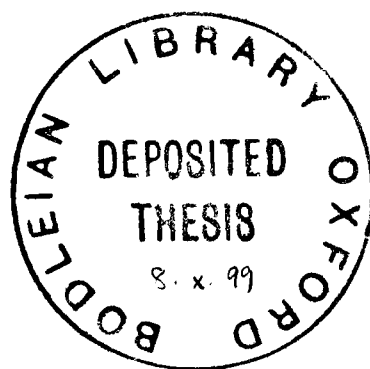


**ACCOUNTABILITY:
A PUBLIC LAW ANALYSIS OF NATIONAL
HEALTH SERVICE CONTRACTS**

A. C. L. DAVIES

**All Souls College
Oxford**

D.Phil. Thesis



To my parents

Acknowledgements

This thesis would not have been possible without the assistance of the NHS staff who found time in their busy schedules to answer my questions. They have been promised anonymity and cannot therefore be named here, but I am grateful to them all for their patience and interest. I am indebted to my supervisor, Professor Denis Galligan, for reading endless drafts and offering constructive criticism. Various friends and colleagues (it would be invidious to attempt a list) have offered advice, or tried to keep me sane. Margaret Lord provided secretarial assistance. Finally, I owe a special debt of gratitude to my parents, who have been a constant source of support and encouragement, and who have called me to account with consummate skill.

Anne Davies

Shrove Tuesday, 1999

Anne C. L. Davies

All Souls College, University of Oxford

Hilary Term, 1999

D.Phil. Thesis: Accountability: a Public Law Analysis of National Health Service Contracts

ABSTRACT

The thesis takes as its subject the concept of accountability. It examines the use made of the concept in the public law literature, and advances a novel analytical model of the individual accountability mechanism. The model identifies the essential features of that mechanism: setting standards against which an account can be judged; requiring the person being called to account to explain and justify his or her actions; judging the account rendered against the standards set; and responding to the account rendered, where appropriate, with enforcement measures.

This analytical approach provides a way of examining, in detail, an individual accountability mechanism, and identifying the main practical problems faced by the parties to it. The approach is applied to an empirical case study of National Health Service (NHS) contracts. (The fieldwork involved an examination of

contractual relationships between purchasers (Health Authorities and GP fundholders) and providers (NHS Trusts) in three sample areas, using document analysis, interviews and observation.)

The study's main findings fall into three groups. Firstly, purchasers were subject to various pressures and constraints (of time and resources, for example) which affected their actions in calling providers to account. Secondly, the study uncovered some of the complexities of the relationship between the parties to the accountability process. Analytical models of the accountability relationship were developed in order to classify different types of relationship according to the parties' behaviour and their degree of mutual trust. Thirdly, the study examined whether purchasers, as callers to account, could render the accountability process effective. For various reasons, purchasers often lacked the authority to set and enforce the standards they required.

The model of the accountability mechanism developed in the thesis also has evaluative potential. Drawing on the public law literature as well as the empirical data, a notion of the good accountability process is evolved. This includes, for example, requirements of maximising the accountability achieved within available resources, maintaining good relationships by using fair procedures, and finding ways of making the whole process effective. Some of these principles may be of more general application to other accountability processes. Possible generalisations are explored, particularly the contribution of the thesis to the development of an explicitly public law concept of contract.

Contents

Chapter I: The Concept of Accountability.....	1
DEFINING ACCOUNTABILITY	4
CATEGORIES OF ACCOUNTABILITY MECHANISMS	9
CATEGORIES OF ACCOUNTABILITY AS AN ANALYTICAL AND EVALUATIVE TOOL: THE CASE OF THE ‘NEW PUBLIC MANAGEMENT’	16
ANOTHER PERSPECTIVE ON ACCOUNTABILITY: THE MECHANISM OF ACCOUNTABILITY	31
CONCLUSION	42
 Chapter II: NHS Contracts: a Case Study	 44
THE NHS REFORMS: A SYSTEM OF PURCHASING AND PROVISION	45
INTRODUCING THE CASE STUDY: NHS CONTRACTS	52
THE ACCOUNTABILITY FUNCTION OF NHS CONTRACTS	57
<i>Were the parties to an NHS contract in a relationship of accountability?</i>	58
The three preconditions	58
Purchasers’ onwards accountability	62
<i>How might NHS contractual relationships manifest the features of an accountability mechanism?</i>	65
<i>Conclusion</i>	69
TOWARDS A ‘PUBLIC LAW CONTRACT’?	70
CONCLUSION	75

Chapter III: Accountability through NHS Contracts: Models and Hypotheses..... 76

PART I: MODELS OF THE CONTRACTUAL ACCOUNTABILITY PROCESS	77
<i>The hard and soft models of contractual accountability relationship</i>	82
<i>A caveat: the models' hidden assumption</i>	89
<i>Which model best described NHS contracts?</i>	89
PART II: RESEARCH HYPOTHESES	93
<i>Hypothesis 1: Pressures and constraints</i>	94
<i>Hypothesis 2: Relationships and procedure</i>	101
<i>Hypothesis 3: Effectiveness</i>	112

Chapter IV: Hypothesis 1: Pressures and Constraints..... 119

FINDINGS AND EXPLANATIONS: HOW DID PURCHASERS RESPOND TO THE PRESSURES AND CONSTRAINTS THEY FACED?	121
<i>Choosing the subject-matter of the accountability process</i>	121
<i>Choosing techniques for performing the accountability tasks</i>	138
<i>Conclusion</i>	146
EVALUATION: PRESSURES AND CONSTRAINTS IN THE GOOD ACCOUNTABILITY PROCESS	147
<i>The caller to account should be subject to effective accountability mechanisms to all interested third parties</i>	148
<i>The caller to account should be given sufficient resources in order to operate an effective accountability process</i>	154
<i>The caller to account should strive to maximise the accountability achieved</i>	

<i>within the resources available</i>	156
Taking ‘short cuts’	156
Pooling resources	158
Relying on other mechanisms	161
<i>Conclusion</i>	163
CONCLUSION	164

Chapter V: Hypothesis 2: Relationships and Procedure..... 168

FINDINGS AND EXPLANATIONS: WHICH MODEL DID PURCHASERS ADOPT, AND WHY?	171
<i>Standard-setting</i>	171
Health Authorities	172
Fundholders	177
<i>Contract drafting</i>	181
Health Authorities	181
Fundholders	187
<i>Monitoring</i>	190
Fundholders	190
Health Authorities	192
<i>Enforcement</i>	196
Hard model	197
Soft model	199
Intermediate model	202
<i>Conclusion</i>	207

EVALUATION: PROCEDURAL FAIRNESS AND TRANSPARENCY IN THE GOOD ACCOUNTABILITY RELATIONSHIP	209
<i>The good accountability process is characterised by its regard for the principles of due process</i>	210
Consensus	211
Fairness and the models	212
<i>The good accountability process is transparent to interested third parties</i>	219
CONCLUSION	224
 Chapter VI: Hypothesis 3: Effectiveness.....	229
 WAS THE CONTRACTUAL ACCOUNTABILITY PROCESS EFFECTIVE?	232
<i>Could purchasers set the standards of their choice?</i>	233
Competition	236
Conciliation and arbitration	242
Expertise	244
Joint purchasing	249
Central government pressure	250
Conclusion	251
<i>Could purchasers obtain compliance with the standards set?</i>	252
Obtaining information for monitoring	253
Obtaining compliance with the standards set	255
Obtaining a reasonable explanation for a breach	268
<i>Conclusion</i>	272
EVALUATION: IMPROVING EFFECTIVENESS	273

CONCLUSION 277

Chapter VII: Conclusions and Prospects..... 281

ACCOUNTABILITY IN CONTEXT: PURCHASERS’ CHOICES 283

Minimising the constraints on callers to account 284

Minimising the pressures on callers to account 287

ACCOUNTABILITY AS A RELATIONSHIP 290

Procedural fairness 292

EFFECTIVE ACCOUNTABILITY 297

CONCLUSION 306

Appendix 1: Methodology..... 308

SAMPLING 308

ACCESS 313

TIMING 316

METHODS OF DATA COLLECTION 317

Document analysis 318

Observation 319

Interviewing 322

ETHICAL ISSUES 325

METHODOLOGICAL LIMITATIONS 326

ANALYSING THE DATA 328

Appendix 2: Interview Codes..... 331

Bibliography..... 335

Statutes..... 353

Statutory Instruments..... 354

Cases 354

I

The Concept of Accountability

Whatsoever our callings are; we are but stewards over some part of God's household: and it were good for us... to remember, that our Master will require of us an account of our stewardships. The time will come, when we must appear before the judgement seat of Christ, to give in our accounts: And we must look to have them examined most strictly, even *ad ultimum quadrantem*, to the very utmost Farthing. (Sanderson 1656)



Accountability is an important part of everyday life. To begin with a homely example, let us imagine that a friend offers to do some shopping for me. I give him a shopping list and the money, and expect him to appear with the shopping and perhaps even the change. If he brings the wrong goods, or brings them several weeks later than expected, or simply pockets the money, I am likely to ask him to explain and justify his conduct - to *account* for it. My response, as he is a friend, will depend on the situation: bringing the wrong goods may be an innocent mistake; pocketing the money is at least careless, perhaps deliberately dishonest. If his account does not satisfy me, I may rate him less highly in the future as a person to be trusted, or spend less time with him as a mark of my displeasure.

In the political sphere,¹ a democratic government exercises power on behalf of its citizens, who have a legitimate interest in what is done in their name. They can express their approval or disapproval through the ballot box: elections are one key

¹ Accountability is also relevant in a variety of private law contexts which are beyond the scope of this thesis. See, for example, McCahery *et al.* (1993) on companies; Fridman (1996) on agency; and Martin (1997) on trusts.

mechanism of accountability. Moreover, while a government is in office, a healthy democracy will provide a variety of ways - further mechanisms of accountability - in which its policies can be examined, checked and challenged (Weir 1995).² As Hirst comments: 'Assessments of how democratic a country is concentrate on the degree to which government is accountable to the people and the effectiveness of the means of ensuring accountability' (1995: 341).³

This thesis takes as its broad theme the analysis of particular mechanisms of accountability applicable to government. Accountability is a central concern of public law. Much is written about the adequacy, or inadequacy, of the totality of the accountability mechanisms applicable to British government today. But when looking at particular mechanisms of accountability, the analytical tools available to public lawyers are weak and under-developed.⁴ This means that we lack a general conception of the difficulties facing those charged with the task of *implementing* the ideal of accountability. The aim of the study is to remedy this situation by setting out a framework for analysis at the level of the particular accountability process. The value of the framework is tested by applying it to an empirically researched case study. As we shall see, the framework has evaluative as well as analytical dimensions: principles of 'good accountability' are developed over the course of the study, and summarised in the concluding chapter.

² The exact nature of these mechanisms depends on whether the conception of democracy being espoused is pluralist or unitary (see below).

³ For examples of such assessments see Harden and Lewis (1986); Longley (1993); Oliver (1991). The legitimacy of government is measured in other ways, too. Baldwin and McCrudden's (1987) discussion of the legitimacy of regulatory agency action is instructive in this regard.

⁴ For an outstanding exception, see the pioneering study by Day and Klein (1987).

This chapter sets the scene by examining the meaning of the concept of accountability and the existing literature on the subject. Accountability has risen to prominence as an issue in recent years, first because of concerns that existing mechanisms of accountability are inadequate to cope with the size and complexity of modern government, and second because of a series of reforms to government and therefore to mechanisms of accountability, often grouped together under the heading of the ‘new public management’. It will be argued that the literature on the ‘new public management’ demonstrates the value, but also the limitations, of the existing approach to accountability analysis, which looks broadly at different categories of accountability mechanisms and the balance between them. A novel framework for the examination of a particular accountability mechanism will then be set out, in the hope that this will provide a useful supplement to the current methodology.

Chapter II introduces the accountability mechanism to be used as our case study: contracts between purchasers and providers in the National Health Service (NHS). Drawing on the accountability literature and existing socio-legal research on contracts, Chapter III sets out some research hypotheses which seek to focus on the likely problems facing the parties to an accountability process. Chapters IV-VI test out these hypotheses, using empirical data from the NHS case study. (Appendix 1 details the research methods used in conducting the study.) Finally, Chapter VII sets out the conclusions, identifying explicitly some of the key issues which should be addressed in an effective accountability mechanism.

DEFINING ACCOUNTABILITY

Writers on accountability agree on two points: that accountability is a core value in a democracy, and that accountability is very difficult to define. Loughlin sees accountability as a ‘rather ambiguous and multi-faceted notion’ (1992: 1), and Hinton and Wilson describe it as ‘familiar yet intriguing in its complexity, history and implications’ (1993: 123).

The Oxford English Dictionary (Simpson and Weiner 1989) defines accountability as ‘the quality of being accountable; liability to give account of, and answer for, discharge of duties or conduct; responsibility, amenableness’. To be accountable is to be ‘liable to be called to account, or to answer for responsibilities and conduct; answerable, responsible’. One is accountable ‘*to* a person, *for* a thing’.

Three preconditions must be satisfied before a person can be called to account for his or her actions. It will be seen that these are closely related to the dictionary definitions just given. The first precondition is responsibility: ‘One cannot be accountable *to* anyone, unless one also has responsibility *for* doing something’ (Day and Klein 1987: 5). But this does not necessarily mean that the person to be called to account can only be accountable for those acts which he or she has performed him- or herself: the constitutional convention of ministerial responsibility is in part premised on a notion of accountability for the acts of others, even if this ideal is not always fulfilled in practice (Woodhouse 1994). The

responsibility may therefore be either for the performance of a particular task, or for the supervision of people and systems through which the task is performed. In Hart's terms, the responsibility may be a role-responsibility coupled with a liability-responsibility, or simply a liability-responsibility on its own (Hart 1968).

The second precondition is that others have a legitimate interest in how the responsibility is discharged: the person to be called to account must not simply be acting on his or her own behalf. This may occur, for example, when others have delegated responsibility for performing the task, or supplied the money for it. This gives them the right to ask for an explanation: they are the people *to whom* the person discharging the responsibility is to be answerable. Their relationship with the person to be called to account need not be direct: they may be members of an interested group, such as taxpayers or voters, whose 'delegation' of responsibility is at most indirect, as we shall see below.

The third precondition is that those with a legitimate interest in the performance of the task have chosen to call the person responsible to account. Instituting an accountability process is, in principle,⁵ optional.⁶ The person with the right to call to account may choose not to exercise his or her right (though the liability to be called to account subsists even where the right is not exercised). At one level, the decision to institute an accountability process may be seen in terms of fundamental pairs of values: as a choice of control over delegation, of checking

⁵ In practice, this choice may be frustrated where those who are entitled to call to account are dependent upon the co-operation of others in setting up an accountability process: members of the public may be dependent upon government in this regard.

⁶ It may be mandatory in some contexts, notably where the caller to account does not act on his or her own behalf and is accountable for calling another body to account.

over trust. But as Power (1997) points out, one cannot eliminate trust by choosing checking, or autonomy by choosing control. Accountability does involve checking, but it cannot function without trust: trust in those calling to account, and some degree of trust in the information being supplied by those being called to account. Accountability simply involves striking a balance between the two values.

How do these ideas apply to government?⁷ A democratic government involves two types of delegated power. Firstly, power is ‘delegated’ by the electorate to their representatives, whom they elect to govern on their behalf. Secondly, governing itself is a complex activity, particularly in the modern state, which requires power to be delegated to a variety of individuals and agencies to perform different government functions. These two types of delegated power are linked to two types of accountability process. On the one hand, ‘external’ accountability processes are required, in order to allow members of the public, or their elected representatives, to call those who govern to account. On the other hand, ‘internal’ accountability processes are required in order to ensure that the lower tiers of government are accountable to ministers.⁸ The reason for choosing to use an accountability mechanism, rather than simply trusting the delegates, is rather different in each case. We will examine this in more detail in the next section.

Two main functions are usually claimed for accountability processes, whether ‘external’ or ‘internal’. The first is to guard against the abuse of delegated power.

⁷ For historical analysis, see Day and Klein (1987).

⁸ This distinction is similar to that drawn by Loughlin (1992) between political and administrative accountability, and by Day and Klein (1987) between political and managerial accountability.

