned by senior officials in each organisation. However, it must be acknowledged that this association may have influenced the responses of some policy officials.

Service Managers and Providers

As will become apparent, in shaping the reality of the two case study services and the outcome delivered, managers and staff exercise substantial discretion in managing limited resources. While there is a great deal of evidence of this in the literature (e.g. Huby and Dix, 1992; Ham, 1997; Harrison and Pollitt, 1994), to understand better the nature of the discretion exercised, I arranged interviews with a range of managers and providers in each organisation. There are important differences between the two case studies.

In the case of the Social Fund, I was able to gain access to two Benefits Agency district offices. Each district serves an urban population with high levels of poverty and deprivation. In addition, there are substantial minority ethnic communities and

high levels of homelessness. This access was negotiated with local managers with whom I had worked in the past, when a civil servant. As a consequence, it was relatively easy to negotiate access to Social Fund Officers and Social Fund Review Officers. As I began to undertake these interviews, I was offered access to a third district, one being merged with my second district office location.

In the case of the NHS, two health authorities, both covering regional cities within the same NHS region were selected. Similar in size, the main relevant difference between the two is the level of funding. The resources allocated to the first are below the level suggested by the weighted capitation formula (see next chapter for a fuller explanation), while the second is allocated more than the formula would indicate. This difference was a deliberate choice. In discussions of the NHS, resource levels tend to emerge as the dominant issue, an issue directly influencing priority setting, inequalities and rationing. At an early stage, a central issue seemed to be the relationship between financial resources and accountability.

Having selected two authorities, interviews were again arranged with managers in the health bodies. In similar fashion to policy officials in the first case study, the NAO liaison officer within the NHS Executive made contact with the relevant Regional Office, where I conducted three interviews with senior managers. I made contact with the selected health authorities directly, again arranging interviews with senior managers responsible for commissioning and planning. Only at this stage did my focus begin to narrow and to centre upon mental health service commissioning. I arranged interviews with managers in Trusts and in other services responsible for the management of mental health services and for the commissioning of services from the voluntary and charitable sector.

Other Statutory Bodies and Agencies

In addition to those bodies directly responsible for the delivery of services, a range of other bodies with a role in each case study service were identified. These included senior staff in the Audit Commission, the office of the Parliamentary Commissioner for the Health Service, the Independent Review Service for the Social Fund, the Association of Community Health Councils of England and Wales, two local Community Health Councils and the Commission for Racial Equality. Each, in their

own particular way, plays a part in holding the case study services to account, whether through audit, by handling appeals and complaints or by representing local views at a national level. In each case, my interviews were not concerned to establish how these other statutory bodies and agencies are accountable for their own actions. Such an inquiry would be another research project in itself. Rather, I was concerned to understand the role played by each organisation in holding the case study services to account.

Voluntary Sector Providers

A particular feature of mental health service provision is the extensive involvement of voluntary bodies. As will be discussed in the next chapter, they play particular roles in reaching communities and individuals that might otherwise not be served by statutory bodies. This is particularly true in the case of minority ethnic communities where, in addition to the barriers associated with stigma, a barrier sometimes greater because of specific social attitudes to mental ill-health, there are also cultural and language barriers. Statutory bodies have, in the past, failed to reach such communities and so a significant feature of this case study is the degree to which the boundaries between provider and user organisations are blurred. Voluntary bodies also involved in delivery provided a very particular insight into statutory bodies. Their dual role, as both provider and advocate for a particular community interest, made for interesting observations on the relationship between the two. In all, I conducted interviews in six such organisations, one dealing with the homeless, the rest all concerned with minority ethnic communities.

Local Advocates

In addition to local voluntary sector mental health service providers, a range of advocacy and rights groups were interviewed at the local level. These groups were particularly valuable sources of accounts of the case studies, presenting the user view. While it might be argued that actual users should have been approached, this would have presented access problems and, by providing responses based on very particular experiences, might have misrepresented the general situation. Instead, user representatives were approached and asked to reflect on the relationship they observe between their clients and the public agencies. Using illustrations and examples, they presented an image that was both much more balanced and, at the same time, carried

greater force. But it must be accepted that the image they portray of public bodies is not undistorted. The service provided to an individual supported by an advocate or adviser is likely to be very different to that provided to an individual alone. This is an issue that was raised by interviewees throughout the research and one to which we will return.

In the case of the Social Fund, local advocacy groups included law centres, Citizens Advice Bureaux and welfare rights advisers. These were identified with the cooperation of the Benefits Agency district office managers, who provided a list of all the agencies with which they had local contacts. From these lists, local coordinating agencies were approached, and in discussion with them, those local bodies most closely involved in the Social Fund were identified.

A similar approach was taken in the case of mental health services. Voluntary sector coordinating agencies were asked for their advice, and a list of agencies drawn up. These lists were much longer than those for the Social Fund, and many more interviews were undertaken with local branches of MIND, advocates, user representatives and carers.

National Advocates

In addition to local rights groups, policy staff from national umbrella organisations were interviewed. These included associations, such as the Local Government Association and NHS Confederation, rights groups, such as the Child Poverty Action Group and the National Association of Citizens Advice Bureaux, and other expert organisations, such as MIND and the King's Fund. These organisations provided a useful overview of developments in the field, in addition to experience of dealing with the public agencies, involved in each of the case study services, over a number of years.

Others

Finally, a range of individuals were also approached for particular expert insights. These included academics and other commentators, whether at a local or national level, and Members of Parliament. While only three MPs agreed to be interviewed, and these were not representative (all being Labour members), they each had a

specific interest in the case studies and, consequently, provided some useful insights into the working ways of Parliamentary accountability.

A detailed breakdown of the interviews, indicating the numbers and broad roles of subjects and the split between the two case studies, is provided at Appendix 1. In all, I conducted 75 interviews involving 112 people. Interviews around the Social Fund case study began in the second half of 1997 and ended in the summer of 1998. The mental health case study took place over a longer period of time, starting in late 1997 and ending in the summer of 1999. This was for a number of reasons. First, I deliberately started this case study later than the Social Fund. Because of my past experience as a civil servant in the Department of Social Security, the Social Fund represented familiar territory. Undertaking this study first allowed me to gain some confidence in my approach and methods. Second, the Labour government's reform agenda (Department of Health, 1997a) was emerging as I was beginning my work. While it is probably true to say that there is never a period of calm in the NHS, the period of my work was a time of rapid change. This was particularly true of mental health services at the time, with a review of mental health legislation underway (Department of Health, 1999) and the development of a National Service Framework for mental health (NHS Executive, 1999a) in the background.

All but 12 of these interviews were tape-recorded. Taping proved impractical in a number of instances, entirely because of the venue available. In none of the 12 cases did the interviewee object. Of those taped, the majority were transcribed in full. Because of time pressures and, in some cases, because of the large amount of extraneous material, some editing took place at the transcribing stage. This mainly affected some interviews towards the end of the mental health case study. However, the key themes of this research had already begun to emerge and, in selectively transcribing material, I was able to identify both those elements of each interview that chimed in with these themes and, at the same time, any dissonant notes.

Public Meetings

In addition to written material and the range of interviews detailed above, I attended a number of meetings. Of the Community Health Councils I approached during the course of my work, one invited me to present my work to the full board and to lead a

discussion of the subject. This interest and openness arose in part because the Community Health Councils were in the process of reconsidering their role in light of government reforms of the NHS as a whole (Department of Health, 1997a; Rolfe, Holden and Lawes, 1998; Commission on Representing the Public Interest in the Health Service, 1999 and 2000). One of the members of the board subsequently invited me to speak, briefly, and to lead a discussion at a further forum of voluntary organisations involved in mental health services.

Further, I attended two NHS Trust monthly management meetings, opened to the public following the 1997 election, as an observing member of the public, some observations from which will inform reflections on openness in the health service.

Finally, and at the suggestion of the National Audit Office, I attended a witness session of the Committee of Public Accounts at which the chief executive of the Benefits Agency was giving evidence on performance management and measurement, following a critical value for money study (National Audit Office, 1998; Committee of Public Accounts, 2000). Again, some observations from this hearing will inform my observations on Parliamentary accountability.

Analysis

I have already noted that I began work on the Social Fund study before that on mental health. At an early stage, a number of themes (the complexity of policy and of institutions; oversight of service deliverers; and responding to service users) began to emerge from interviews, themes developed in two publications (Rowe 1999a and 1999b). However, as the research progressed, these themes proved too crude a schema for the analysis of the material I was gathering. A number of further issues lay beneath these broad headings. For example, while the failure of formal accounts to represent complexity by placing services in context was an issue pursued in my early thinking, this began to fragment as it became apparent that I needed to distinguish between the organisational context of agencies providing services and the social context of those seeking to access those services.

Before beginning to draw the two case studies together, I reread the material I had gathered and began to identify pieces that spoke to the various points I had identified.

At the same time, I was looking for other issues and for further themes. In doing this, I simply extracted relevant material, grouping clippings under headings. At the same time, I began to develop a structure, arranging and rearranging the themes together. Rereading the material under each heading, I then sought to interpret and connect the thoughts expressed in each extract, developing my thinking under each heading in turn and selecting the evidence that most clearly illustrated the issues, before assembling it in the form presented in chapters five through eight.

In taking this selective course, I have a wealth of material that does not appear in this work. I have retained all of this, in the form of tapes, of notes taken during interviews and while observing meetings. In addition, there is a substantial volume of supporting material, such as annual reports, local policy papers and a variety of leaflets and other information, gathered in the course of the research. Together with the files of clippings and the wall chart with which I ordered the material, I have retained a substantial archive that might be further exploited.

Reflections

With this range of evidence, from each public body, from advocates, from voluntary providers, from inspectors and from observers, the research has sought to consider the manner in which accountability actually operates, and the extent to which it can be said that it exposes the case study organisations to external scrutiny and understanding. I will not claim that the evidence and perspectives presented by interviewees represents, in any sense, the 'true' picture of those services. Rather, they represent accounts that, at times, conflict with and challenge formal accounts. Their omission from our understanding of the case study services suggests fundamental flaws in our current concepts of accountability. Before presenting the evidence, and in order to inform discussion of it, it will be worth describing in some depth the nature and form of the services that form the case studies.

CHAPTER FOUR:
POLICY, MANAGEMENT AND ACCOUNTABILITY OF THE CASE STUDIES

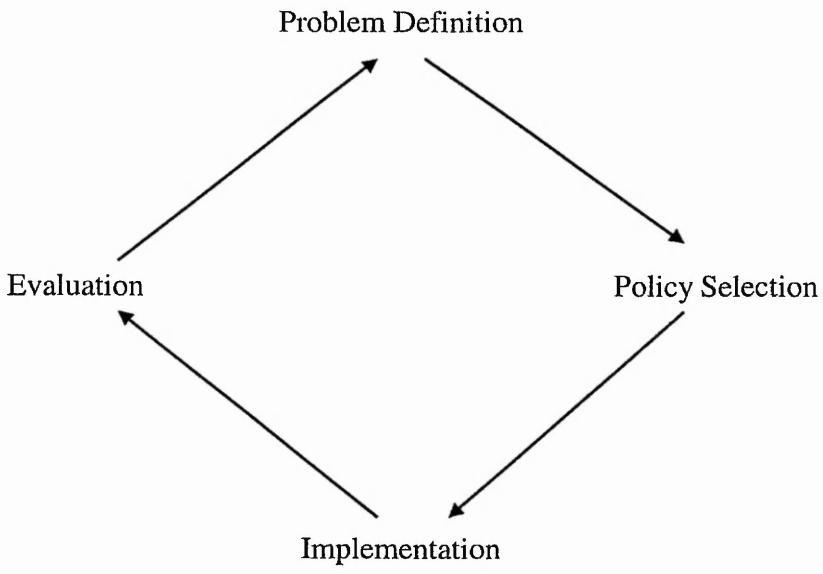
This chapter will seek to introduce and describe the complex relationships and interconnections between policy, procedures, finances and management that inform the actual manner in which services are delivered and decisions are made in each of the case studies. However, before doing so, I will reflect on the problems associated with actually understanding a public service.

What is Policy?

Establishing the nature of a policy is, in itself, contentious, much literature being devoted to a debate about the policy process (Hogwood and Gunn, 1984; Hill, 1997; Dunn, 1994). Various models have been developed, detailing various stages in lesser or greater detail. However, each tends to gravitate to a cycle involving problem definition, policy selection, implementation, evaluation and further problem definition (Figure 4.1). Hill (1997) has emphasised the continuity in this process and the blurred divisions between the various stages, arguing that each element might be in progress at any one moment in time.

Figure 4.1

The Policy Process



Others (notably Lipsky, 1980; but see also Hudson, 1993) place emphasis upon the importance of service providers in defining policy through their actions. The design of systems, the actions of those providing the services and, even, the attitude of recipients determine, to some extent, the actual nature of a policy. Indeed, the internal management systems and external evaluation arrangements applied to a programme, in that they affect the actions of officials and indicate the priorities of the programme, are not merely a matter of the collection of information but of guidance and policy. Thus, while studies of the policy process might identify distinct elements in the development of services, it is the whole of these elements that is the policy.

In describing the two case studies, it will become apparent that I lean towards the latter interpretation. Indeed, as already outlined in the introduction, my own experience and previous research (Bolderson *et al.*, 1997) indicates that the formal statements of policy and structures of implementation conceal a more complex pattern of frameworks and interactions. At this stage, the discussion of the case studies will be limited to an overview of the development, policy, financing and management of the two services. As the research findings are unveiled, it will become apparent that there are other significant themes within this work, amongst them the nature of policy.

The Social Fund

The origins of the Social Fund are to be found in two discrete, though related, arenas: the first, a long-running debate about the relative merits of regulation and discretion in providing for unforeseen needs; the second, the reform proposals of the Conservative governments of the 1980s.

Regulation or Discretion?

There has been a long-running debate about the best means of providing for additional or unforeseeable needs in a social assistance scheme (Berthoud, 1985). Indeed, it is part of a wider debate about the delivery of public services (see e.g. Hill, 1997), reflecting differing approaches to questions of implementation. A regulated approach is associated with democratic values, conferring rights through public discourse, delivering those rights consistently through bureaucracy, and guaranteeing those rights through access to channels of appeal and redress. Discretion, on the other

hand, sits comfortably within the New Right philosophy of markets, flexibility and choice (see Figure 4.2).

Figure 4.2

Regulation and Discretion

	Regulation	Discretion
Organisation	Hierarchy	Networks
Framework	Rigid	Flexible
Control	Inputs	Outputs
Primary Goal	Programme Implementation	Client Satisfaction
Accountability	Legal Process	Customer

Throughout the 1970s, the Supplementary Benefit Commission, an independent body charged with oversight of the Supplementary Benefit scheme, discussed the relative merits of regulation and discretion. At that time, Supplementary Benefit provided for additional needs through a discretionary scheme. This provided for extra weekly payments and one-off payments in addition to a means-tested benefit. Two eminent social scientists were divided on the merits of this approach, Richard Titmuss favouring more discretion, while David Donnison preferred regulation (Donnison, 1982). Reflecting on these debates of the late 1970s, a later government White Paper commented:

> 'One view was that the problems arose essentially from the exercise of discretion and that a more formally regulated scheme would solve the admitted difficulties of running special needs provision. But there was a counter view that a regulatory approach can be inflexible and lead to excessive prescription of detail which is difficult to understand and difficult to operate.' (Department of Health and Social Security, 1985b, p.36)

In 1980, a new scheme was introduced, following this debate. This took the form of regulated provision for additional weekly payments and for one-off special needs. While the first element, additional weekly payments, worked well, the second, provision for special needs, did not. The government concluded that this:

> '..., at one extreme, is insensitive to particular needs and, at the other, has to help people on defined regulated criteria which in practice can only be a broad approximation of need. Moreover, it is a system which requires claimants to

> define their needs in terms of what the regulations provide rather than simply explaining their needs as they find them.' (*ibid.*, p.37)

Perhaps worse, in the eyes of the government, was the inability of the Department to control escalating costs. Patterns indicated that tendencies to claim were stronger in some parts of the country and among some client groups than in other areas or amongst other groups:

> '... although the theoretical objection to regulated entitlement is that some genuine needs, which cannot be predicted by rules, will not be met, the political and administrative objection was that too much money was being spent on needs which were not perceived to be genuine.' (Dalley and Berthoud, 1992, p.4)

Against this background, the Social Fund represents a redrawing of the line between regulation and discretion. However, to some minds, the line has moved too far:

> 'One of the legitimate complaints against the 1980-88 scheme was that detailed regulation could not cover every situation; some real needs could not be met because they were not specified. This was a good argument for introducing some discretion, but not a reason for discarding entitlement.' (Berthoud, 1991, pp.16-17)

It was, in fact, more than a redrawing. The imposition of cash limits on top of discretion alters the balance entirely. Whereas debate had concerned *need*, and the best means of meeting need, the new proposals were concerned with *demand* and the best way of restraining it. The solution was to place a cap on *supply*. The language had moved from that familiar to social policy and welfare, to that familiar to economists.

The Conservative Reform Agenda

The introduction of the Social Fund in 1988 was part of the wide-ranging reforms of social security initiated during the second term of the Thatcher government. Their purpose was to overhaul the system for the payment of pensions, income-related and other benefits. Five key weaknesses were to be addressed by these reforms: complexity; failure to help those in need; the existence of poverty traps; failure to support self-provision; and the cost of social security (Department of Health and Social Security, 1985b, p.1). This list, indeed, echoes the New Right analysis of many of the problems posed by the state: bureaucracy; ineffectiveness; disincentives; dependency; and wastefulness (e.g. Niskanen, 1971).

The proposals in the 1985 Green Paper outlined a variety of reforms. Of most interest to this examination is the introduction of a simplified structure of means-tested provision. Supplementary Benefit had become increasingly complex, providing, through a plethora of regulations, for basic income, additional on-going needs and also for one-off or intermittent needs. This scheme was difficult to deliver, hard for applicants to understand and open to varying interpretations and abuse:

> 'At present these problems [exceptional needs] are dealt with ineffectively through single payments and urgent needs payments. These systems have become unacceptably cumbersome and expensive. They are subject to complex regulations and instructions as a result of which help is often dependent more on intricacies of interpretation than on a genuine assessment of need. These arrangements will be replaced by a new *social fund.* It will be administered by DHSS local offices on a discretionary basis so that appropriate and flexible help can be given to those in genuine need.' (Department of Health and Social Security, 1985a, p.32, emphasis in original)

Income Support replaced Supplementary Benefit with weekly payments of a basic rate supplemented by premiums to be paid to certain categories of applicant. In effect, these premiums encompassed many of the definable additional needs met previously under discretionary or single payment schemes, including additional benefit for the disabled, lone parents and for the elderly.

The Social Fund, reflecting the lessons learned from the failings of single payments, provides for one-off and intermittent expenses, and was to:

> '... be new in a number of ways:
> - **First,** it will be better able to respond to individual needs as they arise. This does not mean that there will be no guidelines or that decisions will be capricious. But it does mean that decisions will not be constrained by a very detailed framework of rules and precedents.
> - **Second,** the fund will offer greater flexibility in adapting to changing needs. The Government will consider developing its scope and operation over the years as experience is gained of the most effective methods of providing individual help.
> - **Third,** decisions will be made locally by specialist officers with the minimum of formality. Arrangements for review will also be handled locally to ensure that the final decision is not delayed and that it continues to reflect a local judgement based on an understanding of local circumstances.
> - **Fourth,** social fund officers will, as part of their job provide a focus for liaison with social service and social work departments, health authorities and voluntary agencies.' (Department of Health and Social Security, 1985b, pp.37-38, emphasis in original)

Again, the parallels in language in this outline in the consideration of the merits of discretion and the New Right understanding of accountability are striking. Deakin (1994b), in discussing the Conservative agenda for change, remarked upon the degree to which social security represented all that was evil in New Right demonology. The solutions developed reflected their prescription for change nowhere more clearly than in the Social Fund.

The background to the Social Fund shaped its design. Debate following the publication of the Green and, subsequently, White Papers (Department of Health and Social Security, 1985a and 1985b) and during the passage of the Bill through both Houses of Parliament further shaped the policy that was to emerge.

The Government's Proposals

Most of the elements of the Social Fund, contrary to common belief, are not new. Discretionary decisions had been a feature of the Supplementary Benefit scheme for some years, and some urgent case payments under single payments were subject, in certain circumstances, to repayment. The new elements were, in reality, the imposition of cash constraints and the removal of rights to appeal.

Initial proposals outlined a scheme providing assistance in three forms:

- **specific payments** - payments for expenses associated with maternity (Maternity Payments), funerals (Funeral Payments) and with heating bills during bouts of cold weather (Cold Weather Payments). Awards were to be made in defined circumstances.
- **discretionary grants** - payments for expenses associated with moving, or keeping, an applicant out of institutional care (Community Care Grants). Payments were to be made from a cash limited budget and so assistance was to be given on the basis of decisions about priorities made at a local level.
- **discretionary loans** - assistance with meeting budgeting for unforeseen expenses through two sorts of interest free loans. The first of these was to be for assistance in a crisis where there is an immediate risk to health and safety which financial assistance could avert (Crisis Loans). The second, and more common, was to be paid for large items of one-off expenditure (Budgeting Loans). Again, because the

fund was to be cash limited, assistance was to be given on the basis of priority decisions at a local level. Additionally, the assistance given was to be repayable. It is with the last two elements, grants and loans, that this work is concerned. The first element allows for payments in a manner similar to much of the rest of the social security system. Discretion is deliberately applied only in the cases of grants and loans from a cash limited fund.

There was to be no independent right of appeal beyond the local office:

> 'The first stage of review will therefore be for the social fund officer to look again at his decision when an applicant disagrees with it.... Where someone remains dissatisfied, the case will be reconsidered by senior management in the local office... This will link the task of reviewing individual cases with the general management responsibility for monitoring the operation of the fund.' (Department of Health and Social Security, 1985b, p.44)

Explaining this before the Social Services Committee, the Minister of State, Tony Newton, declared:

> 'We are saying that we do not believe that the social fund and decisions of the social fund officers are appropriate, are amenable, to the same kind of - using the word as neutrally as I can - legalistic adjudication machinery as is applied to regulated entitlement to weekly amounts of benefit.' (Social Services Committee, 1986a, p.19)

Consultation on the Green Paper prompted criticisms of the proposals for a cash limit, of the adequacy of the budget for grants, of the proposals for recovering assistance given in the form of loans, and of the adequacy of appeal arrangements (Huby and Dix, 1992). However, the White Paper and Social Security Bill that emerged addressed none of these criticisms to any substantial degree. Such criticisms were to re-emerge during the passage of the Social Security Bill through the Houses of Parliament during 1986.

In itself, the government's unwillingness to take significant notice of comments on the Green Paper proposals, in advance of the publication of a White Paper and the Bill itself, demonstrates a concern more with the form and appearance of accountability than with the content of that process. Subsequent changes to the legislation, during its course through Parliament, might have been avoided had, it seems to me, a genuine consultation process taken place.

The Social Security Bill, 1986

The introduction of a cash limit to payments from the Social Fund was not the only innovation in the solution to the problem of providing for intermittent or one-off expenses. The legal framework, set out in the Social Security Bill 1986, was unique in itself.

Whereas most social security legislation empowers the Secretary of State to make regulations, the clauses for the Social Fund allow for directions to be made instead. These have several features that bear directly on questions of accountability. Principally, directions are not open to the same Parliamentary scrutiny as regulations while having the same legal force as secondary legislation. Regulations are subject to scrutiny by the Social Security Advisory Committee, are tabled in Parliament together with the comments from this advisory body, and are then subject to either affirmative or negative resolution procedures of the House. Directions are subject to none of these checks, being the fiat of the Secretary of State. They are published and might be the subject of debate as a consequence of this, but need not formally be approved by Parliament.

The degree to which regulations are actually subjected to any rigorous scrutiny is disputable:

> 'The degree of "control" implied is small, so long as the government has a working majority in both Houses.' (Drabble and Lynes, 1989, p.307)

While directions by-pass this process, it is not clear that this results in any substantial loss of accountability. The majority of regulations are not, in fact, subjected to rigorous Parliamentary scrutiny. As such, the introduction of directions did not, in the Conservative government's opinion, significantly undermine democratic control. Instead, directions allow for a more adaptable response to the provision of unforeseeable needs:

> 'Legislation will outline the purpose of the fund and how it will run. It will provide for appointed officers - social fund officers - to administer the fund. In view of the need to retain flexibility it will not however set out detailed rules for help. The Secretary of State will be empowered to issue directions on how the fund is to be administered.' (Department of Health and Social Security, 1985b, p.38)

The directions are supplemented by guidance that Social Fund Officers are obliged to consider in reaching decisions, though they are not binding. Decisions on cases are, within this framework, local ones.

The degree to which the Social Fund, in such circumstances, could be said to have been subjected to Parliamentary scrutiny and, thus, to have been legitimised has been challenged. While a Secretary of State may give directions of which Parliament may approve, that they have not been so approved in advance makes them, to some extent, illegitimate (Beetham, 1991).

Passage of the Bill

While the Bill passed largely unaltered, some concessions were forced, despite the size of the government's majority at the time, on the key issues of rights to appeal. Three changes were extracted:

- **regulation of payments:** payments for maternity, funeral and cold weather expenses were to be regulated in the same manner as other benefits. This made them part of the normal adjudication process, subject to oversight by the Chief Adjudication Officer, with right of appeal to independent Social Security Appeal Tribunals.
- **review:** the House of Commons Social Services Committee forced a concession on the status of the reviews in local offices, adding a further tier, the Independent Review Service. This was to be independent in so far as it was to be conducted by DHSS staff unconnected with the local benefit office network:

  'But the Government, on further reflection, accept the Committee's view that there should be arrangements for Social Fund decisions to be reviewed beyond the local office. A new clause has accordingly been added to the Social Security Bill. This provides for a formal right to a review, first at local level and, secondly, by a Social Fund inspector. Those inspectors will be appointed by the Secretary of State, but will be located outside the local office and the local office management chain.' (Social Services Committee, 1986b, p.vii)

- **independent review:** the House of Lords extended this by introducing a Commissioner responsible to Parliament for the quality and independence of the Independent Review Service. The Social Fund Commissioner was, however, to be appointed by the Secretary of State for Social Services and might appoint Social Fund Inspectors from candidates offered by the Secretary of State.

In effect, these amendments shifted the proposal's centre of gravity back towards rights, conferring them for funeral, maternity and cold weather payments and strengthening the right of challenge to decisions on loans and grants. The review provisions, as they stood then, represented a compromise (Drabble and Lynes, 1989) conceded under pressure.

The compromise reached raises two interesting points. The first, and most contentious, is the form and lack of independence of the review mechanism, and the problem this potentially poses for accountability. The second relates to the ability of Parliament to amend legislation during the passage of a Bill. Despite a large government majority, concessions, albeit limited, were extracted, concessions which might have been made earlier had the Green Paper responses been given more weight.

Policy as Defined in Legislation

At this stage, the enactment of the legislation, it was not clear how the Social Fund would operate. High-level objectives had been set:

> 'The Government's key objectives for the Social Fund are:
> a) to support the Government's economic objectives by containing expenditure within the Social Fund budget;
> b) to handle the arrangements in a way that does not prejudice the efficiency of the main Income Support scheme (which replaced Supplementary Benefit);
> c) to concentrate attention and help on those applicants facing greatest difficulties in managing on their income;
> d) to enable a more varied response to inescapable need than could be achieved under the previous rules; and
> e) to break new ground in the field of community care.' (National Audit Office, 1991, para. 1.5)

However, these objectives say very little about the Social Fund, particularly how the scheme will deliver the flexible response to those in greatest difficulties. Before the issue of directions and guidance, before the allocation of budgets, the scheme's impact was impossible to anticipate. In effect, then, the policy for which account would be given was undefined:

> 'The proposal for the social fund is long on desirable objectives - help, sympathy, flexibility and so on - but very short on methods for achieving these objectives.' (Berthoud, 1985, p.111)

After all of Parliament's scrutiny of the Bill, it is not apparent that MPs could be clear what it was they had enacted. The nature of the Social Fund was still, at that stage, to

be determined, but further development of the Social Fund would not be influenced or legitimised by Parliament. Key, then, to understanding the Social Fund is its operation. The operation of the fund is a product of the framework of instructions that constrain discretion, and of the financial constraints upon decisions. Yet it is also, finally, dependent upon those making the decisions and the way they use their discretion. In Lipsky's formula (1980), street-level bureaucrats, operating with a degree of discretion, make policy by their actions.

The Street-level Bureaucrats

The Social Fund is administered on behalf of the Secretary of State for Social Security by the Benefits Agency, an executive agency. The policy and financial framework, within which the agency operates, is laid down by the Department of Social Security. Delivery of the majority of benefits is carried out through a network of local offices organised into districts. The Social Fund is administered through this network.

Within each district, an Area Social Fund Officer (ASFO) is responsible for the management of the Social Fund budget and for ensuring that the cash limit is not exceeded. While formally independent in fulfilling their role as ASFOs, they are, in fact, part of the management team of a Benefits Agency district. In performing their function, the ASFO may issue local guidance to Social Fund Officers (SFO) regarding the level of priority that might be met from the district's budget. This must be taken into account alongside the directions and guidance issued to SFOs by the Secretary of State.

The Framework of Directions and Guidance

Both directions and guidance have, since the passing of the Social Security Act 1986, been the subject of legal challenge. The challenge to directions was prompted largely by concern at the degree of freedom they allow the Secretary of State:

> 'The courts have confirmed on several occasions that such directions are legal, although several of the judges have expressed surprise that Parliament should have offered the Secretary of State so broad a power.' (Dally and Berthoud, 1992, p.105)

Early cases of judicial review also considered the question of the nature of guidance. In addition to the directions issued, social fund officers must also take into account guidance from the Secretary of State, as supplemented by the Area Social Fund Officer. However, judgements determined that the guidance could not be considered binding in law. This presented significant problems, requiring hasty adjustment of directions and guidance, since early rules made the instruction to stay within the cash limit part of guidance rather than direction. Thus, the courts effectively dismissed the cash limit at a stroke.

These early challenges having been settled, directions now define matters such as:

- the manner in which applications should be dealt with;
- those applications excluded by various qualifying conditions;
- the requirement to stay within the cash limit;
- the requirement to ensure the applicant is able to repay a loan; and
- the circumstances in which, and items for which, an application will be considered.

It is this last element that presents the problems. Slightly different approaches are taken under each of the three types of discretionary payment:

- **Crisis Loans:** for expenses in an emergency or as a consequence of a disaster and the loan must be the only means of preventing serious damage or serious risk to the health and safety of the applicant or a member of their family;
- **Budgeting Loans:** intended to meet important intermittent expenses for which it may be difficult to budget. Some items are specifically excluded;
- **Community Care Grants:** are intended to promote community care by: helping vulnerable people who need help to live independently in the community; easing exceptional pressure on families; helping with the living expenses of prisoners and young offenders on release on temporary licence; and helping with some travelling expenses. Some items are specifically excluded.

Guidance further details priorities. In the case of Budgeting Loans, these list priority items, such as beds, bedding, cookers or clothing. In the case of Community Care Grants, this specifies those circumstances considered priority. Crisis Loans are different in that, if there is a genuine crisis and since the loans are normally for small

amounts, the need will be met. Allowance is made for local management to adjust the level of priority they are able to meet throughout the year to reflect the state of the budget and, thus, the capacity to meet needs.

Directions and guidance, then, tightly constrain the discretion of social fund officers. This has lead some to comment that, in fact, it is not simply discretion being exercised, as early proposals indicated, but a 'closely circumscribed framework' (Drabble and Lynes, 1989, p.302).

The combination of a national framework of directions and the more flexible application of guidance at a local level presents one of the chief problems in accounting for the Social Fund. While the directions may be known, the way in which these operate is, in practice, unknown, inequitable and not easily accounted for. A key determinant of the actual practice is financial.

The Financial Framework

The Social Fund is a White Paper Account and, as such, is reported separately to Parliament. Annually, the Secretary of State accounts for the operation of the scheme and for the way in which monies have been spent.

The Social Fund is financed through a separate account:

> 'The Fund has a working balance from which the Benefits Agency makes grants and loans. Expenditure on regulated benefits (maternity, funeral and cold weather payments) are 'demand led'. Net expenditure on discretionary payments (Budgeting and Crisis Loans and Community Care Grants) is cash limited.' (Department of Social Security, 1997, p.9)

It is a feature of the fund that the total monies available for loans is dependent upon the level of recoveries in-year:

> 'For 1997-98 the net discretionary Social Fund budget will be £138.2 million. The level of the gross budget will depend on the forecast level of recoveries in that year.' (*ibid.*, p.77)

The expenditure on those elements which are 'demand led', the regulated payments for which claimants have an absolute entitlement, is met in full. That is, the level of demand is forecast and a level of funding secured to meet that demand. For grants, a fixed budget is decided at the beginning of the year, from which all expenditure will

be met. For loans, a payment is made to the fund, intended to cover losses to the fund through bad debts, and to increase the total size of the fund in line with inflation and/or with government policy. Table 4.1 details the form of the account.

Table 4.1

The Social Fund Financial Framework

	1995/96 outturn	1996/97 outturn	1997/98 outturn	1998/99 estimated outturn	1999/2000 plans
Regulated expenditure					
Maternity payments	21.899	22.006	19.994	19.000	19.500
Funeral payments	46.543	41.273	36.791	37.500	36.900
Cold weather payments	59.961	41.032	0.586	8.000	8.000
Total expenditure	**128.403**	**104.311**	**57.371**	**64.500**	**67.100**
Discretionary expenditure					
Community care grants	95.815	96.200	96.499	98.000	(1)
Budgeting loans	248.574	284.254	311.070	347.700	(1)
Crisis loans	56.410	53.176	55.155	55.000	(1)
Winter Fuel Payments	-	-	190.640	190.000	155.000
Gross expenditure	**400.799**	**433.630**	**653.364**	**690.700**	**155.000**
Repayment of loans	-263.214	-299.125	-334.188	-363.000	(1)
Net expenditure	137.585	134.505	319.176	138.200	138.200
Net total SF expenditure	**265.988**	**238.816**	**376.547**	**202.700**	**205.300**

Notes:
(1) Ministers decide the size and allocation of the gross discretionary fund budget shortly before the start of each financial year. Expenditure plans and the expected level of repayments for 1999/2000 will be placed in the House of Commons Library towards the end of March.

Source: Department of Social Security, 1999a

Throughout the year, a balance of £15m is retained in the account to cover immediate future payments.

Allocations to office budgets are made from a notional total budget based upon the net payment to the fund from revenue, together with the anticipated level of recoveries in the coming year. If the level of recoveries is greater, and working with

a view to maintaining the working balance, additional monies might be allocated to offices through the year (normally in October). It should be noted, however, that an office does not receive an additional allocation on the strength of its performance in recovering funds, but on a pro-rata basis adjusted where there is evidence of significant pressure on the budget.

Allocations to Districts

While the accounting regime is clear at this summary level, the allocation of monies to the cash limited local budgets is a more problematic issue. While directions and guidance spell out the way in which decisions are to be made regarding the merits and priority of individual cases, it is the budget which determines the degree to which those needs can be met. Thus the means by which cash is allocated to each district is important in understanding the way in which the Social Fund deals with individual applications for assistance.

The Secretary of State's annual report details the basis of allocations:

> 'Each year the national cash limited budget is allocated between all Benefits Agency District Offices. Three main factors are taken into account when deciding the allocation of the loans budget:
> - "the baseline" - the previous years budget for that District;
> - "need" - the District's Income Support and income-based Jobseeker's Allowance caseload, including a per capita minimum of £40 a head for each person included in the caseload; and
> - "legitimate demand" - the value of awards made by the District in the previous year plus an estimated value for any application refused on priority grounds.' (Department of Social Security, 1997, p.12)

Each of these presents particular problems. The baseline, in effect, ensures that no office budget has been reduced. While this is not the intention, and there must be circumstances in which it would happen, the political implications of reducing a budget might be expected to be severe. More seriously, it has the effect of preserving the unequal distribution that arose under single payments.

However, the concepts of need and legitimate demand are particularly awkward. The first, based upon numbers in receipt of means-tested benefit, is an expression of the likely incidence of needs that the fund can meet. Receipt of these benefits is a qualifying condition for an award from the fund. This head count is weighted to take

account of actual patterns of applications and awards. Lone parents are most likely to use the fund, while pensioners are the least inclined to seek help from the fund. The per capita amount is, then, higher for lone parents. In that it does not indicate *actual* need, the measure is a crude approximation, though the best available, the DSS argues.

Legitimate demand is an attempt to estimate what the total expenditure from the fund would be were all demands that are deemed legitimate to be met. In practice, a significant number of cases, in addition to those refused on priority grounds, might be defined as legitimate. Many are refused because they have not been in receipt of the qualifying benefit for 26 weeks, as required in directions. This rule is founded upon the idea that the longer a person is on benefit, the more likely they are to need assistance with budgeting. Evidence in fact suggests that many people also need help when they first claim and are becoming accustomed to surviving on a lower income (Huby and Dix, 1992). Others are refused because they have already borrowed as much from the fund as they are permitted (a £1,000 limit applies to each *family unit*, whether the family be a single man, or the family includes three children), or are judged unable to repay the loan because of other debts. These last two categories might, in fact, be considered more deserving of assistance, but are, in effect, defined as illegitimate demands.

Problems of targeting resources to those areas with the greatest need are inevitable. Defining need is the Holy Grail of social policy, and it would be too much to expect an easy solution. However, the consequences of the distribution, based upon these three elements, are significant. Some areas receive more than their 'need' level. Over time, other areas will catch up but, given the political constraint on reducing an area's budget, the rate of catch up will be slow. The Department is, over time, reducing the variance from the assessed need level.

The allocations to Districts are also altered by a further factor. Each Area Director within the Benefits Agency is given £100k to allocate amongst the Districts within that Area. This recognises the fact that the formula will not be capable of addressing all the variations between Districts. However, this amounts to £1.3m nationally and represents little flexibility from a total loans budget of £300m. The additional

allocation made from this money is included in the initial cash limit for each District as communicated to Parliament each year.

The financial framework, which, as has already been noted, significantly affects discretion, is a confused one. The inequalities in distribution aggravate the vagaries in the application of directions and guidance, such that the control and understanding of the outcomes of such a scheme becomes problematic in the extreme, and the requirement for adequate management information systems essential.

Accountability for the Social Fund

In understanding the Social Fund, it becomes clear that the actions of the officers making decisions on individual applications are important not just to the individual applicant concerned, but also in so far as they are part of a pattern of discretion which forms a national picture. Accounting for the Social Fund, in more than purely technical monetary terms, might be expected to reflect this. Without clear entitlements for applicants, without certain outcomes and with room for the irrational application of discretion, the means of securing accountability might be expected to be particularly robust.

The arrangements consist of a variety of mechanisms. In reporting the performance of the scheme as a whole to Parliament and to the electorate, a plethora of performance targets and annual documents are provided. Further, and for the individual applicant, there are various means by which the decisions of Social Fund Officers might be challenged and redress secured. At face value, these means provide substantial checks upon the operation of the fund.

Reporting to Parliament

In comparison to other areas of government activity, the Social Fund is well covered by reports and information presented to Parliament. The following table outlines the range of documentation published annually.

Figure 4.3

Accounting to Parliament for the Social Fund

Document	Purpose
Department of Social Security Departmental Report	Details financial expenditure trends and outlines the direction of government policy in the coming period.
Annual Report of the Secretary of State	Details volumes of claims, awards by purpose and refusals by reasons.
Social Fund Accounts	Details expenditure and recoveries on the Social Fund. Signed by the Chief Executive of the Benefits Agency.
Benefits Agency Annual Report and Accounts	Details activity and expenditure against targets set by the Secretary of State.
Benefits Agency Business Plan	Presents proposals and targets for the coming period.
Annual Report of the Social Fund Commissioner	Reports on the standards of reviews conducted by Social Fund Inspectors.

It is noticeable that, in line with the separation of roles between policy and operational responsibilities, the reports deal with different aspects of the Social Fund. The Secretary of State for Social Security reports for policy and its outcomes, detailing the limits and targets to which the Benefits Agency work. The Benefits Agency, as the executive agency responsible, reports for the performance against targets, including the financial limits imposed upon the Social Fund. The accounts are subject to audit by the National Audit Office and presented to Parliament. It will be useful to consider some of the data presented in some of these reports.

Accounting for the Policy

In accounting for the performance of the Social Fund as a policy, the statistical appendices to the Secretary of State's annual report (see Appendix 2) present details of the numbers of applications, the items for which awards were made, the average amount of an award for such items, and the reasons for refusing other applications. As an illustration of the data, the items for which awards were made and the reasons for refusal for Budgeting Loans are set out in Appendix 2, Tables 2 and 3.

While useful as a source of basic information, these figures raise some interesting points. The majority of those refused assistance did not qualify because they had not met the basic rules of eligibility, such as being in receipt of Income Support for a minimum of 26 weeks. However, the third most significant reason for refusal is that of insufficient priority. These are claims from applicants whose need has been established. Due to budgetary pressures, the office to which they applied was unable to provide assistance, judging that other needs were more important. The interpretation of priority may be different from one area to the next. Patterns of refusal on priority grounds are not indicated, nor is it clear what items such applications were for. The statistics do show that Budgeting Loan awards were made in 64% of applications, in 1998/99, although this rises when those paid after review are included.

The value of these figures is, however, not clear. They do not answer key questions. Are those in most need getting enough assistance? What is the impact of loan repayments upon these people? What are the circumstances of those refused assistance? Fundamentally, such measures present problems familiar in social policy. Questions of poverty and need are much debated, but conclusions depend upon an elusive objective definition (Berthoud, 1991). Information about the definitions used and conclusions reached by Social Fund Officers is missing from the statistical summaries presented in reports to Parliament.

Accounting for Performance

In accounting for the performance of the Benefits Agency's administration of the Social Fund, the figures presented in other documents emphasise the financial control aspects of the fund. The principal performance targets are set by the Secretary of State, and are the indicators upon which the performance of the Benefits Agency is judged. There were, for the 1998-99 reporting year, only two targets for the Social Fund: adherence to the cash limit; and repayments to the fund. Secretary of State targets are the key performance indicators reported to Parliament. The financial emphasis in recent years indicates a clearly discernible shift in policy. Ministerial focus upon control of costs - whether through anti-fraud initiatives or restricting entitlement - has outweighed any concerns with quality. In the case of the Social Fund, while financial control has always been key, the loan recovery targets have

increased.

The second tier of targets are management targets within the Benefits Agency, upon which the performance of the 13 Area Directors and their district managers are judged. The principle targets, in addition to those reported to the Secretary of State, relate both to benefit delivery and financial performance. Benefit related targets focus upon the speed with which cases are processed. As management targets, these indicate the speed with which most claims are processed. Initially, the targets were expressed as an average time taken to process cases. In recent years, performance has been reported as a percentage of cases processed within two (primary and secondary) targets, expressed in numbers of working days. The target is to process 65% of all claims within *x* days, and 95% within *y* days. Performance is generally assessed against the primary target. However, these targets present particular problems. They form the basis of Citizen's Charter undertakings, yet they contain no commitment to a specified performance, merely to process as many cases as possible within a certain period. An individual case may, however, take an indefinite period. The time taken to clear those remaining 5% of cases, not covered by the targets, is not reflected in the performance data. As such, the standards outlined are unenforceable in any one case, providing no undertaking to provide a given standard of service.

As examples, these figures serve to illustrate the problems that the data reported to Parliament present. Nevertheless, there remain many channels for clarification. These include all those one would expect: Parliamentary questions and debates; public audit; and scrutiny before Parliamentary committees. In addition, an independent government advisory body, the Social Security Advisory Committee, is tasked with commenting upon government policy proposals and reporting its conclusions to Parliament.

Parliamentary Questions and Debates

Parliamentary questions and debates are, in the Westminster model of democracy, a key tool in holding the government to account for its policy and actions. Attached, at Appendix 3, is a chart of the numbers of Parliamentary Questions raised concerning the Social Fund since the publication of the first consultation paper in 1985. The figures illustrate the extent to which the tabling of questions is politically driven,

reflecting electoral cycles, the extent to which an issue is current, or the publication of specific reports and criticisms. While not a precise measurement of volumes, the table suggests that questions are not used as a systematic means of holding the executive to account for its policy and actions. Nevertheless, the volume of questions does illustrate the extent to which the Social Fund was controversial, while also suggesting that Parliament has not sustained that attention.

Within these figures there are some examples of individual Members of Parliament seeking to extract information or to challenge the basis of policies, including some heated exchanges in debates and at oral question times. However, as an example of the ability of Members of Parliament to extract information using Parliamentary questions, the series detailed in Appendix 4 illustrate the information imbalance and the ability of the executive to evade awkward questions which might expose inequality in the administration of the Social Fund.

Select Committee Studies

A further, and potentially more powerful, instrument for the scrutiny of executive activity are select committees. These committees, consisting of Members of Parliament from all of the main political parties, shadow government departments, such as the Department of Social Security, questioning ministers and officials on the policies and practices for which they are responsible. The Social Security Select Committee has, in recent years, developed a good relationship with the Department of Social Security. Indeed, the committee has taken the lead in remedying the failings of some aspects of government policy, with the cooperation of the executive.

In contrast, and possibly because of the controversial nature of the fund, until recently there were no specific examinations of the Social Fund, except as part of initial inquiries into the first year of operation of the 1988 reforms (Social Services Committee, 1989). In evidence to the Liaison Committee, Frank Field MP, then chairman of the Social Security Select Committee and later Minister of State at the Department of Social Security, commented that the committee 'has been concerned to lead forward the public debate on the future of welfare spending and has not tied itself down to a routine of examining Departmental and Agency publications' (Liaison Committee, 1997, p.78). Indeed, the Social Security Select Committee's

only recent foray into the 'routine' of the executive's activities (Social Security Select Committee, 1995) did not dwell upon the Social Fund at all. At the time of writing, the Social Security Select Committee (2001) has published a critical report on the Social Fund, some thirteen years after its first implementation.

Audit and Independent Research

Aside from original scrutiny of the bill in 1986, the only other systematic Parliamentary inquiry into the Social Fund was conducted by the National Audit Office. Indeed, this report represents as close a study of the effectiveness of a policy as any undertaken by the National Audit Office (1991), and was critical of the Social Fund. Recommendations covered a range of issues: the allocation of budgets; the lack of consistency in the treatment of applicants; the degree to which the fund helped those facing greatest financial difficulties; the recovery of loans; the variations in the response to inescapable needs; and rights to an independent review. These criticisms were reflected in the subsequent Committee of Public Accounts hearing, though it was noted that further research had been commissioned by the Department of Social Security (Committee of Public Accounts, 1991). The government's response, in the form of a Treasury Minute (Her Majesty's Treasury, 1991b) relied heavily on this further research by York University, proposing to await its conclusion before making substantial changes to the Social Fund.

Similarly, a wide range of academic research and analysis has been undertaken into the impact of the Social Fund (Becker and Silburn, 1990; Dalley and Berthoud, 1992; Social Security Advisory Committee, 1992; Social Security Consortium, 1993; Craig, 1998). Much of this has been critical of the government. However, as was the case in response to the National Audit Office scrutiny, the government suggested that the York University research would provide a more robust analysis (House of Commons Debates, Sixth Series, Vol. 177, Col. 734, 1989-90; Vol. 207, Col. 47-8, 1992-93).

