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ACCOUNTABILITY - Public Control of Executive Bodies
A briefing note

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Ronald G Young Tashkent – 6 February 2001

INTRODUCTION
Democracy requires that the decisions of both politicians and officials are -
- transparent
- legal
- subject to critical scrutiny.

This involves the establishment and effective operation of several systems -
1. the effective operation of an **effective system of scrutiny of the Executive by the elected representatives** of the Council or parliament (eg specialist committees and question time).
2. **systems of reporting** by public organisations about their activities and performance
3. **legal systems** to allow appeal about the legality of decisions (courts)
4. **audit systems** to check the financial probity of public organisations - and, more recently, to analyse whether their policies give "value-for-money"
5. **inspectorates** to ensure that the activities of the services managed by them are consistent with (any) agreed national standards.
6. **Complaint and Redress** systems - such as the Ombudsman and Citizen Charters
7. Media coverage of these issues

There are three different levels which should be the subject of scrutiny - policy, management and practice.
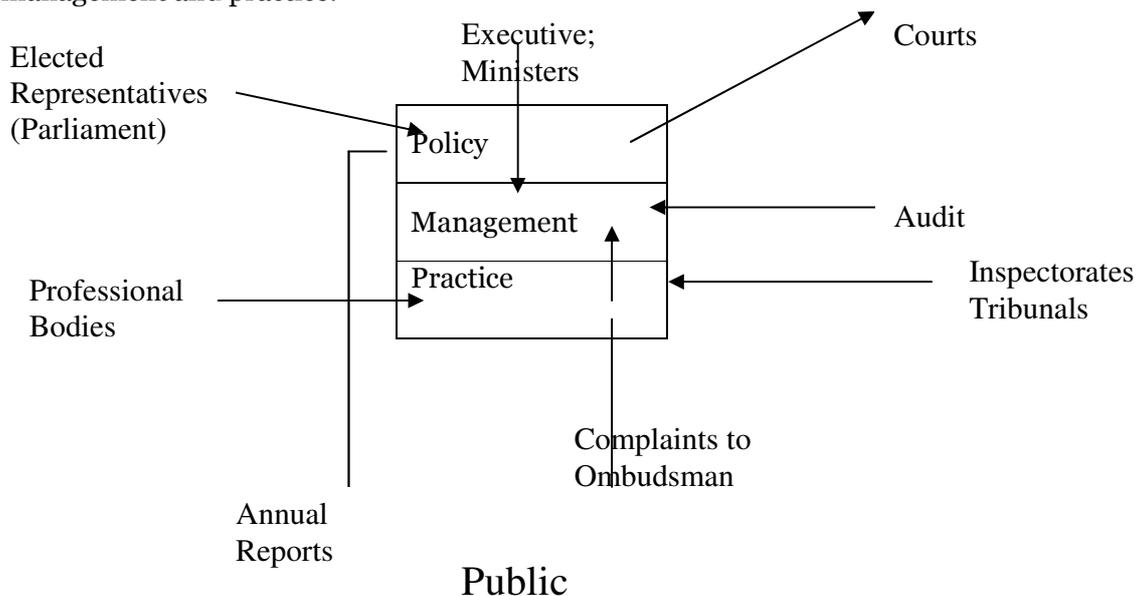
Some important questions which arise in the development of such systems are -
- How does one define information which is not "in the public interest" to publish - eg security issues and personal information? Who decides on such issues?
- How can complex matters be made comprehensible to the public at large?
- how should policies and practice best be monitored?
- How do the public voice their complaints and get results?
- How can the independence which such systems require best be established and protected?

This briefing note gives a broad indication of the sort of institutions and mechanisms Britain has set up to deal with such questions.

1. WHAT INFORMATION SHOULD BE MADE PUBLIC?

There are two general arguments for governments to be open about both their policy deliberations – and how effective public spending on specific items is. There are also two arguments in favour of restricting the right of the public to specific bits of "information"

1.1 Consultation

Governments have not generally favoured letting the public know that there are several ways (options) of dealing with an issue. They have preferred to create the impression that there is only one effective policy. Increasingly, however, they publish "**consultative" documents**, defining any given problem; indicating different ways of dealing with it; justifying their preferred option and inviting comment. That way they give themselves the possibility of improving policies - and of getting wider acceptance of the chosen one.