The existence of checks might either deter potential abuses, or detect those which have taken place. The concept of abuse may be narrowly defined, covering for example the deliberate pursuit of personal gain, or broadly defined, to include wasteful or inefficient behaviour. There are, however, two dangers identified in the literature. One is that we might place undue faith in the mechanisms of checking: as Power (1997) explains, although we must at some stage fall back on trust, we should not assume that particular checks can guarantee that standards are being met. The second danger relates to the balance between autonomy and control, noted above. One of the central dilemmas of the modern state has been to find ways of controlling and structuring discretion without instituting so many checks as to impede the efficient conduct of public business.⁹ Some have seen the notion of accountability as the solution to this dilemma: an official may be given discretion provided that he or she is accountable for its exercise (Normanton 1971). But as we shall see,¹⁰ a process of accountability in fact involves the same dilemma, since it may subject the official to more or less detailed scrutiny of his or her performance. The more detailed the scrutiny, the more the official's autonomy is threatened.

More recently, theorists have begun to point to a second, constructive role for accountability processes (see, for example, Harden and Lewis 1986; Oliver 1991). An accountability process can promote efficient and effective performance of the required task because it encourages the primary actor to gather information and to exchange ideas with those calling to account, thus helping to overcome problems

⁹ Smith and Hague (1971); Galligan (1986); Thynne and Goldring (1987); Hawkins (1992).

¹⁰ This is an important theme of the empirical study: see Chapters IV-VI.

of ‘bounded rationality’ (Simon 1947). As Normanton explains: ‘[P]ublic accountability should not only provide administrative safeguards but should, by improving the flow and the quality of information, make an important contribution to the efficient conduct of government. Accountability can and should be *useful*’ (1971: 338; emphasis in original). In part, this may be seen as the discovery or rediscovery of a second key strand to public law.¹¹ Ogus comments that ‘public law is not only about preventing the abuse of power; it is also about selecting legal forms which can best achieve the instrumental goals of collective choice’ (Ogus 1994: v). Ironically, he blames the neglect of the latter on a preoccupation with accountability, taken in the sense of controlling power and preventing abuses.

The various accountability mechanisms applicable to government are usually rendered more manageable by theorists for the purposes of discussion by dividing them into a series of categories according to their specific goals: legal accountability, financial accountability, political accountability and so on. The next section develops a working typology, with the aim of introducing the usual approach to accountability analysis. Some of the complexities of accountability are also illustrated: the different justifications given for the different categories, and the variety of mechanisms within each category.

¹¹ For a useful typology of understandings of administrative law, see McCrudden (1999b).

CATEGORIES OF ACCOUNTABILITY MECHANISMS

Governmental accountability can usefully be divided into six core categories: political, public, administrative, financial, legal and professional. The first two categories correspond loosely to the broad group of ‘external’ mechanisms discussed above; the last four fall into the ‘internal’ group. This overarching distinction between ‘external’ and ‘internal’ mechanisms aids exposition only at the highest level of generality: as we shall see when examining justifications, the categories themselves are a more helpful focus for analysis. Two caveats about the typology are in order. Firstly, it is important to remember that the categories do not necessarily constitute a common currency among writers in the area: particular mechanisms may be assigned to different categories by different writers, and of course not all writers use the same scheme of categories. Secondly, using categories is not always analytically straightforward. One problem is that some mechanisms of accountability are hard to classify, appearing to span more than one category. For example, the role of the Parliamentary Commissioner for Administration can be interpreted in more than one way (Harlow and Rawlings 1997). The office is treated here as a support for MPs and therefore as part of political accountability. It could also reasonably be construed as a grievance resolution procedure and therefore as an aspect of consumer accountability, or as an element of administrative accountability because of the possibility that broader recommendations about good administration could emerge from a specific investigation. Thus, in order to devise a workable typology, some mechanisms

must simply be allocated to a particular category, along lines which may differ from those used by other writers.

Political accountability includes the accountability of government ministers to Parliament and Select Committees, the Prime Minister and the Cabinet, and the accountability of local authorities to central government and Parliament (Oliver 1991).¹² The key mechanisms of political accountability are very familiar: periodic elections, debates, Select Committee sessions, parliamentary questions and so on (Turpin 1995).¹³ The political processes derive support from specialist institutions, notably the Parliamentary Commissioner for Administration, and the Comptroller and Auditor General, which could also be included under the administrative accountability heading. 'The point about this form of accountability is that it exposes the bodies to politically motivated control, to public censure through elected institutions - the House of Commons or local authorities - or to electoral risk' (Oliver 1991: 23).

Accountability mechanisms in this category find their justification in fundamental ideas about the characteristics of a democratic constitution. The most obvious manifestation of accountability in a democracy is the periodic election. This provides an opportunity for the electorate to judge the performance of their representatives, particularly those forming the government, and to decide whether or not to re-elect them on the basis of their past performance and stated future

¹² Oliver (1991) also includes civil servants accounting to ministers, but it is preferable to include this under the heading of administrative accountability because it is an aspect of the government's internal management (though as we shall see below, the modern role of 'agency head' has blurred the boundaries between political and administrative accountability for some senior civil servants).

¹³ In which the media often play a key role.

intentions. Elections by themselves are not, however, sufficient to ensure a healthy democracy.¹⁴ Election results do not necessarily relate in a very precise way to the government's performance. Firstly, voters may make their choice on a variety of other grounds, simply deciding, for example, that they want a change of leadership. Secondly, to the extent that voters do make a judgement of performance, it is of overall performance. This overall 'assessment' does not adequately make the government accountable for its performance of individual tasks. For this, more specific accountability mechanisms are required. As Day and Klein comment, 'it is precisely day-by-day accountability, in which the rulers explain and justify their actions directly to the ruled, which distinguishes a democratic society from an elective tyranny' (1987: 7). The doctrine of the separation of powers, albeit imperfectly realised in the British constitution (Vile 1967), gives Parliament a role in calling the executive to account between elections. The deficiencies of political accountability mechanisms, despite attempts to strengthen them, for example through the Select Committee system, have been well-documented (see, for example, Woodhouse 1994; Oliver 1991), and have even led to claims that we are indeed governed by an 'elective dictatorship' (Hailsham 1976).

The category of *public accountability* includes any mechanism which involves explaining and justifying policies or actions to the general public or to particular groups (Oliver 1991). For example, a public body may be placed under a statutory duty to report on its activities or to consult interested parties before making a

¹⁴ The idea has a long pedigree: in the words of one of the founding fathers of the US constitution, 'A dependence on the people is, no doubt, the primary control on the government; but experience has taught mankind the necessity of auxiliary precautions' (Madison *et al.* 1788).

particular decision. Mechanisms in this category are, as we shall see, not well developed in the British constitution. In part, this is because of the largely unitary tradition of democracy in Britain, which emphasises Parliament as the crucial checking mechanism. But many theorists are turning to pluralist conceptions of democracy, arguing for enhanced public consultation and participation as a way of compensating for the heavy burden of scrutiny currently placed on Parliament.¹⁵ They place a high constitutional value on public accountability mechanisms. More controversially, the category of public accountability may also include consumer accountability, a relative newcomer to public administration, which involves enhancing users' influence over the quality of public services (Oliver 1991). Obviously, this does not apply to those aspects of government which affect no-one in particular but from which all citizens derive some indirect benefit, such as defence and foreign policy. But it has had a significant influence over thinking about services with identifiable consumers, such as health, social security and social services. As we shall see in the next section, many theorists argue that consumer responsiveness policies put the consumer into a passive role and are no substitute for the more active participation in decision-making usually advanced under the public accountability heading.

Legal accountability obliges a public body to justify its actions in terms of their compliance with the general law and with the legal mandate given to that public body. Its justification derives from the doctrine of the Rule of Law¹⁶ and from ideas about the appropriate constitutional role of the courts. Very broadly, the

¹⁵ For discussion, see Craig (1990).

¹⁶ Dicey (1885); Fuller (1969); Raz (1977).

executive is subject to the Rule of Law, and the courts may act as a check on the executive's actions in order to uphold the Rule of Law (Turpin 1995). The main mechanism for this is judicial review, the expansion of which since the decision in *Ridge v Baldwin*¹⁷ has been well-documented (Craig 1994). Given the executive's ability to stifle parliamentary criticism, judicial review is a key safeguard of legality, procedural fairness, and increasingly, human rights.¹⁸ There is, of course, room for further development, for example in responding to the changes in the shape of government to be discussed in the next section. Moreover, law has an important role to play in other categories of accountability: 'legal accountability' does not exhaustively describe its influence. Oliver comments, for example, that administrative accountability relies on the development of administrative law, not in the sense of judicial review 'but other mechanisms such as the use of standards, guidelines and codes of practice, tribunals and inquiries and various forms of audit, internal review, appeal and complaints procedures and performance indicators' (Oliver 1991: 27).

The category of *financial accountability* contains two major strands. One is the government's own internal financial controls, for example through the Treasury and the departmental Accounting Officers.¹⁹ The other is the work of the public auditing bodies, the Comptroller and Auditor General (and the National Audit Office),²⁰ and the Audit Commission.²¹ The basic criteria of financial probity are

¹⁷ 1964 A.C. 40.

¹⁸ Craig (1994); Human Rights Act 1998.

¹⁹ HM Treasury (1995); Harden (1993); McEldowney (1994).

²⁰ The Comptroller and Auditor-General is an independent officer of the House of Commons, responsible to the Public Accounts Committee, and assisted by the National Audit Office: National Audit Act 1983. See generally Harden (1993); McEldowney (1991; 1994).

²¹ See the consolidating Audit Commission Act 1998; Radford (1991); Loughlin (1992), McEldowney (1994).

relatively uncontroversial, although as we shall see, financial accountability has expanded in recent years to include the more contested benchmarks of efficiency and effectiveness (Power 1997). Day and Klein (1987) argue that the justification for this category of accountability is very different from that for political accountability. Government is seen here as the management of an estate: both ministers and their subordinates must be made accountable for their stewardship of public funds. Financial accountability has a fundamental role to play in political and public accountability. On the one hand, it should ensure that ministers have some control over the actions of their departments: political and public accountability are ineffective if the government cannot influence the behaviour of those implementing its policies. On the other hand, it provides information to members of the public and politicians to assist them in calling the government to account. The role of the National Audit Office in relation to Parliament is a prime example of this.

The category of *administrative accountability* is closely related to financial accountability, covering as it does the government's internal management, but it is not solely concerned with finance. It includes the accountability of contractors to government through their contracts, and the accountability of executive agencies to ministers through their framework documents.²² It also covers accountability from subordinates to superiors in a managerial hierarchy, within the civil service and other public bodies. The justification for the mechanisms in this category is similar to that for financial accountability mechanisms: they promote good estate

²² See generally Harden (1992); Greer (1994).

management, and ensure that ministers have some control over the implementation of their policies, thus supporting public and political accountability mechanisms.

Our final category is *professional accountability*. This is included because many major public services are delivered by professionals: the NHS is an obvious example.²³ By definition, members of a profession are self-regulating. The profession's governing body sets standards for entry into the profession, operates disciplinary procedures, and may encourage the maintenance of skills through continuing education and peer review. The usual justification for professional self-regulation is that the profession undertakes to guarantee the competence of its members, in return for its monopoly rights, and that professional expertise is in any event required in order to judge the performance of individual professionals. Doubts about the validity of this justification, and about the effectiveness of professional self-regulation, have been expressed by a number of writers (see, for example, Allsop and Mulcahy 1996). From the government's perspective, professional accountability has advantages and disadvantages. On the one hand, it provides an important means of maintaining appropriate standards among expert service providers, but on the other hand, it represents a challenge to government because it gives professionals an alternative source of norms which may conflict with those the government seeks to impose through the techniques of administrative or financial accountability (Day and Klein 1987).²⁴

²³ Our case study of accountability takes place in the NHS context (see Chapter II). A number of NHS examples will be used in this chapter by way of background.

²⁴ See generally Loughlin (1992); Kirkpatrick and Martinez Lucio (1995); Power (1997). For a specific case study, the medical profession, see Allsop and Mulcahy (1996); Ferlie *et al.* (1996).

Having set out our six working categories of accountability - political, public, administrative, financial, legal and professional - we are now in a position to put them to work in order to analyse the accountability arrangements currently applicable to government.

CATEGORIES OF ACCOUNTABILITY AS AN ANALYTICAL AND EVALUATIVE TOOL: THE CASE OF THE 'NEW PUBLIC MANAGEMENT'

This section examines recent reforms to the shape of government in Britain, often dubbed the 'new public management',²⁵ from the perspective of accountability, using some of the categories set out above. The section has two aims. The first is to illustrate the kind of analysis and evaluation which can be performed using the categories,²⁶ and to assess how far it helps or hinders our understanding. The analytical element involves describing the changes in each category, and in the balance between categories, brought about by the 'new public management' changes. The evaluative element is closely linked to this, in that it involves an assessment of the strengths and weaknesses of each category, and of the relative balance between the categories. The latter reflects the fact that, on political grounds,²⁷ theorists may value particular categories highly and seek to promote them, particularly where their requirements appear to conflict with those of other

²⁵ See generally Ferlie *et al.* (1996); Foster and Plowden (1996); Rhodes (1997). For earlier debates about accountability, see Stewart (1984); Day and Klein (1987).

²⁶ For other examples of category-based analysis, see Oliver (1991) on government generally, and Longley (1993) on the NHS.

²⁷ The term 'political' is intended to include differences on matters of constitutional theory as well as party politics: it will be seen that both senses are needed to understand the debate.

‘less valued’ categories. The debates about consumer and public accountability, discussed below, are illustrative of this. The second aim of the section is to set the scene: for accountability in modern government generally, and for our case study accountability mechanism, the NHS contract, to be introduced in Chapter II. It will introduce the current debate about accountability, and the context in which any research on the topic must take place.

As Foster and Plowden (1996) explain, much of the impetus behind the ‘new public management’ reforms was a perceived need to control public expenditure. *Financial accountability* was therefore a key area of change, in two major ways. Firstly, in order to cut bureaucracy and stimulate financial awareness throughout the public sector, budgets were devolved to lower levels in the administrative hierarchy initially under the Financial Management Initiative (Zifcak 1994) and later under structural reforms to be discussed below. This was coupled with a strong emphasis on financial accountability: for remaining within budget, and for meeting associated financial targets such as annual efficiency gains. The intention was that individual departments should develop strong financial control systems, allowing the Treasury to take a more ‘hands-off’ approach by simply monitoring the operation of those systems (Zifcak 1994). Two criticisms have been made. On the one hand, it has been argued that devolved budgets, coupled with an increased emphasis on entrepreneurialism, might damage the sense of financial probity which was a key part of the traditional civil service ethos, and increase opportunities for fraud (Doig 1995; Lewis and Longley 1994). On the other hand, it has been claimed that in reality, the reforms involved such tight controls that

their true effect was centralising, despite the rhetoric of devolved powers (Bruce and McConnell 1995; Hughes and McGuire 1992).

The second major change in the sphere of financial accountability was in relation to audit. The roles of the National Audit Office and the Audit Commission were enhanced by an increased emphasis on the value of audit (Loughlin 1992; Harden 1993). In particular, the concept of audit was extended to cover not just financial regularity, but also the more contested requirements of economy, efficiency and effectiveness. Power (1997) argues with some force that we should be wary of placing excessive reliance on the reassuring overtones of the term 'audit'. With regard to efficiency and effectiveness audit in particular, audit techniques may not have been able to keep pace with the high expectations placed upon them.

As financial accountability has expanded, it has impinged on other categories, notably political accountability. Firstly, assessing effectiveness requires the auditor to define the goals of a particular policy (Hopwood 1984). This is often a highly political decision, given that the legislation and surrounding documentation may not contain a clear statement of aims, and may even involve the pursuit of several potentially conflicting aims. Secondly, some trade-off may be required between economy and effectiveness: the effective pursuit of a policy may require more resources (Power 1997). Once again, funding levels are a highly political issue. Thirdly, although audit reports may assist parliamentary accountability by providing information, and thus ammunition, for MPs, they may have the adverse effect of 'professionalising' certain issues, making them appear to be matters for

experts rather than for politicians (Hopwood 1984). Fourthly, and most fundamentally, Freedland (1996) argues in the context of executive agencies (see below) that the financial changes have seriously limited the scope of departmental, and ministerial, responsibility for agencies, confining responsibility to the task of supervising agencies' use of resources. He writes: 'As if by a conjuring trick, the spell of financial accountability has enabled ministerial responsibility not only to be sawn in half but actually to be spirited off the stage' (Freedland 1996: 28).