Commissioned by the government, the York University report was heavily analysed before publication. When it was published, it was highly critical of the Social Fund, criticism which underlined points made by other researchers. Findings indicated substantial inequalities which could not easily be explained by reference to the circumstances of the applicants (Huby and Dix, 1992). The government's response

has been to question the methodology used by the researchers to establish 'need', a methodology agreed in detail in advance with the Department of Social Security (Huby, 1996; see also chapter 6). These exchanges emphasise the extent to which an assessment of the Social Fund will be contestable, dependent upon an understanding of need.

Accounting to the Applicants

In parallel, and as a means to challenge individual decisions taken by Social Fund Officers, a series of options are available to applicants. Appendix 5 illustrates, in a simplified form, the channels available. These might follow, broadly, two paths: the first deals with complaints about the decisions reached by Social Fund Officers; the second pursues those complaints related to the administration of the scheme.

Social Fund Reviews

There is no appeal against a Social Fund Officer's decision. Instead, there is a more flexible and informal two-stage review procedure, designed to be swift, in responding to urgent cases, and sensitive to the priorities and guidance of the Secretary of State. The first review is conducted within the local office which originally made the decision. The applicant is offered the opportunity to attend for an interview, the purpose of which is to allow them to present additional evidence in support of their application. After this interview, a further determination of the case will be made and the original decision either upheld or substituted. Those still unhappy with the decision at this stage may seek a second review from the Independent Review Service. A Social Fund Inspector, on reviewing the case, may substitute a new decision; confirm the decision of the Social Fund Officer; or refer the case back to the local office for their further consideration. Finally, and where the High Court gives leave, application may be made for judicial review.

A significant light is shed upon the Social Fund process in the review mechanisms. Statistics indicate that the more persistent an applicant, the better their chances of receiving an award (see Appendix 2, Table 4). In total, of those applications reviewed, decisions were revised in 34% of cases. This suggests either that the evidence gathered with the initial applications is inadequate or that Social Fund Officers are making poor decisions. The experience of the Independent Review

Service, and of independent advice agencies, suggests that the first of these explanations is the more common. Because of poor form design, and because of management targets requiring the swift consideration of applications, evidence may often be insufficient to make a proper decision. The first stage of the review is, in many offices, an extension of the initial application and provides no form of redress.

The second review of the case is undertaken by the Independent Review Service. While not technically independent (Drabble and Lynes, 1989), the service has been argued to be independent in practice. Substantial effort has been made by the review service to maintain a standard approach, ensuring, so far as possible, that applications for review are treated in the same manner. The review service has recently sought to communicate these standards more widely, generating information about standards of evidence and decision-making. In many ways, this information, published in *The Journal of the Independent Review Service* and in regular releases of a *Digest of Decisions*, represents the most coherent source of qualitative information on the Social Fund. In taking this approach, care is being taken to maintain the independence of the Social Fund Inspectors, reflecting the degree of comment on this element of the process (Council on Tribunals, 1994; Ogus and Wikeley, 1995).

Yet, despite these best efforts to improve consistency, the review process ensures merely that all cases are treated properly, that due consideration is given to the relevant evidence and that the Social Fund Officer has exercised discretion in a reasonable manner. The office budget still determines whether an award of assistance can be made in light of the merits of the case. While this review process can ensure that claims are handled in a consistent manner, there are no means of ensuring consistent outcomes.

Citizen's Charter Standards

Key elements of the Citizen's Charter undertakings are the targets relating to the speed with which applications will be processed, as outlined above. These are, as indicated, flawed, in so far as they make no guarantees to an individual. They take the form of processing $x\%$ of claims within y days. In reality, the clearance time undertakings are those defined in a leaflet which offers compensation where claims take 6 months. The contrast is stark. Performance targets and annual reports to

Parliament do not represent undertakings in any conventional sense.

The Benefits Agency's Citizen Charter further specifies quality service standards. These include:

- minimum hours of opening for offices and switchboards of 36 hours a week;
- to respond to letters within 10 working days;
- to respond to complaints within 7 working days;
- to advertise the name of the Customer Services Manager in each office; and
- to have in place an independent tier for handling complaints.

As such, and together with the targets for case clearance listed above, these do not confer rights upon applicants, merely expressing aspirations and providing information. They may, however, be taken up through the second of the complaints processes (see Appendix 5). Broadly, they represent the areas most usually examined by the ombudsmen as constituting maladministration:

- assorted mistakes, errors and oversights;
- failing to impart information or provide an adequate explanation;
- giving inaccurate information and misleading advice;
- misapplication of departmental rules and instructions;
- peremptory or inconsiderate behaviour on the part of officials; and
- unjustifiable delay. (Birkinshaw, 1985)

A separate complaints procedure operates. This process has evolved over some years and is now well established. Its principles are that complaints should be dealt with quickly and at a local level, wherever possible. Only where this is not possible should other, more time consuming processes become involved. The consequence of this is that contested complaints may take some time to resolve, but many others are speedily addressed. Only after these channels of review have been exhausted might cases proceed, through Members of Parliament or other representatives, to further review, such as referral to the Parliamentary Commissioner for Administration, the ombudsman.

The speed and effectiveness with which easily resolved complaints are dealt with has improved substantially since the advent of the Citizen's Charter. That, to this extent, has increased the responsiveness of public services to users.

A Reformed Social Fund

Despite this dearth of information, reforms of the Social Fund were introduced on 1st April 1999 following the passing of the Social Security Act 1998, commonly known as the Peter Lilley memorial bill because it included large parts of the previous government's policy. The reforms are intended to reduce administrative costs by cutting down on duplication and by introducing, in the case of Budgeting Loans, a decision-making process based on more 'objective' criteria (Department of Social Security, 1999c). During the second reading debate, the then Secretary of State, Harriet Harman, sketched out the thrust of the changes:

> 'At the moment, decision making on applications for budgeting loans from the social fund is unnecessarily complex. When the social fund was introduced, the idea was that it should be a simple, discretionary application of common sense, but it has not turned out like that. The current system is confusing for customers and time-consuming for staff.
>
> 'I shall give an example of a family on benefit, whose washing machine breaks down and who cannot afford to get it fixed. They apply for a budgeting loan of £80 for the repair. It is a simple matter, but they must complete a 20-page application form. They have to answer questions that may have nothing to do with their application, because by statute the form must cover both loans and grants, each of which has different requirements for an award. Staff are required by statute to consider which member of the family the washing machine is for, why and how badly it is needed. Staff are also required by statute to use their discretion to judge whether the requirements for a grant rather than for a loan have been satisfied, even though the applicant has not applied for a grant. Only when they have decided that the requirements for a grant have not been satisfied can they use their discretion to judge whether the original loan application is of high enough priority to receive an award.' (House of Commons Debates, Vol. 198, Col. 787, 1997-98)

In fact, discretion remains in Budgeting Loan decisions (Collinge, 1999; Child Poverty Action Group, 1999), just as for Crisis Loans and Community Care Grants. The most significant change has been to require applicants to understand the Social Fund in advance. No longer are claims considered as an application to the Social Fund. To reduce staff costs, applicants must apply to relevant parts separately.

The revised system has still to settle in and, anecdotal evidence suggests, has prompted an increase in requests for review to the Independent Review Service. In any case, it should be noted that my research, and particularly the interviews on the Social Fund, all pre-date the change.

Mental Health Commissioning

Just as the Social Fund represents a complex and contentious area of social security policy, so mental health services are a controversial element of the welfare services. Not only is an understanding of the provision of these services shaped by wider debates about the NHS, but there is also contention about the nature of the service itself. Debates about the cause, nature and appropriate treatment of illness are aggravated by the range of professions involved at every stage. Nor are the professions confined to one organisation, the police and especially social workers having important roles and duties under the Mental Health Act 1983.

The Health Service

Established in 1948, the National Health Service is badly named. From the outset, it has been a service that, in the main, provides treatment for illness, rather than health, through a network of local hospitals, each with a character and service profile derived as much from history as from national policy (Klein, 1995). Indeed the NHS was founded to raise standards and to reduce the patchwork of variations and inequalities. Since 1948, a string of reorganisations have sought to address these same, lingering problems. Reflecting on mental health services, one pamphlet, originally published in 1966 and reprinted in the mid-1970s, comments:

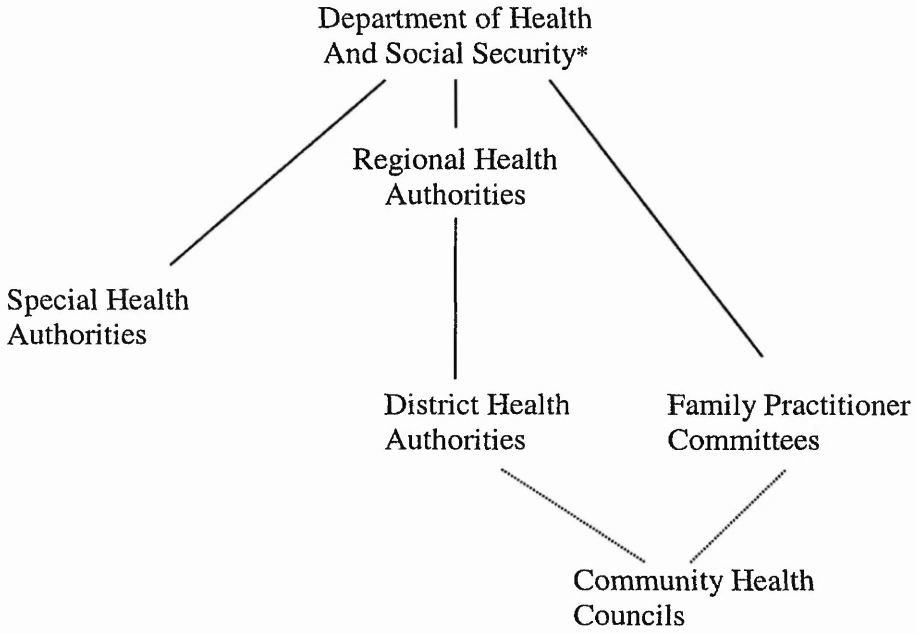
> 'Whenever hospitals and local authorities are asked to say what services they are now providing, and what developments they propose in the next ten or fifteen years, the range of replies could hardly be wider, and certainly seems greater than can be accounted for by variations in local needs alone. The first essential, therefore, seems to be for the government to lay down minimum standards and insist that these be maintained.' (Mittler, 197?, 7-8)

Similar sentiments can be found in government publications to this day (Department of Health, 1997a and 2000).

While there have been a number of changes in organisation, notably in 1974, the most dramatic changes in the management of the NHS have occurred in the past twenty years, and it is with these changes that this overview will be concerned. Indeed, until 1990, the organisation was only slightly altered from that introduced in 1974, Area Health Authorities having been eliminated in the early 1980s (see Figure 4.4).

Figure 4.4

The Structure of the NHS in England, 1982-90
(Source: Ham, 1997, p.2)



* The DHSS became the Department of Health in 1988.

The structure is essentially hierarchical. At a local level, District Health Authorities were responsible for the management of hospitals and community health services, while Family Practitioner Committees managed general practitioners, dentists, pharmacists and other independent contractors. Community Health Councils, established in 1974, are tasked with representing the public interest at a local level.

While the structure remained largely unchanged through the 1980s, attempts were made to reform the management of the NHS. Chief amongst these efforts were changes introduced following the publication of the *NHS Management Inquiry: Report to the Secretary of State for Social Services*, generally referred to as the Griffiths Report (Griffiths, 1983). This described a service without clear purpose and with no leadership. In a memorable phrase, the report suggested that 'if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge' (Griffiths, 1983, p.12). The solution proposed, and accepted entirely, was to introduce management at all levels of the NHS: a supervisory board, an NHS Chief Executive, and general

managers in hospitals would provide the leadership and direction necessary to an efficient service.

The impact was much less dramatic than the language would suggest. The report did not take full account of the problems of managing professionals, and particularly doctors. Indeed, the attempt to control professionals entailed inherent dangers and problems (Harrison and Pollitt, 1994). Where, previously, individual decisions were the responsibility of autonomous clinicians operating to standards and values widely accepted, if not widely understood, the introduction of management techniques was controversial. Rationing began to surface as an explicit feature of the health service, one for which politicians were in part responsible. The line between policy and operations proved difficult to hold (Klein, 1995). Where waiting lists and ward closures had previously been local issues, they began to take on a national significance, one that attracted significant attention in the run-up to the 1987 general election.

Internal Market Reforms

If the Griffiths report sought to introduce management disciplines to hospitals, the 1990 Health and Community Care Act began to impose financial disciplines directly upon clinicians. Responding to constant political and public pressure over health, Margaret Thatcher announced, on television, a thorough review, an announcement that surprised her fellow ministers. The review was conducted with little reference to the wider health policy community, the traditional form of a Royal Commission for such a review having been rejected in favour of a small cabinet committee taking evidence from a select few:

> 'In short, the way in which Mrs Thatcher set up her Review was a direct challenge to the medical profession's view of its own position in the constellation of power. Nor was the style of conducting the Review likely to smooth down resentment. As part of the exercise, there were two meetings at Chequers with NHS doctors and managers respectively. However, those invited to these meetings were selected not because they were representatives of the professional interests involved (the Royal Commission model) but precisely because they were unrepresentative in their sympathy for ideas of radical reform.' (Klein, 1995, p.185)

The White Paper that emerged from this review was, thus, controversial from the very start.

Once again, as noted in the discussion of the Social Fund, quite how much influence should be attributed to the ideas of New Right thinkers is unclear. However, the degree to which the White Paper and reforms that followed reflected the ideas emerging from some thinkers is striking. One in particular, the American economist Enthoven, has been identified with the 1990 reforms. Undertaking a study in the mid-1980s, he examined the manner in which the NHS operated and identified a range of perverse incentives that inhibited the efficient use of resources. Amongst these, a key issue was the fact that money was allocated on the basis of a population rather than work done:

> 'For example, a District that develops an excellent service in some specialty that attracts more referrals is likely to get more work without getting more resources to do it. A District that does a poor job will "export" patients and have less work, but not correspondingly less resources, for its reward. The RAWP [Resource Allocation Working Party – see later] formula, though generally sensible, is inadequate in this regard.' (Enthoven, 1985, p.13)

Further, individual clinicians have an incentive to attract a waiting list:

> 'A consultant's NHS waiting list creates a demand for his services by private pay patients. Thus clearing a waiting list is directly opposed to the economic interest of the consultant. This is open to abuse, and serious abuses have generated complaints.' (*ibid.*, p.14)

In the case of general practitioners, the absence of any responsibility for the resource consequences of their decisions not only undermines efficiency but might also not be in the best interests of the patient:

> 'GPs have weak or no incentives to reduce referrals. They have neither the incentives nor the resources to make extra efforts to keep people out of hospital. For example, extra attention to ante-natal care might save some costly weeks in the neo-natal intensive care unit. In fact, the Hospital and Family Practice sectors each have incentives to dump their problems on the other.' (*ibid.*, p.15)

In conclusion, Enthoven prescribed a reformed service that rewarded efficiency and quality by giving power to managers as purchasers of medical services, imposing management disciplines and competitive incentives upon the medical professions:

> 'The theory behind such a scheme is that the managers would then be able to use resources most efficiently. They could buy services from producers who offered good value. They could use the possibility of buying outside as bargaining leverage to get better performance from their own providers. They could sell off assets such as valuable land in order to redeploy their capital most effectively. Unlike the normal bureaucratic model they would not get more money by doing a poor job with what they have. Managers would be assured they could retain all

the savings they make, and use them on the highest priority needs in their Districts. The under-bedded areas could buy services from the over-bedded areas if, in their judgment, that was the way to get the best deal for their patients. The flow of services to people could be adjusted smoothly and rapidly without the need for facilities to be built or closed.' (*ibid.*, p.40)

The White Paper, *Working for Patients* (Department of Health, 1989), that emerged from the ministerial review presented a very brief description of the problems in the NHS as the government saw them. Indeed, much of the report describes the structures that were to support the reformed NHS (though even this description left many questions unanswered). Having asserted that more money would not resolve the financial strains caused by rising demand and advances in medical technology, two paragraphs outline the principles that underpin the conclusions reached:

> 'The Government wants to raise the performance of all hospitals and GP practices to that of the best. The main question it has addressed in its review of the NHS has been how best to achieve that. It is convinced that it can be done only by delegating responsibility as closely as possible to where health care is delivered to the patient – predominantly to the GP and the local hospital. Experience in both the public service and the private sector has shown that the best run services are those in which local staff are given responsibility for responding to local needs.
>
> 'This White Paper presents a programme of action ... to secure two objectives:
> - To give patients, wherever they live in the UK, better health care and greater choice of the services available; and
> - Greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.' (Department of Health, 1989, pp.3-4)

The White Paper went on to describe broadly the arrangements for the establishment and resourcing of Trusts and GP Fundholders, for management of these units and a new role for Health Authorities.

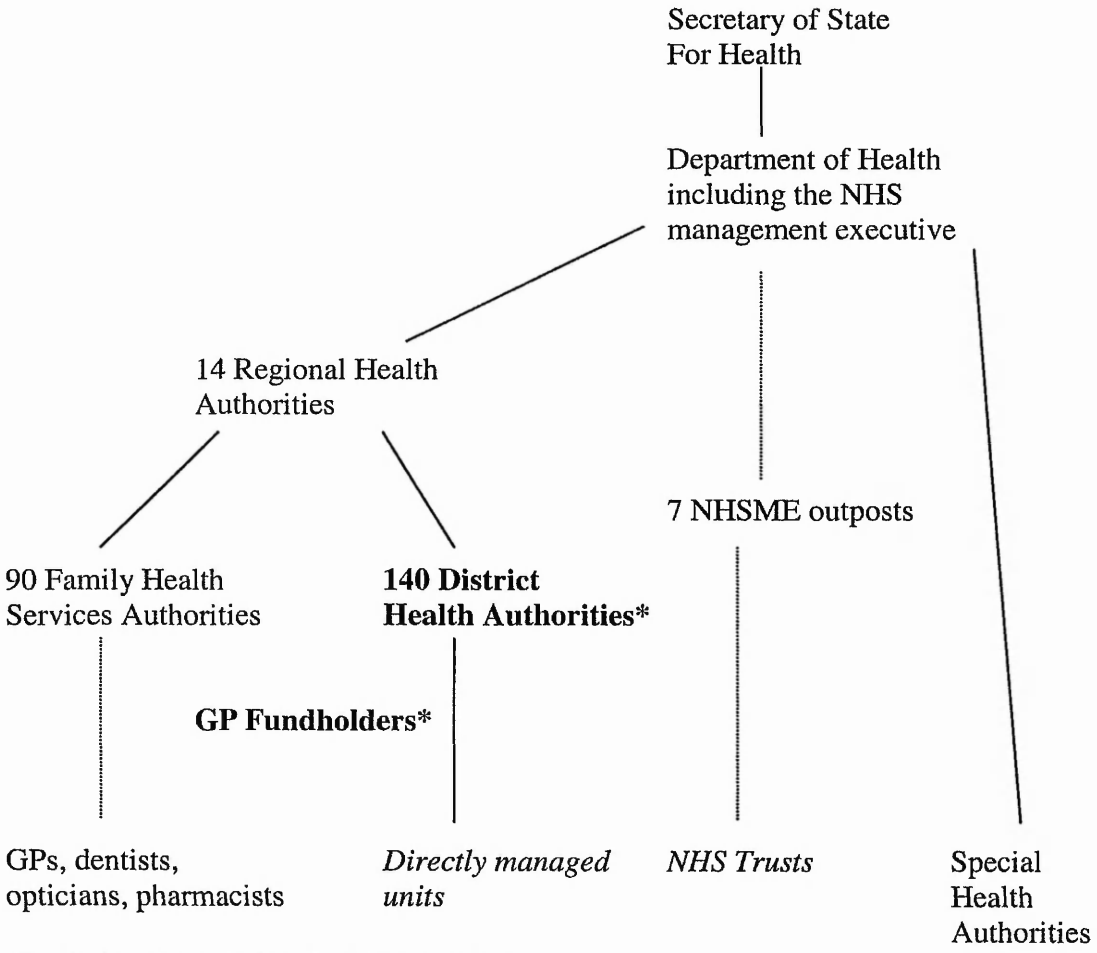
Taking on many of the points made by Enthoven, the provision of health services was separated from the purchasing of those services. District Health Authorities were to provide for a population, purchasing services from hospitals. While many of these hospitals were directly managed at first, over time they took on autonomous Trust status, competing with other Trusts for contracts to provide treatments. At the same time, general practitioners were encouraged to take on fundholding status. Fundholders were given budgets with which to purchase certain hospital and other care services for their patient list. A new contract for GPs was introduced which gave

greater weight, in calculating remuneration, to the numbers of patients on a GP's list as an incentive to attract patients who were to be allowed greater choice of GP. This change prompted some concern about the formation of a two-tier health service, the one a quality service provided by GP fundholders, the other poorer provided by non-fundholding GPs who purchased services through their local health authority (e.g. Bartlett and Harrison, 1993).

Figure 4.5

The Structure of the NHS in England after 1990

(Source: Ham, 1997, p.10)



*Emphasis added to indicate 'purchasing' bodies

What did not emerge from the government's proposals was any clear image of the internal market that was to develop during the implementation of the reforms. Indeed, just as the specifics of the Social Fund were unclear at the time of the passage of the Social Security Act 1986, the internal market has been described as an

emergent policy, one arising as a consequence rather than as an aim of government reforms:

> 'Whether this is described as an emergent strategy or "making it up as we go along", the effect is the same: much of the detail involved in the reforms was missing at their inception and policy has been made on the hoof.' (Ham, 1997, p.47)

And just as the market emerged, so, in the course of its first few years, it was tamed and curbed. Indeed, in many areas, while the language of choice and competition was in use, the reality was a service unchanged in many respects. Only in substantial cities, where a genuine choice of hospitals was available to purchasers, whether GP fundholders or health authorities, did competition begin to emerge (Flynn, Williams and Pickard, 1996; North, 1998). And in such locations, planning emerged as the means to coordinate services that, because of the political character of the health service, could not simply be left to the vagaries of the market. Most prominently, the organisation of hospital units in London was the subject of substantial debate and political pressure (Tomlinson, 1992; Department of Health, 1993). After a few years, then, the language of competition was less appropriate to describe the NHS and was replaced by another language reflecting changing circumstances:

> 'Purchasers became transformed into commissioners: a recognition that monogamy rather than polygamy characterised the internal market, with most purchasers and providers locked into permanent relationships in which both partners sought to modify the other. The internal market became the managed market: a recognition that purchasing was all about shaping the nature of the services available to the local population over the long term, rather than buying off-the-shelf to satisfy immediate needs. Competition became replaced, as the key word, by contestability: acknowledging that the NHS internal market appeared to be creating regulated local monopolies rather than a free-for-all, it was argued that this did not matter as long as new providers could move into the market and purchasers could threaten to switch their custom.' (Klein, 1995, p.206)

When, in 1997, the Labour Party secured its landslide, the market so prominently abolished had, to many, long since withered away.

Health of the Nation and Public Health

Two reports published during the 1980s (reproduced in Townsend, Whitehead and Davidson (eds.), 1992) examined patterns of health, exposing significant inequalities across the country, inequalities that were increasing in many places. The government substantially failed to respond to the evidence presented in these documents,

challenging the conclusions and arguing that there was no evidence that action would correct the imbalances (*ibid.*, p.5). With the introduction of the 1990 reforms, the issue again surfaced, aggravated by claims that fundholding created a two-tier health service. In response, in part, to this controversy, the government's White Paper, *The Health of the Nation* (Department of Health, 1992) outlined the need to address health in a more rounded fashion, arguing that the separation of purchasers from providers allowed room for the development of a public health strategy:

> 'The old system of planning by decibels, in which the providers of acute services won the biggest share of resources, has been brought into question, and there has been a shift in emphasis in favour of public health.' (Ham, 1997, p.61)

In essence, the new agenda sought to require action from health bodies on behalf of all those people within their geographical area of responsibility and not just those presenting themselves for treatment. Five key areas for action were identified from a range of 16 options presented in the Green Paper and others suggested during consultation:

- coronary heart disease and stroke;
- cancer;
- mental illness;
- HIV/AIDS and sexual health; and
- accidents.

The inclusion of mental health in this list was justified 'because it affects many people and because there is much that can and should be achieved, particularly in relation to improvements in services to reduce the harm that mental illness can cause' (Department of Health, 1992, p.17). For each area, indicators of success were defined, those for mental health being:

> 'To improve significantly the health and social functioning of mentally ill people
> 'To reduce the overall suicide rate by at least 15% by the year 2000 *(Baseline 1990)*
> 'To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 *(Baseline 1990)*' (*ibid.*, p.18)

Achieving these targets required cooperation from other agencies and, in the case of accidents, employers and others. The White Paper acknowledged this, but glossed over the problems of requiring cooperation without actually allocating significant funds with which to secure it:

> 'The *challenge* for the NHS is to establish a more direct link between what it does

> and the results in terms of improved health both for individuals and for the population more widely. To help achieve this, the NHS can mobilise local action through healthy alliances and explore with other organisations and groups the common ground on health issues. It can provide expertise, assistance with negotiations and monitoring of arrangements in respect of joint operational health programmes and strategic target setting.' (*ibid.*, pp.33-4, emphasis in original)

As such, the targets and actions illustrate both the uncontroversial nature of the aspirations (who could argue with such objectives?) and their problematic nature. What action should health authorities take to reduce suicide? And if suicide rates fall, who is to say that the health authority has contributed to it?

Reviewing the strategy, The National Audit Office commented that it 'has influenced health authorities' plans to purchase health care to meet needs of local people, and is reflected in local programmes carried out by hospitals, community health units and primary health care teams' (1996b, para.4), but that it was too early to declare whether it had been a success. No more than two years later, an independent academic study, undertaken after the general election of 1997, declared that:

> 'The HOTN [Health of the Nation] failed over its five year lifespan to realise its full potential and was handicapped from the outset by numerous flaws of both a conceptual and process-type. Its impact on policy documents peaked as early as 1993; and, by 1997, its impact on local policy-making was negligible. It wasn't seen to count while other priorities, for example waiting lists and balancing the books, took precedence.
>
> 'The HOTN was regarded as a Department of Health initiative which lacked cross-departmental commitment and ownership. At local level, it was seen as principally a health service document and lacked local government ownership.' (Department of Health, 1998a, p.1)

Furthermore, an inquiry into inequalities suggested that the differences in health provision and outcomes remained and that a response embracing wider determinants of health (among them poverty, unemployment, education, housing and transportation) was required (Independent Inquiry into Inequalities in Health, 1998). Some of the lessons appear to have informed both the new public health strategy and the wider health reforms.

The New NHS

Within days of the May 1997 general election, the Labour government took steps to end the internal market, to abolish the two-tier health service and to address health

inequalities. These moves formalised some of the changes that had, in effect, occurred in recent years, with greater emphasis being placed on cooperation than on competition. The White Paper, published in December of the same year (Department of Health, 1997a), set out a new vision of a health service 'based on partnership and driven by performance' (*ibid.*, para. 2.2). Retaining the separation of planning (rather than purchasing) from provision, six principles were set out:

- 'first, to renew the NHS as a genuinely **national** service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country
- but second, to make the delivery of healthcare against these new national standards a matter of **local** responsibility. Local doctors and nurses who are in the best position to know what patients need will be in the driving seat in shaping services
- third, to get the NHS to work in **partnership**. By breaking down organisational barriers and forging stronger links with Local Authorities, the needs of patients will be put at the centre of the care process
- but fourth, to drive **efficiency** through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients
- fifth, to shift the focus onto quality of care so that **excellence** is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service
- and sixth, to rebuild **public confidence** in the NHS as a public service, accountable to patients, open to the public and shaped by their views.' (*ibid.*, para. 2.4, emphasis in original)

The White Paper describes a more strategic role for health authorities, responsible for developing, and agreeing with partner organisations, Health Improvement Plans (HIMPs) for the population as a whole. New Primary Care Groups, bringing together a number of general practices in an area, will take on, over time, much of the responsibility for commissioning care on behalf of patients. Trusts remain independent, but are to be subject to a regime of clinical governance to ensure high standards of care, based on evidence, are available across the country. At a national level, National Service Frameworks will set out the patterns and levels of service in key service areas. Furthermore, a National Institute for Clinical Excellence will provide guidance on clinical and cost-effectiveness, supported by a Commission for Health Improvement, responsible for overseeing quality in clinical services.

Initially, the proposals were welcomed by a number of academics and practitioners. The *British Medical Journal* described the proposals as 'sound ... welcome and

sensible' (*BMJ*, 20th December, 1997). Glennerster and le Grand suggested:

> '... the proposals deserve a cautious welcome, not least because despite the rhetoric, they preserve the features of the old quasi-market that research has demonstrated to be the most successful.' (*The Guardian*, 10th December, 1997)

While conducting my research interviews, these new arrangements were beginning to emerge and to take shape. While there is now more certainty about the nature of the new arrangements, many of the respondents were less than clear as to what the future would hold. To retain some of this sense of uncertainty, I will not proceed to describe the form that the 'New NHS' has begun to take two years later. Instead, I shall turn to the position of mental health services in this changing context.

A Brief History of Mental Health Services

If knowledge of its history is helpful to any understanding of the NHS, mental health services make no sense without such background. Some of the current arguments about treatment find their echoes and origins in Victorian attitudes that linger on. For no issue is this more true than for community care. And these debates stem from deeper ones between medical and social models of mental illness and of mental health services. It is not my intention to delve deeply into these but to indicate some of the broad themes (for a fuller discussion, see Pilgrim and Rogers, 1993; Rogers and Pilgrim, 1996; Jones, 1993).

Throughout the early modern period, mental health needs were met locally, and in a piecemeal fashion through the Poor Law and through charitable 'lunatic asylums'. Madness was, at that time, related to nonconformity, whether that be the village idiot, witches or people who professed to see visions. From the middle of the seventeenth century, and associated with significant social upheavals of that period, a 'great confinement' began across Western Europe (Foucault, 1988). The rise of the asylum represented a fundamental change in the treatment of mental illness, a change for which there is a variety of competing explanations. The rise of the asylum can be attributed to:

- a rise in the rates of mental illness attributed to various medical causes;
- medical progress and increasingly humane ways of treating mental illness;
- a breakdown in family and other social ties associated with the industrial revolution and urbanisation;

- a capitalist economy's need to discipline and control 'those elements of the work force who were apparently more resistant to the monotony, routine and regularity of industrialised labour' (Scull, cited in Rogers and Pilgrim, 1996, p.49);
- changes in psychiatric knowledge; and
- changes in the administration of the Poor Law. (Rogers and Pilgrim, 1996, pp.46-50)

These arguments are not simply historical, similar ideas and debates being evident in discussion of community care, and other policies, to this day and in the different perspectives of mental health professionals, whether psychiatrists, psychologists, social psychologists or social workers.

During and after the First World War, the dominant medical model of mental illness, associated with the asylum and with psychiatry, was challenged by evidence from the trenches. Shell shock and other trauma, even among the sons of the finest families, could not be attributed to medical or genetic causes. Instead, psychologists pointed to the peculiarly stressful environment of war, of the trenches and of a slaughter like never before. While psychiatry remained the dominant profession in the treatment of mental illness during the inter-war years, the experience of the Second World War again undermined confidence in the medical model (Pilgrim and Rogers, 1993; Rogers and Pilgrim, 1996).

Anti-psychiatry

If divisions between professionals are apparent in a discussion of mental health, there is a further current of debate highly critical of the professions as a whole. Emerging in the 1960s, trenchant critiques of psychiatry were launched from a number of directions (Goffman, 1968; Foucault, 1988; Szasz, 1973). Goffman's work examined the features common to a number of 'total institutions', such as prisons, monasteries and asylums. Detailing and describing the relationship between inmates, warders and professionals in these different settings, he revealed the distorting impact upon an individual:

> 'The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. In the accurate language of some of our oldest total institutions, he begins a series of abasements, degradations, humiliations and profanations of self. His self is

> systematically, if often unintentionally, mortified. He begins some radical shifts in his *moral career*, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others.' (Goffman, 1968, p.24, emphasis in original)

Separated from their sources of identity and support, inmates begin to behave in ways alien to themselves and that support the views and perceptions of the professionals:

> 'Mental patients can find themselves in a special bind. To get out of the hospital, or to ease their life within it, they must show acceptance of the place accorded them, and the place accorded them is to support the occupational role of those who appear to force this bargain. This self-alienating moral servitude, which perhaps helps to account for some inmates becoming mentally confused, is achieved by invoking the great tradition of the expert servicing relation, especially its medical variety. Mental patients can find themselves crushed by the weight of a service ideal that eases life for the rest of us.' (*ibid.*, p.336)

Foucault (1988) argues that psychiatry does not simply describe particular behavioural patterns but actually produces, through discursive activity, the behaviour described. As such, psychiatry is 'part of the apparatus of regulation and control which disciplines persons who have been identified as in some way problematic' (Middleton and Shaw, 1999, p.50). A third, closely related strand argues that madness is an artificial construction (Szasz, 1973). Medical approaches to the study of the brain present models of illness capable of being cured. By arguing that individuals can be returned to some form of normal state, psychiatry acts as a moral and political instrument of social control.

In a series of fascinating vignettes, Laing and Esterson (1970) described cases of schizophrenia, ascribing symptoms to factors other than disease. In language similar to that of Roberts (1996) and Wilmott (1996), they describe a dialogue with one subject:

> 'Maya made the point that her parents did not think of her, or "see" her as "a person", "as the person that I am". She felt frightened by this lack of recognition, and hit back at them as a means of self-defence. But this, of course, was quite bewildering to her parents, who could not grasp at any time any sense in this accusation. Maya insisted that her parents had no genuine affection for her because they did not know, and did not want to know, what she felt, and also that *she* was not allowed to express any spontaneous affection for *them*, because this was not part of "fitting in".' (Laing and Esterson, 1970, p.36, emphasis in original)

This failure to hear the account of Maya and the failure of the parents to understand

the consequences of their actions and their impact on Maya's perceptions of herself lies behind Maya's behaviour. In another case, the conclusions encapsulate the very problem of understanding oneself:

> 'Finally within this situation of contradictory attributions, inconsistencies, multiple disagreements, some avowed, some not, not able as we are to see it from outside as a whole, Ruby could not tell what was the case and what was not the case, she could not have a consistent perspective on her relation to herself, or to others, or on theirs to each other, or to her.' (*ibid.*, p.143)

This case will be echoed again in later discussions and interviews conducted as part of this research.

These arguments, about the failings of psychiatry, have important implications for our understanding both of mental health and also of mental health services:

> 'The importance of such critiques is to expose the inadequacies of the positivist views of insanity which underlie the medical model of psychiatric deviance. In practice it has been shown that psychiatric judgements reflect the norms and expectations of society and should be sharply distinguished from the assessment of illness in medical terms. That is not to say that depression and schizophrenia do not exist but to recognise that the definition of the condition is dependent upon social conventions as well as clinical grounds.' (Middleton and Shaw, 1999, p.50)

These arguments are not simply ones about the appropriate treatment of mental ill-health. If psychiatric interventions reflect, to some extent, views of normality and socially acceptable behaviour, these arguments provide some explanation of the apparent inequality with which some social groups are treated, notably women and minority ethnic groups.

Gender and Ethnicity

A central critique of mental health services in recent years has been around issues of discrimination. An analysis of patient statistics indicates that certain groups are over-represented in institutions and that patterns of diagnosis and prescription vary between groups:

> 'Whereas the major directions of mental health policy are frequently formulated without explicit attention to issues of gender or ethnicity (or class), such policies equally frequently end up being implemented in ways that embed bias, discrimination and division.' (Busfield, 1999, p.70)

Discrimination illustrates the central themes of the debates between medical and social models of mental ill-health, and critiques are often divided on the problems that

underpin discrimination.

There are differences in the treatment of men and women. More women are admitted to institutions each year than men, and more women in the community are diagnosed with mental illnesses (notably depression) than men (Pilgrim and Rogers, 1993; Busfield, 1996). At the same time, while evidence is contradictory at times, ethnic minorities are over-represented in institutions and are more likely to be diagnosed with a mental illness than white people. Within this, there are indications of important differences in the treatment of Asian and African Caribbean groups, the former being much less likely to be diagnosed with a mental illness than the latter (Rogers and Pilgrim, 1993; Rack, 1982).

There is little evidence that there are medical or biological roots to the differences in diagnosis and treatment. Instead, the differences are generally explained in a number of ways. The first suggests that over-representation reflects a socially constructed view of mental illness. Differences in behaviour, and particularly emotional reactions to circumstances, are considered evidence of illness. The second suggests that, because of the pressures a prejudiced society imposes on women and ethnic minority groups, they are more likely to suffer stress and develop mental illnesses. Others suggest that the two are not mutually exclusive, that stresses are very real and that social prejudice means that professionals and others are then more likely to identify symptoms in women and minority groups. Some evidence suggests that the response of professionals is further distorted by the prejudice of the general population because people are more likely to seek assistance from the authorities in handling the behaviour of ethnic minority groups than others (Rogers, 1990). These debates are complex and highly contested, and this is not the place to rehearse them (for useful summaries, see Pilgrim and Rogers, 1993; Busfield, 1996; and Rack, 1982).

The priority attached in recent years to addressing institutional and professional prejudice presents further issues. In seeking to eradicate discrimination, there is a danger of failing to identify difference:

> 'To treat a Sikh as if he were not a Sikh is unproductive if he is determined to remain a Sikh. The implication is that everyone who comes to live in Britain should make haste to become British, and that is a theoretical view attractive only to people who are ignorant of practical and psychological realities. For the

> practitioner, dealing with real and immediate issues, the only choice is between recognising differences in order to do his job well, or failing to recognise them and doing it badly.' (Rack, 1982, p.244)

Getting this balance right is key to treating people appropriately and effectively. Institutions have been widely criticised for failing to strike that balance.

Community Care

From this declining confidence in medical models of mental health and illness emerged community care. At the heart of the policy is a belief that treatment in the community, among a patient's family and other forms of social support, represents the best course in the majority of cases. To support this, resources need to be diverted from the old asylums into community facilities. While discussion of this policy concentrates on the past decade, it has a long history, but that history has been one of slow progress, inaction and prevarication:

> 'The Ministry of Health's *Hospital Plan for England and Wales* (Cmnd. 1604, HMSO) published in 1962 envisaged a reduction of beds in mental hospitals from the then ratio of 33 per 10,000 of the population to a ratio of 18 per 10,000 in 1975. At the same time there was to be an increase (though not a corresponding increase) in the proportion of psychiatric beds in general hospitals, and also a stronger emphasis on community care.' (Mittler, 197?, p.9)

For a number of years, community care has been accepted policy. It is only in recent years that the closure of asylums has gained any significant momentum. Indeed, in the late 1980s and early 1990s, it has been suggested, the pace of change was too great and driven by the need to cut costs as much as to improve services. There remains an immense imbalance in the funding provided to acute as opposed to community care services in mental health, and some patients were placed in the community without adequate support and without the required transfer of resources from institutional care facilities:

> 'Though there are fewer psychiatric beds, most resources still go on inpatient services and there is far too little in the way of half-way houses, sheltered accommodation and support for those discharged from the acute units.' (Busfield, 1999, p.61)

At the same time, the reforms have been accompanied by negative media coverage that has depicted violent and unpredictable patients being put out on the streets without support posing a threat to the communities in which they live. The numbers concentrated in inner-city areas has led to these areas sometimes being called

'asylums without walls' (Manning and Shaw, 1999, p.9). While there have been a number of prominent cases of individuals left without care, including some linked to murder, this is not the whole story, and few would suggest that the asylums should be restored to their former role.

The Roles of Professions

A striking feature of mental health services is the plethora of professions (general practitioners, psychiatrists, clinical psychologists, Community Psychiatric Nurses, Approved Social Workers and the police) with a role in the identification, treatment and incarceration of mental health service users, each with its own culture and dominant approach. Each jealously guards its integrity and independence and, if professions embody a different model of accountability (see Chapters 2 and 3 for a brief discussion), several professions in the same field present particular problems of accountability. In the area of mental health services, these problems are aggravated by rival models of mental illness and the different institutional settings within which the professionals are located. Again, this is a complex subject, one that it would be inappropriate to discuss here in great depth. Put simply, while Community Psychiatric Nurses and Approved Social Workers are, through their training and environment, more inclined towards social models, clinicians and the police, as a result of training and the context in which they encounter mental illness, will tend to take a more institutional approach. This generalisation obscures differences among clinicians, between psychiatrists and clinical psychologists, but it serves to illustrate the fault lines and tensions between service providers (Rogers and Pilgrim, 1996).

One further tension to be observed in the role of professionals in mental health institutions is the ambiguous nature of their roles as both clinicians and prison warders. Powers of detention and coercion are central to the functioning of institutions:

> 'The norms of psychiatric routines are built upon paternalistic considerations outweighing those of the civil liberties of patients. This paternalism is not merely a self-serving habit of the medical profession but it is formally enshrined in mental health legislation, suggesting that the political governance of the central and local State requires the delegation of these powers of control. Without prescribed rules of State-defined legitimate coercion, professionals would be regularly guilty of common assault.' (Pilgrim and Rogers, 1999, p.20)

While the nature of these powers and roles have been reviewed intermittently, and are at present the subject of consultation and possible reform, the balance between the two roles has important implications for concepts of accountability. How can an account be given to patients of care administered against their will?

Organisations, Institutions and the Voluntary Sector

Often the focus of debates about accountability, the complex web of institutions and organisations, whether statutory, private or voluntary, presents particular problems in understanding health services. The main health institutions have already been described. However, the provision of mental health services is also the concern of local authority social service departments, the police and of a large number of charitable, voluntary and self-help organisations and groupings. While the role of the police is relatively discrete, limited to the exercise of certain powers of detention under the Mental Health Act, 1983, the relationship between other bodies is fraught with difficulties.

As in other areas of health care, the boundaries between health and social services is not clear and often subject to local negotiation (Health Select Committee, 1999). The boundaries become particularly difficult in cases involving long-term care, where the costs of individual patients may be significant and the responsibilities unclear. Recent discussion about long-term care for the elderly have surfaced some of these issues and, specifically, the problem of determining what constitutes medical care, for which the health service is responsible, and social care, for which social services are responsible (Royal Commission on Long Term Care, 1999). In mental health services, similar issues arise around patients with a dual diagnosis. Where an individual is addicted to drugs or alcohol, in addition to mental health problems, a failure to coordinate care often occurs with neither service, the one provided by social services, the latter by health, taking responsibility for coordinating and liaising with the other. Aggravating these problems are the different structures, cultures and frameworks within which practitioners operate. Where an individual is supported in the community, a failure to coordinate services can jeopardise the effectiveness of the care provided. Joint commissioning groups and structures have proliferated, but problems have persisted, as was highlighted in a Green Paper published before the 1997 election (Department of Health, 1997b). More recently, efforts have been made

to promote joint working through the development of Joint Investment Plans between health and social service agencies (Department of Health, 1998b).

These issues are more apparent in the voluntary sector. At a local level, many organisations are involved in providing services. Bringing particular capacity and skills, these organisations are able to operate with freedoms not always available to the statutory sector. For instance, voluntary organisations can deploy innovative therapies, and can command greater legitimacy among certain excluded groups, notably minority ethnic communities. However, they are dependent for funding upon gaining financial support from and contracts with statutory services. If cultural differences exist between statutory services, this is more clearly the case between statutory services and the voluntary and community sectors:

> 'A key point which emerges is that voluntary sector board members may hold rather different assumptions about the public policy process from the governmental staff and elected representatives who monitor the implementation of social welfare.' (Harris, 1998, p.185)

The increasing emphasis on competing for contracts and performing against targets and financial indicators has changed the relationship between the sectors, a change with which not all are comfortable. Resolving these tensions is the purpose behind the development of the idea of local compacts, establishing stable long-term relationships (Craig *et al.*, 1999). However, at the time of this research, these were only beginning to emerge in many areas.

The Legal Framework

The legal framework within which health services are provided is fragmented and limited. There are duties on health authorities to provide health services to a specific population. However, there is no enforceable right to any specific treatment:

> 'The consumer's only right is to have access to the health care system: once that has been achieved, it is for the professional providers to determine what treatment is appropriate.' (Klein, 1995, p.232)

Individual decisions may be subject to judicial review of the manner in which they are made but, as long as discretion has been exercised reasonably and the local procedures are not unjust, the scope for challenging decisions is limited.

However, in the case of mental health, there are some specific duties placed upon

authorities by the Mental Health Act 1983. Central to the legal framework are powers of compulsory detention. Much of the Mental Health Act specifies the circumstances in which someone may be detained in a hospital, the manner in which they may be treated and provisions for discharge. While the safeguards are elaborate, requiring the agreement of two doctors and, in some circumstances, of an Approved Social Worker and of relatives, the powers allow for actions by the state against the will of an innocent citizen. In view of this, the circumstances in which the powers might be appropriately used are loosely specified. The legislation speaks of detention in the interests of the safety of the patient or of the public. Yet, it is not clear what constitutes a threat to either and thus the circumstances in which the powers should be used (for a fuller discussion, see Hoggett, 1990; McHale and Fox, 1997). Given the strength of debate about the very nature of mental illness, this uncertainty becomes even greater. Detention is subject to review by a Mental Health Review Tribunal and the conditions in hospitals subject to inspection by the Mental Health Act Commission (1999), but the coercive aspects of mental health remain contentious.

A further provision is also relevant to this work, the requirement for authorities to put in place a proper regime of supervision and treatment for people released from institutions. While again there is not an enforceable right to any particular treatment, failure to agree a care package has provoked much discussion, not least in connection with failures in community care. Failures in the coordination of care have been noted in many inquiries into community care tragedies, yet the tragedies continue. Commenting on the common themes that have emerged, Reith notes the continued failure to act upon these suggesting that further inquiries are a waste of resources (1998, pp.197-200).

The Financial Framework

Funding formulas are 'potentially a powerful instrument for securing equity within the NHS' (Health Select Committee, 1996, p. xxxv). Perhaps one of the most significant reforms to be introduced to the NHS in the past thirty years was the system of health authority funding that followed the Resource Allocation Working Party (RAWP) report in 1973. Where, previously, resources were allocated on the basis of historical costs, RAWP suggested an approach using population data. A weighted capitation formula, introduced in 1974, was designed to transform the

allocation system from one based on historical demand to one based on an assessment of need (Klein, 1995; Webster, 1998). In this respect, the change is like that in provision for one-off needs in social security, occurring much earlier. Initially, there were a number of problems with the formula. It sought to measure relative rather than absolute need, and it did not include primary care, relating only to hospital and community services (Klein, Day and Redmayne, 1996). With regard to need, in evidence to the Health Select Committee, the then Secretary of State, Stephen Dorrell, encapsulated the problem of funding:

> 'I would have thought that it was common ground in all parts of the House that as society gets richer, the common experience in this and all other countries is that consumers spend a rising share of their income on health care and no society has yet come up against the position where, as the consumers are willing to spend more money on health care they run out of things to spend it on. Decisions about how much resource the Government is prepared to commit to our NHS are driven frankly by factors other than assessment of emerging need within the Health Service. That is not to say they are unimportant and we do seek to calculate them. The judgement about how much resource to commit is quintessentially a political judgement.' (Health Select Committee, 1996, Vol. 2, p.152, Q.333)

Subsequent refinements have incorporated more aspects of health care, including wider socio-economic factors affecting need. The 1990 reforms also changed the basis on which allocations were made. Health authorities were to be funded on the basis of a resident population, for which they were to purchase services, rather than a catchment population to whom they provided services, answering Enthoven's criticism of RAWP:

> 'Thus RAWP has left many inequalities of access and spending. Some are because of geographic propinquity, some because of social class, some because it has been politically impossible to move to equality at the sub-Regional level: resistance to closing facilities combines with lack of capital to build new ones.' (Enthoven, 1985, p.36)

More recently, with the removal of the Regional Health Authority tier in 1996, allocations have been made to individual health authorities rather than to regions.