1.2 Performance

Public organisations seem to have an aversion to publicity about their **performance**. The initial instinct is to publish nothing. When they eventually realise the benefit of good public relations, they continue to control information by printing only the good news. It is only at the third stage that they start to treat the public as adults - and they generally have to be forced to do so. It required legislation, for example, before British local Councils sent out clear statements to the taxpayers on where their money went - and before they started to publish clear **annual reports** of their activities (see 2.2 below). More recently still, successive British governments have published comparative statistics on the performance of schools. This, in conjunction with the parental rights to change schools and greater autonomy in school management, has put powerful pressure on schools and teachers to improve performance. And an independent analysis has just been published in Britain which, for the first time, gives a "league Table" of the performance of hospitals[1]

A balance has to be struck always between the public's "right to know" and "protection of state interests". Advance information, for example, about tax changes is generally discouraged. In the last decade policy guidance has often been enshrined in -

1.3 Freedom of Information Laws

These set out the areas of state activity which remain confidential - and beyond the scope of publicity (eg defence issues). And the police are understandably reluctant to release information about "operational management" even to elected representatives. The problem is giving practical definition to such a concept! The British government has been trying for the past couple of years to agree such a statement[2]. It has not so far succeeded. This should not, however, discourage particularly transition governments from demonstrating their real commitment to openness. The media need hard information - not press handouts - if they are to play their democratic role.

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[1] see the "Good Hospital Guide" produced by the Dr Foster foundation (on www.drfoster.co.uk)

[2] For a very comprehensive discussion of the issues involved see Freedom of Information - the Continuing Debate (House of Commons research Paper 99/61) and The Freedom of Information Bill (H of C research Paper 99/98)

1.4 **Libel Laws**

In some transition countries, the media have celebrated their new-found freedom by personalised attacks on politicians. This can breed cynicism in the public about the democratic process. On the other hand there are too many examples (eg Turkey) where legitimate and necessary policy criticism is muzzled and opposition figures are thrown in prison for carrying out their basic function of challenging those in power.

2. MAKING INFORMATION ACCESSIBLE

2.1 **Making it understandable - and relevant to the citizen**

Organisations tend to have their own jargon; even if they want to communicate with the public they are not therefore very good at it.

The "**Plain English" campaign** has been very effective in helping to remove mystifying technical language from documents of the private and public sector. The organisation (an NGO) publishes guidelines; trains - and gives annual awards - both for good practice and bad practice ("wooden spoons")

2.2 **Making it objective**

Organisations will naturally present good aspects and want to conceal the failures. This is possible when the organisation has vague and general objectives. It becomes more difficult when targets are set - or negotiated - for which they can be held accountable.
See UK Ministry and **Agency Annual Reports** for examples of key output measures.

2.3 **Making it available**

There is not much point in developing coherent statistics and attractive publications if they are then difficult to obtain. There need to be clear codes governing the distribution of key material - eg leaflets for the public in post offices; key documents to be placed in all libraries etc

3. MAKING COMPLAINTS and GETTING SATISFACTION

As the public have become more educated (not least through the media), they have become less inclined to accept the treatment given to them by public servants - whether administrators or professionals. Governments themselves have encouraged this eg

3.1 Ombudsman

The role of such bodies is generally to investigate complaints by individual citizens that they have been the subject of inefficient or unfair treatment. Britain has several specialist Ombudsmen (eg Health; Local Government). The Offices do not have powers to rectify any mistake - but rather to recommend changes in procedure. The Uzbek Ombudsman seems to have much wider functions than is normal elsewhere - their interest, for example, in the rights of the handicapped are generally pursued in Britain by local Social Services departments and by NGOs.

3.2 The British "**Citizen Charters**" which set out what the public can reasonably expect from each public service (eg waiting time) - and a redress procedure which, for rail travel for example, offers financial compensation for late trains. Other systems are -

3.3 "Peer" Review

The first stage of a complaint against a public professional (such as a doctor or social worker) is often the procedure set up by the profession itself to ensure good standards of practice. As examples of poor practice have multiplied, the British Medical Authority (BMA) has put in place a stringent new system of attestation and review.

4. HOW DO WE ENSURE THAT THE SERVICES ARE WORKING EFFECTIVELY?

Soviet countries had a highly developed system of administrative control - of both policies and personnel. The culture was a centralised one - assuming, that is, that wisdom and competence was at the centre and that lower levels could not really be trusted – and that ex-ante control was needed .

OECD systems have moved away from this bureaucratic model; increasingly recognising that lower levels of organisations and society have skills and insights which can, if given encouragement, improve performance. And that major mistakes were more often made at higher levels. Several types of "control" mechanism can be identified – all of which are ex-post

4.1 Political

One of the functions of parliamentary (or local) assemblies is to challenge and control the political executive. This requires information - and its analysis. Usual practice is to set up specialist committees of parliament which focuses on the coherence of policies and programmes of specific Ministries.