Administrative accountability is perhaps the area in which the changes were, however, most fundamental. A variety of structural changes took place, driven by a set of linked policies. These policies included a preference for the private sector over the public sector for service delivery; a belief that private sector methods (notably competition) could and should be adopted in the public sector; a preference for smaller agencies over large, hierarchically-managed organisations; and a preference for formal, 'contractual'²⁸ relationships between organisations.²⁹

The most obvious change occurred in those parts of the public sector which were privatised.³⁰ Here, accountability to ministers was replaced with accountability to shareholders in the normal private sector mould. For the utilities, accountability to government was not, however, entirely removed. Regulators were put in place to ensure that dominant market positions were not abused, and

²⁸ Such 'contracts' were not normally enforceable in private law when both parties to them were in the public sector.

²⁹ For advocacy of an evangelistic nature, see Osborne and Gaebler (1992). For analysis and critique, see Foster and Plowden (1996); Harlow and Rawlings (1997).

³⁰ See generally Kay *et al.* (1986); Vickers and Yarrow (1988).

that certain social obligations were fulfilled.³¹ Private involvement in the provision of public services was also increased through the drive to contract out certain functions. For example, local government was compelled to invite tenders for a wide variety of functions, from refuse collection to (later) legal services.³² This replaced direct line management with relationships of accountability through contract, supported by the prospect of competition for the award and subsequent renewal of the contract. Finally, the Private Finance Initiative sought to involve private parties in the public sector in more fundamental and far-reaching ways, through the provision of capital assets for public projects.³³

Where services remained in the public sector, often because privatisation was politically too controversial, an attempt was made to introduce contracts and competition to mimic the supposed discipline of the private sector. In the NHS, for example, purchasing organisations were introduced to replace line management of providers of care. In order to obtain income, providers were obliged to attract the custom of purchasers, who placed contracts with them for a specified quantity and quality of care at an agreed price. As we shall see later, the introduction of markets was both controversial and problematic.³⁴

Not even the civil service was spared: the concept of devolved budgets was taken a step further, so that parts of the civil service were hived off into executive

³¹ See generally Baldwin and McCrudden (1987); Ogus (1994); and n. 30, above.

³² Local Government, Planning and Land Act 1980; Local Government Act 1988 and orders made under s. 2(3). See generally Vincent-Jones (1997), and (1998) for recent developments.

³³ For useful detail and critique, see Freedland (1998).

³⁴ See generally Chapters II and III, below; Ferlie *et al.* (1996); Flynn and Williams (1997).

agencies.³⁵ Here, an attempt was made to separate the two traditional roles of the civil service: delivering services and giving policy advice to ministers. It was argued that service delivery was neglected because senior civil servants' main role was policy advice, and that traditional civil service management techniques were unduly bureaucratic and therefore inefficient. The reforms were designed to give more responsibility and autonomy to service deliverers by breaking down hierarchies and introducing more formal relationships between a smaller core civil service, and agencies with high-profile chief executives. Each agency had a specific service delivery function, a budget within which to perform that function, and an agreement with its parent department, a 'framework document' analogous to a contract,³⁶ setting out targets for performance.

These structural changes were claimed by their proponents to be an advance in administrative accountability. Firstly, the move from line management to 'contract' made it possible to formalise standards of performance, monitoring mechanisms and so on. The accountability process would be more obvious and transparent.³⁷ There were, however, problems with implementing this. Devising clear performance measures is not as easy as it sounds (see, for example, Zifcak 1994: 43). Secondly, it was believed that separating policy-making or purchasing from provision would enhance accountability by making it less likely that those responsible for calling to account would identify with those responsible for

³⁵ Greer (1994); Woodhouse (1994); Zifcak (1994).

³⁶ The degree of analogy is a matter for debate. Freedland (1994) makes the analogy quite strongly, but more recently he has sought to distance himself from the view taken in the 1994 article (Freedland 1998). See also Greer (1994); Vincent-Jones (1994).

³⁷ See the Next Steps Review 1993, quoted in Freedland (1994). For a strikingly similar account of the advantages of contract in a very different context, see Nelken (1987).

provision. The ‘new public management’ was in part driven by ideas from public choice theory that bureaucrats are inherently self-interested, working to enhance the budget and status of their organisation, rather than working in the interests of those they are meant to serve.³⁸ They cannot be trusted to run an effective and efficient service of their own accord. Independent scrutiny, for example from a purchaser, is needed to ensure genuine accountability (HM Treasury 1991; Ferlie *et al.* 1996). Thirdly, competition could support or even supplant entirely the formal processes of contractual accountability: service providers would meet the required standards because they would be afraid of losing out to their competitors if they did not.³⁹

Critics of the reforms, on the other hand, were concerned about their impact on public and political accountability. Because responsibility for a given service is divided between purchaser and provider, each side may be tempted to evade being called to account, particularly when problems arise, by blaming the other. Even without this temptation, the split is at least confusing to the service user and reduces transparency (Bruce and McConnell 1995).⁴⁰ For example, although ministers remain responsible to Parliament for agencies, which are still part of their parent department, there were situations, most notoriously in relation to the Prison Service, in which there was doubt as to whether a minister or the head of an agency should take the blame for a problem (Foster and Plowden 1996).⁴¹ This is exacerbated by the trend, identified by Woodhouse (1994), for ministers to

³⁸ Buchanan and Tullock (1962); Olson (1965).

³⁹ See, for example, Department of Health (1989) which makes the same point in a positive way: successful providers would attract more resources.

⁴⁰ See Chapters IV and V for empirical evidence on this point.

⁴¹ See also House of Commons Public Service Committee (1996).

reinterpret the convention of ministerial responsibility in such a way as to cover in full only those decisions personally taken by the minister. Moreover, the situation has not been helped by the reliance placed on the distinction between responsibility for policy and responsibility for operations (Woodhouse 1994). The dividing line is notoriously difficult to draw, particularly when ministers are tempted to interfere behind the scenes with operational details, as they did with the nationalised industries, and when agencies, because of their expertise, have a key role in giving policy advice.⁴²

Professional accountability as traditionally understood (disciplinary procedures, peer review and so on) was left largely unchanged by the reforms. But professionals were fundamentally affected because managerial and financial accountability mechanisms were made applicable to them (see generally Ferlie *et al.* 1996). Their traditional autonomy was radically circumscribed.⁴³ On the one hand, management was given more say in various aspects of the employment of professionals: for example, managers were allowed to sit on the committees which decided on NHS consultants' distinction awards (Hughes 1991). On the other hand, professionals were obliged to take more account of managerial concerns, notably the resource implications of their decisions (Hughes and McGuire 1992; Loughlin 1992). Budgets were devolved to fundholding GP practices⁴⁴ and to clinical centres within hospitals, forcing professionals to consider cost as well as clinical need. Even non-fundholding GPs were made aware of their prescribing

⁴² Oliver (1991); Greer (1994); Zifcak (1994).

⁴³ Examples are taken from the health sector because our case study takes place in that context. See Chapter II.

⁴⁴ National Health Service and Community Care Act 1990, s. 14.

costs through the indicative drug budget.⁴⁵ Professionals could, of course, gain power through these reforms. GPs gained as against hospital clinicians, because through the fundholding scheme they could acquire the power to make hospital clinicians answerable to them in their capacity as purchasers of care (P. Hunt 1995).⁴⁶ Moreover, professionals who worked with the reforms and adopted managerial roles could be seen as having gained power as a result (Ferlie *et al.* 1996).⁴⁷

Political accountability was ostensibly unaffected by the ‘new public management’ reforms.⁴⁸ But we have already seen a number of instances in which the reforms had an indirect impact on the category. In addition, theorists have argued that it was wrong to leave political accountability untouched: positive reforms were needed to enable it to keep pace with the changes to government (Woodhouse 1994).⁴⁹ For example, one feature of the use of executive agencies in the civil service has been to raise the profile of the head of the agency as the person responsible for its performance. Parliamentary accountability has responded to this in some ways: MPs are encouraged to write to agency heads about constituents’ grievances, and agency heads are designated Accounting Officers,⁵⁰ a key civil service check on the activities of ministers (Woodhouse 1994). But Woodhouse argues that these changes do not go far enough, and that

⁴⁵ National Health Service and Community Care Act 1990, s. 18.

⁴⁶ Discussed in detail in later chapters.

⁴⁷ Encounters during this study (which took place at a later date) with professionals who had adopted these roles revealed a high level of disillusion with the amounts of paperwork involved and the inability to achieve the changes which they had hoped for at the outset.

⁴⁸ Its effectiveness was, however, already a subject of debate prior to the reforms. See, for example, Harden and Lewis (1986).

⁴⁹ See also House of Commons Public Service Committee (1996).

⁵⁰ See n. 19, above.

there is a case for allowing agency chief executives to account to Select Committees in their own right, rather than on behalf of the minister. Although this would acknowledge the changing role of these high-profile civil servants, it would not remove the problem of determining the respective responsibilities of ministers and agency heads for a particular decision.

But it is in the category of *public accountability* that the greatest controversy has arisen.⁵¹ Two major changes have occurred. One is a diminution in the role of public representatives on boards and advisory councils. In the NHS, for example, large Health Authority boards of appointees which were intended to reflect the local community and local government were replaced by much smaller boards of appointees with ‘business experience’, in the style of a company’s board of executive and non-executive directors (Department of Health 1989).⁵² Proponents of the reforms argued that the new boards would be more effective:⁵³ the old boards had been criticised for their lack of cohesion, strategic focus and control over service providers (Day and Klein 1987). Moreover, extensive citizen participation in the running of public services was argued to be unnecessary provided that those services were responsive to their needs (D. Hunt 1995). In short, it was said that people were more interested in receiving good services than they were in running them, a proposition for which there is some empirical support (Wistow and Barnes 1993).

⁵¹ To sample the controversy, see the special issue of *Parliamentary Affairs* (Volume 48, No. 2; 1995) entitled ‘The Quango Debate’

⁵² For detailed discussion and empirical research, see Ferlie *et al.* (1996).

⁵³ Ferlie *et al.* (1996) found some empirical evidence for this.

Commentators criticised the changes on several grounds. They challenged the way in which board appointments were made: they were shrouded in secrecy and there was a suspicion that appointments were being used to reward the government's political supporters (Stewart 1995).⁵⁴ Moreover, they argued that business experience was not necessarily a better qualification for the task of, for example, rationing health care, than was the ability to represent some sector of the community (Longley 1990). Finally, although the old boards were not democratically elected, the reforms heralded a 'democratic deficit', because they paid even less attention to notions of representativeness⁵⁵ than the system they replaced (Ferlie *et al.* 1992).

The second linked set of changes was designed to ensure that consumers received high quality services. The changes are exemplified by the Citizen's Charter initiative, a relative late-comer to the 'new public management', introduced by John Major's government in the early 1990s.⁵⁶ The Citizen's Charter set out general rights and expectations for the consumers of government services, and gave rise to specific charters for particular services, such as the Patient's Charter in the NHS (Department of Health 1991). These initiatives set explicit standards of performance for services, and required public bodies to publish information about performance and to institute complaints procedures for aggrieved consumers. Consumers would be empowered because they would be

⁵⁴ These concerns led to the establishment in 1994 of the Committee on Standards in Public Life, and a gradual opening up of appointment procedures in accordance with the Committee's recommendations.

⁵⁵ Though the 'new right' response to this might be to argue that the old boards were more radical politically than, and therefore not genuinely representative of, local people.

⁵⁶ See HM Government (1991); Barron and Scott (1992); Willett (1996).

able to voice their views through these complaints procedures and because service deliverers would seek out their views through consumer surveys. In some circumstances, for example by persuading their GP to refer them to a hospital of their choice, consumers would be able to use exit.⁵⁷ The publication of clear standards and performance information would help them to make well-informed comments and decisions.

Commentators also criticised these reforms. It was argued they did not offer genuine empowerment: even the use of the word ‘consumer’ implied passivity.⁵⁸ For example, as Harden (1992) points out, despite a rhetoric of increasing consumer choice, patients were not party to NHS contracts. If a patient was unhappy with a service, he or she would have to persuade the GP to contract with another provider, or move to another GP. The weakness of the sanctions available to consumers casts doubt on whether a genuine accountability process exists, as opposed to the volunteering of accounts by the public body.⁵⁹ Moreover, it has been argued that consumers are not the only stakeholders in the provision of public services (Foster and Plowden 1996). Taxpayers and staff, for example, may also have relevant views. When demand for a service outstrips supply, consumers may want more money to be spent to increase provision, but not all taxpayers may agree. If a service must be rationed, consumer responsiveness is only of limited value as a principle for deciding who should be given priority (Foster and Plowden 1996). But perhaps most significantly, traditional notions of citizenship are weakened if the citizen is redefined as an economic actor (Barron and Scott 1992).

⁵⁷ The terminology originated with Hirschman (1970).

⁵⁸ Bruce and McConnell (1995); Stewart (1995); Weir (1995).

⁵⁹ See the discussion of sanctions in the next section.

Finally, *legal accountability* is another category which appears to have been left untouched by the reforms, but has attracted considerable attention from commentators. They have argued, rightly, that public law needs to develop new principles in order to cope with the changes. As Freedland (1994) has demonstrated, the increasing use of contract by government may take particular activities outside the scope of public law altogether. Harden's (1992) argument for the development of a notion of a 'public law contract'⁶⁰ is one of several suggestions of how public law might expand to encompass the reforms. More broadly, other writers have argued for an aggressive development of public law principles to safeguard values such as public participation which are challenged by the reforms themselves (Longley 1990). Such radical developments have not, however, been forthcoming.

We have seen that the 'new public management' reforms made some fundamental changes to relationships of accountability in the British state. Attempts were made to strengthen the government's internal accountability, particularly for expenditure but also to some extent for service standards, through changes in administrative and financial accountability. These changes are, in themselves, probably to be welcomed. But commentators have rightly been worried by the impact of the changes on other accountability categories. Despite their fundamental constitutional importance, political, public and legal accountability mechanisms were either ignored or indirectly harmed by the

⁶⁰ This is a key theme of the thesis and is explored fully in later chapters.

reforms. The argument that greater efficiency and consumer responsiveness might compensate for the reduction in political and public debate is questionable.

Some writers have gone so far as to argue that accountability has been redefined as a result of the reforms. For example, Bruce and McConnell (1995) argue that public accountability has been redefined in economic terms: citizens have become consumers, and any notion of discussion or debate inherent in the concept of accountability has been replaced with the idea of financial control. Others have argued that accountability has been 'privatised'. Belcher notes that in the field of private sector corporate governance, accountability is defined as 'the monitoring, evaluation and control of organisational agents' (Belcher 1995: 290). She contrasts this with public sector definitions emphasising explaining, justifying, debating and making amends. The majority of the changes in accountability identified above involve forms of accountability which fit the private sector definition much more closely than the public sector one.

But the argument that accountability has been redefined is problematic. An element of debate characterises public and political accountability, because the standards against which conduct is to be judged are contentious (Day and Klein 1987). But it does not characterise all forms of accountability in the public sector. The notion of controlling individuals through precise standards of conduct⁶¹ is not new to the public sector (Day and Klein 1987). In fact, it sums up the traditional hierarchical management structure of the civil service, and also has links to other

⁶¹ Though as Day and Klein (1987) note, political processes do not always yield precise criteria (of the objectives of a policy, for example) to be used in assessing the performance of service deliverers.

control mechanisms such as judicial review for legality, and audit for financial probity. Mechanisms which are in some way internal to the civil service, or lower down Stewart's 'ladder', inevitably emphasise control rather than discussion, even though they take place within the public sector (Stewart 1984). Accountability mechanisms designed to promote debate and accountability mechanisms intended to control behaviour can be seen as opposite ends of a spectrum, discussed further below. Moreover, it is not necessarily helpful to describe the changes which have taken place as a 'redefinition' rather than an alteration in the balance between categories. It is true that when introducing the reforms, the government often referred in a general way to accountability, meaning financial rather than political accountability; but it is equally true that when theorists refer to accountability they tend to mean political or public accountability.⁶² For analytical purposes it is better to acknowledge the variety of categories of accountability, rather than to claim that one category should be inferred when the term is used. This still allows a debate as to whether the balance between categories is correct.