The current formula takes account of a number of variables: population; age-related need; additional needs for acute, psychiatric and community services; and a market forces factor reflecting geographical differences in costs. Further special allocations are made for AIDS prevention, drug misuse, joint finance and General Medical Service Cash Limited budgets covering general practitioner's pay and other costs

(NHS Executive, 1997a).

The formula, in similar fashion to the Social Fund allocation system, identifies an ideal, a target for each health authority. Actual funding is still based, largely, on previous allocations. Each authority receives a small proportional addition to previous funding. Any increase in funding left is then allocated to those authorities where funding is below the target in proportion according to how far from the target they are.

The process takes no account of spending, or of over-spending. Additional reserves are held centrally to cover some eventualities, including overspends and major restructuring initiatives. Access to these funds is mediated by Regional Offices, which are better placed than the NHS Executive to assess the merits of arguments, proposals and bids.

These efforts to equalise resource distribution are, however, no guarantee of increasing uniformity in service provision. The British Medical Association, in evidence to a Health Select Committee inquiry, stated:

> 'We should bear in mind that the breaking down of health expenditure into its constituent programmes to derive a resource allocation formula does not oblige health authorities to reflect that national split locally. Resource allocation formulae are not a substitute for policy. It will always be possible for those at equal risk to receive other than equal access to health services as a result of local policy decisions.' (Health Select Committee, 1996, Vol. 2, p.169)

Through raising standards and specifying priorities, some efforts are being made to complement resource equalisation with some elements of policy standardisation.

Planning and Priorities Guidance

Clearly, within the financial and legal constraints, there remains significant room for discretion at a health authority level. This freedom is further constrained by an annual planning round in which priorities for action are identified. Circulated in the autumn, the guidance informs the following year's commissioning decisions and discussions between health authorities and trusts. These local plans are then subject to approval by the Regional Office, which draws on a knowledge both of national priorities and local needs to reach a judgement as to the appropriateness of the plans.

While this process has been operating for a number of years, senior officials suggested that, with the election of the Labour government in 1997, a greater emphasis was being placed on long-term priorities, around which strategic plans could be developed locally. The planning guidance for 1998/99, the first under the Labour government and the relevant ones for the period during which the majority of my fieldwork occurred, listed six priority areas:

'A Work to develop a leading role for primary care in the commissioning and provision of health care that is responsive to patients' needs, recognises the contribution of others and addresses local health inequalities...

'B In sustained partnership with local authorities, primary care and other service providers, including the non-statutory sector, to review and maintain progress on the effective commissioning and provision of comprehensive mental health services to enable people of all ages with mental illness to receive effective care and treatment in the most appropriate setting in accordance with their needs...

'C Improve the clinical and cost effectiveness of services throughout the NHS and thereby secure the greatest health gain from the resources available, through supporting R&D and formulating decisions on the basis of appropriate evidence about clinical effectiveness...

'D Give greater voice and influence to users of NHS services and their carers in their own care, the development and definition of standards set for NHS services locally and the development of NHS policy both locally and nationally...

'E Ensure that older people, adults with a physical or learning disability, children and other vulnerable people with continuing health care needs are enabled through the NHS contribution to their care to live as independently as possible in their own homes or in homely settings in the community...

'F Develop NHS organisations as good employers with particular reference to workforce planning, education and training, employment policy and practice, the development of teamwork, reward systems, staff utilisation and staff welfare...' (NHS Executive, 1997b, pp.11-14)

Underneath each of these headings, context and objectives are detailed, making the broad priorities a little more concrete. Under the mental health priority, for example, the guidance goes on to state:

'**Context:** the NHS Executive will maintain a focus on taking forward the *Health of the Nation* targets for mental health through: the development of the Mental Health Minimum Data Set (MHMDS); support for the introduction of the Health of the Nation Outcome Scales (HoNOS); an integrated communications strategy; and working closely with other Government departments. Regular performance reviews of Health Authority plans to commission comprehensive mental health services show that most have made significant progress, but considerable effort is still needed in some localities.

'Objectives:

'B1 Health Authorities should demonstrate commitment to effective multi-agency and multi-disciplinary planning to meet the health and social needs of

mentally ill people of all ages, giving priority to those with the most severe mental illness, but including the care and treatment of patients in primary care settings. Strategic plans should be explicitly endorsed by all relevant managing bodies, underpinned by robust workforce education and training plans.

'**B2**Joint action plans including agreed timetables for achievement and specific monitoring and evaluation arrangements should be developed from these strategies.

'**B3**Health Authorities should continue to progress the implementation of mental health information strategies and should have established the basis for the operation of MHMDS and HoNOS by March 1999.' (*ibid.*, p12, emphasis in original)

At the same time, a substantial programme of work has been set in train to develop a performance framework as the basis for assessing achievement against priorities. Six key areas were identified in the consultation document: health improvement; fair access; effective delivery of appropriate healthcare; efficiency; patient/carer experience; and health outcomes of NHS care (NHS Executive, 1998, p.4). Again, however, these came into effect during the course of the fieldwork and were not fully part of the systems of local management (NHS Executive, 1999b, 1999c and 1999d).

Accountability for Mental Health Services

It is within this framework of law, resource allocation and priority setting that health authorities commission services on behalf of their resident population. Within these bounds, and in light of local circumstances, wide variations in services and in patterns of provision exist. The means by which these decisions and services are held open to scrutiny is similarly complex. Some of the central issues regarding the accountability of health institutions have already been addressed in chapter two. The following sections will deal with further details

Audit

Where audit arrangements for the Social Fund are relatively clear, there are anomalies in the health service. Responsibility for financial audit is divided between the National Audit Office and the Audit Commission. The accounts of health authorities, Trusts and general practitioners are inspected by District Audit under the auspices of the Audit Commission, while the national accounts of the NHS Executive and of the Department of Health are audited by the National Audit Office (different arrangements exist in Northern Ireland and Scotland). However, value for money

studies are undertaken by both agencies throughout the service. While only one major study of mental health services has been undertaken in recent years (Audit Commission, 2000a), a review of the studies of health institutions undertaken by both audit bodies indicates the degree of oversight exercised and the degree of overlap that exists.

The Audit Commission's recent study (*ibid.*) is the product of an extensive investigation of twelve areas, usually following heath authority boundaries. Interviews were conducted with GPs, clinicians, carers, service users and commissioners, documentation was examined and case files studied. Furthermore, the study crossed the boundaries into social service provision, a practice only recently introduced to public audit. As such, the study represents a conscientious attempt to get beneath the surface of health services to understand the needs of users and carers, and their experience of the services provided. Within the twelve areas studied, variations, gaps and good practice are identified through statistics and through more qualitative data. It is intended that the same methodology be extended to all authorities to assess performance across the country. However, follow up will be largely through comparative indicators published annually, losing some of the qualitative material in translation.

It is noticeable that the main audit bodies are beginning to take a more rounded approach to audits in the health service. For example, the National Audit Office has recently conducted a study of services to tackle obesity, including interviews with people seeking assistance and access to support services in order to identify how and where gaps appear in those services (National Audit Office, 2001). This reflects a recognition that the impact of services is not simply the product of the actions of staff in institutions. In addition, some account needs to be taken of the quality of personal contact, of the role of other agencies and of other determinants. In line with the emerging public health agenda, a more rounded view of services and of their effectiveness might emerge from these efforts.

Performance Management

If measuring performance is problematic in many spheres of public service, it is particularly the case in health care (Carter, Klein and Day, 1992). The development

of performance indicators in the NHS illustrates developments throughout the public sector. Emerging, as has already been noted, during the mid 1980s, early indicators focused upon costs, inputs and outputs. However, waiting lists and ward closures represented the key indicators upon which external judgements (whether those of the public, the media or of politicians) were based (Klein, 1995). Later, during the 1990s, elements of quality featured in the contracts negotiated with health authorities. In addition, public health targets were developed. Nevertheless, debate continued to surround waiting lists and specific examples of inequalities arising from rationing decisions, such as the Child B case in Cambridgeshire.

The focus upon crude indicators and particular cases conceals an increasingly complex pattern of performance assessment and monitoring. Recognising the inadequacy of crude measures of output and efficiency, the current Performance Assessment Framework (NHS Executive, 1998 and 1999b) seeks to develop a more rounded picture of performance along the lines of the 'balanced scorecards' being developed in the private sector. The framework encompasses six key areas: health improvement; fair access; effective delivery of appropriate health care; efficiency; patient/carer experience; and health outcomes of NHS care. Among these, mental health indicators feature consistently and include:

- suicide rates;
- mental health in primary care (covering detection and prescribing patterns);
- unit cost of caring for patients in receipt of specialist mental health services; and
- emergency psychiatric re-admissions.

Intended as a basis for discussion within local health communities, the indicators inform plans as much as they assess performance.

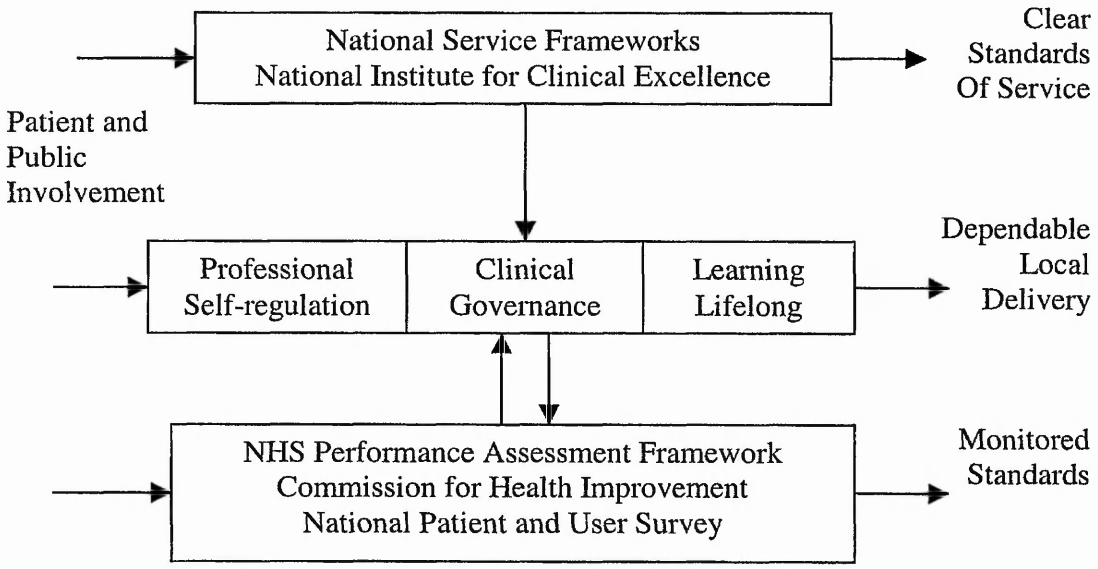
In addition to assessing health authorities in this fashion, a package of indicators for NHS Hospital Trusts has also been developed around six key areas: deaths in hospital following surgery; deaths in hospital following a fractured hip; deaths in hospital following a heart attack, readmission to hospital following discharge; returning home following treatment for a stroke; and returning home following treatment for a fractured hip (NHS Executive, 1999c). While only two of these might apply clearly to mental health institutions, they represent a serious attempt to grapple with the

difficult issues underlying questions of clinical quality and effectiveness. Together with the clinical governance agenda (see below), there is, then, an increased emphasis on the standard of treatment and care provided by Trusts.

These new indicators are now also to be overseen in a context illustrated in Figure 4.6.

Figure 4.6

What the Quality Framework Means for Patients



Source: NHS Executive, 1999b, p.5

Clearly placing indicators in the context of a framework for the management of quality, this new structure represents a more coherent attempt to use indicators to prompt change with the objective of raising clinical standards.

Clinical Governance

The concept of clinical governance, often closely associated with clinical audit and evidence-based medicine, has been used with increasing frequency in recent years. Essentially, it represents an attempt to raise standards in the medical professions by challenging traditional practices of the sort described by Harrison:

> 'A very practical consequence of these apparently rather abstruse observations is that clinical doctors are more likely to be influenced in their practice by their own

> (and close colleagues') experience with similar types of patient, and by their own reasoning about treatment logic, than by the publication of meta-analyses of large numbers of cases. This of course is highly consonant with the individualistic ethic of the practice of medicine and the habit of doctors of being influenced by their own experience of single cases, a habit that is reflected by the occasional column in the *British Medical Journal* entitled "A memorable patient".' (1998, p.26)

There are three key elements to clinical governance: giving clinicians ready access to the results of medical trials; extending the range of evidence to include data from other than the medical gold standard, the randomised controlled trial; and the withdrawal of treatments proven ineffective:

> 'Evidence-based healthcare is the conscientious, explicit, judicious use of current best evidence by health care professionals when making decisions about the care of individual patients.' (David Rogers, 2000, private communication)

Harrison identified three key groups to whom evidence based medicine, a concept that underpins clinical governance, appeals: politicians benefit because it appears to provide an answer to the problems of rationing; clinicians benefit because they retain a monopoly of clinical decision making, protecting them from managerial interference; and the approach draws on science and rationality in a manner reassuring to patients (Harrison, 1998, p.21). Following the 1997 White Paper (Department of Health, 1997), two key institutions will have a role in clinical governance: the National Institute for Clinical Excellence (NICE), concerned with investigating the efficacy of treatments and for establishing protocols for their use; and the Commission for Health Improvement (CHIP), with the powers to intervene in authorities and Trusts to raise standards of care.

What appears to make perfect common sense has, nevertheless, prompted debate. Studies have suggested that 'clinicians are loath to acknowledge the possibility that they may not be providing effective treatments' (Barnes, Stein and Rosenberg, 1999). This reaction to the criticism of a professional's practice is supplemented by a belief that what really underpins clinical governance is the desire to control the profession. In a debate imagined by Grahame-Smith, between Socrates and a colleague, Enthusiasticus, about raising clinical standards, Socrates states:

> 'It would be nice, Enthusiasticus my gullible friend, if it were really so, but I doubt it. The main barrier they perceive is an anarchic medical profession spending money in a profligate and unnecessary manner. They see your beloved evidence based medicine as a means to shackle the doctors and bend them to their

> will. That, I am certain, is why they are so enthusiastic about it. Beware, Enthusiasticus, that you are not used as a dupe in a political game of health economics. Remember, hemlock may be down the line.' (Grahame-Smith, 1995, p.1127)

While distinctly cynical, there is more evidence of realism in these attitudes than in those expressed by exponents of evidence based medicine:

> 'Some fear that evidence based medicine will be hijacked by purchasers and managers to cut the costs of healthcare. This would not only be a misuse of evidence based medicine but suggests a fundamental misunderstanding of its financial consequences. Doctors practising evidence based medicine will identify and apply the most efficacious interventions to maximise the quality and quantity of life for individual patients; this may raise rather than lower the cost of their care.' (Sackett *et al.*, 1996, p.72)

The statement, in refuting the possible use of evidence-based medicine by managers and commissioners, employs the very language of health economists. At the same time, it expresses a certain naivety about the possibility of costs rising.

These arguments are more detailed than there is room to do justice to here. However, the debate hinges on key themes: the independence of clinicians, almost to the point of tolerating gross incompetence; and the distortion of medical practice by managerial concerns. As such, it is another manifestation of a debate that underpins much of the healthcare system in this and other countries to which we will turn shortly: rationing.

Legal Oversight

Clinical governance might also be seen as a response to increasing legal scrutiny in recent years. This scrutiny has not been channelled through formally established routes, such as the Health Service Ombudsman, whose jurisdiction scarcely impacts upon the exercise of commissioning decisions, let alone clinical judgements. Instead, patients have increasingly had recourse to judicial review to challenge administrative and commissioning decisions. High profile cases, such as that of Child B, starkly illustrate rationing and the impersonal calculations of bureaucrats in contrast to the emotional appeals of patients and families. More recently still, litigation has become a more common recourse for patients wishing to challenge the decisions and competence of individual clinicians.

In addition to these rather *ad hoc* forms of legal scrutiny, there are some specific

checks on the exercise of powers of detention under the Mental Health Act 1983. The first of these, Mental Health Review Tribunals, hear appeals against detention. Apart from discharge at the end of a detention order or at a clinician's discretion, the Mental Health Review Tribunal is the only other way of escaping a compulsory detention. They consist of a panel of three: a lawyer, a medical practitioner and a lay member. However, research indicates that the decisions of tribunals are heavily influenced by reports from clinicians (Pilgrim and Rogers, 1993; Richardson, 1999). Moreover, in the absence of resources to provide adequate care in the community, tribunals will err on the side of caution and of protecting the community, rather than considering the patient's condition (Pilgrim and Rogers, 1993).

A further scrutiny function is played by the Mental Health Act Commission (MHAC). Formally a regionalised special health authority, the commission conducts visits, notified in advance, and investigates complaints concerning the standards of care provided to detained patients. From the start, this limited investigatory role has meant that the commission is restricted in its ability to address systemic issues:

> 'The first ten years of the MHAC has witnessed a public acknowledgement of its failure to deal with neglect and brutality, whilst, arguably, raising the expectation that civil liberties were now to be protected by such a statutory body.' (Rogers and Pilgrim, 1996, p.89)

Furthermore, reporting biennially, the MHAC represents a form of oversight even more *ex post* than most of the others overseeing public functions.

The Role of Consumers

Legal oversight has already been briefly discussed. However, increasingly, the role of patients as consumers has come to the fore in recent years. Since 1974, the public interest in health has been formally voiced through Community Health Councils (CHCs). CHCs consist of people nominated by local authorities, NHS Executive regional offices and the Secretary of State and, on the whole, cover each health authority. Since their formation, some debate has arisen over the meaning of 'public interest', a debate that has meant individual CHCs interpreting their roles in various ways, some seeking to act as a voice for patients, while others seeing their function as a voice for a wider community:

> 'While users may still have a National Health Service they certainly do not have a national watchdog, given the enormous differences between CHCs that actually

exist in practice.' (Pickard, 1997, p.277)

This confusion was aggravated by the changing role of health authorities in the 1990s, and particularly the change from managing delivery to commissioning on behalf of a population. They were expected to be 'champions of the people' advocating for all residents in an area. In undertaking this role, health authorities have been increasingly encouraged to engage in consultation and to open up decision making to users and other groups, particularly in community care. As such, CHCs ceased to have a distinct role:

> '... it was hard to see how their role vis-à-vis the consumer was to be differentiated from that of the Health Authorities themselves, except inasmuch as CHCs, by contrast, remained small, inadequately staffed, poorly resourced and with the right to inform, the possibility to influence, but not the power to enforce their recommendations.' (Pickard, 1997, p.277)

This uncertainty has prompted a number of reviews intended to redefine the role and effectiveness of CHCs (Insight Management Consulting, 1996; Rolfe, Holden and Lawes, 1998; Commission on Representing the Public Interest in the Health Service, 1999 and 2000). More recently, and after the completion of the research, it has been announced that CHCs are to be abolished and replaced with advocacy services within each Trust (Department of Health, 2000).

As a result of these changing roles, in recent years an industry of consultation and involvement has emerged. Plans and priorities have been opened up to extensive discussion and debate. Lay people have been engaged in overseeing complaints processes (NHS Executive, 1996). However, a large body of research has repeatedly questioned these new forms of engagement. While, in theory, engagement has been regarded as positive, even therapeutic for some (Barnes and Wistow, 1994), the processes are often not genuinely open:

> 'Practitioners may view their practice of giving service users a copy of their care plan as an example of empowerment, and this could be seen as the sharing of expert power. However, if service users do not fully understand the care plan because of its language or style, or if it does not give them any greater sense of control over arrangements for their care, then the effect of its being given to them is not in itself empowering.' (Tanner, 1998, p.448)

Furthermore, evidence suggests that commissioners are unwilling to share decision making about resourcing decisions (North, 1998; Tanner, 1998; Guay, 1994) and that, in reality, consultation and engagement may result in professionals retaining control

over decisions (Gilliatt, Fenwick and Alford, 2000). Consultation may be used to support professional and organisational practices and priorities rather than challenge them:

> 'Thus "playing the user card" is a concrete manifestation of a situation where a particular set of officials happens to be in agreement with a user group but in disagreement with other officials. In such circumstances it makes sense to build up the legitimacy accorded to the user group. Conversely, in circumstances where officials do not agree with users it makes sense to challenge their legitimacy by means of various criticisms. Thus, for instance, they might be dismissed as extremists, unrepresentative of some unspecified broader social group; in other words, the wrong "people" or perhaps themselves the wrong champions. They might be criticised for being badly organised, that is not working like a welfare bureaucracy. They might be patronised as sick people who cannot give continuous attention to their duties.' (Harrison and Mort, 1998. p.66)

If the views of users can be dismissed readily, it is even more the case of mental health service users:

> 'Essentially four professional responses have been present:
> - Users' views unsupportive of professional interests are rejected.
> - The irrationality of patients is emphasised.
> - Patients and their relatives are deemed to have the same interests and to hold the same views.
> - Patients' views are re-framed to suit those of professionals.' (Rogers and Pilgrim, 1996, p.168)

The diversity and critical perspectives espoused by a number of mental health user groups (Rogers and Pilgrim, 1991) make them particularly easy to dismiss:

> 'User groups, especially in the mental health field, could also be viewed as containing views outside the paradigm of mainstream politics, and for whom it was therefore difficult to operate in any kind of partnership with statutory agencies' (Harrison and Mort, 1998, p.65)

Arguments that challenge professional models of mental illness may go unheard. As such, the extent to which there is more than a public adherence to the new language of consultation and empowerment must be questioned.

Mental Health Reforms

Throughout the period of this research, further reforms were emerging, both of mental health and of the NHS more widely. While these did not take effect during that time, many of the interviews were conducted against the background of a review of the Mental Health Act 1983 (Department of Health, 1999), a programme of

modernisation (Department of Health, 1998c; NHS Executive, 1999a), a review of Mental Health Review Tribunals (Council on Tribunals, 2000) and of a review of the handling of patients with severe personality disorders (Home Office, 1999). While many were awaited with some anticipation, the last of these, published shortly after a high-profile murder trial involving a man with a personality disorder, was a cause for some concern among interviewees. The single case was, it was suggested, distorting the review of legislation and of services in a manner that might undermine the aim of raising standards across the board. Harsh compulsory detention and community treatment orders as a response to public alarm were the focus of some media attention (*The Independent on Sunday*, 25th July, 1999, p.25). At the same time, media attention was also focused upon waiting lists and the government's failure to address under-investment in health. In response, a further reform agenda has emerged (Department of Health, 2000). Again, however, this reform occurred after the research was completed.

Reflections on Rationing

Behind many discussions of the Social Fund, of health and of health priorities lie questions of rationing. It would be a mistake to believe that rationing is a recent phenomenon, it being a feature, in one form or another, of all public services, and particularly welfare services. While demand for services and the cost of those services have both increased in recent years, it has always been the case that the resources available have not met demand. However, rationing has become more explicit in the past decade, particularly in the two case studies that will form the focus of this research.

Much attention has been focused upon the role of the internal market in shaping the decisions of health authorities and a number of rationing mechanisms have been identified:

- deterrence – that is obstructing patient access to services to control take-up;
- delay – particularly in the form of waiting lists;
- deflection – by shifting responsibility for problems to other services, such as social services, demand on health resources can be contained;
- dilution – reducing the quality of service, whether by using generic drugs or by

adjusting diagnoses to fit the resources available;

- denial – by not providing certain services, treatments or drugs, particularly expensive ones, costs can be controlled. (Harrison and Hunter, 1994, pp.25-30)

While delay and denial receive attention in the media and political discussions of rationing, the literature clearly indicates the presence of the others in the NHS (Klein, Day and Redmayne, 1996; New and Le Grand, 1996).

These same mechanisms can also be observed in the literature on the Social Fund and other public services. They are a feature of social services, of education and of housing. Throughout the research, rationing, often couched in the language of priority setting, is an ever-present undercurrent. Accounting for the way in which scarce resources are allocated and for the outcomes of these decisions lie at the heart of the remainder of this work.

Reflections

It has been necessary to describe in some depth the policy, management and accountability mechanisms of the two case studies, in part to inform the findings presented in the remaining chapters. However, in addition, it will now also be apparent to the reader that a simple account of either service is difficult to conceive. The image of the two case studies gleaned from the official accounts presented of them is of ordered, rational services, open to challenge, scrutiny and understanding. Yet the outline of the formal frameworks, within which each case study service is delivered, suggests a more confused reality lies beneath the information presented in official accounts. An unravelling of the policies reveals: a complex framework of law, priorities and financial provision; organisations characterised by interdependence; substantial scope for variation, whether from case to case or from place to place; and vulnerable citizens engaging with this complex scenario, sometimes against their will. Indeed, official accounts are undermined and contradicted by the accounts of interviewees, reflecting on their experiences of managing, delivering, receiving or challenging services. These are accounts to which we turn in the next chapters.

CHAPTER FIVE:
UNDERSTANDING DISCRETION

Introduction

In discussing the process of the research, I indicated that the first case study I pursued was that of the Social Fund. By way of explaining the structure that will emerge as I present the evidence gathered, I started interviewing in the Department of Social Security's headquarters, before moving on to the Benefits Agency and to local offices. Having conducted interviews within the organizations responsible for delivering the Social Fund, I drew the material together, describing the policy, legal and financial frameworks and management systems, much as set out in the previous chapter, together with a description of the way in which decisions were made in the three offices I studied. Only then did I make contact with welfare rights groups, locally and nationally, and other commentators on the Social Fund. In effect, I was unravelling the case study, through interviews. This reflects, in part, my understanding of policy as being more than a statement of intent, encompassing the actions of officials and their effect. However, it also reflects a simple view with which I started the research. Drawing upon my past experience as a civil servant in the Department of Social Security, I anticipated elucidating the nature of the discretion exercised by Social Fund Officers and suggesting that this was inadequately captured in official accounts. While this certainly emerged from the evidence, a number of other issues also began to appear. If this was the case with the Social Fund, it was even more so when I began to immerse myself in the mental health case study. In that study, I followed a similar pattern, unravelling the framework of policies and systems before going on to interview advocates, lobbyists and experts.

The material raises a number of issues that cross the boundaries of any simple analytical framework. I have, therefore, elected to follow a path that progresses from a discussion of the frameworks within which each service is delivered, to the way in which discretion is exercised, and to the impression of users and advocates of those decisions. Along the way, a number of other avenues and cul-de-sacs will be explored and the reader will be referred back and forth to other related discussions.

But what I hope will emerge is a clear picture of complex and conflicting accounts. This picture will illustrate the problems of presenting a simple account of the services in the form of annual reports and statistics as at present, suggesting the need for a more sophisticated form of accountability, one that reflects different perspectives.

In chapter three, I indicated that material was drawn together under a number of themes. Throughout, the accounts of policy makers, managers and deliverers will be interwoven with those of user advocates, lobbying organisations and academics. Nor will evidence from the two case studies be separated. However, the source and context of any evidence will be indicated, with due regard to anonymity. In this way, I hope to develop a discussion that draws upon themes relevant to the two case studies and identifies generic issues along the way. These themes, it will be argued in conclusion, are also ones relevant to many other public services.

This is not a work about discretion, though it may appear to be at times. Rather, in exploring discretion, the intention is to recognise the need for a critical understanding of discretion and of the forms of account given of discretion. In describing and unpicking discretion at some length, my intention is to understand better what our systems of accountability describe and what they omit. The discussion will commence, in this chapter, by reassessing the framework within which decisions are made suggesting that, even at this level, official accounts present a simplistic image of the way in which resources are allocated. In the following chapter, this image of discretion will be reconsidered, drawing upon the experience of the representatives of recipients and users. The discussion will then turn to some reflections on the roles of various accountability mechanisms before proceeding to discuss alternative visions of accountability discussed by interviewees.

Bounded Discretion

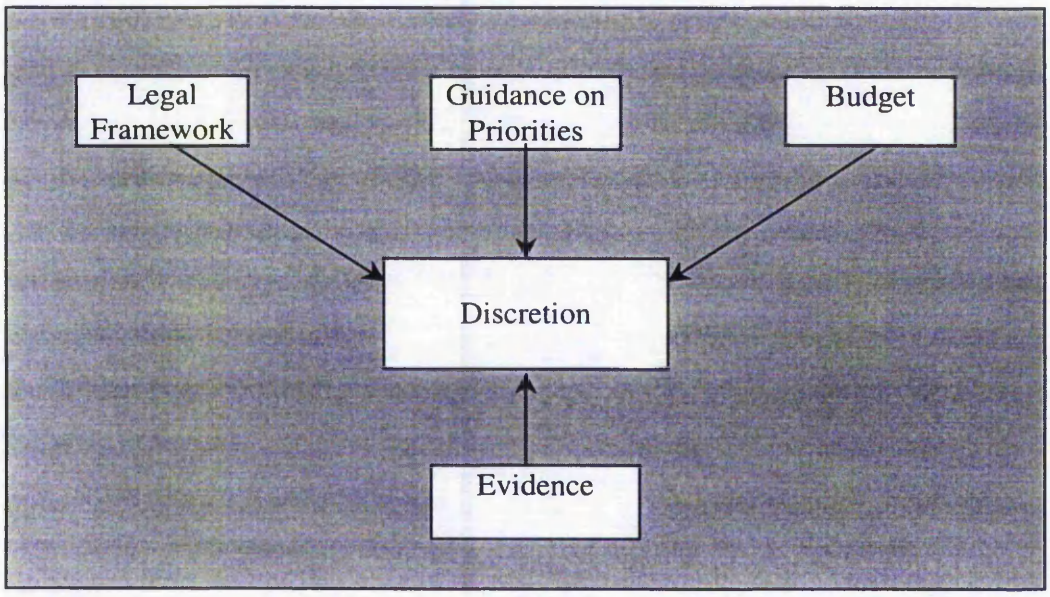
Before proceeding, some brief reflections on the case study services. What emerges, from the discussion of the two case studies in the previous chapter, is a picture of public services, delivered using discretion at a local and/or individual level within a framework of rules and other restrictions (see Figure 5.1). Discretion is bounded by constraints that seek to direct resource allocation decisions in the manner intended, and resources to the recipients and client groups intended. The way evidence is

presented by service users forms one of these constraints upon discretion. Indeed, it is the very reason for discretion. If services are intended to be tailored to individual circumstances, no matter how clear the law, priorities and financial constraints, decisions *should* vary according to the specifics of the case. So, at the heart of these services lies discretion exercised by individuals over others.

The mechanisms of accountability, described in chapter two, are closely aligned to the bounds to discretion. Financial reporting systems ensure that financial constraints are adhered to. Primarily, this means that budget limits are not exceeded. Performance indicators report upon management targets and policy priorities. Reviews, tribunals, ombudsmen and courts provide assurance that legal constraints have been observed and discretion exercised appropriately. Indeed, accountability systems appear as an adjunct to the framework within which services are delivered. They report upon the control systems that bound discretion. As such, they inform us that the boundaries have not been breached, that discretion has been constrained as intended.

Figure 5.1

Bounded Discretion



In essence, then, the accounts presented of discretionary services merely confirm that discretion was exercised within certain limits. No clear account is given of the way in which discretion is employed. Mechanisms of accountability form part of a system

that controls and limits actions rather than opening up the workings of public services to understanding. It is this failing with which this research is concerned and to which I turn in this chapter. Before going on to look at the problems discretion presents, it is important to gain a more sophisticated understanding of the way in which the frameworks, already described, actually affect the behaviour of those making decisions. The intention is not to discuss discretion for its own sake, but to get behind the images presented by policy documents and statements to better uncover what it is that accounts are seeking to represent.

Discretionary Decision-making: the Social Fund

The Social Fund appears to operate within a clear framework. Discretion is clearly defined, constrained and subject to oversight. However, the variations that can be expected within these confines are also substantially affected by the circumstances and practices of the offices and officers involved. Research conducted by various independent agencies has questioned the consistency of the application of directions and guidance (e.g. Becker and Silburn, 1990; Huby and Dix, 1992; National Audit Office, 1991). In addition, while not representing a scientific sample, the three cases detailed below indicate the differences in the actual operation of the Social Fund from one District to the next nearly ten years after its implementation. These studies together demonstrate the problems posed by the particular levers used to influence the decisions and the complex array of outcomes that might be possible in any given case, dependent upon the timing of an application and the location of an applicant.

Case Office A

The District budget allowed high and medium priorities to be met for loan applications, and high priority for grants. Medium priorities were not met for grants, and low priorities were not met for either grants or loans. Circumstances, while not too tight, meant that claims were carefully, and critically, examined:

> 'So we are looking initially at eligibility where we are bound by law and directions; we are then looking at qualification where again we are bounded by law and directions; we then look at priority for which again we are guided by law and directions, and which we are guided on by our Area Social Fund Officer; and then we use all the information, evidence, facts, circumstances available to establish the level of priority that we attribute to a particular item or service that the customer requests, and that's where we use our discretion.' (Social Fund Officer)

In this discussion, eligibility refers to qualifying conditions (e.g. applicants for budgeting loans must have been in receipt of Income Support for at least 26 weeks) and qualification refers to the items requested, some items being explicitly excluded. While, legally, Social Fund Officers are bound to accept as evidence the information provided, in examining the circumstances, the Social Fund Officer might conduct a home visit to verify conflicting evidence. The problems of verification, and of applicants 'playing the game' were emphasised in discussion:

> 'I get these telephone calls, before an application form has been sent out. They say to me "what can I claim, what should I claim?" That's the strangest question you can get when they ring up and say "I've got this application form, but what should I claim?" They do, don't they? They will ask you that. "You tell me what I should claim." Now, if there were a genuine need, you wouldn't be asking that when you ring up for an application form. You apply for a clearly defined need, but not "what should I claim?" And again the genuine people, who do need, suffer. Especially at certain times of the year.' (Social Fund Officer)

The impression of applicants using the rules to their own advantage is a recurrent theme suggesting that, with an understanding of these rules, claimants can secure outcomes not intended. Ignorance of these rules places an applicant at a distinct disadvantage, to which we will return.

Having established a level of priority, and bearing in mind the budgetary situation and directions from the Area Social Fund Officer, an award is made. The officers discussed at length the means of managing the budget:

> 'The law says that we should pay the customer the amount that they request as long as it falls within a range of average local market prices. We know what things cost locally. Therefore, if it's not too excessive, then we are obliged to pay it. But we've had cases whereby we've been strapped for cash and we've reduced award amount to, well not the very minimum, but certainly sufficient to purchase the item new at the likes of Argos.' (Social Fund Review Officer)

At certain times, when financial constraints are greatest, decisions will differ from those made at other times. A frequent observation made of the Social Fund is that decisions might vary from day to day and from month to month.

The officers suggested that the level of review activity in their office was high. The number of decisions altered at the review stage was a consequence of the lack of information available when the initial application was considered:

'At the initial stage you use the evidence that's available and in a lot of cases that's when you can get away with using quite a bit of discretion. That's up to the customer really. If the customer disagrees with that then it's reviewed, in which case you are then in the evidence gathering stage. The more evidence you have, effectively, the less discretion you have because there is only one decision you can make in accordance with the law when all the evidence is there in front of you.' (Social Fund Review Officer)

The targets for processing claims require completion within 5 working days. Within this period it is not possible to seek more evidence from an applicant, militating against them receiving proper consideration at the initial application stage. With knowledge of this 'rule of the game', an applicant might either present more information at the initial stage or persist to seek a review of the initial decision. Without information, discretion might again be exercised in ways not intended.

Case Office B

The district loans budget was not under pressure, while pressure on grants was extremely high. Applications for loans were, consequently, not submitted to rigorous scrutiny so long as they qualified under the directions and were not applying for items which it would be unacceptable to pay for:

'If they've got no debt, because we've got the underspend at the moment, I'll award and it'll go. If I have to juggle, that's when I start to cut back. We are in the fortunate ... fortunate, unfortunate, whichever way you look at it ... financial scenario at the moment, that we can do that, but that is really the process that should be applied at the beginning ... We used to ask for reports - on evidence. "Oh, my cooker has broken". "Can we have an engineer's report that it is irreparable?" So we'd get this stamp from Mick, who's an engineer, saying the cooker is irreparable. And he has taken a week to do it. If that's the level of evidence I am working to... they want the money, what is the point? If the level of evidence is they want a pram, they're a couple, give them the pram.' (Social Fund Officer)

The state of the budget for loans meant that discretion was scarcely exercised at all. Only where budget constraints were severe, such as on grant funds, was supporting evidence sought. Even then, as this account indicates, reliable evidence was not readily available. The problem of confirming the information presented in applications was raised on a number of occasions. Management targets also affected the manner in which this takes place, as the following discussion about handling grant applications illustrates:

Social Fund Officer 'I would write out to possibly less than 1% of my claims. The management targets are just as important [as Secretary of State targets]

because obviously they are performance. It's one of the problems with management by target. You concentrate on certain areas to the exclusion of others, so it leads to a lop-sided service. The concentration on those means we are often brutal in our decisions. One of my beliefs is you can ask for a review and it keeps [name of a Social Fund Review Officer] in a job. If I've got a dubious decision, which is 50:50, I will give them a loan and [name] can sort it out. Because, otherwise, I start writing correspondence. Second class post, which we have to use. It takes three days to get there, three days to get back.'

Social Fund Review Officer 'Sometimes when I ask for confirmation, they don't give the information for three or four weeks.'

A range of targets affect the manner in which decisions are made. Pressure on the Social Fund grants budget mean that there is a tendency to offer a loan instead. Targets for clearance times means that a letter might jeopardise its achievement. Finally, pressures on administrative budgets, requiring the control of costs on postage, aggravate this concern for speed. It has already been noted that the more information is available, the less discretion an officer is able to exercise. However, rather than resolve a case properly, this exchange depicts officers making partial decisions. Because there was no clearance time target at the review stage, there was less constraint upon seeking information to support an application. It also introduces a theme that will emerge from other discussions. Rather than make thorough decisions, and in order to protect scarce funds, discretion is used to put up barriers to applicants for assistance, requiring persistence to overcome them.

And yet, an officer described another extreme:

'We know that things go on. For example at Christmas, it's normally like downtown Beirut, isn't it? Everybody's cooker explodes. It would be easier if people could apply for Christmas money of £250. They don't have to go through the farce of concocting a disaster. We don't have to go through the farce of listening to it. "Oh, you've got the ability to repay. Here's £250, off you go." Other times are September for school uniforms, May and June for summer holidays. They know. We know. They know they are lying. We know they are lying. We don't care.' (Social Fund Officer)

Case office B, in managing its loans budget, was faced with a different imperative to that faced by case office A - the imperative to spend the budget. Refusals and reduced awards were more likely to be the result of the financial constraints upon applicants. Problems particularly arose with the level of debts accumulated by the applicants. In many cases, applicants were already in debt to the Social Fund to the maximum allowed, in addition to other debts:

'In the end, if they get into debt, one of the problems you might say with the scheme with our budget status at the moment, it is intended to provide such and such a need. But if we are giving them as much as we can at the start, then for other needs that arise, we are not able to do so. The political imperative to spend the budget, the consideration of Direction 42 which allows that - you can't overspend. At the moment we are underspending by about 2%, which in real terms is £80,000. That's a lot of money of an underspend. Give it to them. Then the next time something happens, say in 3 weeks time, "I am sorry. You are up to £1,000. I can't lend it to you." It is not anywhere near in the spirit of the scheme. But, on the other hand, that's their problem. They want £1,000, give them £1,000 and they can sort it out.' (Social Fund Officer)

These two accounts together suggest that the processes undermine the policy intentions that lie behind them. The 'rules of the game' can be manipulated by those knowing the rules to produce unintended outcomes. At the same time, the combination of high levels of debt and genuine needs places greater pressure on the grants budget. Case office B operated in similar fashion to the first example, so far as grants were concerned, tightly controlling applications and awards:

'So you can get a cooker on a grant for £200. But on a loan you can have £400. Which is ridiculous isn't it? That's Direction 42, which underpins everything. You must have regard to zeroing the budget at the end of the year.' (Social Fund Officer)

Financial constraints on the grants budget necessitated tight control over each application while the same financial imperative operated differently on loan applications. These consequences appear perverse, even to those delivering the Social Fund.

Case Office C

The interview conducted in the third office became particularly forthright in discussing discretion. The interview was dominated by one person who had been working on the Social Fund for many years. She described a number of instances in which the system failed to respond effectively to individual needs:

'The worst cases to decide on are the ones where you sit there and think "why didn't this person ask me for a cooker?" I would've given them £300 for a cooker, but I ain't going to give them £300 for ... Because he's asked for that item, I can't pay him. That's the worst sort of decision to make because you've seen all those other people who you know play the game. You are paying money out to them. Some poor soul who ain't been on benefit very long, doesn't know what's going on and he asks for what he wants, and we say "no way".' (Social Fund Officer)

Again, the image of a game is used in this account, with rules that can be learnt and used to advantage. What emerged from the interview was a process of deception and attrition, one in which the genuine applicant might lose out and in which the attitude of the Social Fund Officer is central:

> 'You can tell the ones that are really weird, and if you're not happy with it you have got the power, if you like, as the officer making the decision, to ask them to prove as much of the claim as you think appropriate to your decision. So, if you think it's dodgy or strange, you look into it. You don't have to take what they've said. But you wouldn't do that on the majority of claims, because the majority of claims, there is no need to do that.' (Social Fund Officer)

How the Social Fund Officer exercises discretion, 'plays the rules', might also affect the outcome. But, again, this process of writing out to applicants for further evidence can only be taken so far:

> 'You have got to concentrate on the targets, but sometimes you try. Sometimes you try and you still have to do it [refuse the applicant], because they don't write back to your letter or haven't given you permission to contact or haven't given you any social services contact, or anything like that. You might write out and say ring me up, or answer these questions. You've got to make a decision. You can't just say "well, I can't make a decision", can you? In the end you've got to do it on what you've got. The thing is, if you haven't got the information to support a decision to pay, and you've tried everything, you've got to not pay. It might be wrong not to pay, but it's even more wrong in those circumstances to pay. If they ask for a review, you get more information. If they don't, well ...' (Social Fund Officer)

In this account, the officer describes using the rules to assist someone deemed worthy of assistance. But as with any rules, both sides need to be using them to get the intended outcome.

This same officer was, at times, open about the role that prejudice might play in decisions:

> 'I think the hardest ones to do, personally, are the ones where I think "am I doing this because I hate this person?" – not that I know them, you know what I mean. There are circumstances you come across continually and you are thinking "this can't happen to them all." But you have to live with the fact that you can't always get the evidence to say no, because you can't prove that what they are saying is not true. If you can, I think that's fair enough. But if you can't ... You've just got to go with the fact that this person has to have this amount of money because their statement comes in front of your statement. You haven't got anything to dispute it. I know, in some cases, you can do "this is inherently improbable", but it doesn't work.' (Social Fund Officer)

This outspoken officer appears highly judgemental, using the rules both to try to assist those she perceives to be genuinely in need and also to hinder those she deems not worthy of assistance. Behind it all lies the need for adequate information with which to make proper determinations. Reflecting on the problems of evidence, and supported by a rare interjection from a colleague, she describes a process that fails in its basic approach:

> **Social Fund Officer A** 'The thing is, it's all down to reason. You know that there's more to this than meets the eye. The forms are really ... well, I don't know if it's the format ... part of it's the format of the form. Instead of directly asking them what's the matter with them ... Instead of saying "what are your health problems?"; "how does it affect you?", it doesn't say that. It says "do you think you might enter care if you don't get help?" That's a really dumb question. That's putting our directions into English to ask them how they feel about it. It's not evidence. It's not evidence of the right sort. For that one, they should say not whether they feel they should go into care – because that's our decision to make, really, in a way – but "what's the matter with you?"; "how does it affect you?"; "can you look after yourself?"; "do you need help feeding yourself?"; " do you need help cleaning yourself?" or whatever. That's actually more relevant to us than ...
>
> 'People who come in for interview, like ... They will not say "I think I might go into care if you don't help me", because they don't want to admit that. We can say "corr, look at the state of disability there". They won't say that, because they live in the community and that's how they are. They don't want to go into a hostel, do they? So they say "I won't go into care if you don't help me." They tend to put in the other one [question box], "are you having difficult problems?" "Yes." But you still don't always get the full facts. The questions are stupid. You want more about "what are your difficult problems?"; "what are your health problems?"; "how does it affect you?" '
>
> **Social Fund Officer B** 'The ones who lay it on thickest, if you like, straight out front, I tend to disbelieve rather than the people who give slight hints. Because no one likes to tell all their problems to strangers for no reason. We are strangers.'

Without knowing a person's circumstances, properly considered decisions are not possible. Yet, according to these accounts, the forms do not appear to support this process of information gathering. In eliciting highly personal information, it is not clear that forms could suffice in any case. In other services, such as social services, face-to-face interviews, during which a relationship and understanding can be developed, are conducted by trained professionals. Yet the Social Fund asks for this information in forms and in writing. Without understanding what lies behind some of these questions, and without knowing with whom they are communicating, applicants in genuine need may not receive the assistance intended.

Reflections

This image, of being intrusive strangers, is particularly illuminating when discussing a service intended to respond flexibly to individual circumstances and needs. It was something remarked upon by a number of welfare advisers:

> 'The other aspect of Social Fund decision-making that's always intrigued me is the totally impersonal nature, because most customers never really get to have any contact with an actual Social Fund Officer, even verbally.' (Senior welfare rights adviser)

For a scheme meant to be flexible, the Social Fund appears hostile and unresponsive to applicants. Only at review is there some sign that an individual's evidence will play a proper role in the decision. Talking about the review process, two welfare advisers discussed the experience of reviews:

> **A** 'They [applicants for review] don't like to argue really, do they? They are worn out by the process of being there in the first place. Sometimes waiting an hour, sometimes an hour and a half. They sit in a very hostile environment often, and they are completely worn down by the time they get to see somebody.'
>
> **B** 'They sit in a tiny little room on rock solid benches at a very awkward angle with a glass screen in front of them, to go through this appeal. The rooms are filthy, fag ash everywhere.'
>
> **A** 'And we are, both of us, talking about people who are sick. The levels of anxiety among my clients are very high anyway, so the sooner they can get out the better. They aren't going to argue about what's written down. But sometimes they [Social Fund Review Officers] come to the home on a visit.'
>
> **B** 'Yes, you can get them to do a home visit for a review. It can take a bit of forceful pushing to get that to happen, but when they do that the reviews generally go quite smoothly and you get the award. I find, with the reviews done at home, the Social Fund Officer goes away saying well, you should perhaps make another application for that and that and that, because they are actually seeing the conditions someone is living in, and it does in some cases shock people.'