Such committees have their own secretariat and are chaired by an opposition member eg in Britain

- **Parliamentary Select Committees** (eg on Education; Health; Defence). These were set up experimentally in the 1970s[3].

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[3] see Richard Chapman

• **Public Accounts Committee** (which analyses programmes of public spending)
These committees have the powers to conduct public hearings; require the attendance of civil servants and Ministers; and issue reports to which Government gives a formal response.
Effective chairmanship of such Committees is one way of advancing one's political career. And effectiveness means the development of bipartisan agreement.

4.2 Managerial

In Britain one of the most important development has been the work of the **National Audit Office**[4]. This reports to the Public Accounts Committee of Parliament – not to Government. It now employs 700 staff and not only audits the work of all public agencies; it also carries out 50 special studies each year on "Value for money" in the public sector. Its reports exert increasing influence.
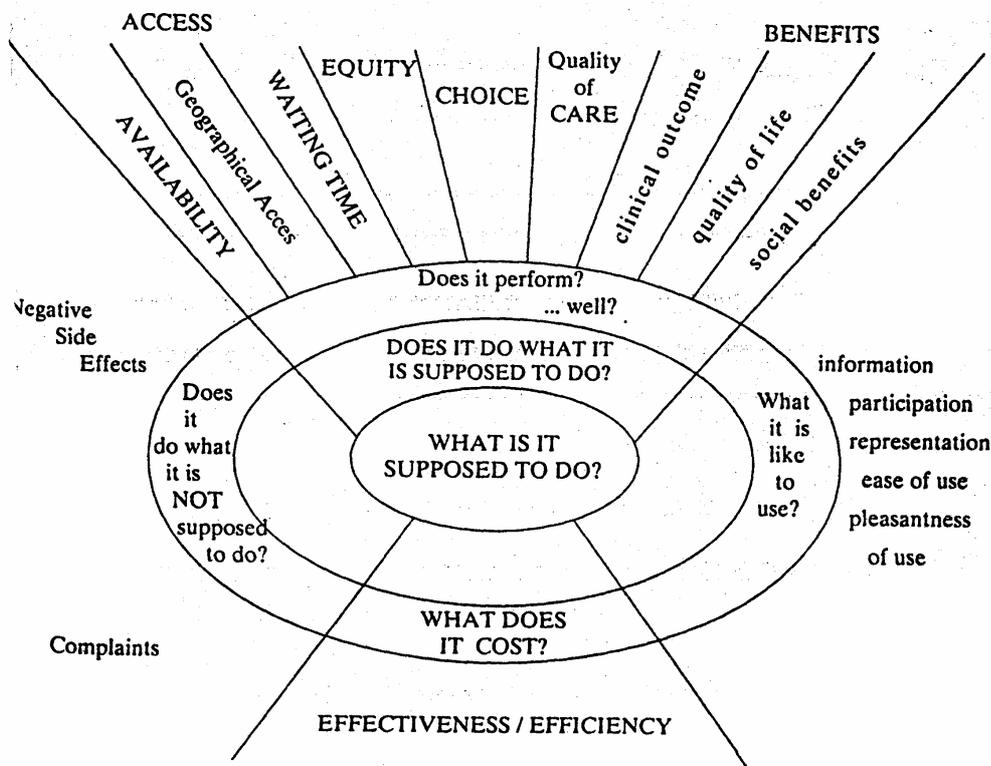
In the past 2 decades **independent** public organisations have developed with the responsibility for examining the cost-effectiveness of policies, programmes and practices of public organisations and issuing guidance on best practice eg The **Audit Commission for Local Government and Health Service in England and Wales**

These bodies explore the operations of services from many perspectives.

The attached diagram indicates some of the questions which might be asked about activities in the health service - and therefore identify the sort of data which needs to be collected for effective monitoring.