By using the categories of accountability, we have been able to put the 'new public management' reforms into an evaluative framework. In particular, it has been possible to show how changes in one category impact on other categories, and to highlight the need to maintain effective accountability mechanisms in several categories in order to achieve balanced accountability overall (Oliver 1991). But the approach has some limitations. Firstly, the broad goal of using several categories of accountability may be pursued in a variety of ways, rejecting some specific categories altogether and achieving any one of a number of different

⁶² Compare, for example, HM Treasury (1991) with Longley (1993).

balances between the categories adopted. The exact configuration of categories of accountability is a matter for political value judgement, as the discussion above indicates. The categories help to structure the debate, but they cannot help to resolve it. This limits the work that can usefully be done using the categories. Secondly, if the categories are the main unit of analysis, there is little incentive to examine particular mechanisms of accountability in detail. Of course, any discussion of the categories must include some analysis of the particular accountability mechanisms within each category. But the categories themselves do not provide any specific analytical or evaluative tools for this process. The next section picks up this second theme.

ANOTHER PERSPECTIVE ON ACCOUNTABILITY: THE MECHANISM OF ACCOUNTABILITY

Although the category method is, as we have seen, a helpful method of analysis and evaluation, it may not be the only way of tackling the concept of accountability. Indeed, given its limitations, discussed above, we need to supplement it with other methods if we are to make further progress in understanding accountability. Rather than looking at the totality of accountability mechanisms applicable to government, and seeking to divide them up into categories, we could begin at the lowest level by focusing on particular mechanisms of accountability. The aim of this thesis is to explore and exploit the analytical and evaluative potential of the accountability mechanism. The approach is not advanced as an alternative to the study of categories: the two approaches

could complement each other. This section identifies the core elements of the accountability mechanism for analytical purposes, and gives illustrations of the various ways in which these elements are manifested in practice. It also notes, briefly, the evaluative dimension, to be explored fully in later chapters. The section gives a basic introduction to some of the central concepts and themes of the thesis.

Our first task is to develop a general, definitional model which fits all accountability mechanisms, whatever their category. What features enable us to look at a particular activity and say that it counts as an accountability mechanism? At the very highest level of generality, all mechanisms of accountability have the same purpose: they seek to make one person or body answerable to another for the performance of a particular task.⁶³ But if we focus on the more specific roles or purposes of particular accountability mechanisms, we will not find the core features we are seeking: the category method uses roles or purposes (promoting political debate or financial regularity, for example) in order to group methods together and to distinguish them from other groups.

Another, more promising, possibility is that particular mechanisms of accountability might have common structural features, even if they do not have common purposes. There is a need to gather information from the person being called to account, to evaluate that information, to deal with situations where information is not supplied, and to address any problems with the performance of

⁶³ Chapter III explores the precise goals of an accountability process.

the task revealed by the information. This elaborates the third criterion of accountability given earlier in this chapter: accountability exists where an accountability process, as described here, is put in place. Oliver's description of the components of an accountability process (which harks back to the homely example with which we began) is instructive: '[Accountability] is about requiring a person to explain and justify - against criteria of some kind - their decisions or acts, and then to make amends for any fault or error, whether by reversing the decision, or paying compensation or in some other way - even resigning from office' (Oliver 1994: 246, based on Marshall 1986). With the aid of this description, and hints from other writers, it will be argued here that an accountability mechanism consists of four key features: setting standards against which to judge the account; obtaining the account; judging the account; and deciding what consequences, if any, should follow from it. These are common to all mechanisms of accountability although, as we shall see, they can be manifested in a variety of ways. We will examine each element of the model in turn, bearing in mind that they are often closely linked in practice, and that some variations in their chronological order are possible.

The first component in the process involves *setting standards against which the account can be judged*: '[A]ccountability... presupposes agreement both about what constitutes an acceptable performance and about the language of justification to be used by actors in defending their conduct.' (Day and Klein 1987: 5). These criteria have an important role to play in determining the scope of the accountability process: they define which aspects of the relevant body's responsibilities are covered by the process, and implicitly, which are not. For

example, the National Audit Office is required to call departments to account for the economy, efficiency and effectiveness of their work but not for the substance of the policies they adopt.⁶⁴ The standards set are likely to include some which apply to the account itself, for example that it should be honest and accurate (Thynne and Goldring 1987), as well as substantive standards relating to the quality of the activity being accounted for. The nature of the substantive standards will vary according to the purpose of the accountability process. In general terms, as Oliver explains, ‘it is for their stewardship of the public interest that state institutions are in practice most commonly accountable, and by this criterion that they are judged’ (Oliver 1991: 23). But in many situations, more precise criteria are evolved. If the accountability process is designed to act as a safeguard against poor performance, the standards set may be minimum requirements below which performance should not fall. If it is designed to improve performance, the standards may be devised as more challenging targets.

Who sets the standards depends on the particular accountability process in question. In some cases, the standards may be set by third parties. ‘Maladministration’ as applied by the Parliamentary Commissioner for Administration is a statutory criterion,⁶⁵ although he has considerable discretion in evolving more precise meanings for the term and applying it to the facts. In other cases, the person calling to account sets the standards: individual voters set their own criteria for judging the government’s performance. Where a technique such as contract is used, the person being called to account may have some input,

⁶⁴ National Audit Act 1983, s. 6.

⁶⁵ Parliamentary Commissioner Act 1967 (as amended), s. 5(1).

depending on the parties' relative bargaining power, into the standards set.⁶⁶ In the case of professional regulation, the notion of having an outsider to set standards is abandoned altogether: it is the members of the profession themselves who determine what is acceptable (Allsop and Mulcahy 1996).

Likewise, the formality of the standard-setting process depends on the context. At one end of the spectrum, a minister's accountability to Parliament or the electorate proceeds on the basis of vague standards: the standards themselves may be contested on political grounds, and the minister may have to justify not only his performance but also the standards against which he himself has measured it. As we noted earlier, the process involves a greater focus on debate as a result (Stewart 1984). Moreover, although it might seem natural to begin by setting out the standards to be applied, in political contexts the standards may be evolved as the accounts themselves are given. At the other end of the spectrum, an agency's framework document sets out formal written criteria and objectives (Greer 1992). Even here, however, there is room for interpretation: applying the standards to the facts may involve a continuing process of standard-setting (Hawkins 1984).

The second component in the accountability process occurs where *the person calling to account requires the primary actor to explain and justify his or her actions*. This may be seen as the most fundamental component at the very heart of accountability: without information and explanation, the process cannot take place at all. Once again, a variety of forms and procedures may be used for obtaining accounts. The person calling to account may simply ask for oral or written

⁶⁶ See Chapters II and III, below.

information, for example through the use of parliamentary questions or Select Committee hearings to obtain explanations from ministers. In other mechanisms, the caller to account takes a more direct role in seeking the information, for example through inspection or audit. Where those calling to account are lay people, they may need expert assistance to supply the information they need: the work of the Audit Commission in producing performance indicators for health and local government services to aid voters and consumers is an example of this.⁶⁷ Calling to account may be a regular activity, or triggered by signs of a possible problem. In the context of the medical profession, for example, medical audit is routine but disciplinary procedures are usually set in motion by a complaint (see Allsop and Mulcahy 1996).

Day and Klein (1987) point out that the accountability process should be compulsory: it should be possible for the person calling to account to take action if the required information is not supplied.⁶⁸ This may appear to be an evaluative point: the accountability process is more likely to be effective if it is compulsory. But it is important to include this in the definition itself, whilst recognising its close links with effectiveness. The distinction made by Day and Klein (1987) is between accountability and giving accounts.⁶⁹ When a public body voluntarily issues an annual report, for example, it gives an account but is not called to account. It has control over what goes into the report, and could gloss over areas

⁶⁷ Local Government Act 1992, s. 1(1); and see, for example, Audit Commission (1998).

⁶⁸ See also Morgan (1993); Oliver (1991); Woodhouse (1994).

⁶⁹ Similarly, Stewart (1984) distinguishes between a 'bond' of accountability, in which the person calling to account has the power to demand accounts, and 'links' of account, in which the person being called to account volunteers information as a matter of custom or good practice to interested parties, even though they do not have the right to call him or her to account.

of poor performance or exclude them from the report altogether (Normanton 1971). Genuine accountability requires an obligation to supply information. This element of obligation may be achieved in different ways. Some accountability techniques rely on legal duties to reinforce the demand for information: for example, many public sector bodies, such as Health Authorities, are under a statutory duty to produce annual financial accounts.⁷⁰ Others, such as parliamentary accountability, rest on convention, public and parliamentary opinion, and media pressure. This demonstrates the close link at this point between our definition and issues of effectiveness: where these ‘sanctions’ are weak, we may question whether parliamentary accountability processes retain a sufficient sense of obligation to distinguish them from processes in which accounts are volunteered.

The third component of accountability is *judging the account rendered against the standards set*. In some accountability processes, this component is clearly separated from obtaining the accounts and deciding on the consequences to follow from them: in court proceedings, for example, the elements of hearing, giving judgment and making any resulting orders are easy to identify. In other processes, however, the components may be harder to distinguish. There is strong empirical evidence from the regulatory context for the proposition that the decision to characterise performance as inadequate is closely linked to the consequences that are likely to ensue (Hawkins 1984). Moreover, in some situations, for example elections, the only evidence of the decision taken by voters on the government’s performance is to be found by looking at the consequences: whether or not the

⁷⁰ National Health Service Act 1977 (as amended), s. 98.

government is re-elected. The process may also be very closely linked to the task of obtaining the accounts. For example, critical questioning by a Select Committee may reflect a decision, during the course of the hearing, that the accounts being given are inadequate, and that as much difficulty as possible should be created for the minister in consequence. In some contexts, such as contract or regulation, the label 'monitoring' captures the connection between information-gathering and judging.

The fourth component of the accountability process is *applying any resulting consequences, or 'enforcement'*. The consequences may have one of at least three possible goals. Firstly, they may take the form of punitive sanctions, forcing individuals to take blame, for example by resigning, or agencies to make amends, for example by paying compensation. Secondly, they may reward good performance. Thirdly, they may seek to improve future performance, for instance by instituting new procedures. A single accountability process may, of course, pursue more than one of these goals. The choice between them will be determined by the purpose of the accountability process. Judicial review, for example, aims to provide remedies for individuals aggrieved by government action, and therefore pursues the amendatory goal set out above. But it also has an indirect role in improving performance for the future: a public body may institute new procedures in response to an adverse decision (Hammond 1998). In contrast, this task of improving future performance is pursued as a primary goal by a body such as the

Audit Commission, which seeks in its reports to collate examples of best practice and spread them throughout the relevant part of the public sector.⁷¹

The value of this analytical approach is that it enables us to identify the common features of all mechanisms of accountability, whilst acknowledging the variety of ways in which they might be manifested in practice. Mechanisms of any category can be broken down into these core components. To give but one example, financial audit and parliamentary questions, though they fall into very different categories, each manifest a version of the key processes: standard-setting, obtaining accounts, judging the accounts and applying any resulting consequences. In financial audit, the standards are usually a combination of the statutory requirements placed on public bodies, and the conventional standards used by auditors and set out in codes of practice (Audit Commission 1995*b*). Public bodies are commonly under a statutory duty to produce accounts and to have them audited, which involves supplying information to the auditors both through the accounts themselves and through supporting evidence and documentation. Finally, auditors have a variety of powers to refuse to certify the accounts and to proceed against individuals guilty of wrongdoing if they are dissatisfied.⁷² In parliamentary questions, the standards for evaluating the answer are largely a matter for MPs themselves, subject to party discipline. Information is supplied orally or in writing, and there is a convention that questions will be answered unless they cover forbidden topics, such as the detail of the operations of the security services (Erskine May *et al.* 1997). If an MP is unhappy with a response, he or she may ask

⁷¹ Audit Commission Act 1998, s. 33(1); and see, for example, Audit Commission (1996).

⁷² Local Government Finance Act 1982, s. 19.

further questions and seek to obtain publicity for his or her cause, for example. Thus, focusing on accountability as a set of practical tasks enables us to identify the common features of a whole range of apparently very different processes, and to explain why they count as mechanisms of accountability. This may go some way towards dispelling the confusion which surrounds the definition of accountability and other attempts to make general statements about the concept. We have seen that most theorists, working with categories, claim that such generalisations are impossible, or at least difficult. By focusing on the core components of the accountability mechanism, the discussion above sets out a model that makes generalisation across different accountability mechanisms a real possibility.

The approach we have outlined may have evaluative potential in addition to its role as a tool of analysis. Having identified the core components of an accountability mechanism, it should be possible to make some evaluative statements about the conditions required to make those processes effective. Such statements could develop into benchmarks against which to assess practical examples of accountability mechanisms. Of course, theorists already comment extensively on the good and bad points of particular mechanisms: we saw some examples of this in the discussion above. But there is a tendency to lose sight of the concept of accountability during these discussions.⁷³ A range of issues is examined: the extent to which a mechanism fosters public participation, the availability of information to support the process, the effectiveness of the

⁷³ See, for example, Oliver (1991). Day and Klein (1987) is an exception, but still does not delve as deeply into the notion of an accountability process as this section proposes.

sanctions applicable to the person being called to account, and so on; but these ideas are not expressly linked to accountability. There is a danger that ‘effective accountability’ might become synonymous with much broader notions of ‘good government’ (Day and Klein 1987). The model we have set out should enable us to evaluate particular mechanisms in a more structured way. In particular, our method provides a means of comparing different mechanisms of accountability for their effectiveness in performing the same tasks. Some adjustments to the model may be needed to take account of the very different purposes served by accountability processes, but broad statements of the conditions necessary for good standard-setting, information-gathering, judging and enforcement should be possible. The evaluative potential of our model is brought to life in Chapter III.

In conclusion, it is worth emphasising the importance of the task upon which we have embarked. Studying particular accountability mechanisms is as vital an activity for public lawyers as studying the balance between categories of accountability. As Harden and Lewis argue: ‘The relationship between scholarship in law and social and political administration ought to concern precisely the matter of experimentation in institutional terms for delivering on canons of accountability’ (1986: 233). Oliver makes a similar point (1991: 28). The reason for this is obvious. Effective categories of accountability must consist of well-designed accountability mechanisms. Informed comment on the categories is only possible if supported by a detailed knowledge of the mechanisms making up those categories. Moreover, public law has a crucial role to play in giving force and content to mechanisms of accountability. If the government establishes a consultation procedure, for example, judicial decisions help to flesh out the detail

of how it must behave when operating the procedure.⁷⁴ Other mechanisms are created by statutes which give them their authority and spell out the scope of their powers: the Parliamentary Commissioner for Administration and the Audit Commission are examples of this.⁷⁵ Designing good accountability mechanisms should therefore be a key concern in public law.

CONCLUSION

This chapter has argued the case for a novel approach to the study of accountability, to complement existing studies based around categories of accountability. How might this novel approach, focused on the component processes of the accountability mechanism, advance our understanding? There are at least four possible ways in which it might prove to be useful as a methodology. Firstly, it offers a way of presenting data about particular accountability mechanisms. Chapters IV-VI demonstrate this approach: the empirical data collected for our case study are organised around the components of an accountability mechanism, identified above. Secondly, analysing an accountability mechanism in terms of the core features of standard-setting, information-gathering, judging and enforcement suggests a number of directions for empirical research. In particular, it encourages a focus on the practical problems faced by the parties to an accountability process. What difficulties do they encounter when ‘operationalising’ accountability? This provides a useful complement to the broad

⁷⁴ *R v Brent LBC, ex p. Gunning*, 1985 84 L.G.R. 168. See generally Craig (1994).

⁷⁵ Parliamentary Commissioner Act 1967, as amended; Audit Commission Act 1998.

assessments of the balance between categories of accountability which results from the traditional approach to the topic, discussed above. Thirdly, the approach has evaluative potential. It should be possible to identify what might constitute a 'good' version of each stage of the accountability process. Importantly, this would enable us to assess accountability mechanisms in terms of accountability, instead of using a range of other benchmarks not explicitly linked to this central value. Fourthly, by making clear the common strands running through all accountability mechanisms, our approach should facilitate the generalisation of research results and comparison between accountability mechanisms. This should in itself be a source of ideas for further research.