Breaking from the impersonal nature of forms and understanding an individual in context allows for a more rounded consideration of the applicant's needs. Other opportunities to obtain a more personalised view of applicants, it was suggested by advocates and welfare advisers, were not taken. Application forms ask for a contact person who might provide supporting evidence, such as a social worker or GP. Two homeless advice workers discussed this point:

> **A** 'But what I find is another interesting point, in terms of accountability, is the form asks for details of, maybe a GP ... GP or their social worker. The client will

always, usually, put that down. They never ever contact those. Why is it on the form? They never account for why they won't or don't deem it fit to contact these people who can speak on behalf of the client, who have got the client's authority. And the letter comes out without any reference to that. It's a standard letter, no decision-making process there involved.'

B 'I think the point about information is crucial. Whenever I've spoken to Social Fund Officers or Social Fund managers about this, they've always said the same thing, which is when a decision is changed on review, it is changed because the reviewing officer had information at the time of the review which they didn't have when the application was made. And I think that's probably true actually. But I think you need to go beyond that and say why didn't they have the information that was there, or perhaps why didn't they look properly at the information they had? Every Social Fund Officer I've ever spoken to has said information is the key thing.'

At the final tier, the independent inspector's review, new information is still emerging in many cases:

'And then it comes to us. And the letter we send out actually says things like "if you need bedding, tell us what bedding stocks you've got and what condition it's in." Nobody might have ever asked them that. Our covering letter along with the papers says "information our inspector may need to know". For example, "tell us what bedding you've got" if you want bedding. "Tell us what happened to your clothes and what stocks of clothes you've got", if you've asked for clothes.' (Social Fund Inspector)

This echoes the points already made by Social Fund Officers. For a system intended to respond to individuals, this is a surprising situation. At the first review, with the Social Fund Review Officer, applicants are given an opportunity to verbally present their case, but formal questions, designed to obtain useful information, are only asked at the second review stage. This suggests a system that is not genuinely striving to respond to applicants.

Indeed, the picture presented during the course of these interviews was of a system that can respond, but this is very much dependent upon the attitude of the Social Fund Officer and the persistence of the applicant. Each is playing a part in a game, though there is an asymmetry in information, particularly about the rules of the game. These rules can be used to achieve the results that might have been envisaged by policy-makers. Equally, the outcome might be to provide assistance to people who have played the game and misrepresented their circumstances.

Constrained by targets and rules, the image presented of discretion in these discussions is not that in government publications. What was intended to be flexible appears, in the accounts above, perverse. Rules that allow room for discretion at times limit that discretion. Instead of responding to the specific needs and circumstances of individuals, the handling of initial applications appears almost routine. Only if an applicant persists to the review stage might they have an opportunity to present a clear description of their case for assistance and gain some understanding of the rules within which the game is being played.

Some of the rules and questions on application forms, in the opinion of Social Fund Officers, actually encourage perverse decisions. Yet directions have scarcely been amended in the past ten years, even though they are a legal innovation intended to be capable of flexibility. At the same time, some of the targets imposed upon Social Fund Officers aggravate this rigidity. Thus, it is not clear that the Social Fund could be said to meet its objectives to 'concentrate attention and help on those applicants facing greatest difficulties in managing on their income', or to 'enable a more varied response to inescapable need' (National Audit Office, 1991, para. 1.5).

Furthermore, these same rules and targets form the very basis of the reports presented in formal accounts of the Social Fund. The structures that constrain discretion, often in ways that could not be intended, are presented as evidence of flexibility and of the successful exercise of discretion.

This is a conclusion to which we will return in later discussions. However, the challenge discretion poses to current accountability mechanisms takes a different form in the case of mental health commissioning. Constraints take different forms in this example, shaping discretion in very different ways.

Discretionary Decision-making: Mental Health Commissioning

When examining the commissioning of health services, a more uniform pattern emerged in interviews from the two case study health authorities. Discretion and the local determination of service provision is, contrary to much academic and press discussion, highly constrained and limited to decisions at the margins concerning new treatments and new monies received. The following sections expand and illustrate

this situation, bringing together discussions that took place in both of the health authority studies and at the NHS Executive.

Financial Pressures

The two health authorities, in which interviews were conducted, were in different financial situations, one over- and one under-funded according to the weighted capitation formula. Anticipating that this would feature as a problem and a pressure on decision-making, I specifically asked the Chief Executive of the under-funded authority whether financial pressures were noticeable. Rather than suggest that funding restricted choices and the ability of the authority to change, it was suggested that the pressures created were rather different:

> 'You cannot say that an under-capitation authority will perform less well against its targets. Because [location] is the example of where that doesn't hold true, because we actually perform very well. And that creates a big problem for us because people say "well you don't need the extra money, so shut up, stop making a fuss." There actually is an incentive to under-perform, because places that under-perform often get bailed-out or rescued because they've got some major problems and have to have some transitional funding. It's very very difficult to win the argument locally that we should continue to try to perform because, basically, good performance isn't rewarded, and there doesn't seem to be any equity either.' (Health Authority Chief Executive)

In fact, since relative under-funding has been a feature of this authority for many years, the pressures were ones that had been managed by tailoring services to fit the funding available:

> 'Also, the supply of money has shaped the development of services. So, perhaps, we've never had more than one A&E [Accident and Emergency] ... well, that's not quite right. We've only got one A&E department in [location] because the fact that the money has been fairly tight has, I think ... We've continually resisted the development of a second A&E department because we know we haven't got very much money, and so we are not in the position of having to take the difficult decision of closing one, like some other authorities. It's not simple.' (Health Authority Chief Executive)

These views were supported by policy officials at the NHS Executive:

> 'Occasionally, we map health authorities having difficulties. What about the ones who are going to have winter crises? You think which are the ones that are going to have winter crises? And you look at which are the ones that have got deficits. And you perhaps look at my allocations and wonder which are the ones that are getting less than their target [on weighted capitation funding]. You'd think that if we hadn't managed to bring somebody to target, they'd be the ones in trouble. But they are not.' (NHS Executive policy official)

While financial resources clearly affect the decisions made, these remarks suggest that they are not the key to the service provided and the standards achieved.

Local Discretion

In other interviews, a different picture emerged, one that does not fit comfortably with the media image of health authorities making god-like decisions to fund or not to fund, bestowing treatment on some and ill-health on others. Described by a policy official, the room for local discretion appears to play a key role in determining the services provided:

> 'I think the idea is, certainly so far with the previous government and, if you like, what's happening now because this government hasn't changed it yet, is that there is a balance between national direction, and this is the national direction [the Priorities and Planning Guidance], and local flexibility which is reasonably generous on local flexibility. The idea being that, locally, you will know where the marginal benefit is to be got, rather than centrally setting overall targets and then holding to account for achieving them, which may not make sense in individual patches. Partly marginal benefit, also there are going to be differences in health needs in different areas, so having exactly the same services doesn't ... different ethnic make-up, mostly age profile ...' (NHS Executive policy official)

The impression given is of authorities allowed room not simply to adapt services to local circumstances but also to work to priorities that might vary from those determined nationally. Yet, in both of the authorities in which I conducted interviews, a different impression emerges:

> 'The core range of services is common across all health authorities. And it's mainly driven by history. I mean the major factor is inertia. It's the inertia of what health care professionals have traditionally provided, which is then built into the supply side in the form of the institutions which exist. And professional codes of conduct, and professional standards, and professional registration determines what they carry on providing, really.
>
> 'So it's, I would say, very strongly professionally determined. But there are areas at the margin where there are differences, and this tends to be to do with new treatments, because they are the things that you can intervene on before they become established in professional practice. And of course, they do get a lot of high public profile, but in fact they represent a very small amount of the service that's actually delivered.
>
> 'So, I have to say, in what determines what we provide, professional practice is very strong. There are a lot of other things that we take into account: national planning and priorities guidance; increasingly, things like NICE [the National Institute for Clinical Excellence], you know, and the guidelines that they produce will become very informative; the law, I guess, which does have some provisions in it about what we should and shouldn't provide, and what we can't, what we

> wouldn't spend money on as well; decisions of the courts on individual cases have implications.' (Health Authority Chief Executive)

In the review of the health service, presented in Chapter 4, efforts to break from the pattern of inherited provision emerged as one key objective of health reforms. Breaking the dominance of large institutions, particularly in mental health services, and of the professions in determining the allocation of resources lies behind many of the reforms of the past twenty years. And yet, it is these same forces, inertia and the professions, that dominate decision-making to this day. Only at the margins do health authorities exercise some control, that is in influencing professional standards through clinical governance (to which we will return later in this chapter) and in decisions about new treatments. Media attention has focused upon geographical variations in the provision of *in vitro* fertilisation, of statins (a treatment for coronary heart disease) and, more recently, of Taxol. Indeed, this last medication, for the treatment of ovarian cancer, particularly exercised one of the MPs interviewed. It is these choices that attract the attention of the media and present the received image of capricious decisions.

A further impediment to change is to be found in the attitudes of service users, advocates, pressure groups and media. Echoing the language of officials, one interviewee remarked:

> 'Very often it's [financial decisions and the failure to redistribute funding] due to kind of inertia, or it's too big to change this because we've done it now, or whatever. And again, it's always ... it seems to be approached from the wrong end, because the people who are losing the service hear about things they're losing before the alternatives are made clear. And so it's always felt as a loss rather than as, well, we're going to do this, this and this. It might mean some changes. You know, it's psychological. It's the wrong way round.' (Voluntary sector mental health worker)

Resistance to change is to be found amongst the public and users, a resistance aggravated by apparent failure to communicate clearly or to explain decisions in ways that might secure support. Again, closures and cutbacks are more readily the focus of media and public attention rather than the way in which diverted funds are to be allocated.

Local freedoms are also constrained by scrutiny at a regional and national level. In allocating any additional resources each year, and through the year, guidance plays a

significant role:

> 'So we'd pick on particular services which were part of the priorities, and so for mental health services, we identified that a couple of health authorities had not developed, had not put the priority against mental health services that perhaps they might have done in their plan, or they said they did, and we would then agree particular plans with them to improve them. So, for example, in [location], we had an issue about them not investing... they were investing in mental health services, so to that extent they were following the priority but they were investing in what we regarded as more institutional as opposed to community based services. So we had a particular plan with [location] to deal with that issue. That came out of these particular reviews. [Location], they were investing in a particular part of south [location], as opposed to another part which was quite clearly not fair and right. And so we agreed with them a plan for redirection of mental health services on the basis of the ... ad hoc is probably the wrong word ... review we carry out from time to time.' (NHS Executive Regional Office official)

Even where authorities exercise choices, these are subject to checks and controls, albeit from a regional body that has some knowledge of the circumstances and conditions in which an authority is working. Nevertheless, instead of the freedoms and discretion described in accounts of the health service, whether in formal documents, academic comment or in the media, the impression given by interviewees was of a closely circumscribed process in which choices are at the margin and inertia dominates.

Clinical Governance

That health authorities might seek to alter services by addressing clinical standards and effectiveness has been remarked upon. As has already been noted in Chapter 4, while at one time closely linked to debates about rationing and priority setting, the focus of effectiveness has shifted in recent years. No longer is it dominated by health economists seeking to establish the value of health gains when compared to the costs of treatments. Instead, the focus is upon identifying which treatments are effective in what circumstances and informing the judgements of clinicians:

> 'We see effectiveness as being mostly about maximising the quality of care and the dimension of quality we are talking about is efficacy, the extent to which the result is achieved. And that does include consideration of the extent to which the resources used are commensurate with the results you are after. And that's how you can relate effectiveness to issues of prioritisation and rationing. But effectiveness would ... in itself, is about the health gain potential of treatment choices. The root of effectiveness is in the interaction between individual doctors and nurses and patients, and about the care decisions they make for individuals and it also has strong links with the evidence based medicine movement and with a trend in recent years to feel that we know with a greater degree of certainty

which treatments work and don't work, and that tends to be a rather gross oversimplification.' (NHS Executive policy official)

Using guidance from NICE and working within National Service Frameworks, clinical governance in its current form, in the eyes of one respondent, will undermine geographical variations in service by placing commissioning in a more constrained context:

'If you take fertility, one of the earlier examples I gave, there is a nonsense that says that access to treatment is determined by your postcode. And that's basically it. Where people have operated within their own local arena, we've been expected to make all the decisions locally, and then there is a certain nasty sort of feeling that all the difficult decisions are pushed as far away from politics as possible. We have been saying, for a long time, there ought to be more national leadership in a national service. That's what Labour said in opposition, and they're following it through. In a way, you could feel some of the local flexibilities being taken away, but there is some sense, or a lot of sense, in saying well, if there is some evidence on something, there ought to be some clearer guidance from the centre, and CHIMP and NICE, and all that sort of stuff, is actually an attempt to give some national leadership. There will still be the scope for discretion locally, but it will be within that national ... you'd have to justify it more, obviously, the way you depart from the information that's coming down from the centre. And developing the national service framework is another way of giving much more of a national leadership. Because, when they produce the national service framework - they've produced the cancer one already - produce the national service framework for mental health and coronary heart disease next year, then that will be very much our programme for action in those two services and they will inevitably take a lot of our time and energy to put them in place.' (Health Authority Commissioning Director)

In essence, a firmer steer will remove further the local freedoms exercised by health authorities. While the interviewee, cited above, seems to look forward to this development positively, it presents a different image of health authorities in their commissioning role than that widely recognised. Another official had a clear image of the way it might begin to look:

'One thing that's coming through, and it's a big change when you actually look at some specifics at the moment, the scene is changing, is that what we're doing is moving away from this system where it's been volume driven, and all the incentives have been to do more and more, whatever it is, to something that's more to do with standards and quality and accreditation and clinical governance. And it's to do with actually doing things properly, and taking into account more and more, as much as we can, the clinical effectiveness of treatments. There is the famous BMJ [*British Medical Journal*] quote that, you know, over 90% of current medical treatments are not proven through any sort of thorough medical research. That isn't to say that they aren't effective, but there is a push to make clinical effectiveness work central to it, and actually what we actually buy from our Trusts should be more and more proven by research and evidence, and more

and more driven by standards of quality that we set, either in patient experience quality measures, or in terms of clinical governance, that the right people are doing the job, they are properly trained and they actually do a first class quality job. And that seems to be the focus.

'Now, that doesn't make commissioning any less demanding, but it makes it less of a bean counting exercise, and a financial exercise, and more to do with setting clear performance standards against which you can monitor, not just something that's vague but something that says that this is the performance standard and we know, with the data, we can show whether that performance standard is actually being met or not. It might be hard things like mortality rates for operations, infection rates, all that sort of thing.' (Health Authority Commissioning Director)

Commissioning becomes less an overt rationing and priority setting function and more one of raising standards and of improving efficiency:

'I've been in the service over 30 years now - if you actually look at the rate at which we treat people, it is really very, very different from what it was 20, 10 or even 5 years ago. I remember doing some planning in the mid-80s, when I was saying there was no way we could become more efficient. Lengths of stay in the acute service were on average, in certain specialisms, below 4 or 5 days, and there didn't seem to be much further to go. But there has been, and I was totally wrong. The transfer of treatment to out-patients, which used to be in-patients, to day services has meant that what happened, in terms of where our energies have gone, is actually getting new techniques into place, which have driven up the efficiency levels and got more and more people through, rather than spending our time saying, should we do 10 hips or 5 fertility treatments. It's that kind of process.' (Health Authority Commissioning Director)

Again, local discretion is not what it seems. This account suggests that the function of local commissioners is much more technocratic, raising performance by improving practices. Instead of deciding between different competing needs, commissioners are engaged in increasing the provision for all needs across the board. This is in contrast to the popular impression of rationing and of discretion.

Ring-fencing

There remains a key aspect of health authority funding where a degree of local discretion is not only allowed but actively encouraged. Indeed, a number of sources of funding have been established in recent years to which proposals and bids must be submitted, outlining innovative ways of working. Being in addition to the mainstream of funding, in theory Health Action Zone (HAZ) money represents an opportunity to change and introduce new services, ones tailored to meet identified

local needs rather than the priorities of the large institutions and the professions. Yet, respondents felt that these funds actually restricted choices further:

> 'And the other thing which is significant is that there is an increasing amount of money coming ring-fenced. And we've seen that over the last couple of years definitely changing. We were moving in the direction of global allocations to health communities on a capitation basis, and you take local decisions about priorities. What's happening now is that more and more of the money is coming ring-fenced. And ring-fenced on a bidding basis as well. Health Action Zones. Winter Pressures money. Waiting List money. Sometimes there's a combination of weighted capitation and bidding, a combination of the two, and, I think, as the result of a comprehensive review, the indications are that more and more will be ring-fenced: the Modernisation Fund ... So that is removing the scope for local priority setting, and making it more centralised, which does fit with the government's interest in a national health service, and a common standard.' (Health Authority Chief Executive)

Rather than the money being simply in addition, it is perceived as a way of restricting the choices available for the allocation of resources by placing tight rules and reporting regimes on authorities:

> 'I think it's [external constraints] in much more scrutiny, and also it's probably getting much more direct guidelines as to what you can spend this money on. For example we've just received something on the Modernisation Fund. That very clearly says, and that has to go on mental health, and on some of the must be dones, so the flexibility, I suspect, is reducing if anything and the monitoring and direction increasing.' (Health Authority Chief Executive)

These two remarks, from each of the case study authorities, were not simply the complaints of local officials resenting greater oversight. The issue was raised by a number of other interviewees, one of whom identified a clear change in the direction of government health policy:

> 'Where the previous government said, here's the broad strategic direction, get on with it, this government says, here's the broad strategic direction, and this is how you get on with it. Part of that is beginning to change slowly as they realise that they cannot tell us how to manage the NHS as well as what they want us to do. They cannot impose because we can't ... organisations just don't work like that. But that has had a profound difference in that there is very, very little scope left at a local level for any kind of local determination of priorities. We have an overwhelmingly large list of national priorities.' (Health policy lobbyist)

The emphasis being placed upon central direction and priorities, a reaction to the perception that the internal market of the early 1990s created variations and inequality, has implications for accountability:

> 'If we're not careful, health authorities in particular will simply be seen as the agents of the Secretary of State in their locality. And their legitimacy will be

derived entirely through that route. They will be able to say we are the agency of last resort, as appointed by the Secretary of State, and we are doing his bidding here in this place. There is a line from us direct to Parliament, as it were. Now, I don't think that is a sufficient justification for the decisions that they arrive at and will not accord them the kind of legitimacy they will need in order to take some of the really tough decisions they are going to have to take.

'In addition to that, they need to be able to say "and we are connected locally in such a way that we can describe and explain a set of processes that involve local people." Not democratically elected, but nonetheless a process of public involvement that is absolutely open and explicit and worthy of challenge and audit by the National Audit Office and the Audit Commission, which traces some set of processes back from a decision through to what happened, and who was involved and how did they arrive at the decision.' (Health policy lobbyist)

This was a concern raised by others, suggesting a bureaucratisation of what is, in reality, a complex system that needs to be able to respond at a local level:

'Now, the losers in all of this, it seems to me, if we're not careful, are local people. Because we've got more central determination, more regional determination, more kind of technocratic control. Where has public involvement in the critical decisions of the health service disappeared to?' (Health policy lobbyist)

The funding streams intended to promote local flexibility through innovations, such as Health Action Zones, instead appear to limit local choice and discretion.

New Initiatives and Mainstream Services

Furthermore, these same initiatives have an impact upon mainstream services. While new projects have emerged, older ones have been starved of resources:

'But services have changed a heck of a lot because of lack of money. There are some people in the mental health services who are also physically disabled, and they used to be able to get cheap transport to the day centre. Now they can't. They've to pay for it themselves. There are also people who particularly enjoy doing group work. Well, all the group work which had a higher cost has been stopped because they ain't got enough money to run them. As for instance, they used to have a woodwork session and they had an outside tutor come in. Well, with the price of the wood, plus the price of the tutor, they decided that it had to go. Of course, they don't have to pay for the heating of the woodwork shop either. So we've seen big differences in services over the last few years, and we don't feel they're all for the good.' (Mental health service user and advocate)

This same interviewee attributed the decline of long-established services to an increasing emphasis on new initiatives:

Mental health service user and advocate: 'The general thing seems to be, if they get any extra money, put it into special projects. And the basic service budgets just goes, in relationship, down, down, down.'

Interviewer: 'Increasingly you have to bid for extra money, and when you bid you have to say we'll do special project X. So is that what's going on?'

Mental health service user and advocate: 'The letter we got from the councillors [about the diversion of funds into new projects rather than the mainstream], who are on the Social Services Committee ... they went on about how wonderful these special projects were. But we feel that probably they are putting the cart before the horse because if basic services were better then maybe the specialist services wouldn't be needing as much, because there's more preventative measures go on in basic services. And, well, we've been trying for a long time to get them to sort of have a good look at that point. But I don't feel they've really looked at it very much. I think it's a case of each service, [location] community health or social services, is looking for the cheapest for their own service, and if somebody goes over onto social services from [location] community health, then great, [location] community health have saved something but social services ... Each are looking after their own budget, forgetting the people that it's all about.'

While this user has the impression of services competing for funding for new projects without regard to the basic purpose of the services they provide, one manager made a different point about new initiatives. Rather than encouraging innovation and new ways of working, the resources were channelled to meet the existing priorities of the main institutions:

'So what has happened is, if you actually look at the process - if I look at the process, and I have raised this with the HAZ director and told her privately of my concerns - we had ... it had become another bidding process for another piece of earmarked money. And this government ... my big criticism about them - I understand the Tony Blair issue of cash for change, which is his big thing - you're not going to get any more money if you're going to carry on in the same old way. But the trouble with the way that they're doing it is that everything has got strings attached, and that means that you have to be always able to demonstrate change. Now this is just another pot that's come down with Winter Pressures, Waiting Lists, with Modernisation, where ... and it's got a £1m sign on it saying HAZ. I mean people just put another whole load of bids that they're probably also putting into modernisation, winter pressures, waiting lists and called it HAZ and somehow built in the children and families angle.

'But they're single agency bids, most of them. So it's like our Trust versus the Community Trust, versus social services. I just think this is not what HAZ was about. So I said to [HAZ manager's name], what a shame it is we've got the money, because that has maybe constrained us thinking we could do things differently. We've just used it as a way of doing more of the same things, or doing something that we did, were doing before, but then being paid for. The

exciting thing, potentially, for the HAZ is to say could we apply for freedoms so that people don't lose their benefit if they go to work and they're disabled. So we get the sort of social gains from going to work, the health gains from going to work, but they don't lose their benefits, which is always a big fear for disabled people. If they lose their benefit, and work doesn't work out, for whatever reason, they may find them hard to get back.' (NHS Trust manager)

When encouraged to use imagination and local discretion, statutory services have responded by competing for funds to support their own priorities and purposes. While, to a large extent, this contradicts the picture presented by the mental health service user, these accounts suggest that the opportunities for flexibility offered by new forms of funding have not been taken. Rather, competing interests among large statutory service providers have undermined local discretion, illustrating the problems of achieving real change in health services. In similar vein, commenting on the HIMP, another interviewee expressed frustration at the missed opportunities:

NHS Trust manager: 'I did always read it as being the intention in the White Paper that this HIMP would become the vehicle for the statutory duty of partnership in delivering the wider issues. And I think where it becomes very exciting is where you actually relate it directly to things like urban regeneration. And then it starts to become potentially very radical. And if the government really is thinking that, then I really think that is exciting. If the government is thinking this is just a bureaucratic mechanism, then oh dear!

'It is bureaucratic at the moment, and it's not lively enough at the moment, because people like me are on it, and the people that we need to change ... or, in the end, people don't get their services delivered by me. They get their services delivered by all sorts of different front line staff. So finding ways of involving them is the really interesting and exciting thing.'

Interviewer: 'Indeed, the service will go on unhindered by the HIMP?'

NHS Trust manager: 'Yes.'

Interviewer: 'Will it affect the behaviour of the Trust?

NHS Trust manager: 'This is non-attributable? Just to be clear?'

Interviewer: 'I'm happy to turn it [the tape] off. I will not attribute this to you. I will not even allow this to be identified with any one particular Trust.'

NHS Trust manager: 'I genuinely cannot see any major change that will result as a result of the year one HIMP. All that has happened is ... we were doing some action anyway around helping staff stress, which is a major issue. We've done that anyway. So, as a result, changes from year one HIMP, I cannot see any. We are doing things under the auspices of the year one HIMP...'

Interviewer: 'But not as a consequence?'

NHS Trust manager: 'No. No, not because HIMP came about.'

Efforts to encourage new and collaborative forms of service provision and to effect change in response to local circumstances confront a bureaucratic service resistant to change.

Individual Cases

The discussion of health commissioning has, so far, suggested that choices are constrained by many factors, almost that few decisions are actually made. One interesting discussion, however, shed some light on the processes that might lie behind decisions in the cases of individuals. The respondent's views initially coincided with those of others on the whole:

> 'I think that there is a real attempt to be publicly accountable, to the extent that the public can ever be able to understand what the hell we're doing. I don't understand what the hell we're doing. It's so complex, you know. I can't possibly understand all the ins and outs, in terms of clinical treatment. I wouldn't want to be in the position of choosing between the bone marrow transplant services and the leukaemia service, or whatever. I think this idea that we are sitting here choosing that rather than that is not the real situation.' (Health Authority Commissioning Director)

However, a little later, we turned to a discussion of the few individual cases that actually came to his attention, largely because of the sums of money involved. While the extract below is lengthy, it is illuminating and will serve as a useful introduction to some of the themes of the next chapter:

> **Health Authority Commissioning Director**: 'I did mention that we're not looking at individuals. Well, one of the nasty things we've come across over the last few years is the need to look at individuals, in terms of complex care cases, where it does actually come down to what we will provide for an individual. And it's the first time we've ever been involved in that, recently, over the last three or four years with the continuing care registration and processes, where somebody emerges from whatever sort of acute episode of care, or they're coming out of a long-term institution after having been [indistinct], and they require educational, social and health support wherever they may be best located. Either at home or in some kind of supported living area. And we're talking about negotiating quite significant amounts of money. It may be, some of them, up to £200,000 a year personal care for one individual. But that is not part of the planning process. We put some money aside and say, well, that's how much we think it's going to cost us this year. We actually are, on a real time, now, basis talking about what we are going to spend on an individual person. Now that doesn't quite fit in to what we were talking about, but sometimes, even at health authority level - at hospitals,

that's what the clinicians are actually doing all the time, really. But here, maybe only small numbers, maybe only 20 or 30 people a year, we're actually getting real people's problems brought to us, and we're actually going to have to decide how much we can afford to spend.

'And, of course, that is within the context of our whole decision-making process. Quite crudely, we'll be looking to cost shift, persuade education to take a bigger per cent, social services, or whatever. You're looking to limit your own exposure. One patient can cost a lot of money. We do get, through the extra-contractual referrals process, things that fall out of ... what common sense would suggest fall outside the normal contract. When a patient is deemed to require very, very expensive treatment, you can't just say to the Trust, well, we're paying you for 1,000, and this is just one of them. The cost is so great that they are saying this isn't within the contract. And it could be a particular drug. A patient's consuming £10,000 or £15,000 worth of drugs per week. When they go into acute phase, it tends to be very specialist and very small numbers. We have actually to decide whether to prescribe or not.

'We have been known to say no. We know as a consequence the patient will die. They don't tend to get priority and ... it's no different from Child B. It's just a matter of chance whether it actually becomes a *cause célèbre*. And we're only doing, I suppose, what clinicians have to do on a daily basis, make a judgement as to whether they are going to treat or not to treat. And they've always taken rationing decisions at the individual level.'

Interviewer: 'How do you make those decisions?'

Health Authority Commissioning Director: 'Essentially, with the clinician, I suppose, at the other end, if they've got a specialist view, and with clinicians at this end who will take a ... and basically we review the evidence and look at the case, and talk to the clinician. But, we have to do it in a proper auditable way. We can be subject to judicial review, and we need to be sure that we've ... So, it's like beta-interferon, very much, in that, in the end, that does come down to the individual really because what we are doing is saying well ... we're talking such small numbers, we're almost saying we're not going to treat you, you and you, we are going to treat you, you, and you. It's not massive numbers, like with hip replacements or tonsils, or whatever. So we have to be clear that the process we've followed is objective and properly evidenced, and has been taken on rational grounds. And rational grounds can include having no resources. And that's been shown. We can't be expected to spend money we haven't got.'

From amidst interviews that talked of constraints, limits and inertia, this respondent spoke of choices affecting the life chances of individuals. More than that, he described a process that begins to sound like the kind of decisions made by Social Fund Officers. A number of other striking points are to be found in this lengthy extract. The interviewee openly states that he is looking to shift costs onto other public bodies to minimise the Health Authority's exposure. He also identifies a

process he considers rational and open to judicial review. But at no time does he mention the views of the patient. Rather, the patient becomes a risk to which the health authority is 'exposed'. He deals with their needs only as expressed in paperwork and mediated by the clinician. As such, and in similar fashion to the Social Fund, the process is impersonal and not clearly responsive to the actual needs of individual patients.

Reflections

The image that emerges from these accounts of mental health commissioning do not readily fit with media images of variations and of rationing. While undoubtedly there is variation, this is as much to do with historical patterns of provision and inertia as it is with deliberate choices and decisions. While there are examples of explicit rationing in individual cases, these are at the margin. In the main, the management of financial and other pressures takes the form of raising standards and improving efficiency. Even the impact of those elements of health expenditure tied to new forms of working and to preventive measures is at the margins. More significant is the impression of a complex pattern of organisations in which there is competition for resources and costs are shifted from one body to another.

Looking at the accounts of the two case studies presented in this chapter, while they are clearly very different services, a number of features emerge. In both cases, the nature of discretion is highly constrained. In the case of the Social Fund, many decisions are routine, while there is scope for Social Fund Officers to treat cases differently according to their perceptions of their relative merits. In the case of health services, their provision is avowed to be dominated by historical patterns of provision and inertia. Only at the margins is discretion exercised. What variations occur from one district to the next, one health authority to the next, do not appear to be deliberate choices, reflecting local needs or individual circumstances. Indeed, each service emerges as highly impersonal and inflexible. These same points emerge even more strongly from the interviews conducted with users that form the theme of the next chapter.

CHAPTER SIX:
USER ACCOUNTS OF DISCRETION

From the accounts of users, a number of themes emerge. In large part, these themes elaborate on those identified in the previous chapter. They identify the impersonal and inflexible nature of the services. They describe organisational confusion and overlap. In this sense, they confirm the complex nature of the case study services. But they provide a further useful insight. They do not merely confirm that the services are more complex than formal accounts and reports suggest. The material in this chapter presents alternative accounts of those services that are developed under a number of themes, rather than under each case study.

Context

In each case study, the reports and accounts have presented an image of discrete services, ones capable of summary separately from others. This impression is one fiercely contested by many interviewed as part of this research. In the case of mental health services, the need for services to address individuals in their wider context was stressed:

> 'As well as the specific medical, medicational needs of the clients and the users, you will understand that when a person suffers from mental ill-health, especially in a community like ours where people will not readily go out and seek help ... Usually it happens that, by the time somebody has had ... suffered from mental ill-health, their world has already collapsed around them. So, practically, it is a question of not only treating the person's mental health problems, but it is addressing their whole problem. One of the major things we do ... by that time [the point at which the project becomes involved] they will usually have lost their tenancy, they will have lost electricity, gas, telephone, income support, everything. We pick up those things, everything.' (Ethnic minority mental health project manager)

The importance of understanding the context and problems service users confront was one picked up by a number of people:

> 'We started by saying, actually, somebody with a severe mental health problem has the same needs as all of us, but actually is probably as disadvantaged as anybody in any of those arenas. Very hard to get and to hold down housing if your behaviour is odd, and if you are disconnected in some ways. Very hard to get money because people with mental health problems tend not to access all of the benefits that are available to people with disabilities. They often don't quite fit in, or the episodic nature of their illness means that they don't qualify for long-

term benefits that have an element related to disability.' (Mental health policy worker for a national charity)

To understand services as distinct and to assess their impact in isolation fails to address such issues. The effectiveness of interventions might depend as much upon the wider context as upon the diagnosis and treatment offered. In a discussion that was not tape-recorded, an interviewee discussed the case of one patient who, having been sectioned, absconded in order to settle his affairs at home. He was worried that he might have left a window open or that bills would not get paid. Who was going to look after his dog? The failure of professionals to understand these concerns has many dimensions. First, they were unable to assure the patient that these issues would be dealt with. The interviewee certainly did not believe that they had contacted relevant relatives, friends or agencies in a position to help. Also, the patient's concern manifested itself in agitated behaviour, confirming the diagnosis and hardening the clinician's resolution to deprive the patient of his liberty. This failure to understand the root of the patient's behaviour might have affected the diagnosis and treatment provided. Furthermore, absconding from the institution only aggravated the situation. While this may represent an extreme example, it starkly illustrates the isolated nature of the accounts presented of services. Representing the actions of organisations without any reference to the context within which those actions occur is, in the extreme, to misrepresent those actions. In addition to the context of the individual service user, a wider organisational context is also omitted from accounts.

Organisational Interdependence

The aims and objectives of each of the case study services are complex, depending not solely upon the actions of a singly agency. This presents a number of problems, both for those organisations held formally accountable for the services and for users of those services.

A constant refrain in discussions with health professionals was the degree to which they are dependent upon others. Discussing the institutional complexities of the new public health agenda and a health authority's lack of influence over other bodies, one respondent remarked:

'And it's particularly clear when it comes to achieving health targets. That's

where it's ... *Our Healthier Nation*. I mean, in many of those areas, the health service has the least contribution, and then there's some very interesting material around about ... if you say look at suicides. The percentage contribution to reducing suicides by a range of different agencies, including health services, employment, of income, leisure, all those sorts of things ... and usually the health service comes out with a very minor percentage contribution out of a hundred. So, that's correct. I think when you get into that area, you have to look at processes, you have to look at whether the health authority has put in place the appropriate processes, made available the appropriate information, informed other agencies about what they could do in order to assist in meeting the targets. And you are holding them to account more for the process side than the absolute target. That's how to deal with the issue.' (Health Authority Chief Executive)

Others suggested that influence would only come with financial resources with which to reinforce the messages. If health authorities are to be accountable for suicide rates, they must also be in a position to change the actions of the other agencies with a role to play.

However, the problem is not simply one of controlling other organisations. The health service, and the professionals within it, is equally difficult to control, if not more so. Referring again to the public health agenda, one regional official emphasised the limits to the influence that could be exerted:

'Though, having said that, what I can't do and don't do in the Trust reviews is insist. I can't insist on them doing any of the things I'd like them to be doing in terms of effective prescribing. I can only ask questions and be disappointed. I can't do more than that.' (Regional Director of Public Health)

and:

'Primary care is ... far less controlled than Trusts. Trusts are bad. GPs ... phew. They are private practitioners and they can practically do what they like. Health authorities try to a greater or lesser extent to influence, and increasingly there are opportunities through the postgraduate agenda ... continuing professional development becomes increasingly important. But really, other than the notional prescribing budget and the taking away of fundholding from those that are fundholders, it's really difficult ... and the accountability is very ...' (Regional Director of Public Health)

Part of the agenda of the new Primary Care Groups and Primary Care Trusts is to introduce peer oversight and pressure to raise standards and improve the use of resources:

'GPs are very nervous about that, as a concept, and don't want to really feel it's their job to sort out their colleagues. A few of them do, but the majority don't like that. But I think, in reality, that will happen. Particularly since they are all sharing budgets. And people who over-refer or over-prescribe will be bound to

get sat upon. Which will be a good start really.' (Regional Director of Public Health)

The prospect of GPs and of Primary Care Trusts commissioning mental health services was one that worried a number of respondents.

Whatever the solution, that close working arrangements between agencies are an important determinant of the standards of service was widely affirmed:

'I think one of the things we've been concerned about for a long, long time is the patchy provision. And we've really pushed for national minimum standards because of that.

'I think one of the key contributors to the differences is the way that social services and health work together, or don't work together. And that varies incredibly. So, in [location], for example, the mental health bit of health and mental health bit of social services have worked really collaboratively, and included in that is housing, for probably about six or seven years now. And there's much less scope for gaps where people can fall through the middle, and there's a single point of referral, and the referral may be to the joint services offered by those two. Or it may be into the voluntary sector.' (Mental health policy official for a national charity)

Yet formal accounts and annual reports, while they may refer to links with other organisations, essentially treat the product of that organisation as independent of others. For users, the organisational barriers make little sense, only serving as another barrier to services. A number of the interviewees in voluntary organisations identified, as part of their role, the need to ensure that people did not fall between statutory organisations:

Mental health and homelessness worker: 'The other thing, as well, that we have difficulty with, if you're looking at the services and whatever else, it's that people are deemed to have a dual diagnosis because they just fall between services, and often homeless people have got complex needs and can have ... will have mental health problems ... or can have mental health problems. If I was living in a shelter and trying to get some sleep, I'd drink and take drugs to excess probably. Then that becomes a drug and alcohol problem, and someone's batted between services.'

Interviewer: 'Is part of the group's role, then, ensuring that they don't just fall between stools, that ...'

Mental health and homelessness worker: 'Yes. It'll be to battle with and try and suggest something that seems outrageous, that the two talk. It seems quite straightforward really.'

The frustration and disbelief in this interviewee's response is only hinted at on paper.

At the heart of the communication problems, it was suggested on a number of occasions, lay financial constraints:

> **Community Health Council Chief Officer**: 'I think the Acheson report ... because he extends beyond, you know, health inequalities, and takes it into social welfare ... you know, benefits. And given all the history of this government's attempts to redraw some of the lines there, I think that's probably why they've [the wider health community] been disgusted by it. I mean it's very interesting ... I'm retracting a little bit. There was a court case reported in *The Guardian* on Saturday [*The Guardian*, 12th December 1998] which I thought should have been headline news everywhere, and that was where a high court judge has ruled that health authorities are acting unlawfully if they do not fund nursing care. The implications ...'
>
> **Interviewer**: 'Is this continuing care?'
>
> **Community Health Council Chief Officer**: 'Absolutely. The implications of that for the NHS, I think, are profound, I really do. I assume it's going to be appealed and I assume it will go to the House of Lords eventually. But, I mean, for many years, as a CHC, we have been arguing that health has redefined the boundaries of what constitutes health and what constitutes social care. I think this judgement is absolutely spot on, and thank god somebody's made it.'

This view echoes some of the words of the commissioning director cited at the end of the previous chapter. Referring to particularly costly treatments, he openly stated that he was looking to pass the costs of care onto other organisations and agencies. However, while he handled relatively few cases, he suggested that similar decisions were made by clinicians on a daily basis. This quote suggests a more systematic approach applying across services. Packages of care are redefined to suit financial constraints as much as the needs of the patient. This issue will emerge again, in the form of 'gatekeeping', later in this chapter.

Even where arrangements were in place for joint commissioning, it was suggested that the collaboration was, to some extent, an illusion:

> 'And it's a nightmare in joint commissioning because ... I don't think joint commissioning has really gelled anyway, because there isn't much jointness. Although health and social services work much better together than they did a few years ago, they still tend to operate in their own individual department, and decisions still get taken elsewhere and they're not brought to the joint commissioning group. So you've got two parallel ... health authorities going about their business, cutting corners ... And it's completely arbitrary as to what hits the joint commissioning agenda and what doesn't. Some things that I think really should be discussed by the joint commissioning group, social services are making decisions about independently and inform health afterwards. Or there'll be a meeting to decide on it between health and social services, but the joint

commissioning group on that topic doesn't know anything about it, which makes them look foolish. It's crazy.' (Officer in a voluntary project aiming to increase partnership working)

The frustration expressed by user representatives is, in this context, understandable. If the relationship between health and social services is unclear in normal circumstances, where even those systems intended to provide coordination appear to be circumvented and undermined, confusion may be aggravated.

At least there is some recognition that there is a relationship between health and social services. Discussing his work in commenting on policy proposals, one policy lobbyist expressed the view that the Department of Social Security scarcely recognised the impact welfare benefits might have on other services:

'In the past, out-with Housing Benefit, there has been an apparent, whether it is a reluctance or an inability, perhaps more an inability to see the implications of changes to social security, or the impact of changes to social security policy on the work and clients of social service departments. Conspiracy or cock-up, you take your choice. Some people would incline to the conspiracy theory, others would incline to the cock-up, but clearly the DSS has become more, in terms of objectives, very much the focus of the last ten years has been to constrain the budget. It has had increasingly little reference to the role that social security benefits play in sustaining vulnerable people in the community.' (Local government lobbyist)

Certainly, accounts of the Social Fund fail to acknowledge the relationship with and impact upon charities, social services or other agencies. Information about claims received and awarded pays no regard to the consequences of a refusal. In the case of health services, the relationship with social services is acknowledged, on the whole, in health authority documents and the Department of Health's annual report. But reports of the two services are not integrated to give a clear impression of those areas of overlap, of confusion or, more significantly, those areas not properly covered by either agency as costs and responsibility are shifted from one to the other. Rather the impression is of organisations endeavouring to work together.

Consequences

Substantial inquiries into the operation of the Social Fund have found variations in outcome and in practice. A further focus of inquiry has been the pressure the scheme has imposed upon other welfare services (e.g. Becker and Silburn, 1990). By controlling access to resources through the Social Fund, the Department of Social

Security has displaced the burden onto other sources of assistance. In the case of families with children, needs that might theoretically be met through the Social Fund are being met by social service departments:

> 'The other side of the coin, of course, for us, is where the Social Fund fails to pay out, there is pressure on Section 17 budgets under the Children Act. Or social work, care worker time spent running around looking round thrift shops for £20 cookers. The time in terms of advocacy, going through the Social Fund application process, and the appeals process, and the other appeals process. But there is also the knock-on effect in terms of local authority budgets where the state fails to pay, at a national level fails to deliver in terms of social security benefits, and that individual is left without, invariably, local authorities, which have a cash-granting power under the Children Act, have been compelled to kick in. And you've only got to look at the research on the use of Section 17 to see where the expenditure has gone. It's gone on assistance with purchase of one-off items. It's gone in tiding people over because their benefit cheque hasn't arrived. Because appropriate use of that money is if it is ensuring that a child is not going to have to be received into care.' (Local government policy lobbyist)

This point was made by a number of interviewees. One explained the behaviour of social workers:

> 'We have a real problem in [location] with benefit awareness in children and families teams, disability teams, adult services. We just can't get the message to them. And, like I said, if they can get the money out of their team leader, then its easier isn't it?' (Senior welfare rights adviser)

Rather than go through the process of applying through the Social Fund, with all the likelihood of having to request a review of an initial decision, social workers are inclined to obtain resources from local authority resources. Where these are not available in particular circumstances, the need might be displaced onto charitable funds. Because of the pressure of meeting these demands, a number of charitable bodies require evidence that an individual seeking funds has been to the Social Fund first. Again, this was mentioned by a number of respondents:

> 'For the result for the person and also our time and effort, we feel its better channelled into that [applications to charities]. It's transferring it [meeting exceptional needs] to the voluntary organisation, which is why they want to know whether Social Fund applications have been made, and if not, why not? And if so, what was the result? Which is perfectly reasonable.' (Advice worker)

> 'As a rule, I find that most organisations which would give money generally require you to apply to the Social Fund first. Once you've been refused, then they'll consider it, but not before you've done that. Certainly most charities now would insist on that. If you're eligible, you must try the Social Fund.' (Welfare rights worker)

The Social Fund is failing to meet needs deemed legitimate by charities to such a degree that those charities were becoming the first port of call. To control the demands on their own budgets, charities have had to insist that the Social Fund be approached first.

In the case of mental health, the failure to provide services can have more profound consequences. One mental health professional, working in the voluntary sector, described the results she witnessed in the caseload she was dealing with:

> **Interviewee**: 'I've got some clients coming to me, particularly young people, where GPs don't believe or don't take on board that they're suffering from depression. Now, they're being referred through the courts. So they've actually ended up going to the GP, being turned away by the GP and ending up on some ... it could be some assault, assaulted someone in a shop. They end up coming back here and, of course, still not on medication, but it's quite clear, to themselves anyway or to anyone else, that there's perhaps something not right with this person.'
>
> **Interviewer**: 'This is common, is it?'
>
> **Interviewee**: 'With young people, yes. With young men. The majority of people coming to me ... Women always seem to get anti-depressants, and men seem to be told "pull yourself together". For some reason, young men are getting a different service from young women, because young women are getting put on anti-depressants.'

The failure to respond appropriately to the needs of some patients can have serious consequences. But it would be unfair to simply suggest such failures are the responsibility of GPs. In certain circumstances, clinicians are unable to respond:

> 'I tried to convince her [the interviewee's wife] that something was wrong there and maybe she should seek some advice. As far as she was concerned, there was nothing wrong with her. I tried very hard, all over the place, to get her in for some treatment, some psychiatric treatment. As far as the statutory authorities were concerned, she wasn't a danger to herself, or to anybody else so ... you know, she wasn't interested in doing it, so she could carry on. And eventually, in 1982, it was me that had a nervous breakdown, and I ended up in hospital, you know, in a mental hospital.' (Carer)

The role that carers play is a particularly precarious one. Once the needs of a patient are recognised and acted upon, the needs of the carer must now also be considered when a package of treatment and care is being drawn up. If the needs of a patient are not recognised, nor will the needs of the carer. There may be circumstances in which a clinician is tempted to reconsider an assessment to suggest that the woman was a

danger to herself or others, but this could be to expose such a clinician to legal challenge. Furthermore, in light of financial constraints, and as will be illustrated in the next section, the general tendency is for service providers to restrict access rather than open it up.

If the failure to consider the context in which a patient lives before receiving care has consequences, the failure to do so when a patient is released from an institution can be just as damaging. It is not simply that the decisions made might have adverse effects. The failure to understand the context and the interdependence of the range of service providers leads to assumptions being reached:

> 'One of the things we're not very happy about is people making exemptions about referring, you know, particularly at the CPA [Care Programme Approach] level. When somebody's in the hospital, admitted to the hospital, they actually have a CPA meeting, just to prepare a care plan for when this person actually goes and lives in the community, or in their own homes. What support network will be available to them? And, you know, a CPN [Community Psychiatric Nurse] would be there, a social worker would be there, and a consultant will be there, and the GP would be there, somebody from the ward would be there. And they would say ... the GP would give information, "oh, there's a counselling service. This woman might be appropriate for counselling, so, I'll look into it." What we actually want to do is we want to be there to say what we can offer rather than somebody else making commitments on our behalf. I have repeatedly addressed that issue, but that's not happening much. But I can see why that's not happening much, because we have actually withdrawn our involvement when patients are on the ward, because we don't feel we have a role to play there.' (Voluntary sector mental health professional)

Some understanding of the support available to a patient on leaving an institution is essential. Yet, in the opinion of this voluntary sector mental health professional, it is often the case that assumptions are made. If this is true of an organisation, what assumptions are made about the role that carers will play after release?