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[4] for a description of how all this process works see the chapter by Lashmar in SIGMA paper 4 on Management Control in Government – obtainable from website www.oecd.puma.sigma/org

Diagram labels: ACCESS — AVAILABILITY — Geographical Acces — WAITING TIME — EQUITY — CHOICE — Quality of CARE — BENEFITS — clinical outcome — quality of life — social benefits — information — participation — representation — ease of use — pleasantness of use — What it is like to use? — Does it perform? ...well? — DOES IT DO WHAT IT IS SUPPOSED TO DO? — WHAT IS IT SUPPOSED TO DO? — Negative Side Effects — Does it do what it is NOT supposed to do? — Complaints — WHAT DOES IT COST? — EFFECTIVENESS / EFFICIENCY

4.3 Professional Inspectorates

The focus of this work is the practice of schools and hospitals. This looks at the performance of individuals units (eg a school), comments on performance and issues recommendations. The inspectorate also issue guidelines on good practice. This used to be done within the relevant Ministry but is now done more independently (see para 5 below for further discussion)

- **eg Office For Standards for Teachers (OFSTED)**

4.4 The Public

Curiously it is only in the past decade that it has been appreciated that the individual citizen is effectively the most important check on the workings of the state system. Now polls and complaint systems are used. But the information referred to in para one – and comparative league tables on the performance of schools and hospitals gives the citizen the power to vote with his/her feet[5]

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[5] what Hirschmann has referred to as the "exit" option – rather than that of "voice" only (see his famous Exit, Voice and Loyalty (

5. LOOKING AT SYSTEMS FAILURE

In particularly serious cases – where an individual failure seems to go beyond the particular case and suggest a failure of policy or management system - the Government will set up an independent Tribunal to examine the facts surrounding a case - and to assess the implications for practice and management.

There have been many such reviews in Britain involving the decisions and behaviour of care-staff in **Child Care**[6].

Two recent examples of **medical practice** in Britain have horrified the nation and led to a critical reappraisal of review systems[7].
- A family doctor (Dr Shipley) was found to have systematically murdered about 20 of his older patients over a long period[8].
- A recent Tribunal report was very critical of the management systems which had allowed an incompetent surgeon to maim many women over a period of more than a decade. The status of surgeons discouraged people form complaining - and the culture of professional self-defence meant that his colleagues did not articulate their own anxieties. Strong recommendations have now been made for an independent Institute for Clinical Standards[9].

But the most serious issue which has shocked countries throughout Europe and forced reassessments of government systems has been the BSE outbreak which has killed about one hundred people – and affected another 100,000 in Britain.

An **Independent Inquiry** into the BSE (or **Mad Cow**) crisis was set up by the British Government in December 1997. It was chaired by a High Court Judge and produced on October 26 2000 a report of 16 volumes and 4,000 pages – at a cost of $20 million (the cost to the economy of the BSE outbreak has been put at almost 9 billion dollars![10])

The report looked at the history of scientific advice and ministerial responses over a ten year period and identified a range of professional, bureaucratic and political errors Amongst the features identified as contributing to the failure to take appropriate action in time were –
- Culture of secrecy in the senior civil service – the failure to share information
- The ability of the system to deliver well-drafted reports but inability to recognise a crisis and the need to take urgent action (that is the continued lack of emphasis in the senior civil service given to implementation[11])
- Political concern to avoid panic
- The inclination to set up advisory committees (which delayed action and confused responsibility)
- Overlap of departmental responsibilities (Agriculture and Health)
- Poor communications between departments

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[6]

[7] see "Doctors' errors cost NHS £2billion a year" in Guardian 14 June 2000 - and "Blair gets tough with doctors - "consultant is king " culture must end" in Guardian 5 June 2000
[8] investigations in late 2000 have put the figure at more than 200
[9]

[10] *almost half of this from the ban on use of cattle over a 3 year period; 3 billion in lost exports*
[11] *see the project*

Governments have become more interested in results in recent years - and have recognised that independent evaluations have more credibility than "in-house" assessments. Universities and Policy institutes are often commissioned by both Government and Parliament to do such evaluations.

6. **WHO IS ULTIMATELY RESPONSIBLE FOR ENSURING and MEASURING GOOD PERFORMANCE?**

This last case illustrates, in particularly stark detail, two fundamental questions about control systems -

- Who has the <u>ultimate responsibility</u> for them? Ministers and Ministries - who have executive powers? Parliament- with its responsibility to represent the public interest? The Professions - who generally have an important role in giving practitioners their right to practice?
- Who is best placed to <u>carry out the detailed monitoring of performance and standards</u> - those in the Ministries? Independent Institutes? The professions themselves?

The answer, at the moment, is that all have a responsibility. And that detailed monitoring needs to be independent of the main source of power. Where that is located will vary. In Britain the social services (Health and Education) were run from 1945 to the mid 1980s by a triumvirate - central government; local government and the professions themselves[12]. And the professions were the strongest group in the Health system.

In ex-Soviet systems the power structure has been different - and the answer to these questions will accordingly now be different.

What matters is that oversight of performance and standards is credible.

That generally requires independence and multiple checks.

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[12] see Simon Jenkins <u>Accountable to None</u> (H Hamilton 1995)