For the present, we must reserve judgement on the question of whether the process analysis set out above will prove helpful in the ways suggested. To assist our decision, we will embark on the case study. The first task in doing so is to choose an accountability mechanism for research. Chapter II explains and justifies the choice of contracts between purchasers and providers in the National Health Service as that case study.

II

NHS Contracts: a Case Study

The purpose of this chapter is four-fold. Firstly, it gives a brief introduction to the NHS reforms of 1990, which sought to apply to the NHS many features of the ‘new public management’, discussed in Chapter I. This sets the scene for our case study of an accountability mechanism. Secondly, the chapter introduces that case study: the NHS contract. This was the subject of our empirical research on accountability.¹ Thirdly, it will be demonstrated that NHS contracts involved a relationship of accountability between the contracting parties. This confirms the validity of our chosen case study. The discussion draws on the analytical model of an individual accountability mechanism, and on the more general ideas about accountability in the public sector, advanced in Chapter I. Finally, we will examine the possibility of generalising from a study of NHS contracts to other accountability mechanisms. Our ability to do this will ensure that the study is of broad relevance. In particular, we will examine whether our public law analysis of NHS contracts might enable us to make progress towards a notion of the ‘public law contract’. This will be an important theme of the thesis as a whole.

¹ The study’s aims are set out in Chapter III and the findings are described in Chapters IV-VI. Methodological detail is given in Appendix 1.

THE NHS REFORMS: A SYSTEM OF PURCHASING AND PROVISION

The reforms to the NHS² introduced by the National Health Service and Community Care Act 1990³ ('the 1990 Act') sought to implement a number of the fundamental tenets of the 'new public management'.⁴ These included structural change to break down existing hierarchies, budgetary reforms to enhance financial control, and challenges to the role of professionals. Space precludes a consideration of all aspects of 'new public management' in the NHS:⁵ we will focus on those elements of the reforms which were most closely linked with the NHS contract, our case study. The arrangements described are those of 1996-97,⁶ when the empirical study for this thesis was conducted.⁷

Prior to the 1990 Act, the provision of care in the NHS was hierarchically managed.⁸ Funds were distributed from the centre to Regional Health Authorities⁹ (RHAs). RHAs gave budgets to District Health Authorities (DHAs) which managed the provider units in their area. The reforms sought to dismantle the

² There is a large introductory literature: see, for example, Spurgeon (1993); Levitt *et al.* (1995); West (1997). For an introduction to the comparative analysis of the reforms, see Ranade (1998).

³ See Department of Health (1989).

⁴ Discussed in Chapter I. See generally Ferlie *et al.* (1996); Walsh *et al.* (1997).

⁵ See Longley (1993) on public and consumer accountability, and Allsop and Mulcahy (1996) on professional accountability.

⁶ See also Montgomery (1997a). After the General Election in May 1997, the incoming government proposed the abolition of many of the arrangements here described (see Department of Health (1997), and the Health Bill introduced in 1999). These proposals are not considered in the thesis: the aim is to examine NHS contracts as a case study of accountability, rather than to give an account of current administrative arrangements in the NHS.

⁷ See Appendix 1.

⁸ For the reforms in their historical context, see Webster (1998) and Klein (1995). For a full history of the NHS, see Webster (1988; 1996).

⁹ Abolished from April 1996 by the Health Authorities Act 1995. For history of the regional tier of NHS management, see Webster (1998).

hierarchical relationship between DHAs and providers, by giving providers organisational independence from DHAs, and by creating a new role for DHAs as the purchasers of care from these providers. This structural change is commonly referred to as the ‘purchaser/provider split’ or the creation of an ‘internal market’.¹⁰ The reforms reflected two key ‘new public management’ principles: that the task of providing services should be separated from the task of deciding what should be provided, and that competition could be used as an effective stimulus to greater efficiency and higher quality.¹¹ The first principle is derived from public choice arguments that service providers have an interest in maximising their own budget, and to some extent their own convenience, and will not necessarily do what is in the best interests of the public or consumers.¹² It was claimed that the reforms would make providers of care more accountable because they would be answerable to independent purchasers for the quantity, quality and cost of the treatment given (Department of Health 1989).¹³ The second principle, that of competition, reflects the preference of these theorists for private sector ways of operating.¹⁴ Under the old arrangements, providers had no incentive to treat more patients: to do so would make it harder to stay within budget, and any extra financial allocation in respect of extra patients would not filter through the system until the next financial year (Department of Health 1989). It was claimed that the reforms would allow purchasers to choose to buy from whichever provider offered the best deal. The White Paper emphasised the principle that ‘money would follow

¹⁰ Both terms are problematic. The first does not convey the novelty of the purchasing role (see Lapsley and Llewellyn (1997)); the second tends to imply a degree of competition which may not in fact be present (Montgomery 1997a). Competition is discussed further in Chapter III.

¹¹ See generally Foster and Plowden (1996).

¹² Buchanan and Tullock (1962); Olson (1965).

¹³ See also Harden (1992).

¹⁴ Osborne and Gaebler (1992); Enthoven (1985).

the patient' under the new funding arrangements (Department of Health 1989). The purchaser would be able to pay the provider immediately for the work done. This plays on the same notion of bureaucratic self-interest which is challenged by the first principle: providers would seek to please their purchasers in order to attract more patients, and thereby maintain their market share or increase their income. If a provider failed to respond to a purchaser's demands, it could be faced with a loss of business. Thus, the enhanced accountability under the first principle would be reinforced by competitive pressures.¹⁵

Providers were permitted to apply for 'NHS Trust'¹⁶ status, which gave them their own board of directors and legal and organisational identity separate from their parent DHA. The National Health Service and Community Care Act 1990, s. 5(1), empowered the Secretary of State to establish Trusts to manage hospitals and other facilities. Each Trust was created by a Statutory Instrument which included a statement of its functions, but in practice this was usually very brief, referring simply to the provision of (for example) 'hospital' or 'ambulance' services from the Trust's address. Trusts usually specialised in a particular kind of service: acute, community, ambulance, and so on. Schedule 2 of the 1990 Act lists general powers and duties of Trusts. Instead of receiving a portion of the DHA's annual budget under the old hierarchical management system, Trusts were to attract income by selling their services to purchasers. They were placed under a statutory

¹⁵ The White Paper itself played down the terminology of markets and competition (Department of Health 1989), perhaps because of its negative connotations (for example, the possibility that unsuccessful hospitals would be forced to close), but this terminology formed a key part of the literature on which the reforms appeared to be based (Enthoven 1985, and see Webster 1998).

¹⁶ Another example of misleading terminology: although provision is made for money to be held on trust for the purposes of a particular Trust (s. 11 of the 1990 Act), they are themselves statutory corporations (s.5(5) of the 1990 Act), not trusts in the private law sense. See Hughes (1991).

duty to ensure that they brought in enough income each year to cover their expenditure,¹⁷ but were not allowed to make a profit or cross-subsidise different services: the price of each service was to reflect the cost of providing it (NHSME 1990a). Moreover, they were confronted with stringent financial targets.¹⁸ For example, Trusts were obliged to achieve a return on their assets, with the express aim of encouraging efficient use of estate and putting them on an equal footing with private sector providers (Department of Health 1989). By the time of the study in 1996-97, it was the norm for providers to have Trust status.

Health Authorities'¹⁹ historical role was to exercise on behalf of the Secretary of State the latter's statutory duties to provide health services. This continued after the reforms. Under the National Health Service Act 1977, s. 1(1):

It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement -
 a) in the physical and mental health of the people of those countries, and
 b) in the prevention, diagnosis and treatment of illness,
 and for that purpose to provide or secure the effective provision of services in accordance with this Act.

More specific duties to provide services such as hospital accommodation, ambulance services and maternity services are given in s. 3 of the 1977 Act. The National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996²⁰ provide for the Secretary of State's more specific duties to be performed on his behalf by Health Authorities.²¹ They may provide services directly, or arrange for them to be supplied through NHS or other

¹⁷ 1990 Act, s. 10(1).

¹⁸ 1990 Act, s. 10(2).

¹⁹ The Health Authorities Act 1995 replaced DHAs and Family Health Services Authorities with unitary Health Authorities. The latter terminology is used hereafter.

²⁰ SI 1996/708

²¹ SI 1996/708, r. 3

contracts. Thus, as the reforms were implemented and providers became Trusts, Health Authorities supplied services increasingly through placing contracts rather than through direct management. They received a budget from the regional tier²² with which to do so, and were expected to remain within that budget each year. They were subject to other financial targets too, such as the requirement to achieve an annual efficiency gain (for example, 2% more work for the same level of funding) in their contracts with providers (NHSME 1990a).

Health Authorities were, however, not the only type of purchaser under these reforms. Larger²³ GP practices were given the option of joining the fundholding scheme,²⁴ a voluntary arrangement under which they were given a budget and took responsibility for purchasing most types of non-emergency care for their patients.²⁵ (Health Authorities took responsibility for purchasing emergency care for all the patients in their area, and purchasing non-emergency care for GP practices which did not take up the fundholding option.) Fundholding practices were obliged to apply their budgets to purchase goods or services listed for purchase by fundholding practices²⁶ ‘as are necessary for the proper treatment of individuals on the lists of patients of the members of the practice and are appropriate in all the circumstances having regard, in particular, to the needs of all

²² In April 1996, regional offices of the NHS Executive took over the regional function from RHAs, which were abolished by the Health Authorities Act 1995.

²³ Initially with a minimum list size of 9000, reduced to 7000 in 1992 and 5000 in 1996 (Audit Commission 1995a).

²⁴ See generally Glennerster *et al.* (1994); Audit Commission (1996).

²⁵ From 1994 onwards, there were a number of ‘total purchasing pilots’ in which fundholding practices also purchased emergency care. From 1996, ‘community fundholding’ was introduced in which smaller practices (3000 patients and above) could hold a budget for community nursing, drugs and practice staff only (see Audit Commission 1995a).

²⁶ National Health Service (Fund-holding Practices) Regulations 1996 (SI 1996/706), r. 20(2).

those individuals'.²⁷ They were expected to keep within their budget each year.²⁸ Fundholding represented a radical departure from previous arrangements: prior to the reforms, GPs had no real influence over the management of provider units. They simply referred patients to consultants for treatment as required. It was claimed that the new administrative arrangements would enhance accountability by making providers answerable to GPs, thus introducing a new mechanism of accountability (Department of Health 1989). In terms of professional accountability, fundholding was remarkable in that it gave one group of doctors, GPs, the opportunity to challenge the practices of another group, consultants, thereby having the potential to alter the balance of power within the medical profession quite significantly. Fundholding was also claimed as an advance in consumer accountability, because GPs were perceived to be more closely affected by the views of patients: much was made of the point that fundholding allowed decisions to be taken 'close to the patient'.²⁹ Importantly, however, patients were not themselves able to place contracts with providers.³⁰

Purchasers (of either type) and providers needed some means of relating to one another: making clear what was to be provided and for how much money. Agreements between purchasers and providers within the NHS were to take the form of 'NHS contracts', defined in s. 4(1) of the 1990 Act as arrangements 'under which one health service body ('the acquirer')³¹ arranges for the provision to it by

²⁷ SI 1996/706, r. 20(1)

²⁸ SI 1996/706, Schedule 2, para. 3.

²⁹ The principle underlies NHSE (1994). See also NHSE (1995*a*: 5-6).

³⁰ For discussion, see Harden (1992).

³¹ The term 'acquirer' has been replaced by the term 'purchaser' in both official documents and academic commentary.

another health service body ('the provider') of goods or services which it reasonably requires for the purposes of its functions.' Although the term 'contract' is used throughout, s. 4(3) provides that 'whether or not an arrangement which constitutes an NHS contract would, apart from this subsection, be a contract in law, it shall not be regarded for any purpose as giving rise to contractual rights or liabilities.'³² Instead, provision is made in the remainder of s. 4 for a special system of arbitration to determine disputes,³³ coupled with powers given to the Secretary of State to issue binding directions to health service bodies in order to enforce the arbitration decision.³⁴ (Purchasers of both types were also permitted to buy care from the private sector through ordinary private law contracts.³⁵) The role of NHS contracts as mechanisms of accountability is discussed in more detail below.

Not surprisingly, these radical, ideologically-driven reforms were highly controversial in the NHS, as 'new public management' reforms were in other sectors. Three main sets of criticisms were made. Firstly, it was argued that the reforms were highly bureaucratic, leading to increased paperwork and management costs.³⁶ Proponents of the reforms claimed that these costs could be justified by the system's benefits: better quality through competition, for example

³² Some of the reasons for this are discussed in McHale *et al.* (1997). For discussion of the legal effects of this attempt to 'oust' the courts, see Jacob (1991); Miller (1992); Barker (1993).

³³ Detailed provisions are made in the National Health Service Contracts (Dispute Resolution) Regulations 1996 (SI 1996/623).

³⁴ 1990 Act, s. 4(6), s. 4(7).

³⁵ This study found that use of the private sector was not widespread. This contrasted with the position in social care: local authorities were obliged to spend 85% of their budgets in the independent (private and voluntary) sector (see Walsh *et al.* 1997).

³⁶ For discussion see Glennerster *et al.* (1994); Audit Commission (1996); Flynn and Williams (1997); Walsh *et al.* (1997); Webster (1998). The argument has also influenced recent reform proposals (Department of Health 1997).

(Department of Health 1989). Secondly, it was argued that the reforms violated the fundamental principle of equity: that patients with the same clinical needs should receive equivalent NHS services.³⁷ In particular, it was claimed that the patients of fundholding practices received preferential treatment from providers when compared with the patients of non-fundholding practices.³⁸ Thirdly, commentators questioned the feasibility of implementing competition in health care: this will be discussed in Chapter III because it is relevant to our research hypotheses. These controversies form an important backdrop to any research into NHS contracts. But these contracts are our primary concern: the next section discusses them in more detail.

INTRODUCING THE CASE STUDY: NHS CONTRACTS

Two main perspectives on NHS contracts have been developed in the literature.³⁹ One is the type of contractual relationship they engendered; the other is how far they resembled their private law counterparts. The former will be discussed in Chapter III, since it constitutes an important part of the material on which our research hypotheses will be based. The latter will be discussed here: it acts as an excellent introduction to the special features of NHS contracts. It will be argued that the contracts are best viewed as *sui generis*.

³⁷ House of Commons Social Services Select Committee (1987-88).

³⁸ For discussion of the complexities of this argument, and empirical evidence, see Glennerster *et al.* (1994). The empirical study conducted for this thesis found greater evidence for the claim that some fundholding practices were able to purchase shorter waiting times than the local Health Authority (on behalf of non-fundholders).

³⁹ Core texts include Flynn *et al.* (1996); Flynn and Williams (1997); Walsh *et al.* (1997). There are also a number of 'practitioner' works, including Øvretveit (1995); Hodgson (1996).

It was explained above that NHS contracts were not enforceable in the ordinary courts. Instead, a special system of arbitration existed to deal with disputes.⁴⁰ It has been debated how far this was similar to dispute resolution by the courts. One major distinction stands out from the statute itself. The NHS arbitration system applied to, and was primarily intended for, problems arising during contract negotiation rather than during the life of the contract. It was as much a mechanism of market regulation as one of dispute resolution, designed to prevent a party's abusing a monopoly position in order to make unreasonable demands during contract negotiations.

Empirical work reveals further unusual features of the system. Firstly, it seems that the formal statutory arbitration system was rarely used.⁴¹ Regional offices of the NHS Executive operated an informal conciliation and arbitration system which avoided the statutory procedure (with its obligation to publish the results) (Hughes *et al.* 1997). Secondly, contracting parties were firmly discouraged from using even this informal procedure. Health Authorities and providers were told that invoking it would be seen as a sign of management failure.⁴² Thus, the procedure was used only *in extremis*, usually by Health Authorities with their main local provider. There was no evidence of its use by fundholders. Lack of recourse to dispute resolution procedures was not in itself a major difference between NHS and private law contracts: the reluctance of businesses to litigate is well-

⁴⁰ 1990 Act, s. 4.