Again, however, accounts of services present an incomplete picture. Where a CPA package is delivered by GPs, clinicians, CPNs, social workers and voluntary bodies, separate reports for NHS Trusts, GP practices, health authority commissioning decisions and social services fail to account for the CPA. It is the relationship between organisations and the way they combine to deliver care that is missing from accounts of services provided to mental health service users. Accounts that report the actions of one body fail to encompass the consequences of those actions for other

agencies, whether statutory or voluntary. They also fail to capture the consequences of inaction. When services are not provided to an individual, or an application is rejected, there is no account of the consequences. In what sense can we form a judgement about the effectiveness of the Social Fund or of mental health services without knowledge of the consequences of a failure to act?

Gatekeeping

In discussing discretion, questions of gatekeeping emerge. In the absence of rights and clearly defined entitlement to specified services in particular circumstances, there emerges room for the management of demand for those services. Referred to in academic discussions as gatekeeping, that is husbanding resources by controlling and restricting access to them in the first place, the concept has crept into the language of practitioners and users also:

> 'But there is rights that they don't know about, because the council's not going to flag them up, are they? Social services aren't going to flag them up because it means work, and more resources. I think it's generally gatekeeping services, basically.' (Mental health service user and advocate)

Two types of gatekeeping have been identified in recent studies of the health service:

> '*Managerial* gatekeeping refers to the types of structures and process which are agreed by managers and direct the functioning of the team – the type of procedures that can be found in staff procedural manuals, for example. *Bureaucratic* gatekeeping is used by street-level bureaucrats such as receptionists and duty social workers in their first engagement with enquiries from potential service users or their agents.' (Rummery and Glendinning, 1999, p342, emphasis in original)

While not always so easily separated, both varieties were clearly in evidence in the case studies selected. Perhaps the most blatant example of bureaucratic gatekeeping was described in a discussion between two homelessness workers:

> **A** - 'The prevention of access to the Social Fund, in terms of Crisis Loans, is quite systematic. Because it starts at the initial reception when the client will ask, inquire about the possibility of applying for a Crisis Loan and they get told by the receptionist, well, you know, you've got no chance, you're wasting your time, you know. The reception may or may not inquire about some brief details, you know. That would deter most clients.
>
> 'And then, if a client does get past that stage, you know, we try to encourage the client to insist on seeing the Social Fund Officer who is the only one empowered to make the decision. But the Social Fund Officer will also, very often, take the same approach, you know, that you're not going to get one. And the clients, by this time, will have waited for some time to see the Social Fund Officer.

'Then the client may ... we've tried to forewarn them ... they may insist on making the claim anyway, and they're told, well, you're wasting your time. You can make one if you want to, but you are wasting your time. That will maybe take to some time mid-afternoon, after the client's been there all the morning...'

B - 'Heaven help you if you go in at 4 o'clock in the afternoon.'

A - 'Then the Social Fund Officer fills in the form, and the clients that have got that far will often report that the Social Fund Officers are reluctant to show them what's on the form. They're asked to sign it, but they're not ... The client's asked to sign it, but the Social Fund Officer doesn't really want them to look at it. And then of course the client will look at it and will not be happy with what's in there. There's a lot of questions on there that they just haven't ... the answer's been assumed or abbreviated. And then, finally ... because we do recommend that the client insists on a written decision, because the verbal decisions that are given are atrocious, you know, are unbelievable. They're told that, for example, because they're using the day centre that they can get food on a credit system and they are not entitled to a Crisis Loan. They're never told that, obviously, in writing, but they're told that frequently. Or they're told things like, if your Jobseeker's Allowance has not been processed yet, we can't pay you until you are on computer, which of course defeats the point of applying for a Crisis Loan.'

Failure to issue forms and stories of verbal decisions and of similar barriers were recounted by a number of interviewees. That these barriers represent a deliberate policy, albeit at a local and informal level, was suggested by a number of interviewees. Echoing remarks made by Social Fund Officers, and cited in the previous chapter, clear motives are attributed to perceived policies:

'One issue is that we've ... there've been periods of time when we've strongly suspected that DSS take advantage of people's reluctance to appeal, and not all of the people we try to persuade to appeal agree to do so. And that would mean they would calculate that only 50% of people turned down will in fact bother to appeal. The reality is that very high proportions of appeals are successful, and we often wonder whether DSS do this as a kind of way of automatically bringing down the amounts they have to pay out.' (Homeless advice worker)

While this represents suspicion, three welfare rights advisers had presented evidence of similar barriers to the Department of Social Security on a number of occasions only for it to be rejected as unsupported:

'One of the other areas where they clearly didn't take account of outsiders was the whole issue of Crisis Loans and people going to the offices and wanting to make an application, but people being turned away. And over and over again we complained about the fact that people were turned away, and people were making arbitrary decisions about whether they would be eligible or not, and they were saying to people "look, I'm sorry, but you're not going to qualify, so you don't need to make an application". So that then altered the statistics because there was then no record of an application being made, so no application had been made.

> And every time we raised that with the Department, it seemed that they would say ... They seemed to deliberately misunderstand the difference between the fact that a procedure relating to an individual had certain provisions in it and the way the centre of the DSS, what their relationship was with the centre of the Benefits Agency was, with the local offices of the Benefits Agency, and that they had a responsibility to make sure the local office provided the service along the lines that it was supposed to do so. And it was, again I can't tell you which year, but it was one year they eventually decided, right, they would go ahead and introduce these forms for people to apply and they could apply externally, and that they would give these forms to agencies like Citizens Advice Bureaux, which was the one way of ensuring that people could get an application in. But before that there was this sort of blindness, that, no, they wouldn't take any notice of the fact there was this ... offices were not actually coughing up the information they should do to individuals, and that they as a Benefits Agency at a national level had a duty to ensure a certain level of service locally.' (National welfare rights lobbyist)

In a discussion with one policy official, conducted off-tape at the request of the official concerned, I was informed of the case of an office refusing to accept Social Fund applications after 3.30pm on Friday afternoons. The requirement to complete the assessment process might eat into the weekend of Social Fund Officers. Informally alerted by a welfare rights organisation, the official resolved the problem, but other interviewees remarked on the same phenomenon.

Another example of systematic local barriers had been uncovered elsewhere:

> 'At one stage it was almost like a constant battle on a day-to-day basis. They, I think, were trying to ... and it's all about gatekeeping because it's about the budget. At the end of the day, that's what it's all about. And they devised, I think, the local office, a whole series of mechanisms for gatekeeping, which is using reception staff as quasi-Social Fund Officers, and then misinformation about "oh, you can't get any help with that item, or this item." On Crisis Loans they would say "well, basically, its your own fault that you've run out of money. You can't get help." That was the classic one. There's no causal judgement built into the Crisis Loan decision-making. And the other interesting one that we found out about was people kept coming across and saying – usually lost money, because usually that is a source of contention, lost or stolen money – and saying "well, I've been told I can't have another Crisis Loan because I claimed for one 6 months ago for the same reason." And we used to go back and ask "is this right?" And they'd say "no, that's not right." And one day we took one to the Social Fund Inspectors. And you know you get all the papers? And there was a little pro-forma they'd devised where claimants actually had to sign saying "I understand that if I re-apply for money which is ..." – and the categories were lost, stolen or miss-spent - "under those circumstances I may not get help with an item again." That was a local form.' (Senior welfare rights adviser)

This clearly illustrates gatekeeping of a managerial form, deliberately introducing means of filtering and excluding applications.

In mental health services, bureaucratic barriers are less conspicuous, partly because the influence of professionals in the service is so great. Managerial gatekeeping was evident in the definition of needs applied:

> 'The way they've categorised the CPA [Care Programme Approach] levels in [location] ... they've done that in a way that eats into the eligibility criteria for a particular service. So in [location], you are either in level one, two or three. But what you find when you try and access services is that the services say, actually, we only take level two and three. And you're level one, and so you've got ... where that happens, I guess one of the points from the service user perspective is that the assessment's been inadequate. Often they've missed huge aspects.' (Mental health user advocate)

More crudely, others identified a simple refusal to recognise need:

> 'In terms of mental health, it is within sort of statutory legislation that they are needs led services and that, if there's an identified need, statutory services have a responsibility now to ensure that those needs are met, and users can now start taking statutory services to court if their needs are not being met. So if they say we don't see the need, they don't have to meet the need.' (Mental health professional in the voluntary sector)

Barriers of a different kind also emerged in two different discussions, referring to the same process of centralisation underway within one Benefits Agency district. For reasons of economy of scale, of reaching a workload volume that would allow for the formation of a specialist team, work on Social Fund Reviews had been centralised. Interviewees suggested this reflected a problem of delays and backlogs and could see the merits in centralising the work. However, there were consequences:

> 'Linked to that fact, we are concerned about the whole centralisation of work in [district location], where work from [office name] has been farmed out to [office name], which means that you've got somebody that's sleeping rough up in north [district location]. Will he or she actually go down to appeal, because it's quite a move? We're trying to monitor that just now, but ... We've recently agreed with the local office, in fact, the client's fares could be paid. It wasn't automatically apparent when the centralisation took place. We asked that specifically at a [district location] liaison meeting, and they agreed that, yes, they would refund the client.' (Homeless advice worker)

An advice worker, in another organisation, was less mollified by this arrangement:

> 'But the big problem is the move to [office name]. We've really got concerns about that. We're concerned about the distance. We were told that people could claim fares when they get to the office ... The big problem is, we're not an advice agency like the Citizens Advice Bureau as such, we haven't done any monitoring, so I don't know how it's working. It's a big concern. When there were questions at the meeting, they said, it's a direct bus line, people travel around [district location] all the time. It shouldn't be a problem. But people who've got to go

there for a review are disabled, elderly, people that can't ... I don't know what's happening.' (Welfare rights adviser)

Some of the frustration and anger can be detected in that last remark. Together with other remarks, already cited, the image emerges of a scheme, intended to aid the most vulnerable, deliberately obstructing and rejecting claims, forcing applicants to seek a review and then making access to a review problematic. And yet, as has already been noted, attendance at a review allows applicants to present their case in a more coherent fashion. As we shall see in the next chapter, attendance is also crucial to the success of any review. Reviews are central to current systems of accountability for the Social Fund. And yet, access can be restricted and what few rights applicants have undermined by the simple use of management's discretion.

In large part because many of these barriers are unofficial, representing local practices designed to manage competing pressures and demands, barriers to access do not feature in formal accounts of services. Instead, the reader of reports is left with the impression that access is unproblematic and that a uniform process applies in all cases. Only from the accounts of users do these barriers begin to emerge

Services for Ethnic Minority Groups

In interviews conducted as part of the mental health case study, a major theme emerged very early. Following-up this theme, I conducted a number of interviews with voluntary sector organisations providing tailored services to ethnic minority groups. The following discussion raises a number of issues emerging from these interviews, illustrating some of the complexities in the provision of services to ethnic minority groups.

First among the concerns raised by ethnic minority voluntary bodies was most clearly expressed by one interviewee:

'There's a cultural difference. I don't know how to explain that. Sometimes I say I walk into an organisation and I can smell white. You can't, but you know it, as soon as you walk in there.' (Black voluntary sector mental health professional)

The settings in which many services are provided are, at least, uncomfortable and, at worst, hostile to ethnic minorities. When asked to explain what it was that left the 'smell', the interviewee was not able to pin it down but gave the illustration of the

magazines and literature left in waiting rooms. *Woman's Own* and Georgette Heyer novels made patients feel that the service was for someone else. When one considers that mental health services are ones to which many go reluctantly, such impressions can only present a further barrier to users.

The second key issue of concern, already noted in chapter four, was the need to address under- and over-representation of ethnic minority groups in mental health services:

> 'But also, people who don't already use services but who, in the case of African communities, Afro-Caribbean communities, perhaps appear to be over-represented in the psychiatric system. They've got a community interest that they clearly feel is not well represented in the statutory agencies. Health is not alone in this. Quite recently, when I did some work I mentioned to you on primary care and mental health, one of the areas I worked in was [location], which has a very large Asian community. Their concerns were a bit different. They were about culturally competent services, sensitive services, language and so on. But they were also about their perception that they don't get into services. People say, oh, Asians, they don't pose a problem. And you get, if you like, if you looked at the straight numbers, a kind of under-representation which probably isn't about serious mental illness occurring differently in different communities but how people deal with it.' (National health policy lobbyist)

The failure of mental health services to deal appropriately with different communities in a fashion that recognises differences without resorting to stereotypes has prompted the growth, in each of the case study authorities, of a number of voluntary sector agencies to provide gateways and avenues of communication to avoid misunderstandings born of ignorance. In discussion, two African Caribbean mental health workers identified part of their role as being to make mainstream services more aware, more sensitive:

> **A**: 'A lot of the training [to Approved Social Workers] is around culturally appropriate services, advocacy, user empowerment...'
>
> **B**: 'There's quite a lot of fear out there you see. Some people shy away from working more deeply with African Caribbean people because they're frightened of putting their foot in it. They feel they don't know how to react and how to respond. So it's about trying to allay some of those fears and saying, we're here for support, advice and help, you know. Don't let that prevent you giving someone a service.'

For many communities, language compounds the problems of access:

> 'Within the community there is the sense of lack of access generally into all mainstream, and all kinds of services. And this is compounded by the fact that

there is a serious language barrier between the communities.' (Ethnic minority voluntary mental health project manager)

This remark was made by the manager of a project dealing with a community that had relatively recently arrived in Britain, fleeing a war zone. Rather than a concern about over-representation in the system, he stressed the need for help with the trauma of war and of the dislocation prompted by emigration. Mental ill-health is heavily stigmatised in the community concerned. Overcoming those barriers within the community and those presented by mainstream services was the key role of the project. Another worker identified a simple lesson:

'They [statutory sector workers] refer, and they work together with us. That's what they do. Because obviously we know the cultural side, and the religious side. They're not aware of all the issues. So, a lot of them, this is where we come in and we work alongside them. It's just like, for example, if you're doing an assessment on an Asian person and there's a white person doing the assessment, you know, the assessment could be totally wrong. Because, for example, in an assessment you look for eye contact, and automatically there'd be no eye contact there. Religious side, culture side, you don't look people directly in the eye. So the assessment could be wrong in that way. What I've noticed ... because I've been raising this issue with the Trust as well ... that staff should have cultural awareness training in their training. It should be very important for them to have that, because when they're doing assessments, they can look out for these things.' (Asian voluntary mental health project worker)

The roles of the groups interviewed was captured in one response:

'Make both parties understand each other. And we do make ... for example, we are working with [location] community health, with the community mental health teams, with the consultant psychiatrists, the whole teams and the whole set up, and help them understand the needs of the community, help them give what's generally known as appropriate and culturally sensitive services to the people. We are uniquely positioned, in between the two of them, that we create the conditions where the community trusts what mental health can deliver for them.' (Black voluntary mental health project manager)

This role, as intermediary, is a particularly fraught one. A number identified problems associated with the dumping of problems onto their projects:

'With a lot of people, who we work with, we have got a very good relationship with the statutory services, in the main. You always get people who tend to want to just shift everybody who is African Caribbean away, without looking at the service they provide and saying, well, how can we make our service better, rather than passing them onto a black organisation.' (Black voluntary mental health professional)

One project had developed its own referral system to deal with the problem presented

by dumping:

> **Asian voluntary sector mental health professional**: 'People would just pick up the phone and say, "oh, I've got this lady. I think there are lots of cultural issues. There is a language problem. Could you see her?" '
>
> **Interviewer**: 'So you were just a way of dealing with things they just can't cope with?'
>
> **Asian voluntary sector mental health professional**: 'Yes, a dumping ground. In some cases, I must say, people were quite genuine, because they wanted to help the clients and felt frustrated. But in some cases, I thought it was overtly racist. This has nothing to do with us. We don't want to deal with it. And what we started saying is ours is a counselling service. We provide a service. We expect you to make an assessment. Why you are sending this particular woman to us? We want you to talk to her and see what is she expecting from us? Because they need to do an assessment at that level. But that wasn't happening. Then we started sending referrals. This isn't adequate information. We want this, this, this information. We've got our own referrals form now. We actually started sending those out saying could you send this referral form. And if the information wasn't filled in then we would say, well, we would like to know the reasons why, why you have referred this woman? And I suppose that was a bit challenging, and some liked it, some didn't. But so be it, this is the way we work.'

At the same time, reliance on ethnic minority projects did not always translate into an acknowledgement of the value of their work:

> **Asian voluntary sector mental health professional**: 'What I have a query on, in terms of a black project, being a voluntary project doesn't get much support and credibility either. I have seen, in the past, some of the statutory agencies have treated us in an inferior way as a voluntary sector service.'
>
> **Interviewer**: 'How do you mean, inferior?'
>
> **Asian voluntary sector mental health professional**: 'Not actually making referrals. Not valuing the service. Not knowing what do they offer, is it good, do they know what they're doing, do they know what they're talking about? And I think we have to break through that as well. That is quite painful actually.'
>
> **Interviewer**: 'So you have that reaction, I'm not going to use them because I don't know if they're any good, and the other reaction, use them as a translation service.'
>
> **Asian voluntary sector mental health professional**: 'And that clearly shows what they want to offer to the clients.'

This struggle is aggravated, in the opinion of many interviewees, by the failure to resource groups:

> 'The black voluntary sector is renowned, because of lack of support, because of lack of funding, because of expectations and demands put on them. They're

always struggling with their resources. And that sense of enthusiasm and will to do so much in such a limited time – it's normally funded for a year, or two years or three years – and you want to do so many things because ... And that struggle is on-going. I want to prove, I want to justify so that I get funding ... That is a pressure, on-going pressure for all black voluntary projects. And in the process, what happens, sometimes even the community may perceive you as weak, as a weak organisation. As an organisation, would they be able to help us, would they be able to do? I'm not that sure. I'd rather go to the hospital. I'd rather go to my GP. Because this power is seen as something that is almost required. All these people to empower them.' (Asian voluntary sector mental health professional)

Caught between the need to do a thorough professional job to satisfy the demands of professionals and of their communities, and the need to prove their value to funders, voluntary sector mental health projects are often reluctant to turn work away. In an earlier extract, one project had developed its own referral system. However, many groups would accept referrals as a way of making themselves valuable to the mainstream. These pressures are potentially destructive:

'I also feel that a lot of the black projects are very creative ... very, very. That drive, and that enthusiasm is tremendous, and they're putting that within the project, and I can see ... It's such a shame that they're always limited funding, and it comes to an end and a lot of the black workers ... How can I say? The system has destroyed them, their enthusiasm and creativity. And it's such a shame.' (Asian voluntary sector mental health professional)

This interviewee was clearly angry about this situation. After the tape had been turned off, she recounted the demise of a black project whose worker had resigned because of stress leaving it with only an administrative officer and unable to operate. At the same time, funds had been given to a large and established voluntary agency to deliver services to the black community. How that decision was reached, and who was accountable were questions of serious concern to her and to the wider community. Yet, she stated that there had been no wider advertisement for the work and no approaches had been made to organisations already operating in the field. Her anger was scarcely controlled.

Behind these discussions, a further issue arose. If statutory services are relying on voluntary groups to provide services to ethnic minority communities, does this not represent a failure, an abnegation of responsibility on their part? That there was a lack of trust, and thus a role for ethnic minority projects, was for some clearly the product of racism:

> 'In an ideal world, the mainstream would be fully open, fully accessible for everybody. We're so far away from that because of the racism in this country that I want to go where I get a decent service. And I don't see why my black friends shouldn't go for exactly the same. There is a separate issue, I think, which is about properly funding voluntary services.' (National voluntary mental health charity policy official)

On the other hand, some suggested that there might always be a role for voluntary groups at the margins:

> 'You could say that the statutory services are failing [by contracting for the provision of services to minority ethnic communities]. And you could challenge them, because you could also say how feeble of them, cynical of them, how uncaring of them not to want to do it better themselves. Or you could say - and this is the bit we're exploring, which is why it's nice to have the extra money, because if it doesn't work, it's not mainline funding and everything doesn't fall over - you could say, well, it's also a recognition that perhaps they'll never be in a good position to work with just a small care group. Clearly, places like Lambeth, Haringey, Nottingham, Sheffield, Birmingham, have got to be able to produce culturally competent services. The statutory services can't duck out of all of it. But are there niches where a well set up service, working in contract, to agreed standards, can actually do something a bit different and produce a service that very untrusting users will actually trust and use?' (National health policy lobbyist)

In the course of my research, I encountered one project that straddled the boundary between voluntary and statutory. Employing an outreach worker in the voluntary sector and a mental health professional in the statutory sector, the project sought to bring both worlds together:

> 'What [location] has a philosophy of ... not segregating but integrating, and they don't want to set up separate services. And I can see that. It's the way forward. But also, an idea behind that, we're a multi-cultural society. We need to be able to work with everybody, black or white. Every individual has a culture, and has differences, and those differences need to be looked at. And we need to gear ourselves to actually meet each individual's needs. And that means black, white, Irish. And that's the philosophy that they use. But when it comes to services like ours, we are treated as a specialist service, because we provide a special service, you know, which includes, incorporates all this need that an individual is expressing. We're not seen as a ... part of the mental health team, based within the mental health team ... and having, given the freedom and access to all the services, and never treated as a separate service. And the very fact that we get a tremendous support from the mental health team ... to be based myself in a community mental health team shows that they want to bridge that gap and learn from each other and transfer skills to each other as well.' (Asian voluntary sector mental health professional)

This interviewee described a scheme that could access community and statutory resources equally. In effect, the voluntary body had a dedicated statutory service

responding to the needs of that community. She described a situation in which she was able to advocate from within by mobilising a constituency of her own. At consultation meetings, this mobilisation was a literal occurrence. In this approach, there appeared to be an interesting innovation, both in service provision and in accountability. Yet, most ethnic minority projects were not in such a positive situation, and it would be misleading to end this section without recognising the persistent failure of services to respond appropriately to the needs of substantial elements of the populations they serve. Nor is this failure a feature of the accounts services present of themselves.

Perceived Irrationality

The complexities described in earlier sections raise questions about the experience of users. If the processes are not simply described, how is the service received to be understood? Researching the Social Fund, two official reports (already referred to in Chapter 4) suggest the difficulty in understanding the patterns of decisions that emerge. The first, a value for money study conducted by the NAO, examined cases in a number of offices and concluded:

> 'This [demand leading to budgetary pressures] meant that, during 1989-90, although these offices met the requirement that the funds available should always be concentrated on those whose needs they had identified as having greatest priority, they were unable to treat similar applications consistently throughout the year.' (National Audit Office, 1991, paragraph 2.14)

and:

> 'The Department told the National Audit Office that these variations [in the priority level given to the same groups of applications] reflect the discretionary nature of the scheme and the requirement for local offices to establish their priorities in the light of local circumstances. In addition there were evident variations between different parts of the country under the schemes which preceded the Fund. In response to changes in the local level of demand and the consequences for their budget local offices are required to review and revise their priority lists, so as to meet the overriding policy requirement that the funds available should always be concentrated on those with needs of greatest priority.' (*ibid.*, paragraph 2.17)

It was this report that indicated some of the weaknesses of the select committee system of the House of Commons. The response of the Department of Social Security was to await the findings of a further research project it had commissioned. This, the second of the studies, was undertaken by the Social Policy Research Unit at

York University. It reached similar conclusions, identifying apparent irrationalities in the decisions of Social Fund Officers, consequent failures to meet real needs and hardship caused by loan repayment (Huby and Dix, 1992). Commenting that there was no clear way to understand the difference between applications refused and those awarded, they observed:

> 'Social fund officers are the repository of the administrative definition of needs and their decisions have a major impact on the extent to which the social fund can be said to be meeting need. Yet officers can reach different decisions about the same applications. They sometimes make identical decisions but for very different reasons.' (*ibid.*, p.86)

A Department of Social Security policy official, during the course of an interview, dismissed these conclusions, suggesting the methods employed were flawed:

> 'Looking at it very closely and in detail, as I have done, some of the kinds of factors for comparing circumstances of those who did get a payment with those who were unsuccessful were sort of ongoing sorts of circumstances like furniture, state of decoration, amenities in the household, sort of general household facilities. It was difficult to relate those ongoing circumstances, background circumstances, to the need, to the specific item in question which might of course be a cooker for example, or some expense like that. That would have no relation to the ongoing circumstances. So the person whose flat or house is in a very poor state of repair, didn't have much in the way of furniture and so on - their cooker breaking down, they are just as likely to get the cooker breaking down as somebody who has an established home. But the person with a well established home would still need a cooker. So these background circumstances, they kind of I think lead SPRU [Social Policy Research Unit] down the wrong alley. There was a huge input from policy group in agreeing the questions in that research. But even so between us we weren't able to quite hit it on the button to be able to monitor need and payments and get it to the people who really need it.'
> (Department of Social Security policy official)

The failure to place decisions in context has already been noted. What emerges from these remarks is a view of the Social Fund as entirely divorced from any context as a matter of deliberate policy. The absence of a cooker may be equally pressing for two applicants. The absence of resources with which to purchase a cooker is, however, clearly more pressing for the applicant with little else. The failure, even refusal, to recognise background circumstances is stark.

Evidence suggests irrationality remains a key characteristic of the Social Fund. Discussing with colleagues the experience of exercising discretion in a consistent fashion, one Social Fund Officer observed:

> 'That's the hardest thing about decision-making, isn't it? It's discretionary, and no two cases are the same. But on our shoulders is the fact that we're supposed to be consistent. There's ten of them, and we're supposed to be consistent. I don't know what's going on inside your [colleagues] heads. We communicate with one another, and we discuss cases, but you don't know what's going on in someone else's brain all the time. So I think it's really difficult being discretionary and consistent.' (Social Fund Officer)

A Social Fund Inspector, commenting on the differences she had observed in the cases she dealt with, commented:

> 'The system isn't fair because different parts of the country have more or less demands on their budget. It may well be that people in North Worcestershire can have anything they ask for at the moment providing they can afford to repay the money and their debt isn't over £1,000. Whereas parts of Scotland you can barely get a cooker. When we look at things like exceptional pressure, if you are dealing with a case like a Scottish case where maybe 60% of families are lone parents with lots of children living in poor accommodation, you do sometimes see a Social Fund Review Officer will say, "oh well their situation is no worse than every other family in this area." So they tend to say they are not under exceptional pressure. Rather than saying everybody living here is under exceptional pressure, or anybody in this situation, overcrowded, 6 children, lone parent, health problems, damp accommodation. They would say that's the norm, instead of saying that's exceptional pressure, now we are going to look at the priority of it. They think its easier to say nobody qualifies rather than saying, ok they do qualify but we just don't have the money, so we can't pay these.'

Effectively, this is a form of gatekeeping, similar to the redefinition of CPA levels noted in an earlier section. Commenting on the nature of discretion, an academic with a substantial record of research on the Social Fund remarked:

> 'The unpredictability relates to all sorts of things, like the time of year, the time of the month and, of course, issues of personal prejudice and all the rest of it. Did they have a bad night last night? Is the claimant black? I have seen people have their Social Fund applications torn up in their face by officers in [location] as it happens.' (Social policy academic)

Similar views were expressed much more explicitly by user advocates:

> 'There's another thing. If you've got a foreign sounding name you are less likely to get an award. We all know that.' (Welfare rights advocate)

Whether this is true is difficult to know. But what it does illustrate is the consequence of apparently irrational decision-making. In one sense, the key question is not whether discretion is tainted by racism and prejudice. As important is the fact that it is hard to demonstrate that decisions are not affected by the individual biases and preferences of decision makers. Referring to studies undertaken by the Commission for Racial Equality, in conjunction with the Benefits Agency, one

lobbyist commented:

> 'They found a considerable degree of discrimination, just generally across the board in the delivery of benefits, whether you were likely to be ... there was a delay, whether or not you were likely to have fraud brought up in association with your claim, and whether or not you were likely to succeed in the area of discretionary benefits.' (Social policy campaigner)

The Department of Social Security and the Benefits Agency, however, will not undertake ethnic monitoring.

Given that discretion is part of the Social Fund, some variation can be expected. The problem arises when trying to account for the variations, to expose them to external scrutiny and to explain differences to users, whether they have been awarded or refused assistance. It will be fruitful, at this stage, to dwell on an account of one couple's experience of discretion:

> 'One I've got, which is ongoing, which is someone paying his hospital fare to go and visit their daughter. This has been going on for eighteen months now, and they have to apply every three months. I think I've done five reviews so far. I think only two of the awards were all right. Each person makes a different award and decides for this three months it's all right for mum and dad to go four nights a week. Then the next person decides, no, only dad needs to go one night a week, or mum two nights a week. Same case. Nothing's changed, and you never know what decision you are going to get out of it. The last time, they refused it on the grounds that they're asking for an excessive amount of money, that it wasn't reasonable. And they were asking for the amount of a weekly travel card. I can't really work out how that would be unreasonable, because that's the cheapest way of getting there. It's just one example.' (Welfare rights advocate)

There are a number of illuminating elements about this one story. From the perspective of the claimant, and of the advocate, the variations appear irrational. Indeed, the advocate believes that there was one 'right' award. The problem is that different Social Fund Officers fail to come to that answer. The review process becomes a means of getting that 'right' award. This perspective on the Social Fund argues that, because the circumstances of the applicant have not changed, the decision reached should be the same. However, other factors may have changed, particularly the state of the budget and the priorities being met on each occasion. It is quite conceivable that, from the perspective of Social Fund Officers, each of the different decisions appear to be 'right' in light of this changing context.

The nature of discretion is exposed in this one account. The potential for variation in

the treatment of the same case is clear because we are able to compare a number of applications for the same item from the same couple. It also throws up a number of dilemmas and questions. The two different perspectives on the series of applications are nowhere reflected in official accounts of the Social Fund. Statistical data presents the number of applications, number of awards and average amounts awarded. Such a summary would suggest consistency rather than variation, in effect presenting a misleading, if not actually false, account. In what sense, then, does the Secretary of State's annual report discharge accountability?

Furthermore, an applicant, making just one approach to the Social Fund, would receive one decision. Without any form of comparator, how is that applicant to understand the decision made? Publicly available information provides no basis on which to understand any single decision. If the couple, in the account presented above, made just one application, would they be in a position to understand whether the decision was 'right'? The response of individuals refused assistance for items can be incomprehension. The following is an extract of a conversation between two welfare rights workers discussing one particular case:

> **A** 'I think it was a payment to set up a business, I can't remember. I've got it in my drawer. Because it wasn't excluded, the Social Fund Officer couldn't say it's an excluded item. They kept telling him it was a low priority, but he kept writing in and questioning it. There's definitely a communication problem here. It's a book, isn't it [the file of correspondence]? It literally is a book, and we couldn't work out why it actually went that far. And because of the way the wording of the regulations are, that what he was actually requesting wasn't excluded, but it was something he was never going to get paid for ... I never thought about that until that happened. I thought it would be very apparent to somebody that they couldn't have a payment for that item. Unless it's in the list of exclusions ...'
>
> **B** 'Yes. When you tell people about the budget, the office is given a set amount of budget and they can't spend over that in a year for grants. It's not something which people ever get from the forms they are sent by the Social Fund, so you never really know why you've been refused. People don't really understand why they've been refused, because the letters don't say you do not meet one of the conditions, or you do not have sufficient priority. It doesn't actually say anything, so you have to explain to people about the budget and how it works.'

The sum of the complexities that underlie the exercise of discretion, so simply represented in formal accounts, is not easily communicated to individuals. Rather, the impression is of a service that simply fails to meet that individual's needs and, thus, fails in its very purpose.

Reflecting on this problem, a number of respondents remarked that, while applicants and their advocates may see irrationality as failure, the Department of Social Security viewed the Social Fund differently:

> 'I think the view, as stated before the Select Committee, Sir Michael Partridge, you know, when he was Permanent Secretary, his view was the Social Fund was working very well. I think it must have been just a departmental review, one of those sorts of meetings, and I think that ... The thing is, if you are looking at it in terms of DSS policy people, it is working well.' (Welfare rights advocate)

Essentially, a system exists to meet unforeseen needs, but the key determinant of its success or failure is, from the Department of Social Security's perspective, financial:

> 'If the objective is, as consecutive Secretaries of State said, is about helping the most vulnerable in a flexible way, I think the jury is out. And I would say, prove it. What do you mean? In that sense, I don't think the Secretary of State has been accountable for the Fund. I think he's been accountable for ensuring that a limited budget was spent within a few per cent, and indeed it wasn't even spent within a few per cent in the first year.' (Social policy academic)

This is a very limited conception of success given the aims formally stated for the Social Fund. In essence, reports confirm that, of the five objectives identified by the National Audit Office (1991, para. 1.5), only the first, the requirement to contain costs, is in any way reported upon.

Accounting for Discretion

The accounts presented in the past two chapters illustrate the problem of understanding discretion in a simple fashion. In each case study, an array of factors affects individual decisions. Managing these factors, and the different ways in which they might combine in any one particular case, is at the heart of understanding the outcomes in each case and of the services as a whole. Among the factors that influence the way discretion is exercised are the mechanisms of accountability. Financial constraints, legal requirements and priorities both influence and are used as a form of account for discretion. The limits on the actions of Social Fund Officers, of health commissioners and of clinicians are used to describe those actions. Returning to the simple diagram presented at the start of chapter five, three of the bounds to discretion are used to illuminate the 'black box' of decision-making. The fourth, the account of the applicant or patient, is omitted from formal accounts. While this may be for entirely practical reasons, in that these would be difficult to capture, at the very least it does suggest that the accounts presented are partial. Partial in both senses of

the word: incomplete and biased. This incompleteness is reflected in the following chapter, in which are presented the reflections of interviewees on the value of formal mechanisms of accountability. However, it is worth noting the way accountability systems present one side of the story, the deliverers' side. Not even the full picture of the deliverers' side. Rather, they present summarised data that serves organisational objectives of control. Policing the boundaries to discretion is not to give an account of that discretion. Policing those boundaries is the function of management.

While this discussion of discretion has been pursued in some depth, it has not been for its own sake. Rather, the purpose has been to illustrate the need for a critical reappraisal of what we understand by accountability for public functions such as the Social Fund and mental health commissioning. Processes of accountability are central to an understanding of these services, but that understanding is limited by the current forms of accountability. The accounts of interviewees present images of worlds not captured by current forms of accountability. The bringing in of these accounts, of advocates and even users and beneficiaries, creates an opportunity for accountability to become reflexive, challenging the current passive and mono-directional models.

CHAPTER SEVEN:
REFLECTIONS ON FORMS OF ACCOUNTABILITY

Throughout, interviewees were asked to reflect on the forms of account currently given and to consider their value. In this chapter, the views and criticisms of these forms of account will be presented in the form of discussions focused upon key accountability mechanisms.

Performance Reporting

Central to current concepts of accountability is the notion that performance can be reported upon, compared and managed through indicators and targets. The preceding chapters have suggested some of the complexities that lie beneath the simple numerical forms of account presented. It would be simplistic to suggest that there was not a widespread recognition of these problems among those interviewed. Indeed, even policy makers were alert to the difficulties. Commenting on the high profile waiting list target applied to health authorities, one official remarked:

> 'Yes, the first flaw in that is that it is rather a misrepresentation of what the health service does. I mean if anybody thinks you can measure quality just by seeing how long you wait, then I don't think that's a very good measure of quality especially if you include, in terms of quality, clinical effectiveness. And it's not a very good measure of the NHS either. So it is a bit unfortunate that that's all that appears in the news as, you know, that the NHS is meeting its targets or whatever.' (NHS Executive policy official)

Similarly, policy and procedures teams at the Benefits Agency headquarters had a clear understanding of the weaknesses of current forms of indicators. When asked what consideration had been given to the question of assessing the extent to which needs had been met, one official responded:

> 'If you go back to what you said about some kind of PI [performance indicator] or percentage figure, then if you think in terms of what that is actually going to say, then it will become almost worthless, because you could have a situation where five of you in this room could come to me time after time for some kind of a loan and I could knock you back. Then you could have a situation where I decide to give two of you something, and each time you come I give you a little bit. If I tell you time and time again that I am not going to give you anything, eventually you will stop coming, but your need is still going to be there. So in districts where the demand is managed more efficiently, then that doesn't necessarily mean that they are meeting the need, it just means that, to go back to legitimate demand, the demands are not being made. So what would be the percentage indicator, in terms

of the Social Fund is addressing national poverty on the basis of its meeting 75% of it? That's a fantasy island kind of figure because you are never going to get that. All we can say is that of the claims we actually handle, we pay a certain percentage, but what that percentage is in reflection to society as whole, that is something we cannot capture.' (Benefits Agency policy official)

These two responses identify the same weaknesses in indicators, that is their failure to reflect key aspects of each service. In the case of the health service, waiting lists fail to reflect any sense of the outcomes achieved or of the very purpose of the health service. In the case of the Social Fund, targets reflect numbers processed and assisted rather than the extent to which genuine need has been addressed.

The accounts in the last two chapters have suggested, on a number of occasions, the impact that targets can have on the way in which services are delivered. A number of examples indicate that a concentration on the speed with which a case is processed can mitigate against the proper consideration of that case. Similarly, practitioners were alive to the consequences of performing to meet targets:

'It's [waiting lists] the other way of husbanding resources. Although, once the waiting list becomes established, then in fact all you've done is secure a non-recurrence of the ... And once the centre start using the waiting list as a performance measure, that measure actually becomes of no use, because you actually ... It has been used, over the period of the health service, as a way of prioritising within specialties, where inevitably those with less clinical priority wait longer and longer. But, since the early '90s, when national waiting times were being controlled and, more recently, the attempts have been made to reduce waiting lists - and it will happen, because it is a political imperative - that no longer operates, and people are required to operate on lower clinical priorities cases because they are reaching the national guidance charter guarantee level. But I don't want to make a big thing about it. That's just life, and we operate within a political arena, and certain things have to happen which you couldn't justify in any other way than it's a political imperative.' (Health Authority Director of Commissioning)

Waiting lists not only fail to reflect the complexity of the services provided, they also distort the way in which those services are delivered by altering priorities in ways that might not be considered desirable were they clearly understood. A form of account intended to report the way in which local management flexibilities and discretion are exercised not only fails to do so, but actually limits the discretion available with repercussions for other aspects of the service:

'Well, I think while waiting lists and emergency admissions are the must-dos, there isn't anything, any time or resource left for anything else. And the health

service don't take their health responsibilities as seriously as their responsibilities for balancing the books.' (Health Authority Director of Public Health)

Focusing actions on the achievement of certain performance priorities will work to the detriment of others, particularly those not readily reflected in indicators.

These reservations about targets were expressed by many user advocates. Their impact is to be found in accounts presented in the previous chapter. Reflecting on the value of the information presented in formal reports of services, a number of more general observations were gleaned from interviews. One interviewee reflected the distorting effects of numerical targets:

'I haven't got a problem with accountability. I've got a problem with accountability that distorts, that actually creates environments where people are saying I know I need to do that, but I can't because the person above me has asked me to do this, and this is what counts. All you need to know about accountability is to go to a project officer's meeting on the Single Regeneration Budget. And what are they talking about? The size of their budget compared to the size of the budget in [location]. Their committal rates. How many outputs? People are not mentioned. We don't talk about impact. We don't talk about the way that we're changing things through delivery, or what we're aspiring to change as a result. Everything's got reduced to saying "mine's bigger than yours. I've got more money, I've got more staff, I've got more resources." Not "this is what I'm doing with these resources." ' (Community regeneration project manager)

Targets hinder the actions of those working in services, while being also the currency for discussions about those projects. This account illustrates the way the boundaries to discretion, such as budgets and outputs, limit the way in which freedom is exercised while also being utilised to demonstrate that it is being exercised. As such, targets reflect priorities other than those the services are intended to address:

'Going back to your question, I am critical of the information in a sense. There are structural problems, because the information is fundamentally geared towards the production of certain kinds of output which are aligned to financial targets and I don't suppose that the information exists that can tell you much about the needs of the population in a particular area, which is what it ought to be able to do.' (Social policy academic)

Other respondents suggested that there was some value in targets, but that these were not those ascribed to those targets:

'The indicators do not necessarily show a true picture, and that's a danger with them, but what they do show is data on the management of the service, and for those overseeing the management of the services, they provide food for thought,

questions, pointers to critical issues which need to be explored further.' (Member of Parliament)

Indicators can act as a management tool, the prompt to ask further questions, but are inadequate as indications of performance. In effect, 'tin-openers', those targets that can act as a prompt for further investigation, are frequently used as 'dials', as simple indicators of performance (Carter, Klein and Day, 1992).

Reports and Accounts

If the performance information presented in reports was deemed to be flawed, the reports in which they appear were subject to almost universal criticism. In each case study, numerous documents are published, locally and nationally. Interviewees were asked to reflect on their value and the use that might be made of them. Even those responsible for their production were surprisingly cynical:

'One wonders what people actually do, what the reader of these appropriation accounts actually does. Reader rather than readers. The sad man that reads these accounts. That's not quite true because C&AG get them and there's accountability through the PAC and all the rest of it. It is right and proper that they are there.' (Social security finance official)

While necessary as part of a system of financial accountability, appropriation accounts provide little information of value to an audience beyond the confines of Whitehall. Reflecting on the Secretary of State's Annual Report on the Social Fund, one interviewee expressed similar views:

'I used to ... I forget what I've been doing in the past. It's a very bland little publication isn't it? It really tells you very, very little. In terms of what it reflects back to us, of what's important about ... and what we get through the [organisation] about the Social Fund ... it doesn't really tell us very much. There are no regional ... Yes. It is very dispiriting, isn't it? What's happened is they've become very routinised, and the whole area has become ... our response is routinised. Our response is to put them in the files. At the time when I really scrutinised them, I suppose ... it's all become a bit sort of flat.

'It's interesting because, of course it was an area where at the start there was a lot of public interest. A lot of interest in local organisations, a lot of real keenness to see how it would work. And I think all that, ... people have just ground down really. It just happened, and that's it.' (Welfare policy lobbyist)

The reports not only fail to reflect the experience of welfare rights advisers and advocates, they have become routine and provoke a routine response. But, in the opinion of the Department of Social Security, accountability is discharged.

The inadequacy of the reports reflects the quality of the information contained in them. It has already been noted that the performance information is of a very limited kind. Discussing what might be in a report intended to genuinely account for the Social Fund, a respondent remarked:

> **Ethnic minority rights lawyer**: 'I presume the Social Fund has got a set of standard questions. What kind of questions do you ask, if you are an interviewing officer? If you have 5 forms that all look equivalent, how do you make your [indistinct]? And it depends upon the articulacy of the applicant and the skills with which they answer, the written skill with which they fill out the form. The ability to speak English when you are answering the questions. Their manners. People who speak English badly speak it aggressively. When we go abroad, we shout when we can't ... We either shout in English or in bad French. So, a whole range of things that may influence the way that decisions are made.'
>
> **Interviewer**: 'So you need to know how decisions are made, shed a bit more light onto that. So not the current six page annual reports?'
>
> **Ethnic minority rights lawyer**: 'That doesn't tell you anything. It doesn't tell you whether the right people got it. You have no idea about whether the discretion was exercised fairly. Let alone the right amounts.'

A more sophisticated annual report of this kind might, however, raise more questions than it would answer, questions as to the effectiveness of the Social Fund in meeting needs.

There was one notable voice of dissent with this common line of criticism:

> 'Yes, they're [Secretary of State's Annual Report on the Social Fund] quite useful. Though interestingly enough, when I was doing the Social Fund briefing, I got [name of the local MP] to ask a Parliamentary Question to tease out the number of loans that were converted into grants. The Social Fund annual reports are pretty vague and bland. I mean, I think actually these Directorate Reports [produced by the Independent Review Service for the Social Fund] that are coming out, quarterly performance reports, might prove to be quite useful. And the interesting thing is they do seem to be publicly available. I think those are quite good. They are also useful for feeding back to staff here who know then what should be happening. So it's another means of challenging the decisions, saying, you know, we understand that you've agreed to do this. But you still have to keep on top of it. Eighteen months, two years almost weekly hassle on the Social Fund and you see a slight movement and there'd be a lull and they'll do it again.' (Senior local authority welfare rights worker)

The Directorate Reports referred to were, at the time of the research, a relatively new innovation from the Independent Review Service. Produced quarterly, they provide details of the reviews referred to the Social Fund Inspectors, commenting on

standards of decision making and any common errors in each Benefits Agency District. As such, they provide the basis for challenging individual decisions that fail to conform to the standards being laid out in the reports. They also provide a means of understanding what kind of decision might be anticipated in any one particular case. There always remain financial pressures that might alter particular decisions, but by presenting some information about the 'rules of the game', the reports might make these factors more transparent. Unfortunately, the Directorate Reports were not widely in circulation at the time of the research, and the interviewee cited above was the only one aware of them. Nor do these reports form any part of the formal systems of accountability, being an innovation beyond the formal remit of the Independent Review Service. Nevertheless, they begin to illustrate the potential for a form of reporting that begins to answer some of the weaknesses in the formal annual reports.

Health authority reports, produced with a local audience in mind, while more widely read were not regarded highly, even by the officials producing them. Commenting on the Health Improvement Plan, one interviewee remarked:

> 'We have written our HIMP and put it out for consultation. What's changed? It's just like the old purchasing intentions, or whatever it was a couple of years ago, all fairly meaningless and high level. You say all the right things, get all the jargon words, make sure that you mention inequalities in every paragraph, joint working, partnership, all those kind of words. But what's changed? That will probably get the boxes ticked, but I don't think it's what we're all about.' (Health Authority Director of Public Health)

From the same health authority, similar views were expressed about the annual reporting system:

> 'I have to say, we don't make as much as we could of annual reports. And I think, in some ways, I don't mind that because there's a whole range of other areas that we fulfil our accountability. In some ways it's sad, I think, that it's almost regarded as a chore and I think ... I do welcome the fact that we have to produce an annual report. I mean, that does concentrate the mind a bit. But it is balancing priorities really. It sounds like I'm making an excuse. I don't think it is. I would rather have an ongoing accountability that says, right, in April I'm going to produce that report on mental health services and share it with the local community. In June I've got another one on orthopaedics, and in September etc, etc, rather than just concentrate on two weeks in a year where everybody panics and says, right, there's my bit for the annual report, and can I have your bit, and have you handed it in? There's no point in doing it.' (Health Authority Chief Executive)

The role of the annual report, in this account, is a routine, the only value of which is that it focuses the minds of health authority staff for two weeks a year. More useful are other forms of accountability. Reports might take a more useful form if they were to be published throughout the year, concentrating the minds of staff on different issues and themes throughout the year.

A simple review of the annual reports for all health authorities in the NHS Region studied reveals a wide variety of styles, of content and of depth. As such, they do not even readily allow for comparisons to be made from one to the next. A similar situation exists in respect of NHS Trust annual reports. Almost the only common data is financial and high-level performance information, alongside declarations of interests for each member of the boards of each organisation. A further report is published for each health authority, an annual report by the Director of Public Health. Generally more informative, containing detail about a range of indicators, often identifying variations within individual health authorities, these reports do not play an integral part in health authority accountability:

> 'The fact that it [annual Report of the Director of Public Health] had to be produced is an accountability thing, I suppose. But it isn't a Health Authority document. It's an independent document which is presented to the Health Authority, but it doesn't tend to form part of the performance management process. I mean the fact that it is written is as much as the Health Authority are interested in, I suspect.' (Health Authority Director of Public Health)

That they are so clearly separate from the formal reporting channels is further indicative of the difficult position in which public health sits within authorities. Perhaps it also further illustrates the points made earlier with respect to performance indicators. The role of the health service, raising standards of health for whole populations, seems to take a back seat in relation to other objectives.

Asked whether she read the reports produced by the local health authority, an interviewee responded:

> 'No. You see, I'm actually, you know, on the practical side with these people, and there's nothing there for the ethnic minorities. What is the point of reading reports, because reading them is like putting it on paper? It says we work in partnership with so-and-so, and so-and-so. But what have they actually done?' (Voluntary sector Asian mental health worker)

Expanding on a similar point, one service user suggested that the reports do contain some value, though it takes some work to uncover it:

> **Mental health service user and advocate**: 'It is a bit much for all of us to read all reports. It is a bit too much. So we do try to make sure that one person does something in-depth and the rest of us just have a quick flick through, take the main points. It's amazing how many times the person who's sort of dealing with it in-depth brings up something that makes your notes look a bit ... you know.'
>
> **Interviewer**: 'How useful do you find them, though?'
>
> **Mental health service user and advocate**: 'All in all, not very.'

For a small voluntary group to simply read all of the reports, consultation material and other literature represents a considerable investment of time for very little return. Yet local reports have more value than the annual reports of the Department of Health:

> 'I don't take any notice of those. This is something I've basically realised, with the exception of local ones, the constituency, the annual reports are irrelevant. Nobody takes any notice of those.' (Member of Parliament)

This remark was made by a relatively new MP, getting used to finding information from the volumes passing through her office. A more experienced MP was even more sweeping in his condemnation of the information produced by the Department of Health:

> **Member of Parliament**: 'I'm going to two meetings tomorrow with UNISON, the health service union, and I have a permanent dialogue with UNISON on these matters. If I want to know about issues like that [variations in service], I go and ask UNISON and they put the word out to the regions, get them to find out. They come in here every month, and I go to their meetings, and we meet and we discuss these matters.'
>
> **Interviewer**: 'Not the Department of Health?'
>
> **Member of Parliament**: 'I go to UNISON. I would regard that as more reliable. They will do the statistics. They will tell me of developments, because they've got researchers doing it all the time.'

He explicitly turns to those with different accounts of the health service for reliable information. As a form of accountability, the reports do not even address the needs of the MPs interviewed.

Parliamentary Accountability

If departmental annual reports do not, in the view of the MPs interviewed, adequately fulfil their role in discharging accountability to Parliament, Parliamentary Questions and debates are even more problematic. The analysis, presented in Appendices 3 and 4 and discussed in Chapter 4, of parliamentary questions on the Social Fund indicates the political nature of questions. This evidence was supported by interviewees:

> 'Inevitably, in a parliamentary system as polarised as ours is, I don't think it's primarily the role of government backbenchers to make life difficult for the government through parliamentary questions. In a sense we are much more powerful because we can make life much more difficult behind the scenes, and people do. If people are unhappy about things, there's a lot of private lobbying goes on, and all the rest of it. Other than the sense of catching people's eyes, sort of thing, it's a game to find a weakness and to drive the spear behind it as it were. I don't think that particularly useful except in one or two contexts. I think when it doesn't relate directly to services to the country, like foreign affairs and questions of general probity, dealings with the intelligence services, things like that, you can see why that is very important. But if it is how well are we doing in the health service and the education service, I think there are many better ways of holding ministers to account, by select committees and having to respond to select committee reports, there having to be debate about these things, there having to be follow up and then there having to be much clearer monitoring about what's going on. It is sad. I don't know how much the select committee reports are read.' (Member of Parliament)

The peaks in the profile of Parliamentary Questions in Appendix 3 were, in large part, driven by opposition MPs seeking to expose the inequalities from one constituency to the next. Appendix 4 also illustrates an attempt to 'drive a spear' behind the armour of 'disproportionate cost' responses. This limited role is in contrast to the potential value of select committee investigations and reports, however poorly they are read. Of the MPs interviewed, one had asked a particularly interesting question in a witness session held by a committee. She had sought to push the witness on a point about the need for accountability to take specific forms for specific services:

> 'I didn't get a very satisfactory answer, I don't think. I think sometimes you have people in and you expect them to have actually thought about some of these issues, particularly someone in his [the witness'] position, for whom it's been quite an important element of his work. You don't really get the kind of reflective thoughtful answers back that you would expect to get.' (Member of Parliament)

The weaknesses of the committees, their powerlessness in the face of the executive, has recently been picked up by two Liaison Committee reports (2000a and 2000b). As was noted in Chapter 4, even the Committee of Public Accounts, often cited as the

most powerful Parliamentary committee, was powerless to force through changes to the Social Fund.

But MPs do have a role representing the interests of constituents in a number of ways. Dealing with complaints against the actions of public bodies is a key one of these. Each of the MPs interviewed was sceptical about the formal channels for resolving complaints:

> **Member of Parliament**: 'The ombudsman's hopeless. Absolutely hopeless.'
>
> **Interviewer**: 'Do you use him?'
>
> **Member of Parliament**: 'No. No, I correct myself. I attempt to use him, and then invariably find that because of this, that or another technicality, they are not responsible. Or they spend 3 years gathering more information.'

The slow, deliberate processes deployed by the ombudsmen have often been criticised. Other avenues are both swifter and potentially more lucrative for the complainant:

> 'Don't know about it [the ombudsman]. Don't use it. I leave that to my secretary. I haven't got much faith in all that kind of thing really. I mean it's going through the motions. It's like complaining about solicitors. I had a case. I did take it to the ombudsman. I went to [location], picked a lawyer and we won over £2m for one of my constituents. I never really muck around with these people like that. In my view, I look at it and if I think they've got a case... I'm not saying I haven't taken a case to the ombudsman, don't get me wrong. But my secretary would do that. I just don't have faith in those sorts of things, really. They write nice letters, but they don't actually get into the meat of things.' (Member of Parliament)

This bleak, if confused, image of the ombudsman was widely shared among the user representatives interviewed. Rather than a route for resolution, one identified the process as a threat that might influence the handling of complaints at a local level:

> 'I think it's quite ... In terms of accountability, I think it's quite important that both the local authority and the Trust know that ultimately an organisation like us would go to the ombudsman.' (Mental health service user advocate)

In both health case studies, scarcely a case has been taken to the ombudsman in recent years. In the case of the Social Fund, there is little that the ombudsman is able to question and, as a result, he has scarcely had a role to play.

Reflecting on the role of an MP as advocate for the interests of constituents, the following remarks are particularly telling:

> 'When I came here, I very rapidly - I've only been here a year - discovered that people thought the chamber was really an important ... I mean you get a much stronger sense of this from being within, and the processes of the select committee and all the rest of it ... But actually, my view about it is that we don't have very good mechanisms for holding people to account, and that actually most of the holding to account here is done by the mechanism of picking up the pieces, often very much subsequent to the event. And I actually think that that is pretty useless as far as people are concerned. I mean, I have my own views about these things. I tend to think about it and I have my own views about it. My personal view about it is we ought to put more effort into getting things right, and that that is a more important sense of what accountability is than it is actually for somebody to come along several years after the event and being able to get some limited redress for something which is by then history and unalterable in a lot of cases.' (Member of Parliament)

Like many mechanisms of accountability, redress for aggrieved users occurs too late. Where services are intended to meet the needs of vulnerable people, the delays are particularly acute. Resolving problems swiftly and locally, ensuring that services reflect the needs of applicants or users, represents a more effective form of accountability in such circumstances.

Complaints, Reviews and Tribunals

In recent years, the role of complaints processes has been emphasised and expanded. In part, this is due to the undertakings often included in Citizen's Charter statements. But some have also begun to recognise the value of complaints as a form of management information, an indicator of problems and issues that should be addressed:

> 'We encourage and expect health authorities and Trusts to evaluate the complaints by looking at the issues. And some do. We know that some do. Some don't. Evaluating what the complaint is all about and recognising trends is a worthwhile thing to do, but it's not a high priority for a lot of Trusts who are trying to deliver a service with all the pressures they've got. But it's all very much, which is why this branch is here, it's all about patient partnerships, going out there and listening to what patients have to say, feeding back in the loop - listen to what they say, do something about it, and then you tell everybody what you've done about it and record it in your annual report.' (NHS Executive policy official)

If handled well, complaints might also avert other actions by aggrieved complainants. With the increasing recourse to medical litigation, this is no small benefit:

> 'We generally believe that if something's happened to them, people want an apology, want to know why it happened and want to know that it will never happen to anybody else. I think most people would want that. We can't stop people suing doctors and we can't stop people taking everything under the sun to the ombudsman because that may be just how it is. But most people, we think, would like to have an apology, understand what happened and know that it will never happen again - people learning from their mistakes.' (NHS Executive policy official)

However, whatever the advantages might be, the response to criticism is often defensive, refuting charges rather than listening to the points being made:

> 'The difficulty with the NHS as an organisation is that it operates in a huge blame culture, and it's very hard to get the NHS to look at complaints as qualitative messages about our services, to use them to improve our services. It's very difficult. And a lot of that is tied up with how NHS staff feel about themselves and their job - whether they feel valued or not. I'm sure you know all the stuff.' (NHS Executive policy official)

Equally, handling complaints badly can have adverse consequences, presenting the impression that concerns have not been properly addressed and that a standard apology has been issued as a sop:

> 'The outcomes [of complaints] are getting better, and that's partly because we ... early on ... You get into this quite absurd situation where you start making a complaint about the way complaints have been handled. One of the points that we found service users were very unhappy about was if they thought that their complaint hadn't been thoroughly, really seriously looked into ... That was something that people really found ... When you would get a short paragraph back saying we're very sorry that this happened. No actual examination of what the substantive issues were.' (Mental health service user advocate)

The experience of interviewees of complaints and formal legal challenges suggest a frustration as much with the response to a challenge as with the initial grievance itself. Before progressing to these cases, it is worth emphasising that in all these cases, an advocate was involved, in the form of the interviewee. The response of users unassisted by advocates can only been seen partially through these accounts.

The response to challenge most often encountered from health professionals and institutions was defensiveness:

> 'I've had all sorts of reactions to my intervention. Some, at first, are quite defensive, but if in the way that you challenge you put the point that all you're trying to do is obtain the best service for your client, they tend to back down a little bit, and try and say "well let me see what I can do." Some outright will just tell you that they just don't have the time for that, but they realise that government directives are saying advocacy is the way forward, and you will get advocates

coming in. Some of them are changing their views, but what we find is a lot of the statutory services, sometimes social services, are very challenged by the term advocacy and by the fact that they've a client who they'd normally be able to speak to and say "well, this is what they want", now has got somebody representing them who is quite *au fait* with what their role is and what the client should be getting, and the Mental Health Act in general.' (Mental health user advocate)

Where advocacy work is conducted in other organisations where the role of user representatives is not being pushed as a matter of policy, the reaction is more straightforward:

'I tried, early on, to develop some advocacy work in private residential care homes, and it didn't ... They found it very hard to tolerate challenge at any level.' (Mental health user advocate)

Others might see the benefits of dealing with complaints through an experienced and informed advocate:

'In terms of GPs, some of them have given me good comments, and I've got a letter from another GP saying how much easier it was to communicate with that particular patient now that they have an advocate. Because in situations where the client would become quite frustrated, because they didn't feel the doctor was really understanding them, we discussed what the issue was beforehand and actually established a plan of going to say to them this is what I want, this is what I'm not happy with, rather than going in and shouting and screaming and then being removed off the property, or being taken off the list. And as you know, GPs are not required to give a reason for why they take you off the list anymore.' (Voluntary sector mental health professional)

The purpose of advocacy is, in some respects, to give a service user confidence in their own capacity to challenge and argue their own case:

'It opens a channel for communication. You've got a user who's normally quite dis-empowered, and in a vulnerable situation, and who also may have had very bad experiences of the health service, and specifically mental health services. But if they've got somebody, sort of almost in their corner, just there to support them, sometimes you don't even have to say anything. It's just about being supportive and being there with them. You find that they will be able to, quite eloquently, declare what they want.' (Voluntary sector mental health project worker)

The position of individuals, unaided by advocates, is an issue to which we return after some accounts of Social Fund Reviews.

In chapter five, a number of Social Fund Officers were cited saying that information was key to the exercise of discretion. The important element of the review process

was the acquisition of further evidence. This was also the impression of welfare rights advisers:

> 'It's [the review] usually reconsidering it [the application]. We don't usually bring much fresh evidence because, to be honest, if there was fresh evidence that we knew about or the Social Fund didn't, we'd let them know. Although, interestingly enough, the importance of actually sitting down with someone and having the time to do it, fresh evidence can emerge, even that I haven't got from a client. And we'll uncover things that neither of us knew. I think, having criticised Social Fund first tier decision-making, I think in the context in which that application takes place, you ... A client will very often not do themselves the best service. Most of them think "it's a loan, why can't I have it?" They don't think they have to justify their case. The vast majority of people, certainly that we deal with, you'll be able to find health, disability, stress problems, none of which will have come out when they made the initial application. Although in some cases we've had some people write detailed stuff about disabled members of the family and they've still got rejected. So most of my reviews are not about fresh evidence. They are about the fact that they've been ignored or not given the right emphasis.' (Senior local authority welfare rights adviser)

The process emerges, from these observations, as a civilised discussion of the merits of a case. A discussion, cited in chapter five, described a more hostile environment, including solid benches, cigarette ash strewn rooms, long waits and highly emotional exchanges. A discussion between three homelessness workers echoes this earlier account:

> **A** 'It's amazing how many people get quite upset at the review because they're having to stress all the negative aspects about their health, their mental health and it's in front of a total stranger. And it's just amazing how often people start to break down a bit, or get a bit choked. But I have found them to be, I would say, highly successful reviews because I do encourage clients to go and I generally go with them, accompany them. In this job, and in my previous one, I find that that's where Social Fund Officers are often affected by meeting the person. And I think our job is, maybe, to facilitate that review and, kind of, bring it about that they don't end up having a slanging match between them. Which has happened, I've witnessed that. Generally just trying to be an honest broker, and hope that they can start to communicate a bit. And then often it works. And like people have said, the Social Fund Officer sometimes ups it, you know, ups the amounts. It does happen often enough.'
>
> **B** 'A very high proportion of reviews are successful, at the end of the day, if you follow it all through. I mean independent Social Fund review, and even second independent review. There are hardly any, at the end of the day, that will remain unsuccessful if you go through all those processes.'
>
> **C** 'I think one of the difficulties, and here we come back to the accountability, is, again, that this very much disfavours the unassisted applicant. People who are applying on their own resources probably won't get as far as following it to the absolute end of the trail.'

The image of applicants having to open up to a stranger again emerges from this discussion. Persisting to a review, at which a Social Fund Officer might get to understand something more of the needs and circumstances of the individual is a stressful process.

The impression left by these accounts is that appeals are generally successful. Statistics indicate that, in fact, the majority are not. Assisted by advocates, perhaps success rates are significantly improved. Unaided by welfare rights workers, the experience of accessing services is very problematic for some:

> 'We all have learnt about it [mental health] the long hard way. But, when it first hits you, you have to understand everything. All of a sudden, you know, here you are, you've got a problem. You need to understand all about mental health issues, all about social issues, social services issues, about benefits, about, you know, where you can get help. It's an awful job, trawling trying to find all the different information, gathering it together, trying to understand it, and also trying to help the person who's become ill.' (Carer)

This same carer handed to me a copy of a booklet of contacts, abbreviations and technical terms covering health, social services, employment, housing and social security. He had produced this himself as an aide for people confronting the challenge of caring for a relative while at the same time trying to learn about the public services they might need to deal with.

If just accessing services is fraught with difficulties, challenging decisions is even more so:

> 'I must say that when the [Social Fund] clients go on their own, they come away feeling it's very unfair and they feel that the people have made up their minds before they even get in there. When they get in there, they're not listened to, notes are made and things that they say aren't written down. And they are too tired and upset to fight over it. And if I'm there, obviously, I make sure things go in the notes. But generally people feel that, in my experience, that they are not treated fairly.' (Welfare rights adviser)

The frustration and powerlessness of individuals confronting professionals might aggravate an already difficult situation. These are individuals seeking assistance with financial pressures or with mental health problems. When asked whether she attended appeals with clients, one interviewee responded:

> 'Yes. Because they're so vulnerable, and they don't know the system, and they don't know what the approach is. And some of them are frightened. They're frightened to even appeal. I say no, you've got to do this. And I'll go in with

them. And it's amazing, you know, to have a professional sitting in with you in an appeal. You know, they are so different towards the individual. But if it was a person on their own, I'm sorry, they'd come out with nothing because they've got no leg to stand on, they don't know what to say, and they don't know how to approach the process, and they don't know the system, and they don't know what their rights are.' (Voluntary sector mental health project worker)

Asked to give an example, the same interviewee outlined the case of an Asian woman:

'There was one lady who was sectioned, and she goes "[name], I don't know why I'm sectioned, I don't know why I'm here." And we had to do an appeal and I had to advocate on her behalf, and tell her what her rights are and what she should do, and what's what. She had no idea. One, she couldn't communicate in English. Who's she supposed to go to?' (Voluntary sector mental health project worker)

These discussions suggest that the routes for redress and challenge are somewhat more problematic than their simple description in reports and statistical data indicate. Even advocates can find the experience a difficult one:

'At one stage we were about to take Judicial Review [on a Social Fund decision], on this one particular case, and got the [organisation] solicitor involved in the background. And then we entered into some fairly acrimonious correspondence, and I was actually accused of using people as political pawns because I didn't like the Social Fund system. Pretty personal stuff. I also got involved in quite a lot of backdated reviews. We came across quite a lot of clients who were saddled with crippling Budgeting Loans, and looking at them, my view was that, had they known - because they obviously didn't know about social services involvement - had they known at the time, they would have considered them for a grant. And I did quite a number of those, and they hated them, they hated dealing with those. We got quite a substantial number converted into grants, but, again, in a letter, I was actually accused of actually effectively getting people to request a review against their will, basically with their arm twisted behind their back. They'd allegedly ... They must have rung up a couple of people and these people said "well, no we were perfectly happy with the loan." But I never got to the bottom of that. And I had a particularly heated conversation with one Social Fund Officer who I believed was particularly problematic and it got a bit emotional then.' (Senior local authority welfare rights adviser)

The defensive response to challenge was evident even in a highly bureaucratic organisation like the Benefits Agency.

Despite the difficulties, there are a large number of reviews of Social Fund decisions, many of them successful. In mental health services, one manager indicated the low level of complaints received and suggested an explanation:

NHS Trust Manager: 'So, we get about 60 complaints a year. It's quite low really.'

Interviewer: 'I'm surprised.'

NHS Trust Manager: 'But I'm surprised and not surprised. Because we have enormous power over many of our clients. And for many of them we actually control a substantial proportion of their lives. And going back to the analogy with the school, even where I have felt very unhappy about things at my daughter's school, I recognise how much influence they have over her, and that has at times held me back slightly from making a complaint or raising an issue. So one of the things that we've been talking about a great deal on the quality side is how do we discuss it at an intermediate tier, that is predominantly anonymous, so that people don't have the fancy that it will affect their care, but nevertheless will assist us improving the services that we deliver. And I think that is potentially the most powerful area, and for us the most unexplored area. Because at an individual level it may not be that powerful, and at a complaint level again, immediately the defences are up.'

In this environment, where power lies in the hands of professionals and staff, issues and complaints may not be aired at all. It is not sufficient to have systems and channels of redress in place. The experiences recounted in this section suggest they are flawed, at least to some extent, presenting barriers and preserving imbalances in the power and knowledge between professionals and users, providers and applicants.

Openness

Studies of accountability in the NHS raise the question of openness through public discussions, suggesting it is central to the oversight of the service. While the interviews were being conducted, the new Labour government made a number of changes, requiring Trusts to open up their monthly meetings in the same way that health authority meetings had been public for some years, where previously Trusts held only annual meetings in public. In an interview that preceded these changes, one manager commented on the role of public meetings:

'There's no requirement on a health authority to hold an annual public meeting. That's Trusts, and that's an interesting point. The annual reports do seem to get read, people do seem to use them. The Health Authority meetings are held in public, which we always have done. The press attend, and we hardly ever get a member of the public, very rarely. But the press, again, are a very good vehicle of getting through to the public, and they do come to our meetings and they have been encouraged to do that. They have been cultivated, if you like, and talked to and educated by our public relations office. And so I think that is actually quite a useful mechanism.' (Health Authority Chief Executive)

It is interesting to note that this Chief Executive encouraged the press to attend, as a means of reaching a wider public. Cultivating the press, educating them in order to ensure they understand the issues, takes the place of a wider audience. Indeed, there is no mention of encouraging the public themselves to attend.

Among other regular attendees at public meetings are representatives from Community Health Councils. Experienced and knowledgeable observers of the health services at a local level, they questioned the role that such meetings play:

> 'Well, I'm an observer member of the Health Authority. It's sad. I have to say no decisions are made there, at the board. It's actually very, very difficult to see where decisions are made, and the rationale for lots of decisions. We are ... as a CHC we make our presence felt, and where we are aware that something important is going to take place, we stake a claim and say we want to be involved. More often than not we are allowed to be involved. For example, the Strategic and Financial Framework decisions, we edged our way in this time. But what amazes me is the Non-Executive Directors on the Health Authority seem less informed than we are across the range of issues affecting the NHS.' (Community Health Council Chief Officer)

The Chief Officers of Community Health Councils are also often included in confidential discussions that follow at the end of each public meeting:

> 'I sometimes get the impression that they deliberately prefer not to consult with the non-executive directors in any degree. I mean there are certain issues, not across a raft of issues, but I think there are certain issues. There was an example at the last Authority meeting where the Health Authority officers had taken a particular action in relation to a joint financed voluntary project. And I won't go into the detail of the action that they had taken, but I think it was pretty appalling, what they had done. And lo and behold, quite to my surprise, on the agenda, the confidential agenda, was a verbal report to the Health Authority of what had happened with this voluntary sector project. The acting Chief Executive did an introduction to it, and my words to him were "I know what the issue is that you are talking about, but I haven't understood a word that you have said." The Non-Executive Directors were completely flummoxed, because what he was saying ... he seemed unable to do, was be truthful about what had happened, because if he did, the Non-Executive Directors, some of whom are quite acute, would have said you can not do that as a Health Authority. You can not do that. So he put it in this circuitous way which made no sense at all. I've just received the minutes of that and it looks as though I have asked for this matter to be raised, which I hadn't. It looks as though my concerns are around the project rather than the Health Authority's actions. And you sort of think, these people are paid lots and lots of money, and either this is quite deliberate, you know, these minutes are deliberately made to read as though this is me doing this, or they're not. There are big things which I don't actually think get to Non-Execs, and when they do I think they're not put in ... put forward often in a truthful kind of way.' (Community Health Council Chief Officer)

This impression, of meetings that decide nothing, of cover-up and deception and of ill-informed participants was shared by others.

As part of the research, I attended open public meetings at two NHS Trusts. The first, a mental health Trust, was very formally set out in a large boardroom. There was a chair at the table for the Community Health Council, and a separate table, set back from the main board, for the one member of the local press present. Other chairs were available around the wall for any members of the public that might attend. I was the only one. A substantial bound volume of paperwork had been circulated to all those present, except for press and public. Despite the fact that I had rung in advance to find out the time and location of the meeting, no paperwork was available and a separate pack had to be assembled. In the pack, the Chief Executive presented a paper covering strategic developments in the Region. In addition to minutes of the Audit Committee and of the Risk Management Steering Committee, the Director of Finance's report covered fourteen pages, the Director of Planning and Performance's nine pages, of Nursing and Quality five pages, of Personnel's seventeen pages and the Medical Director's only one page. This balance reflected the discussion. Only at the end of the open session was I asked if I had anything to contribute before leaving. While I understood the issues being discussed, there was scarcely a mention of patients, except in respect of a litigation case.

The second, a community healthcare Trust, was much less formal. A small room was used, containing one large table at which everyone sat, including the public, though I was the only member present, and the press, had they attended. Little information had been tabled in advance, papers being circulated as each item was discussed. Because of my unexpected attendance, additional copies of papers were required. Each time this happened, I was offered a copy while a member of the secretarial team left to get a copy for any Directors left without. Again, the matters discussed had little connection with patients or a health service, the focus being financial allocations and Year 2000 computer compliance. However, a three-page summary of complaints was included in the information circulated. Two dated from the previous calendar year, 1998, the meeting taking place in April 1999. The numerical referencing indicated that fifteen complaints had been received in the first three months of the year. Each summarised the complaint, the process being taken and any conclusions

reached. While not the focus of a lengthy discussion, it did receive some attention. Throughout the meeting, I was included in discussions, offered clarification of some points and made to feel welcome. At the end of the open meeting, rather than simply being asked to leave, I was thanked for attending.

These contrasting experiences provide some interesting insights, not least the fact that the community service appeared more open than the institutional service. In the context of this work, and in both cases, the meetings provided little insight into issues of general public concern. While IT and personnel matters are important to the management of the NHS, they are of little immediate interest to patients or the public. Discussion seemed to be more about Directors informing colleagues of progress and issues than it was about debate and decision-taking. I could find no reports of the first meeting in the local press. While I would not claim these two meetings are representative in any sense, they do provide further illustration of the points made by interviewees about other meetings:

> 'It's a lot [the mental health team leaders meetings] ... the discussions I've been ... or the things I've sat in on are so much about are they going to be all right for money this coming financial year? So that's when I sit there and I battle away and say, well, we're a really small team. We've only got five people in the team and we get, really, a lot of referrals from the statutory services as well. There's talks about this crisis house that they're trying to set up. A lot of it's ... it's very much, I think, it's quite a systems thing. I've only been to a couple of things. They have them once a month and I've been on holiday. A lot of it's systems, like how the computer systems work.' (Mental health and homelessness worker)

I noted that in each of the meetings I attended, a closed session followed my departure. A number of interviewees suggested that simply closing parts of a meeting aggravates the perception that decisions are taken elsewhere:

> 'Just going back to the meetings. The holding of confidential meetings causes more controversy than providing information in response to requests. Because we do have a confidential health authority meeting every month, as well as an open meeting. Every month we have a confidential meeting. And there are, I think, very, very good reasons for that, and it's to do with partly when there is genuinely confidential information, but there isn't a lot of that really - all of it can get into the public arena. But it's also to do with the way ... It's the operation of a team. It's the idea of the Health Authority Board, as a team of people, need, on occasion, to speak very openly, and can't do that if they are in the public gaze. And you won't get an effective Board if it can't air issues in that way, if it's constantly thinking I can't ... I've got to wait five minutes and think how I express that point, because the press are sitting there.

'And the other quandary is about Health Authority sub-committees, like the audit committee, where I very firmly think that the audit committee must be able to meet in private because it needs to turn over every stone, and it needs to be able to ask the very, very difficult questions. If there is a possible query about something that's going on, it needs to be able to dig very deeply into it, and it can't do that, again, if it's a public meeting. But there are pressures coming from areas like the CHC for audit committees to be held in public. So I think there's a bit of a dilemma there.' (Health Authority Chief Executive)

While there may be some validity in these arguments, Community Health Councils are permitted to send representatives to the closed sessions. It is not clear that this hindered discussion in any way. Indeed, both of the Community Health Council representatives at the meetings I attended suggested that the closed session was brief and only controversial in that some staff disciplinary matters were raised. Nor did the minutes of audit sub-committees contained in the information circulated at meetings, suggest a particularly controversial discussion, though minutes often conceal as much as they reveal.

Discussing openness with health authority officials raised a further issue, the question of democratic legitimacy:

Health Authority Director of Public Health: 'You can either be in an organisation that is sort of non-democratic, and have influence in that way, or you can go back to the old days of being in an organisation that is so-called democratic where the decisions of the politicians are more important. And in those days, of course, the medical officers of health had the right to expose the political decisions as having an adverse effect on health. And, I suppose that's what most public health people feel they should still be doing. But, you have this NHS performance management framework at the moment, where, by dint of sleight of hand, Directors of Public Health are also executive directors of health authorities, where they can say, quietly, back at the health authority that this policy is against the interests of health, but they don't tend to say it at public meetings.'

Interviewer: 'So at the public meetings ...?'

Health Authority Director of Public Health: 'They are public meetings. The press attend them as proxy for the public.'

Interviewer: 'Is it that you could not speak out, or that in the longer-term interest you don't?'

Health Authority Director of Public Health: 'I think you don't because ... the whole Health Authority, you need their support to be able to exist in the Health Authority.'

The interviewee clearly confirms the impression that public meetings do not provide a forum for discussion. Whether elected local authority members would change the problem of being tied into a management team, unable to expose decisions that might have an adverse impact on public health work, is not clear. As to whether they would increase the legitimacy of health authorities, one interviewee was very clear:

> **Health Authority Chief Executive**: 'Well I think we are very accountable, actually. I think there's a huge range of mechanisms. The only thing we haven't got is direct election, which the local authorities have. But my view is that almost because they've had direct elections, a lot of the other mechanisms haven't been put in place. And when you bear in mind that the turnout for local elections is tiny, you know, 20-30%, then I actually take issue with the idea that health authorities are less accountable than local authorities in practice.'
>
> **Interviewer**: 'Would accountability be improved by having councillors on health authority boards?'
>
> **Health Authority Chief Executive**: 'No, because they are not. They are not accountable ... I do consider them accountable, obviously. But I think you run into other problems there because what were they elected for? It's this sort of indirect thing. When they are standing for election, they are not standing for election on the basis of what health service there should be, and it isn't the responsibility of local authorities to be accountable for health services. So I just think you get a confused accountability then, because when a local councillor is on a health committee, are they there as a member of the council, putting forward the council's policies, or are they there as a member of the corporate board?'

Not only do councillors have a weak mandate, a charge often laid at their door, but their role on health authorities was less than clear in the past. Rather than having democratic representatives on boards, officials preferred to secure a wider legitimacy for their decisions through other channels, principally public consultation.

Before turning to questions of consultation, the idea that Benefits Agency meetings, at whatever level, should be open in any way was not considered a relevant issue. These meetings, it was suggested were entirely about management. They did not cover issues of interest to applicants or welfare advocates. Discussions, in the previous chapter, of the movement of work between offices and of local procedures suggest this is a particularly narrow view. While interviewees might be critical of public meetings in the NHS, at least there are open meetings of which to be critical.

Participation and Consultation

From a very early stage, it was clear that the concept of consultation had scarcely penetrated into the thinking of managers at a local level in the Benefits Agency. The response, on the whole, was to suggest that there was nothing to consult over. The rules were set. The rates of payment could not be altered. So what would be the purpose of consulting user groups? In the early years of operation, the Benefits Agency had introduced Customer Service Managers responsible for liaison with local groups and other agencies, but cutbacks meant that the majority of these had disappeared by the time of this research. This was the case in each of the districts in which I conducted research. This development, in contrast with the current government's agenda of participation and user-focused public services, was remarked upon:

> 'If one thinks more strategically, and thinking about local authority anti-poverty strategies, of which I have analysed very many now, literally hundreds, the partnership arrangements that have been constructed, that are fairly typical and characteristic of most local anti-poverty strategies, ought to involve the Benefits Agency, but the story is generally a very common one - that the Benefits Agency are quite reluctant partners. There are one or two shining exceptions. But in most areas, the Benefits Agency ought to be one of the lead partners.' (Social policy academic)

Earlier extracts referred to the failure of local offices to consider properly the impact of management decisions, such as centralising functions or of introducing local procedures. The absence of any dialogue was apparent from a number of these exchanges:

> 'You've got the question, can you, through liaison, do anything about the Social Fund. Again, unless there's a very, very clear error, they're not willing ... there's not a lot they can do, I don't think. Where there have been issues, they've not been willing to ... you know, you have to be very, very persistent. Again, like the Crisis Loans, when we were having problems, they weren't letting people apply for it, it was only when that survey was done and we were able to say we sat outside your office all day giving questionnaires to everyone who came out, and this is the result. Then we had the names and addresses of people that we could tell them about. Refer to MPs, and everything. And then they have to do something about it.' (Welfare rights worker)

The perception that the Benefits Agency refuses to listen unless confronted with evidence was remarked upon in earlier extracts. Again, in an earlier example on Crisis Loans, the existence of a local procedure was denied until revealed in an independent review by Social Fund Inspectors.

However, it would be unfair to characterise all benefit offices in this way. In London, with high levels of homelessness, some good links have been established in recent years to improve the way the needs of the homeless are met:

> 'Having said that, last winter – [name] spoke earlier about cold weather shelters - in conjunction with a colleague of mine who's our field worker, and some colleagues of [name], and the homeless liaison officers for [district name] and [district name], we pulled together a big liaison meeting before the cold weather shelters opened. All the cold weather shelter providers in [district name] were there, Homeless Person Liaison Officers from those two districts, Social Fund Officers from those two districts, and ourselves from [organisation]. And that was, I think, quite fruitful. It's difficult to tell quite how much was achieved because of that. They were certainly responsive and willing to come along and hear about what cold weather shelters did. I got the feeling, again, that certain preconceptions were changed. There was a lack of understanding of quite how intensive the support given is. So the feeling initially was that cold weather shelters were about a bed, some food in the cold weather. They didn't realise quite how ... You get a far more intensive service than you do from a normal... I think that may have made a difference. They were certainly quite keen to come along and find out. But that's just an isolated example.' (Policy officer for a homeless umbrella organisation)

If nothing else, liaison and dialogue promotes understanding that might allow Social Fund Officers a useful insight into the circumstances of those they are seeking to help. But this was an example noticeable because it was unique as an example of dialogue between the Benefits Agency and local welfare workers.

In the health service, the picture is very different. Managers were clear about the importance and place of consultation in the development of their plans and priorities:

> 'We're quite good in involving the public in terms of the bidding exercise. Within [location] we've got a lot of community participation, a lot of voluntary action groups, a lot of area-based working across the city, a lot of good links with social regeneration areas, things like that. And so from round about the summer, we've been flagging up the fact that we are now moving in to next year's bids. Would they like to be involved in those?' (Health Authority Chief Executive)

In practice, consultation is not as simple as having good contacts, as one manager responsible for the process suggested:

> 'I think the problem that we have at the moment is, first of all, there's a lot of cynicism about health authority working and, you know, I find it very difficult because I've really tried to bend over backwards to consult on all this. I have really gone ...bent over backwards ... I've done a GP perception survey ahead of the action, so that we could take on board what they felt. I've been as opportunistic as I could in going around every group, any opportunity I've got I've been around to talk to people about this. And yet still you get ... People are

hostile saying, well we don't know what's going on. What's all this about? And it's a fairly complex issue area and to try and do it justice in a half hour here and there with mixed audiences, is very difficult. And there continues to be this hostility. People continue to feel as though they are not up to scratch, and whatever. And it's quite heartbreaking sometimes, because you go and talk to the CHC, the voluntary sector and so on. They all say, it's so complicated and I don't know what's going on and the health authority is deciding. You become pragmatic about it and say, well, you know, fair enough.' (Health Authority Director of Public Health)

His frustration was evident. Despite his best efforts, groups criticised the process and felt excluded from decision-making. In the second authority, the manager responsible for developing plans through consultation was more realistic about the problems of consultation:

'I wouldn't disassociate myself from that criticism of the nature of the service. We are, essentially, a bureaucratic, gray-suited, professionally dominated organisation, dealing with complex issues, and operating with a feeling that, however hard we try to consult, there won't be the people out there who will actually understand what we're doing. So, to that extent, when we say we're going to consult, and yes we do do consultation, but, really, we get very little response and find it very difficult to understand the full gamut of what we're doing. But, having said that, I don't think there's any ... I've worked in [location] for so long, and we've always been essentially a local organisation, I do know ... We've always got along with our CHC. We've never had a problem involving our CHC in all our workings, our planning groups. So they've always been involved, right from when they were established in the '70s, in our planning teams. They actually always attend our boards meetings, and our private sessions. So we've always operated in this spirit of openness, and you get the impression from other places that they fall foul of the CHC, or are fighting about things, or doing things that seem to upset the general public.' (Health Authority Director of Commissioning)

It is not simply a problem of gleaning responses from audiences, but of digesting and incorporating these responses in plans. A Community Health Council, as a formal organisation of experienced and knowledgeable individuals, is easier to deal with. They understand the limits and constraints upon health authorities and, because they have a long-term relationship to maintain, don't make unreasonable demands.

User groups expressed similar frustrations from the opposite viewpoint:

'I think there's a mixture of it [attitudes] really. I mean we do know that we sort of come in handy at times because a token user's needed. But I think that once people have got to know us a little bit, they soon realise that we've got some interesting things to say. I mean we obviously don't see eye to eye. The ideal thing for what we want would cost a heck of a lot more money than they've got, and both ourselves and them have got to be realistic about what can be done with

> what money they've got. But there's always extra money coming in, and we sort of jump about and say "right, what you going to use it for?" And we find there's still nothing for basic services, still nothing for this and that. It does get a bit frustrating then. 'Cos they'll always come up with explanations, but unfortunately it doesn't fit in with what we would like as an ideal.' (Mental health service user and advocate)

The demands of users, when expressed in consultation, will rarely be met in full. Without knowing the limitations on any consultation, what is open to influence and what is not, the process will frustrate users. These users may then be left with the impression that consultation is a token affair:

> 'You do realise at times, and you can get a bit frustrated, that there is still a lot of lack of awareness and ... 'Cos there's one thing when it's lack of awareness and actually, you know, knowledge etc., but when you feel they don't want to do owt about it as well, or they're not interested in actually changing it, that's where you get the most frustrated. Because if people don't know and they say "look, help me, advise me", whatever, you know, that's ... You can work with that. But when people have got no intentions of changing things, or examining the practices, that's where it gets most frustrating.' (Voluntary sector mental health professional)

Generating volumes of paperwork, circulating this to, and discussing it with groups and individuals presents further frustrations:

> 'They haven't got everyone together [to produce the Health Improvement Plan], in the sense that it's again health and social services, the local authority, kept it very close to their chest. You know, we've got to produce this HIMP. Right. We'll have a meeting and we'll come and talk to you about it. Right. So they come and talk to you about it, but they answer none of the real questions about how they're actually doing it and how individual organisations will actually be involved. It's like fighting against jelly. You know. How do you get into it? And very often, if you find out, it's already gone, or whatever, and you have to give comments, or they've already written the report.' (Voluntary sector mental health professional)

A document like the Health Improvement Plan is in itself difficult for user groups, with scarce resources and little time, to digest and respond to:

> 'Well, to me it's on its head of what I think it should be, and it's a traditional health service strategy document which lands on your desk and feels like a volume of the Yellow Pages. The postman has to ring the door to ... because it won't go through the letterbox. And yet, at the end of it, you can read it and still not really know what's going to happen. And I think, going back to the agenda about involving users and carers, what they judge us on is nothing to do with text.' (Mental Health Trust manager)

Consultation in this context becomes an exercise in frustration. On other occasions, constraints leave the impression that the decisions have already been taken:

'The statutory authorities in [location] have really been quite pro-active in involving the voluntary sector. But there are sometimes ... There are some things, like Health Action Zones, which they kind of ... Yes, ok, they had a very short timetable, but they held very close to their chest. And it was kind of those people who have got projects on the stocks, or good ideas, were invited to bid, and the rest of us didn't find out about the bidding process until it was too late.' (Voluntary sector mental health professional)

Consultation is now often required to provide evidence in support of plans or bids for extra resources. As such, health bodies have an agenda that might have little to do with genuinely hearing and acting upon the responses they receive:

'In terms of consulting with us, I think that they're ... A lot of it's paperwork, still. A lot of it's based on "well, we need to consult users, because this is what we've been told to do. Really, our agenda is this, you're going to have to fit into this because this is where our money is." ' (Voluntary sector mental health professional)

The majority of interviewees expressed such views, illustrating the problems that consultation presents in terms of engaging users and groups in a genuine dialogue.

One interviewee described how she had been invited to sit on a clinical advisory group, discussing treatment protocols, management and complaints:

'The only problem with that meeting is that you really have to be quite confident to go because there's probably about 26, 28 professionals round the table and only three users. It can be a bit intimidating for anybody just starting on this. And there are one or two characters that are still fairly daunting because they've not got a particularly good attitude to people with mental health problems. You do still get individuals, and I think you've got to be pretty brave to go back for more if you've had one scathing remark, you know.' (Mental health service user and advocate)

This image of genuine consultation and participation taking the form of three users in a meeting of professionals is almost comical. Yet the presence of users on committees was cited in annual reports as an example of precisely this.

At the same time, there was some realism. One manager understood that his best efforts might not always be appreciated:

'I think I would say we tried our best [to consult] in a very complex arena. We're not secretive. We actually have to ... We do and want to make our... We actually publish the Strategic and Financial Framework. We're actually quite proud. But I do acknowledge there's a weakness. We're not very good at talking to users and carers, and I don't think the CHC is a totally effective proxy for the general public. GPs think they're a good voice for the general public, but they

have a very narrow focus. So, I think, we do try and we do operate in the arena that has the assumption that we are publicly accountable and we take measures to air our discussions and decisions in a public arena, and publish them, and talk to the press about them, and involve as wide a group as possible. But, as I say, it depends where your standpoint is as to whether you think that's just playing or not. I can see both sides.' (Health Authority Director of Commissioning)

Neither the Community Health Councils, representing a more traditional structured approach to user engagement, nor GPs, representing the views of their patients-come-consumers, provide adequate substitutes for engaging directly with users. And in this engagement, the level of understanding and capacity to engage will be key:

'There has been some consultation [on the HIMP], don't get me wrong. But I think people have gone along either with very little knowledge, so it's not been a terribly useful process, or they feel they've got knowledge, but they don't quite understand the nuances. And it's been about a failure, or a lack of opportunity to really engage people. But I think that's been time and resource constraints more than anything else, which can't, I don't think, be laid at the feet of the Health Authority.' (Community Health Council Chief Officer)

To engage in constructive dialogue, there needs to be some effort devoted to building the capacity of users and voluntary groups to engage on an equal footing. This is particularly the case where those users might have mental health problems or be otherwise excluded from traditional channels of influence and debate.

Picking up on this last point, one mental health project sought to use consultation events and public meetings almost as a therapy. The project provides a service to Asian women, recognising that they are often excluded from mainstream services because of language, family and community pressures and because mental health professionals see them as quiet, calm women who have no need of help. Getting these women out of the family environment, giving them a chance to express their views and to do so together might be a means to give them some sense of themselves as having value and something useful to say:

'I should say that we actually empower them to take responsibility for themselves, empower them to say what they feel. For example, I ... Most of the time I empower the women to go into different conferences, different days when they have things like "have your say" consultation days in the community. I actually encourage these women from the group to actually go there and have your say. And in the past this has been done. I suppose the project is playing a part in that, I am playing a role in that in empowering them to have their say. So they become their own advocates, in a sense. Although it might have happened because I push.' (Voluntary sector mental health professional)

Whatever the frustrations of consultation, this is an intriguing insight into the personal benefits to some service users.

Reflections

Earlier chapters have indicated the complex nature of the two case studies. Understanding the way in which decisions are made is in itself difficult. It is not a surprise, at the end of this chapter, to find that current forms of accountability do not meet the challenge of holding the services up to scrutiny or opening them up to challenge. Providers, professionals, user advocates and welfare rights workers were almost universally critical of the systems, identifying weaknesses and failings throughout. Among these accounts there have been glimpses of what accountability might mean in these services. It is to these and other accounts that we turn in the next chapter.

CHAPTER EIGHT:
ALTERNATIVE VISIONS OF ACCOUNTABILITY

The preceding chapters have revealed some of the complexities of the case studies and the inadequacies of the forms of account currently provided of them. In doing so, there have been some glimpses of ways in which these weaknesses might be addressed. On the whole, these glimpses are fragmented. While clearly able to identify problems, interviewees had no simple view of the way accountability might look. Some reflected on particular elements with which they were familiar, such as different forms of statistical information or audit. However, others had been grappling with the same issues and problems and were able to express some interesting visions of an alternative future.

Liberating Discretion

What was striking in some of the more developed responses to questions about alternative forms of accountability was the need to control discretion less. I have already noted that it is not my intention in this work to suggest that discretion is the problem or that it should be restricted. But for some interviewees, discretion and local freedom was the answer. One interviewee had given a great deal of thought to the problems of accountability and the problems it poses for public agencies seeking to deliver a service:

> 'What everybody's trying to do all the time is not get it wrong. So social services is obsessed about not getting it wrong. The health service is obsessed about not getting it wrong. And because everybody's obsessed about not getting it wrong, nobody ever gets anything right. Because you can't have innovations without risk.' (Community regeneration manager)

Bounded by rules and limits, by accountability systems that seek to discipline and control, public bodies are delivering the wrong services:

> 'When you get European funding you get that [thick documents]. Now, you tell me, in an area like ... you know. So this tells me what we can spend the money on, what they can withdraw, what the financial accountability is, how we do this, records, how we monitor it... So we've got five bits of funding. We've got SRB [Single Regeneration Budget], which has its own rules, its own reporting procedures. We've got different financial years. So our European money comes in calendar years. Our SRB money comes in UK financial years. The reporting arrangements are different.

> The European money has to be match funded. The accounting arrangements ... We've been audited three times, for government money. One, we've been audited by the Government Office in respect of European money. We've been audited for SRB money. And we're being audited because we've got the Accountable Body within our role here. So three auditors turned up in the space of 6 weeks, went through the same stuff to audit against different procedures.
>
> 'So what happens is I go to the Government Office and say, right, we want to achieve this. Do you think this is a good thing to achieve? Do you think it's actually consistent with the urban policies that you're saying to us you want us to ... Yes. Then you have to help. It's your job. You can't keep these rules as gatekeepers... We say what we want to do is make an apple pie. But by the time we've gone through the system, what we've actually made is a pair of shoes. That's how our accountability system works. We actually get something that nobody's buying, nobody can justify, because we're all playing this game of fictional accountability that measures the wrong things and doesn't actually give any power to people in the locality to say a very simple thing. "This doesn't work. It doesn't have an impact. It doesn't actually produce anything that is meaningful." Shouldn't that count for anything?' (Community regeneration manager)

At present, such basic information, that a service is failing, does not count. In part this is because it cannot be counted and, as such, does not readily fit into the highly quantitative approach to accountability and control. More fundamentally, the question is rarely asked.

Focusing services upon results, informed and influenced by the perceptions and experience of local people in the manner described above, requires some flexibility at a local level:

> 'What we need to do is give people on the ground more discretionary power. Because what organisations are is totally centralised. Everybody's looking upwards. So if you want to change the way people exercise the responsibility on the ground you have to give them power, because then it is their responsibility. Because you can't give people responsibility if they are not able to respond because they don't have the resources or the flexibility within their jobs. Or the trust to do that.
>
> 'So what I think is we need a more sophisticated accountability. We need an accountability that looks at two aspects. One is about frameworks, criteria, focusing on targeting resources, measuring things, because we need measurement. If you got rid of measurement totally, that would be ludicrous. Then there's another accountability that is about qualitative stuff, which is saying how do people feel about things, what is their experience of it?' (Community regeneration manager)

This was not simply one person's vision. Another interviewee, highly critical of the Social Fund, nevertheless put forward the case for a service capable of being responsive and accountable at a local level:

> 'So, the variations at local level debate, I think it's not easy but I think I am still very much of the view that you need a national scheme, a national framework. But that doesn't mean that there isn't any sense of accountability at a local level, that there isn't any sense in which, within a broad framework, strategic framework, and an appropriate budget, one can be responding to local conditions as you see them. It is possible to get it better than they've got it at the moment. Simply saying we are a branch of a national agency, I think, is a real cop out, but that doesn't mean that they have to be a local agency.' (Social policy academic)

Clearly, discretion needs to be bounded to some degree. It would be unacceptable to allow discretion and freedom to be exercised purely on the basis of prejudice. However, throughout the accounts presented in the previous chapters, some glimpses of the potential of discretion can be discerned. When home visits were conducted by Social Fund Officers, their judgement was informed by the context, by the circumstances of the applicants and, interviewees suggested, their decisions were improved by that understanding. Innovative ways of combining statutory and voluntary services, gaining advantage from the strengths of each, were to be found in the mental health case study. It is these images of discretion, genuinely responding in a flexible manner to local needs, that ministers have in mind, rather than the experience of irrationality recounted by others.