⁴¹ Hughes *et al.* (1997) have discovered only one example.

⁴² Interview data. See also McHale *et al.* (1997).

documented.⁴³ But contracting parties in the NHS were as much concerned about incurring criticism from the centre as they were about causing damage to their own relationship.

A third unusual feature of NHS dispute resolution was that the decision-making model used by the regional offices appeared to be more managerial than adjudicative (McHale *et al.* 1997: 199). This was illustrated by the way in which one regional office in our study had interpreted the requirement to conduct pendulum arbitration⁴⁴ so as to allow it to find for one party or the other on each separate element of the claim, rather than the claim as a whole. The aim was to impose the regional office's preferred solution - a compromise - rather than to adjudicate on the parties' competing claims, as a court would do.

Another point of contrast is the style and content of the contract documents themselves. In general, Health Authorities produced their own documentation, whereas documentation for fundholders was prepared by the provider, in consultation with representatives of the local GP fundholders' group. Health Authority contracts tended to be longer and more detailed than fundholder contracts. The content of NHS contracts was similar to that of commercial contracts. They contained terms specifying their duration, the price to be paid, the amount of activity to be provided, quality standards and so on (Allen 1995). Their drafting was, however, often informal in style (Allen 1995). This probably reflected the fact that lawyers were rarely involved in the process. The only

⁴³ Macaulay (1963); Beale and Dugdale (1975).

⁴⁴ NHSME (1989). This was intended to discourage arbitration by raising the stakes.

exception to this in our study was for contracts with private sector providers: advice from solicitors might be sought because these contracts were legally enforceable. The fact that NHS contracts were not subject to private law doctrine was apparent from some of their terms: for example, many contracts made explicit use of penalty clauses, drafted in such a way as to make it unlikely that they would be enforceable under English law (Treitel 1995).

But perhaps the most significant difference between a private law contract and an NHS contract is conceptual.⁴⁵ The traditional conception of a contract is that it results from the mutual promises of free individuals, who can choose whether or not to enter into the contract and on what terms. The principle of freedom to enter into a contract remains a key part of the modern law of contract.⁴⁶ But in the NHS, little respect was accorded to this principle (Allen 1995). This represents the most striking difference between NHS and private law contracts. Firstly, the parties were (*de facto* at least) obliged to enter NHS contracts. Purchasers had to perform their statutory function of ensuring that care was provided,⁴⁷ and in the absence of any directly managed units this could only be done by contracting with providers. Providers had to secure income to cover their outgoings;⁴⁸ this could only be done by contracting with purchasers. Moreover, for core services, and indeed for most services in some geographical locations, purchasers might be forced to contract with a particular Trust which had a local monopoly over provision.⁴⁹ Secondly, if the parties were unable to reach an agreement, the Secretary of State had the

⁴⁵ See generally Vincent-Jones (1994).

⁴⁶ Though even this is not unconstrained (Collins 1997).

⁴⁷ SI 1996/708 (Health Authorities); SI 1996/706 (fundholding practices).

⁴⁸ 1990 Act, s. 10(1).

⁴⁹ See Chapter III.

power to impose particular terms, and potentially an entire contract, on the parties.⁵⁰ Thus, the concept of a contract freely entered into was alien to the NHS.

The other aspect of ‘freedom of contract’ - freedom to choose contractual terms - was also violated in the NHS.⁵¹ Health Authorities in particular were strongly influenced by a framework of central government priorities when setting contractual standards for providers: as Hughes *et al.* (1996) have suggested, one possible model for the NHS contract may be that of an ‘administered contract’, taking place in a highly regulated environment. But this was not dissimilar to the position of some contracting parties in private law (Collins 1997). Statute has intervened to imply a variety of terms in employment and consumer contracts, for example. The principle may also be breached because of inequality of bargaining power between the parties (often the justification for statutory intervention). As we shall see in Chapter III, this was also a problem in the NHS.

In short, it seems best to treat NHS contracts as largely *sui generis*. Their drafting style, their method of enforcement and the circumstances surrounding their agreement are certainly very different from those we would normally expect in private law contracts. But this should not be taken to indicate that the contractual relationships engendered in the NHS are necessarily very different from private law contractual relationships: some scholars have sought to argue, on the basis of empirical studies of private sector contracts, that the contract itself is largely irrelevant to the parties’ behaviour (see, for example, Macaulay 1963).

⁵⁰ See s. 4 (6) and (7) of the 1990 Act.

⁵¹ See Chapter IV.

This is a matter for empirical research, and will be discussed in more detail in Chapter III. In the meantime, we must set about the crucial task of demonstrating that NHS contracts can be used to support relationships of accountability, making them a legitimate choice of case study for work on that concept.

THE ACCOUNTABILITY FUNCTION OF NHS CONTRACTS

For the choice of case study to be valid, a link must be established between NHS contracts and accountability. This can be done by addressing two questions. Firstly, were the parties to an NHS contract in a relationship of accountability? This requires us to consider whether the three preconditions for an accountability relationship, set out in Chapter I, were present. Secondly, how did the various features of an accountability mechanism - standard-setting, monitoring⁵² and enforcement - manifest themselves in contractual relationships in the NHS? For the moment, no comment will be offered on whether NHS contracts were likely to support or did in fact support an *effective* process of accountability: this is a central theme of the empirical study and is discussed in detail in later chapters. We will concentrate here on establishing the link between NHS contracts and accountability in principle.

⁵² The term 'monitoring' is used as a convenient shorthand to describe the linked processes of obtaining accounts and judging them: see Chapter I for explanation.

Were the parties to an NHS contract in a relationship of accountability?

In Chapter I, we identified three preconditions for the existence of a relationship of accountability: the body to be called to account must be responsible for the performance of a particular task; the caller to account should have a legitimate interest in the performance of that task; and an accountability process should be in place to ‘activate’ the relationship of accountability between the two bodies.

The three preconditions

The *first precondition*, that the body to be called to account should have responsibility for performing a particular task, is easy to apply. NHS Trusts had the function of providing care to patients. NHS purchasers’ main function was to pay the price under the contracts they had agreed. Although NHS contracts involved mutual accountability in principle, our focus will be on the provider’s accountability to the purchaser, because the complex nature of the provider’s obligations makes its accountability a more interesting topic for enquiry.

The *second precondition* is that the body to be called to account is not acting on its own behalf: someone else must have a legitimate interest in how it discharges its responsibilities. A variety of groups and bodies had an interest in the activities of NHS providers. Most obviously, individual patients were concerned with the quality of the treatment they received. If their expectations were breached, patients could have recourse to a variety of accountability mechanisms: actions for

negligence and complaints to the provider Trust, the Health Service ombudsman or professional regulatory bodies (Allsop and Mulcahy 1996). But since NHS Trusts were providing a public service using public funds, patients were not the only group with a legitimate interest in their performance. Voters, taxpayers and anyone entitled to use the services of the NHS, whether or not they have done so, might all claim such an interest. To some extent, these individuals might be able to participate in accountability processes which applied directly to Trusts. For example, the NHS Executive's annual hospital 'league tables' made performance information available to the public.⁵³ Members of the public could then act on this information when voting at elections or when seeking NHS treatment, perhaps by persuading GPs to refer them to particular providers.

But forms of accountability in which members of the public had a direct role in calling NHS Trusts to account were only one part of the accountability regime to which Trusts were subject. MPs, as elected representatives, also had a legitimate interest in the performance of the NHS: through parliamentary questions and Select Committee work, they were able to scrutinise the government's broad policy and its implementation. Finally, since the government, and in particular the Secretary of State for Health, had overall responsibility for the NHS, it clearly had an interest in what went on at all levels of the organisation. To make its own accountability meaningful, the government needed both information about, and control over, the performance of NHS Trusts providing services. In practice, the Secretary of State could not monitor each Trust; there had to be an effective chain of accountability from the lowest levels of the NHS to the centre. The operational

⁵³ See, for example, NHSE (1998).

management of the NHS was entrusted by the Department of Health to the NHS Executive.⁵⁴ The NHS Executive's regional offices monitored both purchaser performance, and to some extent provider performance too, notably in relation to financial targets. But the primary scrutiny of providers for the cost, quantity and quality of treatment was entrusted to those who purchased their services: Health Authorities and GP fundholders.

Purchasers' legitimate interest in providers' performance can be explained in two different ways: on technical grounds, and (more broadly) by reference to the role envisaged for purchasers by the framers of the legislation. The technical explanation has two elements. Firstly, purchasers paid Trusts for the care they provided. Supplying money for a performance obviously gives a legitimate interest in the nature of that performance. This is particularly important where the money is supplied under a contract: it is paid out in exchange for a performance of a particular kind. Secondly, as we saw above, purchasers of both types were under a statutory duty to use their budget to ensure that services were supplied to patients.⁵⁵ They performed this duty by placing contracts with providers. Purchasers therefore needed to monitor their contracts in order to ensure that their own statutory duties were met. But more generally, the framers of the legislation anticipated that purchasers would not confine their scrutiny to checking that services were being provided either as paid for or in order to discharge their statutory duties. It can be seen from the White Paper and other guidance that through the contracting system, purchasers were expected to challenge providers'

⁵⁴ Originally NHS Management Executive (NHSME). See Montgomery (1997a).

⁵⁵ Note 47, above.

traditional freedom to determine the quantity, quality and cost of provision.⁵⁶ Contracts were to evolve as a broad mechanism of accountability for the performance of Trusts. Scrutinising providers was, put simply, part of the purchaser's job. This gives us another reason for focusing on the provider's accountability to the purchaser: the purchaser's accountability to the provider might act as a check on unreasonable purchaser behaviour, but was not the primary purpose of the contracting system.

This view of the purchasing role is reinforced when we consider the *third precondition* of accountability, that the person or body calling to account must decide to institute an accountability process, instead of simply relying on the person discharging the responsibility. Health Authorities and fundholders were likely to use their contracts for accountability because they were themselves under various obligations to give accounts, both directly to the public and up through the NHS hierarchy. For example, knowing that they might be questioned about waiting times in their area, purchasers might set standards on waiting times for providers and require regular reports on performance against the targets. The 'onwards' accountability mechanisms applicable to purchasers were justified because purchasers were not buying care with their own money or for themselves: they were purchasing care with public funds for the population for whom they were responsible. A brief description of the main 'onwards' accountability mechanisms applicable to purchasers will help to clarify our understanding of the third precondition.

⁵⁶ Department of Health (1989); NHSME (1989; 1990a).

Purchasers' onwards accountability

Purchasers could be called to account in various ways within the NHS. Fundholding practices were accountable primarily to the Health Authority in their area. At the beginning of the year, each practice was obliged to send the Health Authority details of its spending proposals, and at the end of the year, it had to produce an annual report and accounts.⁵⁷ They were also required to submit monthly financial accounts⁵⁸ to the Authority, and details of the arrangements made to purchase goods and services for their patients (this usually involved giving details as to the progress of the NHS contracts they had placed).⁵⁹ Finally, various actions by a fundholding practice required the agreement of the Health Authority: spending savings is one example.⁶⁰ Health Authorities themselves were ultimately accountable to the Secretary of State, on whose behalf they exercised their functions.⁶¹ Firstly, Health Authorities were obliged to send annual accounts to the Secretary of State, which were to be audited by auditors approved by the Audit Commission.⁶² Secondly, for other aspects of their performance, Health Authorities agreed to targets set out in a 'corporate contract' (a management tool which was not legally enforceable) with their local regional office of the NHS Executive (NHSE 1995*b*). Authorities were obliged to supply a range of information, including, for example, details of their performance (through the

⁵⁷ SI 1996/706, Schedule 2

⁵⁸ The accounts must be audited: see s. 98 National Health Service Act 1977 and SI 1996/706.

⁵⁹ SI 1996/706, Schedule 2

⁶⁰ SI 1996/706, r. 25

⁶¹ SI 1996/708.

⁶² National Health Service Act 1977, s. 98 (as amended).

contracts placed) against Patient's Charter targets.⁶³ These obligations were taken very seriously by those involved: few wished to incur the wrath of their superiors.⁶⁴ Thus, using NHS contracts for accountability was an important task for purchasers, because they were themselves accountable through the NHS hierarchy to the Secretary of State.

Purchasers were also subject to some external accountability mechanisms.⁶⁵ Health Authorities had a board comprised of non-executive as well as executive directors.⁶⁶ The non-executives might be able to hold the executives to account for their decisions, and act as something of a check on their behaviour. Moreover, there was a Community Health Council (CHC) for each Health Authority, a statutory body of lay people entitled to be consulted on certain aspects of an Authority's work.⁶⁷ CHCs might challenge or help members of the public to challenge Authority decisions, for example during consultation on the Authority's annual purchasing plan.⁶⁸ Fundholders were not subject to these formal mechanisms,⁶⁹ but might be held to account in informal ways by practice patients. Unlike Health Authorities, they had extensive direct contact with members of the

⁶³ Department of Health (1991): The NHS version of the Citizen's Charter initiative, discussed in Chapter I.

⁶⁴ Performance-related pay, and continuing employment, might be at stake. Threats expressed through the managerial hierarchy might be reinforced by the existence of the Secretary of State's formal powers to dismiss Health Authority or Trust boards (s. 85 National Health Service Act 1977, as amended).

⁶⁵ As we shall see in Chapter IV, these mechanisms were much weaker than purchasers' accountability to central government. For a critique see, for example, Longley (1990; 1993), and see also the general discussion, in Chapter I, of the 'democratic deficit' caused by the 'new public management'.

⁶⁶ National Health Service Act 1977, Schedule 5 (as amended, Health Authorities Act 1995); Health Authorities (Membership and Procedure) Regulations 1996 (SI 1996/707). For discussion see Day and Klein (1987); Ashburner and Cairncross (1993); Ferlie *et al.* (1995).

⁶⁷ National Health Service Act 1977, s. 20 and Schedule 7; Community Health Councils Regulations 1996 (SI 1996/640); Montgomery (1997a). For critique see Longley (1990; 1993).

⁶⁸ Consultation was required by Department of Health (1994).

⁶⁹ Although they were expected to consult on purchasing plans (NHSE 1995a).

public, who might comment on waiting times or poor service at local providers, for example. Finally, purchasers of both types might be the subject of a complaint by an aggrieved patient (see Montgomery 1997a).

It is important to note the potential tensions in the mechanisms discussed. Most obviously, different mechanisms might involve the application of different standards: patients might demand higher quality services, whilst central government might demand cuts in expenditure. This raises the question of which set of mechanisms would prevail in a situation of conflict. On the one hand, the reforms were couched in a rhetoric of decentralisation and local autonomy (Department of Health 1989). If realised in practice,⁷⁰ this would imply that purchasers were to have a certain amount of discretion to act in what they perceived to be the public interest in their area, rather than simply behaving as ministers' agents. On the other hand, strict Treasury controls over NHS expenditure were likely to remain, as were ministerial controls over politically sensitive aspects of performance, such as waiting times. Some central controls were, of course, inevitable, but they might be so extensive as to undermine purchasers' discretion altogether. This problem is examined more fully during the course of the case study.

Because of the various mechanisms of onwards accountability to which they were subject, purchasers were likely to seek some means of making providers accountable to them, thus satisfying the third precondition of accountability set out

⁷⁰ For one of the many expressions of doubt on this point, see Hughes (1991).

above. NHS contracts therefore satisfied all three preconditions and could correctly be described as accountability relationships.

How might NHS contractual relationships manifest the features of an accountability mechanism?

To further confirm the validity of our case study, we need to examine the potential of the NHS contractual relationship to involve the core tasks of an accountability mechanism - standard-setting, monitoring and enforcement set out in the analytical model advanced in Chapter I. This brief survey draws on early guidance issued by the NHS Executive to purchasers, which examined in some detail the ways in which contracts might be used (NHSME 1989; 1990a). Some private law analogies are also used, but with caution: as we saw above, NHS contracts were in many respects *sui generis*. It is important to remember that our concern is with establishing links between contracts and accountability in principle: questions of whether NHS contracts were used *effectively* in the ways suggested will be examined in detail in Chapter III.