Bounding discretion in a way that encourages and enhances the potential present in discretionary services will be the focus of this chapter. The key elements have been identified: appropriate reporting systems; and making services genuinely open to the views and needs of users and applicants.

Inclusive Accounts

The remarks of user advocates and welfare rights advisers in the previous chapters have voiced alternative accounts of the case study services. These accounts undermine the simple, uniform summary statistics and documents currently presented as an account of the services. They indicate the variety and complexities of the social problems the

services are intended to address. As such, they are another account, one currently excluded, that helps to provide a more rounded view of the case studies. Not surprisingly, some interviewees were clear that there was a need for their voices and experiences to be heard:

> 'If you look at ... This [financial regulations manual] is the thing that's trying to make it accountable. So if you look at the public sector, for example, a lot of accountability is communicated to people through the people that are actually practising in the area. And a lot of those people don't feel that their organisation is accountable for the spirit of what they are trying to deliver. Now they may be accountable for the outputs, or for particular bits of public funding, providing audit trails, and I think that's what the problem is with accountability. Because what we make people accountable for is what they do, not how they do it.
>
> 'So if you take, say, local provision of health services, the biggest issue that people have is how their services are delivered. The attitude of the receptionist, the kind of information they get shared with them, the way that people are treated. It's the same with the Benefits Agency. It's the relationship between the service deliverer and the service user, not the nature of the service they are providing or not providing. If they were to change one thing about the public sector to make their services more acceptable, it would actually be to be saying, how do we capacity build public sector workers in this area to have an understanding and respect for the issues that affect people locally? Because it's not what they're doing. It's the manner in which they're doing it. It's how they treat people that then impacts upon the quality of that service. Now often that's because the person on the bottom line don't think they can ... that they are trying to explain. That's what I call rhetoric-reality gap.
>
> 'So the problem is the agency which they are working for is maybe saying in its policy document, this is what we're trying to achieve as an organisation. By the time it's filtered down to the ground level, there's a huge discrepancy between what the organisation says it's trying to accomplish, and the experience of people accessing those services. And it's the front-line workers that end up being responsible for accounting to people that are accessing their services, the difference between what the organisation is professing to be achieving and what the experience of the service on the ground actually is.' (Community regeneration manager)

The way in which services are delivered, as well as what is delivered, influences the experience of users. The experience of entering a building that 'smells white', of dirty and uncomfortable interview rooms, of unhelpful and defensive public servants conveys and impression of services hostile to those seeking to access those services. Changing these environments and behaviours, making services accessible, requires some attention

to the skills and the capacity of public servants to understand the impact of their actions and the needs of users and applicants.

In the health service, some efforts have been made to include users in a number of ways. We have already noted that meetings are open to the public and that they are present in some clinical advisory groups. One interviewee, a participant in a number of such meetings, observed:

> 'I think the concept of using users of services in them [service evaluations] is still sinking in with them really. They've accepted that users could go on the evaluation teams, but I'm still not content that they realise how important it is that the users of the services that they're evaluating have a say. If you just talk to the staff, they're not going to say we've made a lousy job of things here. Service users aren't getting this, that and the other. They'll say, well, we're pushed for time. We try and do this, we try and do that. They might try and be as honest as they can, without dropping themselves in it, but they're not going to say we're making a mess of things. So you need the users to get a realistic view.' (Mental health service user and advocate)

To understand the actions of health bodies, managers need to understand that there is another side to the story. Actions have consequences, and are best understood when those consequences are known. Reminiscent of the thinking of Roberts (1996) and Willmott (1996), this interviewee clearly identified the problem at the heart of this work. The accounts of users provide a corrective to the organisational view of a service, allowing that service to better understand itself.

How the views of users and recipients might be genuinely reflected in services and in the accounts of those services was an issue raised in a number of discussions. One manager was alert both to the need for this perspective and to the limitations of the approaches currently taken:

> 'And then the other bit of much more systematic work is that we've made a more strategic decision that user views - and we haven't included carer views within this - but user views and finding out what users think of our services, systematically, will be one of our key priority areas. So the quality assurance manager is working with each directorate to look at what is appropriate to their needs, and trying to develop ways of finding out user views in a systematic way. So we've got physical rehabilitation services, who've got, say, 8,000 patients a year, and little managerial ... They're all frontline clinicians. And they want simple questionnaires, scannable, that just get back big quantities of information. People have short episodes of care. The

> general feedback is very good. And then there are other groups, like people with learning disabilities who don't read and write, who often are not verbal, and the emphasis there will be much more qualitative, often using advocates. And we've done some pilots with just people spending time with the users and actually monitoring what the service does with users. And I mean that obviously affects the care, but it's better than not doing anything at all. And still they were shocked by how little people talked to them, how much they were just part of the furniture really.' (NHS Mental Health Trust manager)

It is interesting to note the willingness to try different approaches in specific contexts. Satisfaction surveys, consisting of little more than tick boxes and Lickert scales, are common. Patient observation, though applied only to certain categories of user, clearly presented a different picture of the service. One wonders whether such an approach might have challenged the satisfactory responses gleaned from the survey approach for those with short episodes of care. This would almost certainly have been the view of another interviewee:

> 'The offshoot of that [individual advocacy] that I got interested in was the issue of service evaluation and accountability and how that links in with the general sort of advocacy, human rights-type approaches to things. That's where the stuff around ... FACE [Functional Assessment of Caring Environments] stuff was interesting. When you read the report, you'll see that we were, whilst we're diplomatic, we're quite critical of the whole methodology that they've used there in terms of how you might get a service user's perception of the service. We thought that the methodology really didn't tap into the perceptions of service users very deeply at all. Their approach was really quite ... It was very positivist. You know, they asked questions. The questions were along the lines of "my psychiatrist has explained my problems to me". Yes, no or not sure. It doesn't ... As soon as you start doing that it became clear that the answer was nearly always yes, but. So there was much more qualitative stuff that could have been gleaned from that situation, but the methodology doesn't get there. It won't get anywhere near it. And that's why we ... The report critiques the methodology, and we've said that we'd like to get into some more talks with the community health service about how we might develop the methodology to make it more user-friendly.' (Mental health service user advocate)

For others the solution was to be found in independent work:

> 'You have to pay somebody independently to facilitate a randomly selected group of your clients and for them to give you feedback that is published.' (Community regeneration manager)

Undoubtedly, the first objection to such a suggestion would be cost. But it reflects the need for independence in the user accounts presented. It might also be remarked that

while we are prepared to pay for independent financial scrutiny, in the form of audits, value for money studies and evaluations, we should also recognise that there is a cost involved in genuinely listening to the accounts of users. At the same time, in discussions about consultation, the key need for service users to be educated and informed, to understand the constraints on public bodies and the limits of the consultation, was drawn out. This is particularly the case when users are vulnerable, unable to articulate their views clearly or feel excluded from services. Their dependence upon the professionals and public servants they may be criticising and challenging adds a further barrier to an equal dialogue. Independent channels for dialogue might represent a means of overcoming such barriers.

Informative Accounts

Again, throughout the preceding chapters, the failure of summary accounts and statistical data to reflect the complexities and variations in services has been prominent. How these might be exposed, in ways that allow for useful understanding of the way in which discretion is exercised in individual areas, is a further issue on which a number of interviewees expressed views.

First, while allocations to areas, whether health authorities or Benefits Agency districts, may be known, the way in which these resources are used is not clear without extensive research. It has already been noted that the Department of Social Security refuses to even collate data on the level of priority items being met at a local level (see Appendix 4). A similar lack of information is to be found in the NHS:

> 'So I would argue the Regional Office performance management function should take the spending that comes down to them, through their pockets down to the health authorities, and divide it up into some broadly understood divisions. Okay, you can argue 'til the cows come home how you do it, but just broadly, and that's indicative. And then you can start to say, okay, let's look at your spending on renal hospital services. I mean, that would be critically important because all we ever look at is do you dialyse two or three times a week? What's the marginal additional cost of dialysing between two or three times a week? That's the critical question. And look at the value of that compared with taking that resource and investing it in mental health, or cancer, or whatever. I mean, we hear about all these variations in cancer services. I've never heard anybody talk about the variations of investment in cancer services.' (NHS management lobbyist)

There is some caution about discussions of this kind. The suggestion comes close to discussions of health economics, health gains and QALYS (Quality Adjusted Life Years), subjects that have provoked controversy about rationing (New and Le Grand, 1996; Harrison and Hunter, 1994). Yet such information might help explain variations. It is not the whole answer, there being many reasons for differences in relative funding levels, but it might allow questions to be asked.

Other indicators of variations are also being considered as a part of the new Performance Assessment Framework in the health service (NHS, 1999b). These might begin to indicate variations in standards of care at a local level:

> 'We've worked with a group involving service managers and the professions to investigate - I think they started with 48 areas and came down to these 15 where they felt there was sound research evidence, a distinct clinical subject area and the data was available. And it's been tabulated by health authority, and in a few weeks time should go out for consultation - not for use yet. It's going out for consultation to health authorities and Trusts, and we are expecting them to look at it seriously. There has to be the proviso with these kind of things that all these measures are only going to be indicators for quite some time. It's not going to tell you that the performance of a health authority is good or bad on something, because all it will tell you is whether some further investigation is justified.
>
> 'If you take an example like the provision of statins as a way of reducing coronary heart disease is again seen as an excellent new development, a new treatment that's highly effective. It's highly effective for those where there is a very good reason to think that they are going to have some sort of coronary event - either people who have already had an event and survived, or have various physiological signs that tell you they are a prime candidate. The benefit of these drugs for those who are at only a very small or average risk aren't proven in the research. The benefits seem to tail off. But, of course, the cost stays the same. So if a district had a high use of these drugs, you might consider that it's showing a poor use of NHS resources, particularly if you opened up and saw that at district level it was all concentrated in particular patches. And it would probably mean that some GPs were prescribing these to everyone that feared heart disease.' (NHS Executive policy official)

Both interviews stressed that these forms of information represent a starting point for further investigation. They do not discharge accountability, indicating success or failure, but inform a more considered debate about the way in which resources are allocated in different areas.

These developments in the health service suggest some potential for uncovering differences in standards. In the case of the Social Fund, a vast range of statistical information is already collected. However, it is not used in ways that inform readers of official publications:

> 'Now whether, if researchers had access to the raw data from local offices, whether you could do anything with that? I don't know the nature of the data. But really you probably need the kind of research that SPRU [the Social Policy Research Unit at York University (see Huby and Dix, 1992)] did, related to some kind of indicator of need and outcome. You can go so far with allowing for socio-economic variations between the areas that local offices are in, but it's all a fairly kind of macro level. But I am not sure how much more you can do. You can probably do more with the raw data than is done at present, because that's not what they're looking at. They're looking at national figures with no attempt to look at variations in figures.' (Social policy academic)

Even the current national summary data, broken down to areas and districts, might begin to indicate the variations in the way the Social Fund is administered and the different financial pressures experienced from one location to the next. In the past, the DSS has refused to make public even basic information about variations in the levels of priority being met from one district to the next.

Getting beneath the simple exposure of variations to look at the way in which decisions are made is even more problematic. At the time of the research, the Independent Review Service for the Social Fund had begun to produce Directorate Reports, detailing standards of decision making evident in the cases referred to them for review. This initiative provides a further glimpse of the potential for opening up decisions, and variations in the standards of decisions, to external scrutiny and discussion. There are further approaches that might be adapted and adopted more widely:

> 'When we've had meetings with the DSS in the past, one of the things that [organisation] does take up ... They've got a forum called the Ethnic Minorities Forum, and one of the things we raise there, and generally, when the issue of the Benefits Agency and its treatment of ethnic minorities comes up, and one of the issues is ethnic monitoring. And the Benefits Agency say "oh, too expensive." And one of the things we've said is maybe what you should do is monitor certain questions and certain benefits only. The Commission for Racial Equality have looked at HRT [Habitual Residence Test] but [indistinct] the Social Fund because this clearly is one of the areas where there is discretion. There clearly could be an element of colour, race and racism. It's an obvious area to look at. The other area is

discretionary hardship payments for teenagers.' (National welfare rights agency policy officer)

Developing this approach, another interviewee began to sketch out a process that might be applied to the Social Fund:

'It seems to me, and I'll bring it back to the police because I deal with them all the time, that the police must have discretion. You couldn't have a system and operate it otherwise. And so, I think then what you have to look at is any kind of patterns in the way they carry out operations. Stop and search is a wholly discretionary operation. Codes of practice say what you should and shouldn't look for. So then you look and see whether ... Because you've got an institutional bias which sees black people with a kind of negative perspective regardless, because as part of an all white service you only meet black people who are criminals, so any black person you meet is more likely to be a criminal because that's your experience, you know. A whole range [indistinct] which reinforce your negative stereotyping which means that in practice, what you do is you are more likely to exercise your discretion, based on your perception, to stop black people than you do to stop white people.

'Now, because they are required to do so, you get some statistical reports on how often black people are stopped and their numbers in the population, and so on. And then ... There's a lot of argument going on about [indistinct] big caveat about, you know, that stop and search has proved a very useful tool in fighting street crime and so on. But you go back and start unpicking, and you could do a whole range of tests and other things to try and validate [indistinct] whether processes are discriminatory or not. It seems to me that, to transfer it to something like the Social Fund, you could have a whole range of objective measures. You have the ethnic groups of your applicants, the success of the applications and if you knew the amount of money they asked for and the amount of money they got, or the fact they got none, and you could look for some patterns. And then there's going to be a whole range of other variables, and you could screen it out and take single parents, you could take elderly, you could take disabled, you could take a whole range of people and see whether there were differences in patterns. And you make a rough guess and say, you know, that elderly people, there's probably not a lot of discrimination, and mentally ill, there probably is. You'd have to do some analysis and then you might go back and put some of it under a microscope to see ... Watch people.' (Ethnic minority rights lawyer)

While this is elaborate and fraught with problems, it could be done. Together with evidence from service users and applicants, a picture might emerge of the ways in which discretion is exercised.

A different approach to the problem of comparing discretionary decisions was proposed by another interviewee discussing the mental health case study:

> 'You can only look at the number of assessments that have been carried out in people's homes, the percentage of assessments that are carried out jointly, on a multi-disciplinary or a multi-agency basis. So we can record those sorts of things. As to the quality of the decision-making, it's much softer, and harder to get at. You just have to look at the sorts of indicators that tell you something about it and you hope that ... An indication of a high percentage of multi-agency assessments, and a high percentage of home assessments... Then you combine that with what you know about the services, benchmarking, the range of services that are available, the specialisms, the use of specialist home-care workers, things like that. And the way, from our observations, teams seem to be working together. So we do have ... in a sense we've got softer data. We've got a checklist now, about 80 items long, that we complete ourselves, and it's at the end of the visit on the basis of judgement.' (Audit policy official)

Such information, in part statistics and in part observations, might begin to give an impression of the way decisions are made and of areas where they might be improved. This is the approach that informed the Audit Commission's recent study of mental health services for the elderly (Audit Commission, 2000a). A further element that might inform judgements was an examination of individual case files:

> 'Again it's qualitative information [from files] as well. So you've been round. You've talked to the teams and the professionals and the commissioners about what they say, and you've observed what they say about the service. But you get another angle on it looking at the case file, see if it really does match up with what they say they provide. The case files should pretty well say what has actually been provided.' (Audit policy official)

From these observations and comments, it is apparent that there is a plethora of information that might be used to open up the 'black box' of discretionary decision making, informing judgements about the way it is exercised and the effectiveness with which it achieves policy objectives.

There remains the further question of capturing information that reflects the consequences of discretion, particularly where users are turned away or applicants are refused. In part, this is addressed by opening up the concept of accounts to other voices, to those of users, of applicants and of other agencies.

Changing Cultures

However, a note of realism was sounded. The public sector operates in a highly political arena. The two case studies were selected in part because they are contentious and problematic. The objectives of officials in Whitehall and of politicians often conflict with the provision of illuminating information and the achievement of long-term outcomes:

> 'I think the real problem is the Treasury feels it needs to measure something in return for giving money to the Health Service, and it wants to measure it within 12 months. All it can do is measure activity. So, presumably, we are accountable for what we spend our budget on, and because we have to show what we've spent it on in a very short timescale, what they want is increased activity. Outcomes take years. So, I mean, if the Treasury holds the Health Service, the Department of Health accountable for activity, and the Department of Health holds the health authorities accountable for activity, then you can't really break into that accountability. You can have Ministers of Public Health 'till you're blue in the face, but they don't seem to have as much power as the Treasury does.' (Health Authority Director of Public Health)

Breaking from the short-term, political nature of accountability is key to a more informed dialogue about the performance of public bodies. Accountability is most often associated with responsibility and blame rather than with any concept of stories, of giving an account:

> 'I think we need a much more sophisticated sense of who to blame and why to blame them, and I think our parliamentary system does nothing to inculcate this behaviour. It needs to be less about blame. There's no point in pointing your finger at somebody saying we'll make you responsible for it. That is quite senseless in my view. Really, we need a much more sophisticated understanding of things.' (Member of Parliament)

What that more sophisticated understanding might be was not made clear, but another interviewee took the point a little further:

> 'I think we have enormous problems, because what people tend to read into accountability is round individual accountability, and shorthand for that is heads on plates. Who do you blame when things go wrong? Whereas I think it should be much more sophisticated and much more of a process of, yes, we need heads on plates ... We need to know at the end of the day should I resign, or should I be sacked if something goes seriously wrong. Should I have known about that thing? But there is something more which is that sense of ongoing partnership with people around saying I am accountable to you.' (Mental Health Trust manager)

Partnership is a word much used of late but with a range of meanings. He expanded on this image, describing a dialogue:

'So I think accountability in the public sector, and particularly the health service is very, very difficult, and I think there are ways of being much more accountable. And I think it would be ... My personal view is it would be good to be much more accountable. It does mean, I think, informing people, working to educate people in a meaningful way, not publishing annual reports. But I think it does mean working in partnership with the public for them to be more educated. Now I think the advantage of that is then, I think, people ... If you talk about meaningful partnership where there is an equality of power, rather than you sitting in on our boards [referring to my attendance at his Trust's board meeting], which isn't meaningful partnership to me because there's no power sharing there.

'But then I think you can start to get into some ideas that I'm less critical of people if I understand the constraints that are on them too. So some of the things that the public might want to beat us up about, like failures in breast cancer, or breast cancer screening services... Well if we actually say do you really think we can always get things 100% right, I think a very informed public would say no, and we will accept a particular failure rate. It is an absolute tragedy for the person, but at a macro level, we make mistakes every day when we drive our car, and as a result of this a number of us die or are injured. We don't ban the car because there are injuries or deaths. So I think there will be real benefits about seeking to try and have meaningful accountability. But it would be enormously complex.' (Mental Health Trust manager)

A more mature attitude towards success and failure, accepting that there are constraints and initiating informed debate about how to work within those constraints is entirely different to the current concepts of accountability. Similar points were made by other interviewees when discussing forms of consultation and participation. These indicate the difficulty of making that shift, but also the benefits of an informed discussion within understood and agreed limits.

Reflections

These views and observations begin to develop the critique of accountability, presented in earlier chapters, into a positive alternative. Central to this alternative image is accountability as a process about understanding – understanding variations, understanding other perspectives and understanding the constraints within which a service operates. It is in stark contrast with the current forms of account, giving scant summary information, confirming that limits have not been transgressed and deaf to the views of users and recipients.

However, it must be emphasised that these views represent only part of the picture. A number of other themes and characteristics of an alternative conception of accountability have come through from the extracts in much of the previous chapters. In that these were not voiced as a clear alternative, I have not incorporated these in this chapter. Among these is the central issue of power in the relationship between the individual and public services and of the role of advocacy, whether at an individual or group level. In pulling together some conclusions from this research, I shall return to this theme in the concluding chapter.

CHAPTER NINE:
CONCLUSIONS

The image of accountability, set out in this work, is at odds with the main thrust of debate on the subject over the past twenty years. From the outset, I have suggested that the literature presented a superficial impression of the reality of accountability. Having had some experience in handling parliamentary questions, value for money audits, ombudsman cases and of contributing to the writing of annual reports, I was aware that some of the mechanisms were as much about evading accountability as about discharging it. While this was recognised in some academic works, there was little discussion in the mainstream public administration and political science literature of ways in which such problems might be addressed.

Instead, academic debate in the mainstream literature focuses upon competing images of accountability. The first, what I have called a social democratic model, places emphasis on a model of collective decisions, expressed through the ballot box, and individual rights (Stewart, 1992). A second, closely associated with the New Right, posits a model drawing heavily on ideas familiar to the private sector: taxpayers as shareholders; and recipients as customers (Waldegrave, 1993). The one emphasises parliamentary accountability and the role of tribunals in defending the rights of individuals, the other financial control and responsiveness to users. Debate focused upon the strengths and weaknesses of the variety of mechanisms, but essentially the focus was upon the control of public bodies. More recently, a further model, centred around the 'democratic audit' project, has risen above these ideological debates to suggest the need to apply the full range of mechanisms to all public bodies (Beetham, 1994; Weir and Hall, 1995; Weir and Hall (eds.), 1994).

While this work addresses these debates, it does so drawing upon an as yet untouched body of thought. In the accounting literature, the concept of 'accounts' as an adequate statement of an organisation's functions has been questioned and challenged. Turning

the idea on its head, some critical accounting literature (e.g. Ezzamel and Willmott, 1993; Munro, 1996; Roberts, 1991 and 1996; Roberts and Scapens, 1985; and Willmott, 1996) has suggested that organisations might understand themselves through the accounts of others. They suggest that traditional hierarchical concepts of accountability, by imposing systems of control and surveillance on public servants and functions, create accounts that are about comparison and conformity to standards. They do not present an account of actions. As an alternative, they develop the idea of a socialising form of accountability, of understanding oneself through a dialogue with others. They suggest that, just as we gain a sense of ourselves through interaction with others, so organisations can only understand themselves through dialogue with others. Such ideas found further echoes in key works of social psychology (e.g. Goffman, 1970; Laing and Esterson, 1970). Toying with the concept of 'accounts', this work has sought to develop these ideas and, in so doing, to question the value of current forms of accountability. Drawing upon the views and perceptions of managers, frontline workers, user advocates and commentators, a rounded image of two case study services has been contrasted with the mechanistic accounts presented of them.

The case studies, the Social Fund and mental health services, were deliberately selected as examples of services that, the literature suggested, would prove most problematic. Being discretionary, the one administered by 'street-level bureaucrats' (Lipsky, 1980), the other by a variety of professionals, they are particularly difficult to describe and to summarise in traditional forms of account. As such, they might be seen as atypical. However, discretion, whether exercised by professionals or public officials, is a mechanism that seeks to reconcile competing demands for services that are responsive to the needs of individuals and for equal treatment within a fixed resource constraint. In this respect, they are like all other public services, differing mainly in that these pressures are resolved by street-level workers or professionals on a case-by-case basis. It is in precisely such services that accountability matters most. The level of political interest in, and user dissatisfaction with these services suggests that, for accountability to have meaning, it must have meaning in these contexts.

A detailed description of the policy, legal, financial and administrative frameworks within which each case study service is delivered suggests that current systems of accountability are weak. The image has emerged of services constrained by systems of accountability rather than being described by them. Readers of official reports gain some impression of the limits to the discretion that lies at the heart of the Social Fund and of mental health services. But they obtain little understanding of how that discretion is exercised, to what effect and, thus, whether the objectives, set out in policy statements, can be said to have been achieved. Indeed, the policy is more than the rules, targets and budgets. Policy is also shaped by the individuals exercising discretion. As such, this work addresses one of the key themes of debate about the 'democratic deficit'. It suggests that the division between policy and administration is, in these case studies, a meaningless one. Separating the parameters within which decisions are taken from the decisions that are taken, declaring one the responsibility of ministers the other of clinicians and officials, makes little sense.

Exploring this impression with service managers and deliverers suggested an even more complex picture. Not only were elements of the nature of discretion revealed in these discussions. Interviewees described the manner in which the surveillance mechanisms of the current system of accountability did more than simply capture data and impose constraints. They also distorted the way in which discretion was exercised. Rather than confirming that discretion is being exercised in the manner intended, they appear instead to constrain discretion, limiting the very flexibility they seek to describe.

Further conversations with welfare rights advisers and mental health user advocates presented another image. They describe organisations and services that function in isolation, failing to respond flexibly or coherently to the complex problems they confront. In order to husband scarce resources, whether financial or in terms of staff time, institutions, and individuals within them, present barriers and pass responsibility. At the extreme, the impression left by the accounts of users is of hostile services, of irrational decisions and of prejudice. For these interviewees, formal accounts fail to reflect these experiences and accounts. As such, they are of little value as a means of understanding

the service, of placing their own experience in context or of predicting the response to any particular individual's needs.

In their stead, interviewees described the need for forms of account that reflect their perceptions, that unveil, describe and explain variations in services, and that open up a genuine dialogue between recipients and deliverers. There are many reasons why individuals feel constrained from voicing their needs and views to people in a position of power and influence. This dialogue is particularly problematic in the two case studies described in this work. In both, users and recipients are particularly vulnerable and dependent upon the services they confront. What does dialogue mean in cases where services are 'provided' against the will of the 'recipient'? How are the views of users to be communicated when those users are deemed to be mentally ill? The need for open and equal dialogue was evident in the comments of providers and of welfare rights advisers and user advocates. Social Fund Officers described the importance of evidence in reaching the 'right' decisions and the problems encountered in obtaining this information. Welfare rights advisers described the problems of communicating with officials and the fraught atmosphere that surrounded reviews. Health service commissioners described the problems of consultation with users and voluntary groups. Mental health user advocates described the difficulty of challenging professionals. These were the views of experienced and knowledgeable interviewees. The few glimpses of the fate of individuals, unaided by advocates or advisers, confronting service providers underlines the importance of and the difficulties in achieving genuine dialogue.

It is not simply that formal accounts fail to capture these experiences that is the problem. Without an equal and unambiguous dialogue between providers and users, between public servants and citizens, discretion appears irrational and unaccountable. In reconsidering our understanding of accountability, this work suggests the need to readdress the relationship between the individual and the state. The competing models of individuals with rights and of customers with choices emerge from this research as weak concepts. Rights prove difficult to enforce through complaints and appeals processes. When provided to vulnerable individuals, they are inaccessible, cumbersome and slow.

Choices prove difficult to exercise where these are almost non-existent. Rather, we might be looking to a different model that alters the relationships between individuals and services:

> 'The key to improvements in the provision of public sector services is not the imposed substitution of one abstract principle of corporate governance by another but the opening and development of processes of communication, accountability and mutual adjustment between those who pay for, receive and provide public services.' (Ezzamel and Willmott, 1993, p.128)

What begins to emerge is the image of citizens with rights, routes for challenge and redress, but also with responsibilities. These responsibilities include the need to understand the constraints within which services operate, in part so that they understand the decisions reached but also so that they might shape those decisions. If evidence is the key to decisions, understanding what evidence is relevant is a means to influencing the outcomes. In this dialogue, public services have a role in opening up the processes and constraints to understanding and to scrutiny, informing and listening to individuals.

Clearly, in the context of the two case studies examined in this work, such a dialogue is fraught with difficulties. The role of advocates and advisers, acting as a conduit between vulnerable and inarticulate users and applicants and the public servants they confront, is a key issue. These agencies begin to take on two roles: acting on behalf of individuals; and, on the basis of knowledge and experience, acting on behalf of a wider community. These roles are problematic, advocacy meaning different things to different organisations and groups. Similar questions might be raised about other respondents, each playing a role and using a script that, at least in part, reflects their part in the drama (Goffman, 1970). For example, Social Fund Officers refer to customers, while social workers speak of clients, health managers talk of patients and mental health advocates of users. Each word reflects different relationships, perspectives and predispositions, and might influence the value we attribute to the views expressed.

The legitimacy of the views and opinions expressed by voluntary agencies and advocates might be challenged as unrepresentative and as tainted by other interests, not least the need for financial support. The perspectives of still others have not been presented in this

work. One notable omission includes the disinterested, though not uninterested, observer or citizen. Nevertheless, the perspectives presented here have a role to play in bridging the divide between individuals and institutions. In the accounts presented in this work, no one clear impression, or 'true' picture, emerges of each case study. Neither are the individual accounts in themselves necessarily complete, having been given in particular circumstances and at a particular time. Instead, we are left with a nuanced and problematic impression of complex services. In this respect, advocates and advisers hold up a mirror to public bodies, presenting them with a different impression. Understanding and synthesising these images and impressions might be the subject of further dialogue.

As such, there is no simple answer to the problems of current forms of accountability discussed in this work. Instead there might be an on-going dialogue engaging individuals with differing perspectives, no one of which is 'right', but all having something to contribute to an understanding of services. The form of dialogue, the way in which information is presented, including information currently produced through extant mechanisms of accounting, and the forums in which exchanges might take place will reflect the different characteristics of each public service. This might sound unsatisfactory. Shifting from set annual reporting to permanent discourse and reflection with no prospect of a simple account, a 'true' picture, emerging does not address the current needs of politicians, managers or auditors. Yet it does reflect the complexity of public services and, particularly in the case of those services seeking to address difficult social problems, the experiences of those to whom accounts are given.

It should be noted that there are some indications of movement in the public sector. The Accounts Commission of Scotland (1998) and, more recently, the Audit Commission (2000b) have begun to adopt and adapt the 'balanced scorecard' to a public sector context, incorporating indicators of quality to present a more rounded view of the service provided by agencies. The new NHS Performance Assessment Framework adopts similar principles (NHS Executive, 1999b). At the same time, the user perspective is beginning to emerge in the reports presented by public audit bodies (e.g. Audit Commission, 2000a). However, these do not represent the reappraisal of the role and

purpose of accountability, of the function of performance measures and of audit, and of the role of citizens advocated in this thesis.

The formulation of accountability, argued for in this thesis, presents a challenge to the prevailing culture of confrontation, blame and defensiveness. And it must be said, it was a challenge that found support from managers as well as advocates. The dialogue described was as much about shaping services for the future as about understanding events of the past. In this sense, accountability takes on some of the language of the learning organisations described by Senge (1993) and Pedler, Burgoyne and Boydell (1991), and of total quality management (Morgan and Potter, 1995). They describe organisations that value the perspectives of street-level workers and that seek to understand themselves in part through the views and experiences of users, whether customers, patients or applicants. But it is not easy to be optimistic about realising the kinds of changes that these models imply. There are a number of barriers to overcome, including political ones. First, there will be the tendency to deny the problem. Even if the weaknesses of our current understanding of accountability are recognised, the change in political dialogue required, from hurling accusations and blame to a mature debate about choices and variations, is not easy to envisage. Then there remain organisational barriers: from professionals and bureaucrats to the sharing of information and knowledge, and to the criticism that might follow; from the voluntary sector, unwilling to adapt and to work together with public agencies; and from citizens unwilling or unable to engage in the dialogue envisaged. And finally, there is the hurdle of cost. Incorporating other views and accounts into the management and reporting structures of public services might entail substantial investment of resources, whether in terms of time or money.

Even if we were to accept that the understanding of accountability presented in this work is unrealisable, it is nevertheless important to challenge the prevailing understandings. Reflecting on the debates in academic literature, they appear almost irrelevant. These debates focus on ensuring that the mechanisms of accountability be extended to cover more services, and be strengthened to ensure that they are more pervasive. Where academic discussion questions the value of these mechanisms, it is to suggest refinements

and to propose alternatives. This research suggests the need to recast the debate. The very understanding of the word 'account' needs to be addressed. When stripped of its financial reporting connotations, the word might be associated more with the stories, the 'accounts' of services. Socialising the way in which we understand services and forming images of those services through the 'accounts' others present of them will allow for a more rounded picture of the services to emerge.

In exploring the notion of accounts and of accountability, this work has not simply provided a critique of current mechanisms. Through the very process of the research, of listening to other accounts, the thesis itself begins to take on the form of a more rounded account of the case studies. Deploying the accounts of interviewees has both exposed current mechanisms and, in so doing, provided an illustration of others. By presenting conflicting and excluded views, this work has sought to demonstrate the value of taking the approach advocated in it.

It could be argued that the selected case studies, the Social Fund and mental health commissioning, are extreme examples and that the argument might not be applicable in other services. Yet many of the themes are common to all public services, and increasingly so. Discretion and local flexibility are a feature of education, of social services, of the police service, of urban regeneration and of an increasing array of action zones and area-based initiatives across the public sector. Current forms of accountability will demonstrate similar failings across the range of these services.

Moreover, as the language of user-focused public services and of partnerships spreads, the critique of accountability in this work points to different ideas about involvement and engagement as well as accountability. A number of authors have identified the problems that joined-up services present for current forms of accountability (Perri 6, 1997; Rhodes, 1997; Wilkinson and Appelbee, 1999). This work, in examining case studies that demonstrate some of the features envisaged in the emerging agenda, does more than address this issue. The research also illustrates the centrality of changing the relationship between services and their users. It is to users that managers might look for insight into

the failings of existing public functions. It is from users that managers might gain an understanding of where public services currently fail to provide a joined-up service. It is only through dialogue with a wider public that services will be able to adapt and to open themselves up to an even more important group: those that currently fall through the gaps, fail to gain access to or do not even know of current public services. Opening up this dialogue is problematic, but it presents the prospect both of a better understanding of public services and a more rounded form of accountability, one that might begin to make some sense of complex public functions.

APPENDICES

APPENDIX 1.

INTERVIEW BREAKDOWN

	Interviewees	Interviews	Taped
Social Fund			
DSS Policy Officials	8	6	5
Benefits Agency Officials	7	3	2
Social Fund Officers	8	3	3
Social Fund Inspectors	2	1	1
Other IRS Members	3	3	0
Academics	2	2	2
National Pressure Groups	10	5	5
Local Welfare Rights Groups	16	8	5
Sub Total	**56**	**31**	**23**
Mental Health			
NHS Officials	5	5	4
Regional Office Officials	3	3	3
Health Authority Officials	6	6	6
NHS Providers	7	2	2
Community Health Council	3	3	1
National Statutory Bodies	2	2	1
National Pressure Groups	6	5	5
Local Advocates	10	6	6
Local Providers/ Advocates	9	7	7
Local Partnership Project	2	2	2
Sub Total	**53**	**41**	**37**
MPs	3	3	3
Total	**112**	**75**	**63**

APPENDIX 2.

STATISTICAL INFORMATION ON THE DISCRETIONAY SOCIAL FUND

Table 1

National Summary Statistics 1998/99

	CCG	BL	CL
Applications received (000)	1,166	1,327	1,135
Decisions (000)	1,173	1,454	1,136
Awards (000)	225	935	866
Awards as % of decisions	19	64	76
Refusals (000)	944	442	247
Gross expenditure (£m)	98	344	59
Recoveries (£m)	N/A	309	52
Net expenditure (£m)	98	35	7
Average award	436	368	68

Source: DSS, 1999b

Table 2

Budgeting Loans Expenditure by Item Category 1998/99

Item	Amount	% of Gross Expenditure
Cooker	64.1	18.6
Beds	65.6	19.1
Floor covering	35.3	10.3
Miscellaneous furnishings	69.7	20.2
Washing machines	38.4	11.2
Bedding	31.1	9.0
Clothing	9.6	2.8
Others	30.5	8.9
Total	344.3	

Source: DSS, 1999b

Table 3

Budgeting Loan Refusals 1998/99

Reason for Refusal	Number	% of Refusals
Not in receipt of IS	83,143	18.9
Not in receipt of IS for 26 weeks	190,847	43.3
Excluded items	13,443	3.1
Inability to repay	11,102	2.5
Loan refused - CCG awarded	37,064	8.4
Previous application	23,987	5.4
Insufficient priority	67,714	15.4
Other	13,238	3.0
Total	440,538	

Source: DSS, 1999b

Table 6

Social Fund Review Applications 1996/97

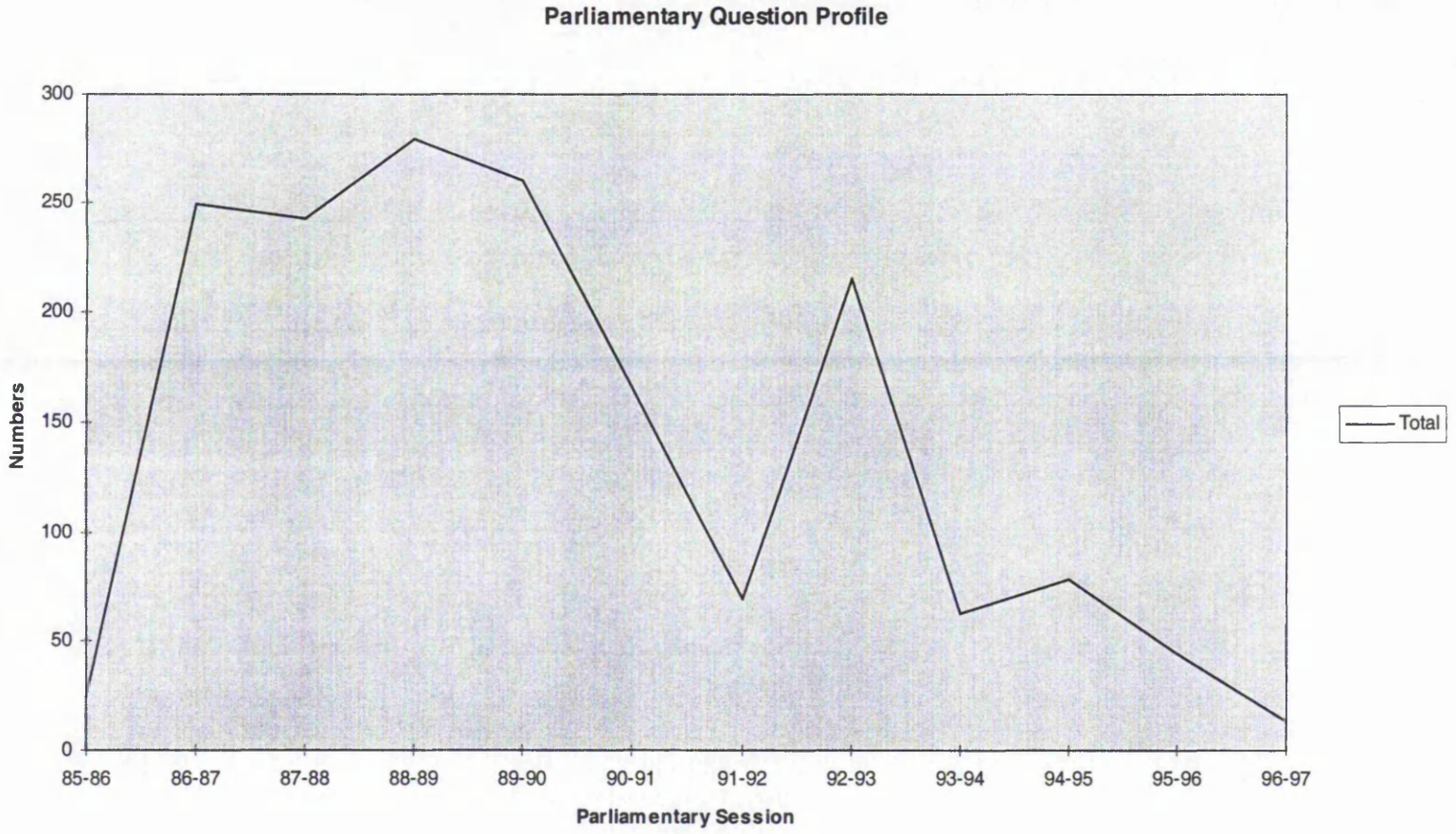
Applications for First Review	Community Care Grants	Budgeting Loans	Crisis Loans	Total
Number	146,039	145,159	35,886	327,084
Decisions Revised	39,163	56,381	15,356	110,900
Percentage	27	39	43	34

Independent Review Service Decisions	Crisis Loans	Others	Total
Applications	N/A	N/A	22,729
Decisions Reviewed	2,793	19,024	21,817
Decisions Confirmed	2,139	11,046	13,185
Percentage Confirmed	77	58	60
Decisions Substituted	633	7,701	8,334
Percentage Substituted	23	40	38
Referred Back	21	277	298
Percentage Referred Back	1	1	1

Source: DSS, 1999b

APPENDIX 3.

PARLIAMENTARY QUESTIONS ON THE SOCIAL FUND



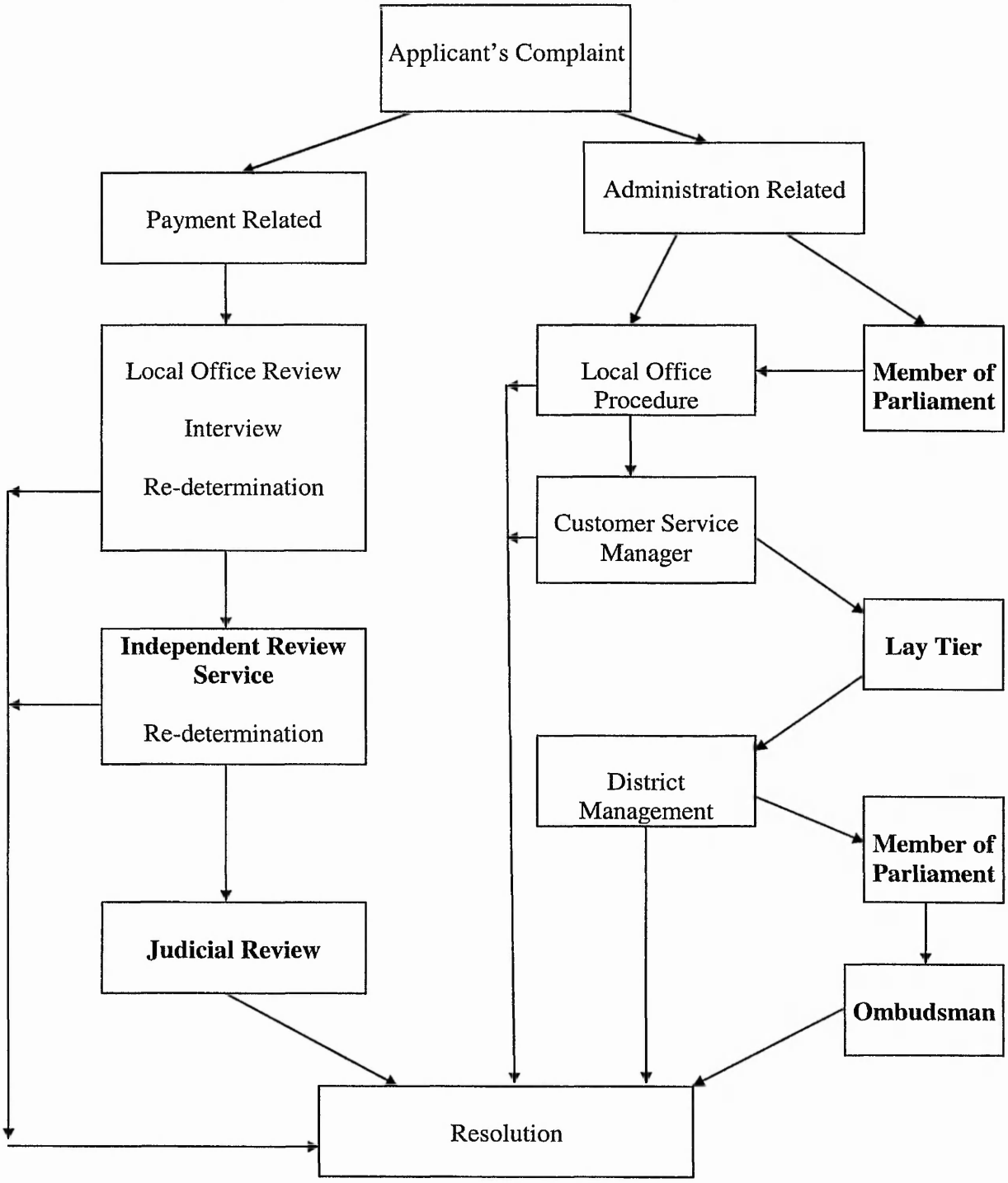
APPENDIX 4.

PARLIAMENTARY QUESTIONS REGARDING SOCIAL FUND PRIORITIES

Reference: Hansard Sixth Series	Question To ask the Secretary of State for Social Security:	Answer
Vol. 186 Col. 403 25/2/91 Mr. Allen	- how many local offices in Nottingham and the UK are currently giving CCGs from the Social Fund to (a) high priority applications only; (b) high and medium priority applications only and (c) high, medium and low priority applications.	The information requested is not available and could be obtained only at disproportionate cost
Vol. 186 Col. 474 26/2/91 Mr. Allen	- if he will list the changes in priority categories used for allocating grants from the Social Fund since its introduction, for each of the local offices where the criteria have changed.	The information can be obtained only at disproportionate cost.
Vol. 186 Col. 606 28/2/91 Mr. Cousins	- what are the local Social Fund allocation priorities in each of the three social security offices serving Newcastle-upon-Tyne, identifying any change in these priorities since April 1989.	This information could be provided only at disproportionate cost.
Vol. 186 Col. 658 1/3/91 Mr. Allen	- if he will list the changes in priority categories used for allocating grants from the Social Fund since its introduction for each of the Nottingham offices, along with the dates and duration of the changes.	The information requested is not readily available and could be obtained only at disproportionate cost.
Vol. 187 Col. 284 7/3/91 Mr. Allen	- what procedures exist for his Department to monitor the local priority categories used for allocating grants from the Social Fund and changes which take place in those priorities.	There are no centrally imposed procedures for monitoring local priority categories, or changes which take place in those priorities. This function is the responsibility of the relevant local manager who, as the appointed area social fund officer and budget holder, is required to issue guidance on matters specified by the Secretary of State. That guidance must take account of local factors in specifying priority needs for grants and loans and the levels of priority which may be met from the expenditure allocation for the local social fund officers for the relevant period. The area social fund officer is also required to monitor and review at least monthly the planned expenditure and the priority needs and levels for his locality and to revise them as necessary. It follows that this guidance can vary from one local area to another, thus ensuring that the highest priority need in a community are met.

APPENDIX 5.

SOCIAL FUND COMPLAINTS PROCESSES



Figures in bold typeface are, to some degree, independent.