The task of *standard-setting* has an obvious link with contracts: the parties must agree terms. The guidance to NHS purchasers saw standard-setting as a key area in which the contracting system could improve on the direct managerial relationships which had gone before: ‘The move to a contract system...[is] above all aimed at improvement in the quality and responsiveness of patient care. The separation of purchasing from provision will require contracts to state in increasingly explicit terms the quality and standard of service which is to be

provided.’ (NHSME 1990a: 6). It was thought that explicit standards would draw everyone’s attention to the need to monitor and improve performance. In addition to quality standards, we might expect NHS contracts to clarify the subject-matter of the contract and the price to be paid.⁷¹ Early empirical work suggested that although some attempts would be made to set standards on these various issues, NHS contracts would not match the drafting standards of commercial contracts (Allen 1995).

Of course, the process of setting standards may vary considerably between contracts. The NHS guidance described a careful negotiation between the parties, particularly on the issues of price, contract type and quality standards. The purchaser would take the lead in setting out its requirements, and the provider would specify the details of the way in which it proposed to meet those requirements (NHSME 1990a). This corresponds to the power relationship required for successful accountability, discussed in Chapter I, in which the caller to account plays the dominant role. But whether the relationship took this shape in practice is, of course, a matter for empirical research (see Chapter III). In the private law context, bargaining power may vary widely, so that some contracts result from balanced negotiations and others from unequal negotiations in which one contracting party is able to impose terms on its partner (Collins 1997).

An examination of the negotiating process shows that explicit contractual terms are not the only link between standard-setting and contracts. ‘Implicit standards’

⁷¹ Macaulay (1963) found that even though businesses rarely planned for default, they would almost always have a clear agreement on price and quantity.

are also important. The NHS purchaser would probably approach contract negotiations with some implicit ideas, or standards, about what makes a good provider. These standards would be used to choose a contracting partner. Some might be translated into explicit terms of the contract, placing obligations on the provider. Others might affect the obligations undertaken by the purchaser. Implicit standards about price would help the purchaser to decide how much it is prepared to pay for the services on offer. Finally, yet others would remain at the level of implicit expectations which affected the choice of contracting partner and continued to be relevant to how the purchaser expected the provider to behave during their relationship.

The *monitoring* component of accountability can also be furthered through contracts, because they can be used to provide for explicit monitoring procedures (Stinchcombe 1985). The NHS guidance emphasised the need to use contracts in this way (NHSME 1990a). For example, one important early document stated that ‘contracts should enable purchasers to pay both announced and unannounced visits to health care units to check whether the standards of facilities being provided are as promised in the specification. The purchaser should also have access to any data which is specified in the contract as being necessary for monitoring’ (NHSME 1989: 18). NHS providers had access to various pieces of information - about the number of patients treated, the time they waited, whether they complained about their treatment, and so on - which were relevant to the purchaser’s assessment of the provider’s contract performance.⁷² Moreover, the

⁷² This is the problem of information asymmetry, discussed in more detail in Chapter III.

services purchased under an NHS contract were supplied to third parties, the purchaser's patients, rather than to the purchaser itself. Purchasers could use their contracts to set clear monitoring arrangements and to make them binding.

In terms of *enforcement*, contracts can act as vehicles for a variety of incentives and sanctions, both directly and indirectly. There was a general assumption in the NHS guidance that competition between providers would ensure that they were reasonably co-operative with their purchasers (NHSME 1990a). During contract negotiations, providers would accede to purchasers' demands in order to win their custom, and during the life of the contract, providers would comply in order to retain purchasers' goodwill and custom, and their own good reputation.⁷³ The extent to which this was successful is a matter for empirical investigation: as we shall see in later chapters, there were severe problems with implementing effective competition in the NHS. Purchasers' choice of providers was constrained in various ways, notably by the fact that patients were unwilling to travel long distances for treatment.

Secondly, contracts themselves could be used to provide for dispute resolution and sanctions. Some provision was made in the NHS guidance for this (NHSME 1990a). The parties were urged to include their own dispute resolution arrangements, such as an arbitration clauses, in contracts, in order to minimise their need to have recourse to the formal arbitration arrangements (NHSME 1990a). Although penalty clauses were not encouraged, it was accepted that the

⁷³ For an introduction to the analysis of self-enforcing contracts through game theory, see Hviid (1996).

parties might wish to include some provisions, for example for liquidated damages, to deal with default: 'In general, penalties that aim to 'punish' either party for non-performance are inappropriate to agreements between NHS bodies. However, both DHAs and units will wish to ensure that there are remedies that provide clear disincentives to non-performance' (NHSME 1990a: 31). As we shall see in later chapters, the use of penalties was quite widespread in the NHS.⁷⁴

The third method of enforcement is that provided by the legal system by which the contract is governed. The NHS equivalent of litigation was recourse to the special conciliation and arbitration procedure. But as we saw above, its use was limited, notably because of the NHS Executive's attempts to discourage contracting parties from referring disputes to the procedure. The implications of this will be examined in more detail in Chapter III.

Conclusion

This section has established that the NHS contractual relationship was a relationship of accountability, and has identified some of the ways in which that contractual relationship might have manifested the key features of standard-setting, monitoring and enforcement. Of course, accountability through NHS contracts was not without its problems: some were alluded to above, including the weakness of competition and the 'legal system' in the NHS as possible methods of enforcing contractual obligations. These and other difficulties will be discussed in

⁷⁴ See Macaulay (1963); Macneil (1978); Stinchcombe (1985) on the behaviour of contracting parties in the private sector in this regard.

more detail in Chapter III. The problems do not undermine the link we have established between NHS contracts and accountability. Instead, they serve to focus attention on the challenges of implementing accountability as a practical process. It is the possibility of acquiring a deeper understanding of these challenges that makes the study of NHS contracts as accountability mechanisms profitable from a theoretical viewpoint.

TOWARDS A 'PUBLIC LAW CONTRACT'?

NHS contracts are but one of an enormous variety of possible case studies. Contractual approaches have been introduced into several parts of the public sector, and of course, contracts are only one type of accountability mechanism. The purpose of this section is to explore some of the reasons for choosing NHS contracts as a topic for research. The most important reason was the possibility of using the study's findings to advance the development of the 'public law contract', an important idea in the recent literature on 'new public management' reforms.

Public lawyers have expressed some interest in the contractual elements of the 'new public management' changes, through discussion of 'the contracting state' (Harden 1992) or 'government by contract' (Freedland 1994; 1998). The main concern to emerge from these discussions is that 'contractualisation' may remove some government activities from the reach of public law scrutiny. In part, this is because detailed principles of public law have not yet been developed for application to novel contractual governance structures (Freedland 1998). More

importantly, these principles may never be developed, because of the courts' tendency, discussed by Freedland (1994), to treat government contracts as a matter of private law. It has therefore been suggested that there is a need to develop a notion of the 'public law contract' in order to keep pace with the changes (Harden 1992).

There are a number of difficulties with this suggestion. One lies in identifying the scope of the proposed concept. There are several possible candidates for inclusion: government procurement contracts with private parties;⁷⁵ more complex, long-term contracts with private parties under the private finance initiative;⁷⁶ contracts internal to government such as NHS contracts and, perhaps, agencies' framework documents;⁷⁷ and even contracts of employment.⁷⁸ Moreover, these different types of contract might require rather different public law responses (Vincent-Jones 1997). Empirical research may be necessary here, particularly in relation to new types of government contract, in order to inform our understanding of the similarities and differences between the various types.

Another problem with the 'public law contract' is that it is not clear who might develop and apply such a concept. We cannot look to the courts, for two reasons.⁷⁹ One is that attempts were made to keep some 'public law contracts' out of the

⁷⁵ For the legal principles governing the award and variation of these contracts, see generally Turpin (1989); Arrowsmith (1992); Craig (1994).

⁷⁶ HM Treasury (1997); Freedland (1998).

⁷⁷ The degree of analogy between framework documents and contracts is a matter for debate. Freedland (1994) makes the analogy quite strongly, but more recently he has sought to distance himself from the view taken in the 1994 article (Freedland 1998). See also Greer (1994); Vincent-Jones (1994).

⁷⁸ For an introduction to the debate about state employees, see Fredman and Morris (1989).

⁷⁹ As Harlow and Rawlings (1997: 251) point out, a 'court-centred' approach to administrative law is of little value in this area.

courts: this is true of contracts within the BBC and NHS ‘internal markets’, for example.⁸⁰ The other is the problem, noted above, that the courts themselves may view government contracts as matters of private law (Freedland 1994).⁸¹ For the present, work on the ‘public law contract’ may have to take the form of theoretical development in the academic literature, in the hope that the government might be persuaded to observe basic principles of public law in relation to its contracts. This need not involve making all ‘public law contracts’ legally enforceable⁸² and encouraging recourse to the courts. A focus on dispute resolution may, in itself, be inappropriate.⁸³ we would not view recourse to litigation as a mark of success in either public or private contracting. Moreover, there may be dangers in excessive ‘legalism’,⁸⁴ and legal costs, in public services. It might therefore be preferable to encourage the government to have regard to public law principles when designing and operating ‘public law contracts’,⁸⁵ for example in its guidance to contract managers and specialist arbitrators.

Our challenge is therefore to develop ideas of how the public sector context, and familiar public law principles, might influence the way in which we analyse and evaluate the operation of ‘public law contracts’, the behaviour of the parties to

⁸⁰ See Coffey *et al.* (1997) on the BBC, and discussion above on the NHS.

⁸¹ See *R v Lord Chancellor's Department, ex p. Hibbit and Saunders* 1993 COD 326, though note also *R v Legal Aid Board, ex p. Donn & Co.* 1996 3 All ER 1.

⁸² Nor does it necessarily imply an entirely separate public law of contract, divorced from private law principles, for those contracts which are enforceable in the courts. For discussion see Harlow and Rawlings (1997).

⁸³ This is not to deny the value of studying dispute resolution as part of a more wide-ranging analysis of the ‘public law contract’. The discussion in McHale *et al.* (1997) makes useful links between the ‘public law contract’ idea and dispute resolution in the NHS.

⁸⁴ Vincent-Jones (1997) argues against the ‘public law contract’ on this ground. The suggestion made here, that the ‘public law contract’ could be developed through soft law, might overcome some of his objections.

⁸⁵ Harlow and Rawlings (1997), referring to Taggart (1992), make a similar argument in their discussion of franchising.

them, and the surrounding regulatory framework. This thesis can be seen as a contribution to this task.⁸⁶ The interpretation advanced here of the NHS contract as a mechanism of accountability locates the NHS contract within a public law discourse from the outset. Moreover, our model of the good accountability mechanism, to be developed in Chapter III, draws on a number of familiar public law principles and applies them to the NHS contract. Finally, the theoretical contribution of the thesis is firmly grounded in detailed empirical knowledge of a case study of one of the more novel ‘public law contracts’. Of course, any generalisation from this study must be cautious: as we saw above, ‘public law contracts’ do not constitute a uniform category. Nevertheless, we can at least suggest directions for future research. We will return to the concept of the ‘public law contract’ at various points in later chapters, and in our conclusions.

NHS contracts were a sound choice of case study on other grounds, too.⁸⁷ They demonstrated particularly clearly the value of breaking away for some purposes from the category approach to the study of accountability, described in Chapter I. NHS contracts were themselves difficult to classify. They were an important mechanism of financial accountability: as we shall see, containing costs was a key focus of Health Authority purchasers in particular. They were also a mechanism of administrative accountability, being internal to government and concerned with a broader range of issues than simply finance. Moreover, it was possible to interpret them as a part of professional accountability. Since purchasers sought to specify

⁸⁶ Other types of study would also advance our understanding. A comparative analysis would be particularly valuable. See, for example, Brown and Bell (1998) on the ‘public law contract’ in French law.

⁸⁷ NHS contracts were also a methodologically sound choice (see Appendix 1).

what services were to be provided, and the quality standards which were to govern provision, contracts had an impact on professional service providers and could be seen as a new line of accountability to which they became subject. It was also relevant, though less significant, that purchasers used contracts to influence Trusts in regard to legal and consumer accountability, by including obligations to comply with relevant statutes⁸⁸ and to conduct consumer surveys. It was helpful to be able to analyse the NHS contract without having to constrain this potentially all-embracing⁸⁹ mechanism within a particular category.

Moreover, despite the fact that research on NHS contracts could be seen as filling a gap in the public law literature, it did not involve ploughing an entirely novel furrow. One consideration was that the NHS contract involved the adoption of a private sector concept in the public sector. Of course, the concept might be radically changed in the process of transplantation: as we saw above, NHS contracts were very different from private law contracts. But nonetheless, existing research on contractual relationships, used with caution, provided a useful starting point for evolving hypotheses about contractual relationships, and accountability relationships, in the public sector. The value of this is demonstrated in Chapter III. A second consideration was that it was possible to draw on a body of research about NHS contracts themselves, and other similar developments in the public sector, conducted from a variety of disciplinary perspectives, notably economics and sociology. This work was an invaluable source of analysis and supplementary

⁸⁸ NHSME (1989). Such terms seemed superfluous, although they perhaps served to ensure that purchasers could not be blamed for breaches.

⁸⁹ The scope of accountability through NHS contracts was problematic. It is discussed further in Chapter IV.

data to complement the empirical study, specifically focused on accountability issues, conducted for the thesis.

CONCLUSION

This chapter has introduced our case study, the NHS contract. We have located the NHS contract in the NHS reforms of 1990, and explained some of its special features. We have established that the NHS contract could be seen as a mechanism of accountability from provider to purchaser. Finally, we have identified some of the advantages of choosing this case study, noting above all its potential contribution to our understanding of the ‘public law contract’. Chapter III embarks upon the case study by developing detailed research hypotheses about accountability to apply to the NHS data.

III

Accountability through NHS Contracts: Models and Hypotheses

Any empirical study must be guided by detailed research questions or hypotheses. They help to bridge the gap between the theoretical issues to be investigated, and the mass of data confronting the researcher in the field. Our task in this chapter is to identify the detailed research questions about accountability that can be addressed in an empirical study of NHS contracts.

The chapter is divided into two parts. Part I sets out two models which can be used to describe the contractual accountability relationship from provider to purchaser in the NHS. They are based on our analytical model of the accountability process, set out in Chapter I, but provide much more detailed guidance as to the patterns of behaviour we could expect to find during the empirical study. The models form an essential background to our research hypotheses.

Part II of the chapter describes those research hypotheses. We suggested in Chapter I that focusing on the individual mechanism of accountability as the unit of analysis would enable us to develop a deeper understanding of the practicalities of operating an accountability process. The research hypotheses further this aim by identifying three groups of practical problems faced by the parties:

- pressures and constraints affecting the behaviour of the caller to account
- the quality of the relationship between the caller to account and the body being called to account
- the difficulties of ensuring that the accountability process is effective - that the body subject to it is made accountable

For each research hypothesis, we will also develop a set of evaluative principles, drawing on the public law literature. These principles are designed to further the second aim of the study: to develop a notion of the *good* accountability process, based on our understanding of the component tasks of that process. The research hypotheses and their associated evaluative principles are applied to the NHS data in Chapters IV-VI.

PART I:

MODELS OF THE CONTRACTUAL ACCOUNTABILITY PROCESS

Our search for more sophisticated models began in the literature on contractual relationships. Models derived from this literature would be likely to fit our case study, the NHS contract, albeit with some modifications to take account of its special features. Two possible sources of models suggested themselves: the literature on trust in contractual relationships, and principal-agent theory.

Principal-agent theory¹ is concerned with the way in which a principal can control its agent's actions, in the absence of competition. It assumes that the agent will pursue self-interest at the principal's expense unless their interests can be aligned: financial penalties could be used to give the agent an interest in performing the principal's requirements, for example. This theory is obviously concerned with the agent's accountability and might have provided the more detailed insights into the parties' behaviour that we required. But the model was rejected, for two main reasons. Firstly, the model assumes that the agent is not subject to competitive pressures. In the NHS, by contrast, the reforms were intended to create a market.² Even though, as we shall see,³ that market was not fully competitive, it was important to employ a model which acknowledged the possibility of competition and allowed us to investigate its role. Secondly, early empirical work showed that this model did not fit the NHS parties' behaviour as closely as did the alternative model.⁴ In particular, it did not account for the role of trust or for actions which did not involve the pursuit of self-interest. Moreover, the model's rationality assumption was not likely to explain all the findings of an empirical study.