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Joined Up Accountability: Bringing the Citizen Back In

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Abstract

Accountability in complex organisational networks has been identified as particularly problematic, and an issue to be addressed, both in academic and in official documents. Indeed, in launching its new public service reform agenda, the Labour government has undertaken to address accountability at a later date rather than as an integral part of its approach to reform. This article seeks to address these questions of accountability, suggesting the need to reformulate our understanding of the concept itself, placing a citizen-focused accountability at the heart of the way in which services are understood and evaluated.

Introduction

That services provided through networks of organisations present a problem for accountability has long been recognised. Rhodes (1997, p.59) offers some 'speculative comments' on these problems, suggesting that the hierarchical and organisationally defined forms of accountability will no longer hold where services are being delivered through collaborative forms of government. Perri 6 (1997), developing his ideas on holistic government, has suggested that there needs to be more 'downward accountability to and involvement of users and local populations' (ibid., p.36). Yet these problems and issues have not been thoroughly addressed. Indeed, in launching its new public service reform agenda, the government in the UK has put these issues aside, merely indicating the need to confront them at a later date (Cabinet Office, 1999, p.18).

Drawing upon a programme of research in two case study public services, this paper will attempt to address the problems posed by new forms of public service. While the case studies are of services that predate the collaborative agenda, they share many of the emerging features of services responsive to local communities and highlight the constraints of extant forms of accountability. Indeed, I will suggest, we need to reconsider the meaning we attach to the concept of accountability as a way both of developing collaborative and responsive services, and of holding them to account.

Accountability: a contested concept

The nature of accountability has been a contested concept for much of the past twenty years. Most famously, debates over the question of the 'democratic deficit' reflect the degree to which there is no agreement as to what we mean by the term. The central themes of the debate about accountability in the UK might best be indicated by reference to an exchange of views between Stewart (1992) and Waldegrave (1993). In discussing the topic, the former used the language of democracy and collective decision-making, while the latter deployed arguments familiar to public choice theory. In this respect, the debate mirrored to a large extent, the wider debate about the nature of public management and the appropriate systems for delivering public services.

Stewart's (1992) vision of accountability is a familiar one of a government and public service controlled by democratically elected politicians. It is a system of control in which the state is accountable to citizens, as a whole, for its use of delegated powers. The state only legitimately exercises authority over citizens to the extent that the powers they use are delegated by the very same citizens. Choices are exercised in a political arena, through debate amongst all citizens and are then applicable to all citizens.

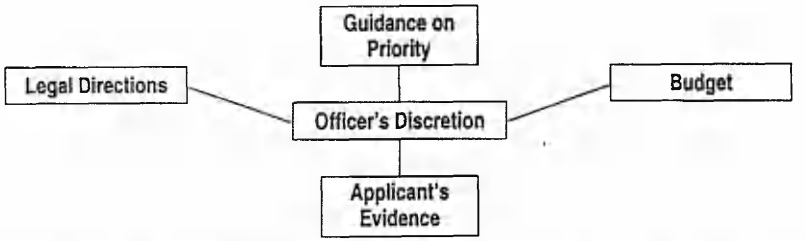
For Waldegrave (1993), then the Minister responsible for civil service reform, such a vision of the public service is fundamentally flawed. He identified bureaucratic tendencies to both expand public services and also to fail to deliver services of the quality citizens demand, tendencies widely identified by public choice theorists (e.g., Niskanen, 1971, and Tullock, 1965). Waldegrave also suggests that democratic control is not a sufficient discipline to counter these tendencies. Collective choices, from this perspective, drive the expansion of the provision of public services. For Waldegrave, market and quasi-market disciplines are the antidote, not democratic ones. The state should be accountable in the same way as any other enterprise. Account should be given to taxpayers-as-shareholders, while customers influence the quality of goods in the way they exercise their choices in a market place. In giving account, this largely removes reference to policy choices on a collective level. Taxpayers seek to minimise their costs while users seek to maximise the services. The citizen does not feature in this model.

These two models present very different understandings of accountability. While both are concerned with controlling the actions of the executive, they approach the problem differently. The first places a greater emphasis upon political control, defining rights, which are due to all citizens. The second emphasises financial controls over services, converting rights into commodities. To progress this debate, my research has sought to understand the nature of accountability as it actually applies to services, considering the extent to which the various forms of accountability actually provide an account of the services selected. This approach has allowed some reflection on the manner in which the variety of accountability mechanisms combine to expose the selected services to outside scrutiny and understanding, and at the same time make them responsive to the users of those services.

The Case Studies

With this in mind, two case studies were identified, each having characteristics that present particular problems for accountability: the first the social security Social Fund; and the second the commissioning of mental health services. Each of these services presents problems of accounting for the allocation of resources and the application of guidance in light of local circumstances while providing two differing approaches to accountability, the one national, the other with a local element. Operating within financial constraints, and constrained by legal and political guidance, the services seek to respond to the needs of individuals and of the communities they serve. In doing so, they utilise considerable discretion, making judgements about priority that significantly affect the lives of individual citizens, and the communities within which they operate (see Figure 1).

Figure 1: Bounded Discretion



These features, of freedom within limits, and particularly financial limits, are present in many of the forms of public service emerging under the new government's reform agenda, for example:

- Health Action Zones: developing innovative and collaborative responses to local health inequalities;
- Urban Regeneration Programmes: allowing a degree of latitude in the use of budgets for regeneration activities in socially and economically deprived communities; and
- Employment Action Zones: inviting private sector participation in efforts to tackle unemployment.

These are clear examples of the group-focused and area-based programmes of which the government speaks in the *Modernising Government* white paper (Cabinet Office, 1999, p.29). They seek to encourage local innovation within a national framework, harnessing bottom-up ingenuity and local knowledge together with a clear national top-down steer. Further, each of these initiatives entails the allocation of additional resources and, behind these allocations, lie questions of choices and priorities affecting the lives of individuals. They are not simply extra services, they are extra services for locally perceived priorities, and are the product of a series of choices.

These are precisely the features of modern public services that, in the course of

this research, have emerged as the ones presenting most problems in giving an account for actions and outcomes. How are priorities, and the choices underlying them, to be open to understanding, to challenge and to the experience of individuals accessing services? The findings of this research, then, will throw some light onto the problems posed in accounting for new forms of collaborative government.

Accountability and Organisational Control

A review of the form accountability for bounded discretion takes reveals the degree to which these forms present a limited picture of the organisations and services they purport to describe. In offering an account to Parliament, emphasis is placed on the degree to which performance criterion have been met. As such, forms of performance management have come to be used to discharge the duty of accountability. In the case of the Social Fund, reports detail adherence to financial limits and the speed with which claims are processed (Department of Social Security, 1998a). These summary indicators present an unproblematic image of the scheme. There is little indication that the fund is a discretionary scheme, or that there may be a variety of outcomes concealed behind these summaries. Further reports give some statistical data regarding the recipients of awards from the fund at an aggregated level (Department of Social Security, 1998b). Yet these too offer no means of judging whether assistance has been awarded to those most in need, no indication of the consequences for those refused, and no information about geographical variations. External evaluations (National Audit Office, 1991, and Huby and Dix, 1992) have uncovered some of the complexities, recommending changes, but no form of political accountability has proved capable of securing action from the executive (for a fuller discussion see, Rowe, 1998a).

In giving an account of discretionary services, these mechanisms merely report on the boundaries to discretion (see Figure 1). They confirm that financial constraints have not been breached, but not how the funds have been disbursed. They indicate that management priorities, such as the speed with which applications are to be processed, are achieved. They confirm that, where individuals have been unhappy with the outcome of decisions, they have had access to a process of review, confirming that rules are subject to checks and redress. As such, they give an account of the boundaries to discretion, but not of the application of discretion (Rowe, 1998b).

The current model of accountability, then, is inadequate as a means of understanding the complex patterns of outcomes that emerge from services intended to respond to local communities. They conceal the form services actually take, and have little regard to their outcome and impact upon individuals or communities. They are not capable of giving an account of collaborative forms of government intended to be responsive to the needs of communities in the fashion envisaged in the government's statements:

> The Government wants public services that:
>
> - *listen to people's concerns* and involve them in decisions about how services should be provided.
> - *are sensitive to the needs of particular groups of people or businesses.*
> - *reflect people's real lives.* Government should be organised so that people don't have to *hunt* down services by a process of trial or error.
> - *make it easy to complain and get a result when things go wrong.* (Cabinet Office, 1999, p.25. Emphasis in original)

Illustrating the discussion with the accounts of health service, social service and voluntary workers, the remainder of this paper will look at key characteristics presenting problems in accounting for public services, problems that suggest a different conceptual approach to accountability.

Representing Complexity

The uniformity depicted in accountability mechanisms is belied by the accounts of others, both within and outside the services concerned. The simple representation of these complexities does not only conceal them from external scrutiny but also hampers the evaluation of management internally.

Figure 2: Illuminating Choices

'So I would argue the Regional Office performance management function should take the spending that comes down to them, through their pockets down to the Health Authorities, and divide it up into some broadly understood divisions – okay, you can argue 'till the cows come home how you do it, but just broadly, and that's indicative. And then you can start to say, OK, lets look at your spending on renal hospital services. I mean, that would be critically important because all we ever look at is do you dialyse two or three times a week? What's the marginal additional cost of dialysing between two or three times a week? That's the critical question. And look at the value of that compared with taking that resource and investing it in mental health, or cancer, or whatever. I mean, we hear about all these variations in cancer services. I've never heard anybody talk about the variations of investment in cancer services.'

Reported in Figure 2 are the thoughts of a senior manager in the health service. Commenting on the value of statistical data, the interviewee illustrates the inadequacy of the picture they present of the service provided. Numbers of patients treated, numbers on waiting lists and summary financial data do not describe the complex patterns of choices that lie behind volume counts. Yet these choices, about services and the resource to be devoted to those services, are key to any understanding of the outcome of the service for individuals and communities. Whether comparative financial data would be sufficient to fully illuminate these decisions is disputable, but the additional data would shed some light.

These complexities in service characteristics are aggravated by the trend to managerialism, allowing public servants freedom, within certain bounds, to deliver outcomes in the light of local circumstances. Such managerial discretion brings variations in services, variations again not easily captured in summarised data.

Figure 3: Managerial Discretion

'But the big problem is the move to [office name]. We've really got concerns about that. We're concerned about the distance. We were told that people could claim fares when they get to the office ... The big problem is, we're not an advice agency like the Citizen's Advice Bureau as such. We haven't done any monitoring, so I don't know how its working. It's a big concern. When there were questions at the meeting, they said, it's a direct bus line, people travel around London all the time. It shouldn't be a problem. But people who've got to go there for a review are disabled, elderly, people that can't .. I don't know what's happening.'

The freedom to move work between offices, as described by the social worker in Figure 3, a freedom that makes sense in a narrow managerial context, has a direct impact upon service recipients. Those users not happy with a decision and seeking a review of that decision are invited to attend interviews to raise their objections. While this is not compulsory, research evidence suggests that those who attend the interviews achieve much more satisfactory results from the review (e.g., Dalley and Berthoud, 1992). Moving work between offices, then, reduces the possibility of a successful review for precisely those vulnerable people for whom funds are intended to be available. Yet the impact of such decisions is only reflected, and then only marginally, as an increased level of efficiency in processing claims. There may also be some reduction in the number of reviews and of successful reviews. But this does not give an account of the decision, and certainly not of its impact. The social worker's frustration is evident in the tone of his remarks. The individual's experience of discretionary decisions is even more problematic.

Figure 4: Discretion and Irrationality

'One I've got, which is ongoing, which is someone paying his hospital fare to go and visit their daughter. This has been going on for 18 months now, and they have to apply every 3 months. I think I've done 5 reviews so far. I think only 2 of the awards were all right. Each person makes a different award and decides for this 3 months it is all right for mum and dad to go 4 nights a week. Then the next person decides, no, only dad needs to go 1 night a week, or mum 2 nights a week. Same case. Nothing's changed and you never know what decision you are going to get out of it. The last time, they refused it on the grounds that they're asking for an excessive amount of money, that it wasn't reasonable. And they were asking for the amount of a weekly travel card. I can't really work out how that would be unreasonable, because that's the cheapest way of getting there. Its just one example.'

Figure 4 reproduces the reflections of the same social worker on the process of assisting a couple in applying for a discretionary grant. The worker's description starkly illustrates the problem of accounting for discretion. While the different decisions reached may be defensible from an organisational

perspective, being the result of budgetary pressures or of changing priorities, from the perspective of a service user, they are irrational. Current forms of account summarise these encounters in numerical form, detailing the speed with which each decision was reached, the number of awards granted or refusals issued, the value of the awards made, and the average value of awards. The applicant is able to seek a review of the decisions but, as long as officers have not exercised their discretion in an inappropriate manner, may not get any satisfactory answer. These mechanisms do not, however, present an account of the transactions described in the gobbet in Figure 4.

Nor do accounts inform us of what happens to those refused assistance. Refusal of assistance from the Social Fund has a wider impact upon other organisations. If assistance is refused from the Social Fund, satisfaction of a need may be transferred to other funding sources, whether that be local authority social service departments, charitable organisations or, with serious consequences for poverty, to loan sharks and the hidden economy. An account of the Social Fund is not complete without some assessment of the outcome of a refusal of assistance, as well as of an award. Figure 5 records a conversation with a senior anti-poverty worker in a local authority social service department describing the impact upon social work resources.

Figure 5: The Wider Consequences

'The other side of the coin, of course, for us, is where the Social Fund fails to pay out, there is pressure on Section 17 budgets under the Children Act. Or social work, care worker time spent running around looking round thrift shops for £20 cookers, the time in terms of advocacy, going through the Social Fund application process, and the appeals process, and the other appeals process. But there is also the knock-on effect in terms of local authority budgets where the state fails to pay, at a national level fails to deliver in terms of social security benefits, and that individual is left without, invariably, local authorities, which have a cash-granting power under the Children Act, have been compelled to kick in. And you've only got to look at the research on the use of Section 17 to see where the expenditure has gone. Its gone on assistance with purchase of one-off items. Its gone in tiding people over because their benefit cheque hasn't arrived. Because appropriate use of that money is if it is ensuring that a child is not going to have to be received into care.'

Even in narrowly financial terms, accounts of services that do not acknowledge the costs transferred to other statutory bodies or to other sectors are fundamentally flawed. How can value for money be assessed without this information? If the terms of an evaluation are widened to incorporate social costs and benefits, an assessment of the impact of refusing assistance upon other sources of funding, such as charities, and upon the circumstances of those refused must be undertaken. Recognising the complexity and interdependence of public services suggests there are inadequacies inherent in accounts designed to control and confine the actions of public servants, rather than understand them.

Overseeing Street Level Bureaucrats

The exercise of discretion, whether by managers or by front line workers, raises concerns about the standards of the individuals exercising authority. Such authority has, on the whole, been limited in the past to the professions. These professions, as independent interests, have been imbued with values of impartiality, integrity and a commitment to act in the best interests of their clients. In a sense, this provides some assurance that, while decisions may be discretionary, those making them are qualified, and to be trusted to undertake the role.

Those exercising discretion in the emerging forms of public service may not be so readily worthy of our trust. In managing the conflicting pressures of organisational priorities and client demands upon resources, there is significant evidence that street level bureaucrats will adopt practices to manage these pressures (e.g., Lipsky, 1980). Figure 6 illustrates this tendency, detailing a conversation with welfare workers providing day centres for the homeless in a large conurbation. They describe Social Fund Officers rationing services by presenting barriers to individuals seeking to access those services.

It is not simply that these barriers do not form part of any account of the service that should concern us. The barriers are entirely improper. Assisted by welfare rights workers, experienced in the behaviour of public officials and the rights of their clientele, applicants may persist against such barriers. Unassisted, and uninformed service users, confronted with administrative rationing strategies, may take the 'advice' given at face value and, consequently, not obtain services they may legitimately need.

Figure 6: Administrative Rationing Strategies

A – 'The prevention of access to the Social Fund, in terms of Crisis Loans, is quite systematic. Because it starts at the initial reception when the client will ask, inquire about the possibility of applying for a Crisis Loan and they get told by the receptionist, well, you know, you've got no chance, you're wasting your time, you know. The reception may or may not inquire about some brief details, you know. That would deter most clients.

'And then, if a client does get past that stage, you know, we try to encourage the client to insist on seeing the Social Fund Officer who is the only one empowered to make the decision. But the Social Fund Officer will also, very often, take the same approach, you know, that you're not going to get one. And the clients, by this time, will have waited for some time to see the Social Fund Officer.

'Then the client may ... we've tried to forewarn them ... they may insist on making the claim anyway, and they're told, well, you're wasting your time. You can make one if you want to, but you are wasting your time. That will maybe take to some time mid-afternoon, after the client's been there all the morning...'

B – 'Heaven help you if you go in at 4 o'clock in the afternoon.'

A – 'Then the Social Fund Officer fills in the form, and the clients that have got that far will often report that the Social Fund Officers are reluctant to show them what's on the form. They're asked to sign it, but they're not ... The client's asked to sign it, but the Social Fund Officer doesn't really want them to look at it. And then of course the client will look at it and will not be happy with what's in there. There's a lot of questions on there that they just haven't ... the answer's been assumed or abbreviated. And then, finally ... because we do recommend that the client insists on a written decision, because the verbal decisions that are given are atrocious, you know, are unbelievable. They're told that, for example, because they're using the Day Centre that they can get food on a credit system and they are not entitled to a Crisis Loan. They're never told that, obviously, in writing, but they're told that frequently. Or they're told things like, if your Jobseeker's Allowance has not been processed yet, we can't pay you until you are on computer, which of course defeats the point of applying for a Crisis Loan.'

Ensuring that those exercising powers are qualified to do so, and assuring users that they will receive quality advice from those public servants must form an important element of services intended to respond to the needs of individuals and communities. Even the standards of professionals, notably the police and clinicians, have come under scrutiny in recent months, demonstrating the degree to which the outcome of such services are heavily dependent upon the quality of the individuals empowered to influence them.

Responding to Needs

While I have described problems and issues in accounting for the kinds of responsive services that are emerging from the collaborative agenda, there is real potential, given room, to meet actual needs in the manner envisaged.

Figure 7: Responding to Individuals

A – 'They [applicants for review] don't like to argue really, do they. They are worn out by the process of being there in the first place. Sometimes waiting an hour, sometimes an hour and a half. They sit in a very hostile environment often, and they are completely worn down by the time they get to see somebody.'

B – 'They sit in a tiny little room on rock solid benches at a very awkward angle with a glass screen in front of them, to go through this appeal. The rooms are filthy, fag ash everywhere.'

A – 'And we are, both of us, talking about people who are sick. The levels of anxiety among my clients are very high anyway, so the sooner they can get out the better. They aren't going to argue about what's written down. But sometimes they [Social Fund Review Officers] come to the home on a visit.'

B – 'Yes, you can get them to do a home visit for a review. It can take a bit of forceful pushing to get that to happen, but when they do that the reviews generally go quite smoothly and you get the award. I find, with the reviews done at home, the Social Fund Officer goes away saying well, you should perhaps make another application for that

and that and that, because they are actually seeing the conditions someone is living in, and it does in some cases shock people.'

Figures 7 reports a conversation with two social workers reflecting upon the experience of seeking a review of Social Fund decisions, an account at odds with the formal accounts presented of the process. While describing the hostile nature of the process of review, there emerges a positive element in this account. Where decisions made on the basis of paper applications can be made with little regard to the individual behind the application, at a review, dealing with a real human being, decisions can be made that are sensitive to their needs. Placing the bland information presented in application forms in a human context potentially transforms the exercise of discretion. Indeed, it is this image of discretion that policy makers hold in their minds, rather than those described earlier in this piece.

Reflections

Current accountability mechanisms fail to depict the complexities that lie behind services intended to respond to local needs, to communities and to individuals. As such, and as suggested by Perri 6 (1997) and Rhodes (1997), these forms of accountability will be inadequate to the task of opening up collaborative and responsive services to external scrutiny and understanding. Interviewees have, in the course of my research, consistently expressed the view that, in focusing upon control, and specifically organisational control, accountability systems fail to provide an explanation, a true picture, of the services they purport to describe. Just as collaborative forms of government seek to break down barriers to service provision, so accountability systems will need to recognise relationships between services, and between individuals and services.

Without information that acknowledges and reflects the patterns of and variations in services, there is no basis upon which citizens might evaluate the outcomes that emerge. This in turn presents problems for the effective exercise of political judgements and, ultimately, democratic choices. Further, this lack of explanation poses difficulties for individual citizens engaging with public services. Without a clear context in which to place the outcome or service received, there is no basis upon which an individual might hold a service accountable.

Our understanding of accountability needs to reflect the changing nature of public services. Systems once suited to organisational and hierarchical control are not capable of opening up the complex relationships described in my research and present in the emerging forms of collaborative government. Accountability needs to be conceived as a means to understanding these relationships, not controlling them in the crude fashion of the functionally ordered services of the past (Perri 6, 1997, p.26).

This must entail the incorporation of the experiences of users and of citizens. Just as Wilmott (1996) describes accountability in terms of learning of oneself through the accounts of others, so public services may only be understood through the accounts of users and their experience of those services. Roberts (1996) suggests that socialising forms of accountability is the basis of understanding reciprocal dependencies. While no easy way to understand accountability, recognising that public services, and the performance of public services, is socially, and not technically, defined recasts accountability as a means to understanding the nature of increasingly complex and variable public services. Bringing the accounts of citizens back in to our understanding of services will allow the presentation of accounts that reflect a reality at odds with accounts generated by organisations alone.

Conclusions

There are early indications of the form the government envisages accountability will take. Picking up on the themes of the Democratic Audit (Weir and Hall, 1994, and Weir and Beetham, 1999) and similar work, there have been some moves to extend the coverage of some of the mechanisms of the past to more public bodies (Cabinet Office, 1998). The Modernising Government white paper has further suggested the role of ombudsmen might be extended (Cabinet Office, 1999, p.32). Moreover, the terms of reference for the Performance and Innovation Unit, formed to 'examine the accountability and incentives framework', mentions 'cross-cutting performance measures and appraisal systems' (ibid., p.18). These proposals do not represent the conceptual transformation of our understanding of accountability that collaborative forms of government demand. Without such a transformation, the patchwork of services that will begin to emerge from the new reform agenda will remain largely closed to external scrutiny and understanding.

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Correction: An error on the part of the Editor led to Josie Brooks' institution being listed incorrectly. She is, in fact, at the Southampton Institute. The Editor apologises for this mistake (Volume 14, 1, p.42).

NOTES FOR CONTRIBUTORS

1 All contributions and correspondence should be sent to: Dr Barry J. O'Toole, Department of Politics, University of Glasgow, Adam Smith Building, Bute Gardens, Glasgow G12 8RT, UK

2 Articles should not generally exceed 6,000 words, including references and tables. Longer articles may exceptionally be considered.

3 Submission of an article is taken to imply that it has not previously been published and that it is not being considered elsewhere. If an author is publishing a related article elsewhere, this fact should be stated.

4 **Contributions should be delivered on disc in ASCII text and in hard copy. They should be clearly typed on one side of A4 paper. All material should be double spaced and with generous margins. Contributors should send three hard copies and keep one of the typescript. Ensure that the final disc version is accurate.**

5 Contributions should be accompanied by an abstract of no more than 200 words.

6 Footnotes are discouraged. However, if it is absolutely essential, they should be numbered in the text and listed at the end.

References should be incorporated in the text using the Harvard system, i.e., the author, date, page system (e.g., Heclo and Wildavsky, 1974, 1981 edn., p.6). References should be listed at the end alphabetically (and where appropriate in year order) in the form: Heclo, H., and Wildavsky, A. (1974, 1981 edn), *The Private Government of Public Money*, (London and Basingstoke: Macmillan).

Journal references should take the form: Fischoff, B. (1977), 'Cost benefit analysis and the art of motor cycle maintenance', *Policy Sciences*, Vol 8, No 2, pp.177-202.

IT IS VERY IMPORTANT THAT THESE FORMULATIONS BE FOLLOWED.

7 Tables should be clearly laid out and designed to fit onto an A4 page. Vertical lines between columns should be drawn, but horizontal lines limited to the top and the bottom of the table, with an additional one below the column headings. Totals and percentages should be labelled and units identified.

8 Single quotation marks should be used (ie 'example')

9 **Articles to be published will always be sent to referees.**

10 Articles will be proof-read at the typesetting stage and by the Editor.

11 **Authors are solely responsible for obtaining permission for any extensive quotations, and for ensuring the accuracy and fairness of their contributions. The journal does not accept responsibility for any of the opinions of the articles published.**

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THE ACCOUNTABILITY OF PUBLIC BODIES

in

Public Administration Select Committee (1999), *Quangos*

HC209-II, Volume II, Pages 209-212

be a "diary" of relationships, meetings, outline programmes of work, reports, minutes of meetings etc. This is merely an instantiation of the Access Laws to which attention has already been directed. All this is a bare minimum and should be included in the equivalent of an Administrative Procedure Act while, of course, the general range of activities would be subject to selective monitoring by the Standing Administrative Conference.

Partnership programmes of work should be published in advance and made subject to "rule-making procedures" which allow all interested members of the public to comment and observe on the programmes and their progress. It would be imperative that an official public record of all such observations be made available. Decisions of such partnerships, as well as of public bodies in general should be subject to a legal requirement to be accompanied by reasons for the decisions.

Although public bodies are currently the main focus of your Committee's concerns, the principles by which their accountability and effectiveness should be judged are substantially the same for all the delivery mechanisms for public services; the private sector, the voluntary sector, partnerships; the whole panoply of "governance".

In addressing these themes it is worth reverting to the recent speech by the Lord Chancellor when he said:

> There are uniting themes and objectives—modernisation; decentralisation, openness; accountability; the protection of fundamental human rights; the sharing of authority within a framework of law . . .[96]

It is to be hoped that a new framework of law does indeed accompany developments in the world of governance. Administrative discretion is no substitute for civil entitlements at the end of the day.

January 1999

MEMORANDUM 45

Submitted by Mike Rowe, Nottingham Trent University

SUMMARY

This memorandum presents evidence emerging from a research programme examining the changing nature of public accountability. It suggests that there are serious flaws in the way accountability is currently understood and identifies some issues for the future:

- because of their focus upon organisations, current accountability systems are not well adapted to the increasingly complex networks of service providers that are developing in many areas of the public service;
- similarly, current accountability systems are better suited to ensuring regularity of implementation in bureaucratic organisations than they are to overseeing local discretion and autonomy, features increasingly common in modern public services;
- a product of these two weaknesses is that current systems fail to fully describe public services, merely that some constraints are adhered to; and
- accounts of the increasingly complex patterns of and variations in modern public services need to encompass not only management information, but also the experience of those citizens engaging with public services.

INTRODUCTION

1. This memorandum is submitted in response to the Public Administration Committee's request for evidence on the Accountability of Public Bodies. In particular, the memorandum will address two of the key issues identified by the committee:

- mechanisms for making public bodies accountable to the public whom they affect; and
- arrangements for accountability where different agencies work together in partnership to deliver services.

BACKGROUND

2. The evidence presented draws upon the findings emerging from an ongoing research project examining accountability, both as a concept and in practice.

3. Inquiries into accountability, whether academic or otherwise, have generally taken one of two foci: either individual organisations/organisational types; or accountability systems, whether political, financial, judicial, managerial or other. By their nature, the conclusions such inquiries reach are that accountability

[96] *Loc.cit.* Emphasis added.

systems should be applied more uniformly across all types of public bodies and/or that accountability systems should have more "teeth".

4. In contrast, the research, upon which this memorandum draws, has sought to understand the reality of accountability as it applies to specific services areas. The findings, outlined below, are the product of extensive research within two government departments, and in-depth interviews with a range of individuals and organisations with an interest in, or affected by specific services provided by those departments.

New Public Services

5. While attention has been paid to the proliferation of public bodies, of new forms of organisation and the accountability arrangements applied to these, the focus of my research has been the developments in what those organisations do and the impact this is having upon accountability. Services are increasingly characterised less by regulation and predictable patterns of outputs, and more by discretion within financial and legal constraints, and complex patterns of outcomes. Understanding the problems that these developments present in making services accountable is the purpose of this memorandum.

6. Thus, in contrast to the focus on organisational types, my research has identified key characteristics of the services those organsations deliver and the functions they perform that present particular problems when giving account for those services:

- **service dimension:** that is the nature of the service being considered;
- **service deliverer dimension:** that is the nature of those providing the service; and
- **service recipient dimension:** that is the nature of those to whom or for whom the public function is delivered, or over whom public authority is exercised.

The Service Dimension

7. The character of the service to be held accountable must be integral to an understanding of appropriate means. Those approaches to accountability that focus upon organisational types assume not only that all services may be treated alike, but that the understanding of particular services is unproblematic. However, the relationship between policy, legislation, implementation and outcomes can be, in many services, complex and contentious. Indeed, the increasing use of enabling legislation, of secondary instruments and, in some areas of public policy, of other forms of direction and guidance, together with the encouragement of greater managerial autonomy, has made such links more complex.

Complexity—policy

8. The extent to which the relationship between inputs and outputs can be defined, and outcomes specified affects the degree to which the accountability of a service may be reduced to numerical performance indicators and to which it will be open to quasi-contractual arrangements. In so far as there is real choice available, consumer (often the "purchasing" body) preference, as a mechanism for securing accountability, is appropriate in some respects. This is particularly so when the "customer" is an internal recipient, such as those of the Information Technology Services Agency in the Department of Social Security. Where a service is more difficult to define, simple mesures may obscure the nature of that service.

9. The clearest examples of such complexity are those services characterised by discretion, whether formal or informal. Discretionary decisions are generally made within a framework of rules and guidance. They entail the allocation of services from a scarce resource, whether financial or human, on the basis of the evidence of need, relative to others, as presented by individuals. Thus heavily constrained, there is, nevertheless, substantial room for variation in outcomes. While these variations may reflect the individual circumstances of each case, they are not easily reflected in performance indicators or other reporting systems. More significantly, accountability systems, in summarising decisions in the form of volume statistics, give no account of the application of discretion. Instead, accountability systems reflect adherence to the constraints upon discretion, rather than the way in which that discretion is exercised.

10. Giving account of services that are not easily defined or characterised, let alone summarised in performance indicators and financial statements, especially where the outcomes can neither be predicted nor easily described, requires a more sophisticated approach to accountability. In giving an account, current mechanisms demonstrate an emphasis on the actions of public servants. No account is given of the service provided.

11. These complexities in service characteristics have been aggravated by the trend to managerialism, allowing public servants freedom, within certain bounds, to deliver services in the light of local circumstances. Such managerial discretion brings variations in services, variations that are not easily captured in summarised data. Indeed, I would suggest, variation is also prevalent in heavily regulated public services. The problems

in making a distinction between management and policy can be seen at the lowest levels of public organisations. Even the location of an office can affect service outcomes, thus affecting policy.

12. Service complexity, then, requires a more descriptive approach to accountability, an approach recognising the impact of discretion and managerial freedoms upon the outcomes of services.

Complexity—institutions

13. The degree to which the product or purpose of a function is heterogeneous or complex, involving various actors, will similarly affect the extent to which policy intentions are easily translated into action and to which outcomes can be anticipated and predicted. More significantly, where services are provided by a range of organisations, accountability systems that apply to organisations will give little account of a service. This is particularly true in areas such as joint commissioning for continuing care packages between local authority social service departments and health authorities. Here tension between commissioners and/or providers arises, tension over responsibility for a service and its cost. Where a service is provided in tandem with external agents, through networks of providers, accountability has become fragmented and problematic.

14. Further, few services have no impact upon others. While the delivery of a service may not be dependent upon others, is an account of that service complete without reference to its wider impact? For example, the social security Social Fund is a discrete element of the welfare system, treated separately even within the Benefits Agency. Yet, refusal of assistance from the Social Fund has a wider impact upon other organisations. If assistance is refused from the Social Fund, satisfaction of a need may be transferred to other funding sources, whether that be local authority social service departments, charitable organisations or, with serious consequences for poverty, to loan sharks and the hidden economy. An account of the Social Fund is not complete without some assessment of the outcome of a refusal of assistance, as well as of an award.

15. Recognition of the complexity and interdependence of public services suggests there are inadequacies inherent in accounts designed to control and confine the actions of public servants, rather than understand them.

THE SERVICE DELIVERER DIMENSION

16. In light of the increasing freedom and discretion available to them, the characteristics of service deliverers, their professional status and the degree of independence with which they exercise their authority, are key issues in accounting for services. Their decisions are immediate and personal, affecting the life choices of individuals, and are not easily open to proscription by rules and regulations.

17. Such freedom and authority has been associated most commonly with professions, applying specialist knowledge and working to codes of conduct developed and supervised by their peers. This status, independent of political intervention, with concomitant values of impartiality, integrity and a commitment to acting in the best interests of individual clients, and not of management, has provided an alternative form of accountability. This form has not sought to describe the services delivered, but to guarantee that those delivering it are individuals worthy of the trust of clients, imbued with certain values and qualified to perform their role. Recent cases involving the police and the medical profession have undermined these claims, yet it remains accepted that such checks have a legitimate role in the oversight of the exercise of professional discretion.

18. No such basis of trust, nor constraint upon improper bias exists in the burgeoning "street-level bureaucracies" exercising discretion and freedom where previously they were heavily regulated. Indeed, evidence suggests significant inconsistencies exist, for example in social security.

19. Behind many of these findings lie suspicions not just of inconsistency but of bias and prejudice on the part of individual officers, suspicions readily confirmed by welfare rights organisations. Whether these suspicions are founded is not entirely the point. That there is no way to refute them is also key. There is no peer review, no easy basis of trust in the competence, independence and impartiality of such officials.

THE SERVICE RECIPIENT DIMENSION

20. Whether a service is provided to institutions or to individuals; whether their involvement is voluntary or compulsory; and the extent to which a public service requires certain behavioural patterns of the subjects will affect the degree to which a service is intrusive and provocative, and thus more likely to be challenged.

21. Where public services with the capacity to significantly alter the well being of individuals are concerned, the question of relative power becomes important. The greater an individual's knowledge of the service with which they are dealing, and the services to which they are entitled, the more likely they will receive the service intended. Where companies, or other associations and groups, come into contact with public bodies, that contact is often mediated by professionals, such as accountants or lawyers, well versed in their client's rights. In such circumstances, the relationship may even involve a degree of negotiation, for instance over tax payments.

22. Relationships will tend to be somewhat different in the field of welfare services. Those seeking assistance from these services will often be vulnerable, due to personal circumstances. In addition, they are more likely to experience other barriers to accessing services and assistance, such as language problems, physical or mental disabilities, or the barrier of stigma associated with poverty. Where the services are highly technical and complex, as is the case in social security, the imbalance in knowledge, and consequent power, makes access to services much more problematic for individuals, presenting an accountability problem. It is characteristic that, in such circumstances, the service provided is not open to negotiation in the way that it might be for others accessing other public bodies.

23. Capturing the reality of these experiences of public services is not simply a matter of further mechanisms to resolve complaints, such as tribunals. Routes for redress are equally difficult for individuals to access. Nor, indeed, is it simply a matter of fairness. The reality of the way in which a service is provided may bear significantly on the outcomes of that service. A description of a service that does not reflect this reality is only a partial account.

Emerging Findings

24. In seeking to account for complex services, ones that by their very nature will vary from one locality to another, current systems emphasise the extent to which those services adhere to certain constraints, be they financial, legal, process or other forms of direction. Within these constraints, ranges of different decisions are taken that are not fully reflected in the information about such services. Accountability systems report on the bounds to discretion, not upon the application of it. These reports present a picture of uniformity and of consistency, accounts that do not recognise the potential for the unequal provision of services and the problematic use of autonomy. Where organisational complexity is also a factor in the form of outcomes provided by public services, the lacunae in accountability systems centred upon organisations became more apparent.

25. Interviewees have, in the course of the research, consistently expressed the view that, in focusing upon control, and specifically organisational control, accountability systems fail to provide an explanation, a true picture, of the services they purport to describe. Inaccuracies of this nature present problems for the effective exercise of political judgements and, ultimately, democratic choices.

26. Further, this lack of explanation presents problems for individual citizens engaging with public services. Without a clear context in which to place the outcome or service received, there is no basis upon which an individual might hold a service accountable. Nor, my research suggests, is it possible to describe that outcome without taking account of the experience of the individual citizen in engaging with a service.

Conclusion

27. These features of public accountability are the consequence of current understanding of accountability as a form of control. Emerging from the research is the need to re-address that conception, to recast accountability as a means to understanding the impact of increasingly complex and inter-related public services, and, at the same time, of informing democratic choices.

January 1999

MEMORANDUM 46

Submitted by Dr Chris Skelcher, The University of Birmingham

The debate about the appointed sector of government (the "quangos") in the mid 1990s produced a flurry of activity to strengthen their governance and accountability. These reforms were a result both of official action—eg following the various reports of the Committee on Standards in Public Life (CSPL) and the change of government in 1997—but also activities by quangos themselves—eg the National Federation of Housing Associations and TEC National Council both produced guidance for their members.

Despite recent improvements in accountability a number of issues remain. Additionally new ones have emerged as a result of recent changes in the public sector.

This briefing note outlines some of the current key issues in the accountability of the appointed sector and identifies possible solutions. The focus is on bodies with an executive role, since extensive work on advisory bodies and Task Forces undertaken by Stewart Weir and colleagues is being reported separately to your Committee.

THE SOCIAL FUND

in

Social Security Committee (2001), *The Social Fund*

HC232, Pages 200-202

— Particular problems in relation to lost and missing giros.

8. South Lanarkshire have concerns regarding many aspects of the Social Fund, its role and operation in practice. It is hoped that through highlighting some of the difficulties experienced locally we will have been of some assistance to the Committee in their inquiry.

January 2001

APPENDIX 21

Memorandum submitted by Mike Rowe, Nottingham Trent University (SF 32)

SUMMARY

This paper presents a summary of evidence emerging from a recent programme of research. Evidence suggests that the discretionary Social Fund remains as problematic today as it was when first introduced. Social Fund Officers themselves describe a system that fails to direct assistance to those most in need. As such, after more than a decade in operation, it is still not possible to say whether the Social Fund is fulfilling its purpose, except in so far as it has contained expenditure within a cash limit.

INTRODUCTION

1. This memorandum is submitted in response to the Social Security Committee's request for evidence on the Social Fund. In particular, the memorandum will address two of the key issues identified by the committee: the role of the Social Fund; and how it works in practice.

BACKGROUND

2. From the outset, the discretionary Social Fund has been controversial. The extension of discretion, requirement to repay loans, removal of rights to an independent appeal and, perhaps most significantly, the introduction of cash limits have ensured that the scheme continues to be the subject of scrutiny by politicians and academics.

3. The evidence presented in this paper draws upon the findings emerging from an ongoing research project examining accountability, both as a concept and in practice. In the course of this work, I undertook some detailed case study work examining the discretionary Social Fund. In addition to the literature on the Social Fund, in the course of this research, I interviewed a range of people concerned with the policy, management and delivery of the Social Fund. I also spoke to leading authorities, welfare rights advisers, advocates and campaigning organisations. It is this material and these conversations that this paper seeks to capture in summary form.

4. It should be noted that the bulk of this research was conducted during 1998. As such, it predates the policy change that occurred in April 1999. However, much of the material retains its relevance in that it concerns the manner in which discretion is exercised in the administration of Community Care Grants and Crisis Loans, and the way in which Social Fund Officers manage the competing demands of financial constraints, management targets and the needs of applicants.

DISCRETION

5. A number of studies were conducted in the early years of the operation of the Social Fund. These suggested that the way in which discretion was exercised varied, from case to case, from office to office and from month to month, in ways that could not readily be justified or understood. At the time, the government evaded any responsibility to account for these variations (see Rowe, 1998) and little further research has been done in the intervening years. While conducted as part of a study of the concept of accountability, my own research suggests variations remain a key characteristic of the Social Fund.

6. Social Fund Officers in three Benefits Agency districts described very similar application and decision-making processes. Each described the need to consider directions and guidance in the light of the evidence presented in an application form. They suggested that the key to the way in which discretion is exercised is the quality of information presented by applicants. The more information that is available, the easier it is to decide on a case.

7. This having been said, Social Fund Officers suggested that more experienced and knowledgeable applicants were able to manipulate the process by presenting false evidence that would be difficult to challenge. With resource pressures and clearance time targets to meet, challenging the evidence is not a viable option. Hence, many loans and grants are awarded in cases where there may be reason to doubt the evidence.

8. On the other hand, applicants unaware of the system and perhaps reluctant to reveal what might be highly personal information in support of a claim for assistance may not receive the assistance they need. Unable to devote time to uncover this information, Social Fund Officers expressed the frustration of knowing

they must refuse to make an award to a person that needs help. This frustration was aggravated by the way in which the forms, and particular questions on those forms, actually tended to prompt misleading responses.

9. Throughout my work, the value of quality information was emphasised. Social Fund Review Officers stated that, in review interviews, they were able to see the applicant, to ask questions and to obtain information that application forms could not. Social Fund Inspectors suggested that, in many cases, they changed decisions on the basis of further information rather than as a result of procedural or other errors. Advocates and advisers told similar stories. Indeed, the process of review appears almost as a continuation of the initial application. Social Fund Officers suggested that, if they had any doubts about a case, they would refuse an award and allow the applicant to seek a review rather than take time to make a thorough decision. If an applicant didn't persist to the review stage, that was an indication that their need was not as pressing as another.

10. Describing the experience of aiding clients with applications to the Social Fund, a number of welfare rights advisers elaborated on these impressions, suggesting the importance of persistence. They describe a series of barriers and hurdles intended to deter applicants and to protect the cash limited budget from unnecessary demands. The barriers take a number of forms. Welfare rights advisers described local unofficial obstacles. They recounted tales of security guards and receptionists asserting that the applicant would be wasting their time trying to get a grant. They referred to offices refusing to accept Crisis Loan claims after 3pm on Fridays because it would take too long to deal with and might eat into the Social Fund Officer's weekend. DSS policy officials confirmed that this unofficial local policy was not unknown. Others described examples of offices introducing new rules as a way of weeding out certain types of application. Some refused to make more than one Crisis Loan award in any six month period for lost/stolen/not received girocheques. Such policies have been uncovered at review by Social Fund Inspectors.

11. Advocates were highly critical of the decisions made, suggesting they were sometimes irrational. By way of illustration, the following is an extract from an interview with a welfare rights adviser:

"One I've got, which is ongoing, which is someone paying his hospital fare to go and visit their daughter. This has been going on for eighteen months now, and they have to apply every three months. I think I've done five reviews so far. I think only two of the awards were all right. Each person makes a different award and decides for this three months it's all right for mum and dad to go four nights a week. Then the next person decides, no, only dad needs to go one night a week, or mum two nights a week. Same case. Nothing's changed, and you never know what decision you are going to get out of it. The last time, they refused it on the grounds that they're asking for an excessive amount of money, that it wasn't reasonable. And they were asking for the amount of a weekly travel card. I can't really work out how that would be unreasonable, because that's the cheapest way of getting there. It's just one example."

There are a number of illuminating elements about this one story. From the perspective of the claimant, and of the advocate, the variations in decisions appear irrational. Indeed, the advocate believes that there was one "right" award. The problem is that different Social Fund Officers fail to come to that answer. The review process becomes a means of getting that "right" award. This perspective on the Social Fund argues that, because the circumstances of the applicant have not changed, the decision reached should be the same. However, other factors may have changed, particularly the state of the budget and the priorities being met on each occasion. It is quite conceivable that, from the perspective of Social Fund Officers, each of the different decisions appear to be "right" in light of this changing context.

12. The nature of discretion is exposed in this one account. The potential for variation in the treatment of the same case is clear because we are able to compare a number of applications for the same item from the same couple. It also throws up a number of dilemmas and questions. The two different perspectives on the series of applications are nowhere reflected in official accounts of the Social Fund. Statistical data presents the number of applications, number of awards and average amounts awarded. Such a summary would suggest consistency rather than variation, in effect presenting a misleading, if not actually false, picture of the Social Fund.

13. Furthermore, an applicant, making just one approach to the Social Fund, would receive one decision. Without any form of comparator, how is that applicant to understand the decision made? Publicly available information provides no basis on which to understand any single decision. If the couple, in the quote presented above, made just one application, would they be in a position to understand whether the decision was "right"? Not surprisingly, the response of individuals refused assistance for items can be incomprehension.

Assessing the Social Fund

14. Government publications do not present a very clear picture of the purpose of the discretionary Social Fund. The Secretary of State's Annual Report for the Social Fund does not mention a purpose at all (DSS, 2000a). The Departmental Annual Report provides a brief and rather misleading definition (DSS, 2000b, p.135). Only in the Social Fund Guide (DSS, 2000c) is there some indication of the different elements within the Social Fund and their particular purpose.

15. Perhaps the purpose of the Social Fund is most clearly spelt out in a National Audit Office study:

"The Government's key objectives for the Social Fund are:

(a) to support the Government's economic objectives by containing expenditure within the Social Fund budget;

(b) to handle the arrangements in a way that does not prejudice the efficiency of the main Income Support scheme (which replaced Supplementary Benefit);

(c) to concentrate attention and help on those applicants facing greatest difficulties in managing on their income;

(d) to enable a more varied response to inescapable need than could be achieved under the previous rules; and

(e) to break new ground in the field of community care." (National Audit Office, 1991, para. 1.5)

16. On the basis of the research I have conducted, of which only a broad overview has been presented above, we must question whether the Social Fund has achieved many of these objectives. Certainly, rather than being flexible and responsive to those most in need, my work suggests the Social Fund is rigid and unresponsive, presenting barriers to applicants and bound by targets and rules that hinder its effectiveness. It is only the first two objectives for which there might be clear evidence of success. In handling one-off expenses separately, the Social Fund has not impinged upon Income Support. And, by its very nature, the Social Fund has contained costs. The cash limit ensures that. Moreover, in recent years the emphasis on two key financial targets (remaining within the cash limit and loan recoveries) has increased. They are the only key Social Fund indicators reported by the Secretary of State, underlining the central importance of controlling costs in the very purpose of the Social Fund.

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APPENDIX 22

Letter to the Chairman of the Committee from The Children's Society (SF 34)

As a national child care organisation working in 90 projects in the poorest communities we are very aware of the practical concerns that arise from the Social Fund. We are keen to pass on the experience of the families and young people who use our projects, with regard to the Social Fund, through this paper, and directly by facilitating a meeting between claimants and the committee.

We have campaigned in this area since the Social Fund was first established, and have conducted our own research (Smith 1990)[33] and worked jointly with other voluntary organisations (Bennett 1996).[34] We have been monitoring the impact of the recent changes to the Social Fund. Our overarching concern is that whilst poverty has increased over the last 20 years, expenditure on the discretionary Social Fund has remained stable. This has been reflected on increased hardship on the very poorest. The increase in loans and reduction in grants in the discretionary part of the Fund has led to a spiral of debt which makes it harder to exit poverty.

Research shows that current benefit levels are not adequate to cover basic expenses over a period of time. Government has always recognised the need to assist with one off expenses or budgeting strains over a period of time. The Children's Society's experience is that the Social Fund in its current form is not meeting its aim of alleviating extreme hardship.

[33]Smith R, (1990) "Under the Breadline: Claimants, the Social Fund and the Voluntary Sector: A Case Study", The Children's Society.

[34]Bennett F, (1996) "Out of Pocket—Failure of the Social Fund", The Children's Society, Family Service Units, Family Welfare Association.