Our other option was to derive models from the literature on contractual relationships in socio-legal studies and transaction cost economics. This literature uses the level of trust between the parties in order to categorise contractual

¹ See generally Bamberg and Spremann (1989). The terminology originates with Ross (1973).

² Department of Health (1989), although perhaps for political reasons, the White Paper avoids market terminology.

³ See 'A caveat: the models' hidden assumption', below.

⁴ Walsh *et al.* (1997) rejected the model for similar reasons, noting also its inability to explain the range of interests at work in the NHS.

relationships, usually employing pairs⁵ of concepts such as ‘transactional’ and ‘relational’ (Macneil 1974), ‘arm’s length’ and ‘obligational’ (Sako 1992), ‘low-trust’ and ‘high-trust’ (Fox 1974), and ‘adversarial’ or ‘collaborative’ (Flynn *et al.* 1996). The models link the level of trust to particular patterns of behaviour, using broad contractual standards as an indicator of high trust, and specific standards as an indicator of low trust, for example. This literature had two major advantages as a source of models for our study. Firstly, the models were developed for competitive markets.⁶ Although, as we shall see below,⁷ we could not assume that the NHS market would be entirely competitive, the models made it possible to test the issue. We could examine whether they were fully implemented against a background of competition, or implemented only in part, in the absence of competition. Secondly, early empirical work showed that they accorded well with the NHS parties’ behaviour, and even with their own perceptions of their behaviour. For example, fundholding practices often had an explicit policy of dealing with providers in a collaborative or adversarial way.

Our models, which we will label ‘hard’ and ‘soft’, distil the essence of this literature. They are given their own labels⁸ to avoid confusion. They are not tied to any particular writer’s version: the literature itself can be difficult to use because apparently similar accounts of the models may have subtle variations. Moreover, they are adapted to fit the needs of our study. Our version concentrates on the models’ implications for the key tasks of accountability: standard-setting,

⁵ Some writers use a tripartite classification: for example, ‘classical’, ‘neoclassical’ and ‘relational’ (Macneil 1978; Williamson 1979).

⁶ This is particularly apparent in the empirical studies by Macaulay (1963) and Sako (1992).

⁷ ‘A caveat’, below.

⁸ The labels are not entirely novel: Lapsley and Llewellyn (1997) use ‘formal’ and ‘soft’

monitoring and enforcement. It also acknowledges the special nature of our case study: our models will test, rather than assume, competitiveness.

Before we describe the models, it may be helpful to offer a brief examination of the central concept of trust.⁹ Part of the dictionary definition of trust is ‘reliance on some quality or attribute of a person or thing, or on the truth of a statement’ (Simpson and Weiner 1989). Trust lies somewhere between faith, which presupposes no evidence for a particular belief, and confidence, which suggests good grounds for that belief (Hart 1988). Trust itself denotes the absence of evidence to the contrary (Gambetta 1988*b*). Importantly, although ‘trust’ may be used to describe situations in which we have no alternative but to rely on another person, these are not genuine instances of trusting behaviour (Lorenz 1988: 197).

Trust provides a way of coping with situations in which we are uncertain about the way in which others will behave, and where their actions might harm us (Gambetta 1988*b*). Its relevance to contractual relationships is obvious: it provides a way of dealing with the risk that the other party might behave opportunistically (Lorenz 1988). Sako (1992) distinguishes three types of trust in contractual relationships: ‘contractual trust’ (that the other party will comply with its obligations); ‘competence trust’ (that it will perform to acceptable standards); and ‘goodwill trust’ (that it will exercise discretion in a way which furthers its partner’s interests). The soft model relies on a high degree of trust to deal with opportunism; the hard model involves a lesser degree of trust (all contracts require

⁹ The discussion follows the approach of Deakin *et al.* (1997: 107-108) in distinguishing relevant ‘dimensions’ of trust.

some trust) and suggests alternative strategies for tackling such behaviour. The relationship between trust and accountability is similarly complex. Like a contractual relationship, accountability inevitably requires some trust (cf. Power 1997). At first sight, accountability implies checking, which may suggest that we should be concerned with keeping trust to a minimum, using the hard model. On closer inspection, however, effective accountability, like effective regulation (Hawkins 1983) and effective contracting (Sako 1992) may require high levels of co-operation. This may be more easily fostered through trust (using the soft model) than through the coercive strategies of the hard model. Thus, both the hard and the soft models suggest different versions of an accountability process, and the soft model may even be more appropriate than the hard model. The latter point will be explored under Hypothesis 3, below.

Perhaps the greatest difficulty in using the concept of trust lies in the considerable uncertainty in the literature as to how trust is created and sustained. A number of factors may be at work. Personal or cultural factors are one important group (Sako 1992; Fukuyama 1995). But empirical work has shown that such values are not a sufficient explanation: the parties themselves can strive to build trust through particular kinds of behaviour, designed to demonstrate commitment and trustworthiness (Lorenz 1988). Indeed, trust can be seen as an activity requiring sustained effort (Flynn *et al.* 1997). Finally, recent empirical work by Deakin *et al.* (1997) has demonstrated the potential for the institutional framework surrounding a particular contract to affect the degree of trust in the parties' relationship. The relevance of these various factors will be particularly apparent from the empirical data presented in Chapter V.

The hard and soft models of contractual accountability relationship

The models' main features can briefly be summarised:

Hard model:

- low-trust relationship between the parties
- standard-setting through adversarial negotiations
- comprehensive and precisely drafted standards
- monitoring through 'policing'
- enforcement through sanctions, particularly exit

Soft model:

- high-trust relationship between the parties
- standard-setting through collaborative negotiations
- broadly drafted, general standards and unwritten assumptions
- monitoring through shared information or trusting the provider to comply
- enforcement through persuasion

This section will give an introductory description of our models, acknowledging their derivation from the literature.¹⁰ For present purposes we will make two key assumptions, both of which will be questioned below. Firstly, we will assume that

¹⁰ We will focus on the contracts literature here, but there are also important parallels, particularly at the enforcement stage, with the choice of persuasion or prosecution faced by regulatory agencies: see generally Ogus (1994), and Chapter VI.

the link between the use of a particular technique (sanctions, for example), and a particular level of trust in the parties' relationship, could be established empirically. Secondly, we will assume that the purchaser has greater bargaining power than the provider, in the sense that the provider is anxious to win and retain the purchaser's custom (usually because the transaction takes place in a competitive market).

The *hard model* describes a purchaser whose actions respond to (and reinforce) a low-trust relationship with the provider. This is immediately apparent from the way in which the purchaser negotiates the contract and sets standards for the provider's performance.¹¹ The hard purchaser sets out the standards it requires and demands that the provider sign up to them. A bargaining process may take place if the provider resists some of those demands. But the parties do not share information or negotiate collaboratively. The provider agrees to the contract by signing it: the purchaser is not interested in any stronger form of consent.

The hard model also has implications for the way in which the contractual standards are drafted. Despite the difficulty of drafting a comprehensive contract, sometimes referred to as the problem of incompleteness,¹² the parties strive to set detailed standards on as many aspects of their relationship as possible (Macneil 1974; Sako 1992). The purchaser's aim is to achieve maximum control over the provider (Fox 1974). Comprehensiveness helps to prevent situations in which the purchaser cannot call the provider to account because no standards have been set

¹¹ This is an extension of some of the ideas found in the literature, which focuses more closely on the life of the contract.

¹² Or 'presentation': Macneil (1978).

to govern a particular issue. The clarity and precision of the standards themselves helps to prevent, as far as possible, disputes about their meaning.

At the monitoring stage, the hard model emphasises the need to check up on the provider's performance. Formal monitoring procedures are included in the contract document, and reinforced by the threat of sanctions (Fox 1974). Any information supplied by the provider is rigorously checked against independent information, wherever possible.¹³ In short, the purchaser behaves as if it suspects the provider of cheating or concealment, and places explicit disincentives in the way of this form of opportunistic behaviour.¹⁴

At the enforcement stage, the hard purchaser values compliance with its requirements above the maintenance of the relationship with its contracting partner (Sako 1992). If the provider does not comply, the purchaser simply 'exits' (Hirschman 1970) to another provider. Of course, the mere threat of exit may act as a good deterrent to poor performance. The hard purchaser might also employ what might be termed 'intermediate' sanctions falling short of exit, such as penalty clauses, to respond to instances of poor performance which do not merit the ultimate sanction of taking the contract elsewhere.¹⁵

The *soft model* describes a very different pattern of behaviour, which reflects and reinforces a high-trust relationship between the parties. When setting

¹³ See discussion of 'competence' trust and monitoring costs in Sako (1992).

¹⁴ The hard purchaser is also likely to check any information supplied by the provider during negotiations.

¹⁵ See Macneil (1978); Williamson (1979) on 'neoclassical' contracts with their own dispute resolution arrangements.

standards during contract negotiations, the soft purchaser works jointly with the provider, on the basis of shared information, in order to negotiate a deal which is fair to both parties. It seeks the provider's full consent to the standards set - not just a signature to the contract. This emphasis on collaboration is reinforced by the way in which the standards are drafted. They are broad and general, and anticipate further negotiation between the parties to work out their details, or even to vary them in response to changing circumstances (Macneil 1974; Sako 1992). The soft purchaser is less concerned than the hard purchaser by the problem of incompleteness: it can rely on future negotiations to fill the gaps in the contract. Trust is essential here. The purchaser is reassured that the provider will not behave opportunistically where there are gaps in the contract and where further negotiations become necessary. The provider is reassured that the purchaser will not use its superior bargaining power to pursue self-interested, short-term gains during the negotiations. Thus, neither party feels the need for the protection of a detailed contract document (Dore 1983).

Where the soft model is fully implemented, formal monitoring procedures are not required because the purchaser trusts the provider to comply and to perform to acceptable standards (Sako 1992). Moreover, a trusting relationship implies a free flow of information between the parties (Dore 1983), thus minimising the problem of information asymmetry: the provider is unlikely to be able to conceal a breach from a purchaser with which it has a close relationship. The fear of losing the purchaser's trust will, in any event, deter the provider from attempting such concealment. But there is one caveat: we noted above that monitoring becomes unnecessary where the soft model is *fully* implemented. At the beginning of the

parties' relationship, some checking may be necessary in order to reassure the purchaser that the provider is trustworthy (Sako 1992: 39).

At the enforcement stage, the trusting relationship of the parties to a soft contract affects their behaviour in several ways. It deters the provider from breaching, because it is afraid of losing the purchaser's goodwill (Macaulay 1963). Where a breach does occur, the purchaser eschews sanctions in favour of persuasion, working with the provider to solve the problem which has led to the breach, and seeking to maintain their trusting relationship (Dore 1983). Finally, we would not expect the parties to plan for default under this model. Any reference to the possibility of breaches might endanger their relationship, by implying that the purchaser does not trust the provider to comply (Macaulay 1963).

A caveat: the models' hidden assumption

Our discussion above assumed that the purchaser had superior bargaining power: that the provider would work to attract and retain the purchaser's custom. The purpose of this section is to examine the role of that assumption in traditional accounts of models of this kind, and to explain why we cannot make the same assumption about the NHS.

Traditional accounts of contractual relationships have developed from studies of competitive markets. They usually describe the dealings of large purchasers with a number of smaller supplier firms, competing with one another for the

purchaser's trade.¹⁶ This gives the purchaser superior bargaining power: the supplier firms are afraid of losing business and are therefore inclined to co-operate with the purchaser. This explains why both models can claim to be effective. The purchaser's threat of exit under the hard model is effective because it is realistic - there are alternative suppliers - and potentially damaging - the provider fears the loss of income. The purchaser's use of persuasion under the soft model is effective because of an indirect reliance on exit. The provider fears the purchaser's loss of goodwill, in part because the parties value their trusting relationship and in part because a loss of goodwill might ultimately lead to the loss of the contract. Soft persuasion is backed by relatively harsh implied threats (Dore 1983).

In the NHS, it was not appropriate to assume that the purchaser had superior bargaining power. One reason for this was that NHS purchasers would not necessarily have the purchasing power of the large firms used in other studies. The budget of an individual fundholding practice in particular could seem trivial by comparison with the annual income of a large provider.¹⁷

But the most important factor affecting purchasers' bargaining power was the extent of competition among providers in their area. It could not be assumed that the NHS 'market' was competitive.¹⁸ Geographical factors are important in the provision of health care: there is usually a limit to the distance most patients will

¹⁶ Macaulay (1963); Dore (1983); Sako (1992). Similar assumptions probably apply in Fox (1974).

¹⁷ Audit Commission (1996) found that Trusts were dependent on fundholders for up to 20% of their income. But this could consist of some fifty contracts with individual practices.

¹⁸ See for example Klein (1995); Propper and Bartlett (1997); Barker *et al.* (1997); Spurgeon *et al.* (1997).

travel for treatment.¹⁹ In urban areas, the purchaser might have several providers within travelling distance. In rural areas, patients who lived on a county boundary might be within reach of more than one provider. This created limited contestability, rather than competition (Walsh *et al.* 1997). But some purchasers' geographical location might mean that there was only one realistic provider for most services. Of course, this monopoly would considerably enhance the provider's bargaining power at the purchaser's expense.

A competitive market may not be the only source of bargaining power for a purchaser. 'Legal' remedies were also potentially available in the NHS, to support a purchaser who felt that a provider was abusing a monopoly, or (less commonly) had failed to comply with its contract.²⁰ The role of factors other than competition will be explored in Chapter VI.

What is important for present purposes is to make clear that our use of the models reflects the special circumstances of the NHS. We will not assume that purchasers had superior bargaining power. Instead, this will be investigated by examining the extent to which the models were effective. We will thus distinguish between situations in which the models were fully implemented - the purchaser had superior power, the assumptions held and the purchaser achieved its goals and situations in which the models were partially implemented - the purchaser was in a weak position and failed to achieve its goals, despite employing the techniques suggested by one or other model. This will help us to acknowledge that

¹⁹ Barker *et al.* (1997). Thirty minutes' travelling time is usually taken as a convenient indicator (Propper and Bartlett 1997).

²⁰ National Health Service and Community Care Act 1990, s. 4. See Chapter II.

competition was possible, but not universal, in the NHS, and therefore to *investigate* purchasers' bargaining power. We will return to this theme in our discussion of Hypothesis 3.

Which model best described NHS contracts?

The model for any given contract is, to some extent, a matter of choice for the parties. But the literature identifies a number of factors which are likely to influence that choice (often using the economist's assumption that the parties are acting rationally²¹).

The *first factor*, and probably the most fundamental, is the *duration* of the relationship between the parties (Macneil 1974; Williamson 1979). The hard model is linked to short-term, discrete exchanges; the soft model to longer-term relationships. A brief encounter is unlikely to involve the close bonds inherent in the soft model. The shortest contracts in the NHS were waiting-list initiatives or one-off specialist treatments for a few patients, lasting only for the time it took to treat those patients. The shortest routine contracts were for a single financial year (Montgomery 1997b). A contract which was agreed for a year and not renewed could therefore count as hard, or at least towards the hard end of the spectrum. In most cases, however, purchasers renewed their one-year contracts over a longer period, or (less commonly) agreed longer contracts with annual re-negotiation of the contract price. The latter clearly counted as soft; the former were towards the

²¹ See, for example, Williamson (1979).

soft end of the spectrum, particularly if there was a presumption that the contract would be renewed. There was also evidence that purchasers preferred on principle to build close relationships with providers (Flynn *et al.* 1996). Duration was therefore a strong indicator that the soft model would prevail in the NHS. Some caution was, however, required. Given the lack of choice of providers in the NHS ‘market’,²² some purchasers might be forced to renew contracts even if they were unhappy with a particular provider. A long-term relationship in the NHS might not therefore be a clear indication of a high level of trust between the parties. Chapter V demonstrates the importance of this caveat.

A *second factor* much discussed in the economics literature is *asset specificity* (Sako 1992; Williamson 1979). If, in order to meet the contract, the parties have to invest in specific assets which will be of much less value when put to alternative uses, a long-term relationship is required in order to obtain the maximum return on these investments. The parties are therefore likely to opt for the soft model. The importance of this factor in the NHS was primarily geographical. If a provider was proposing to build a community hospital to serve a particular area, it might want undertakings from purchasers in that area that they would use the new hospital, because there would be a limit to the extent to which it could replace their custom by attracting patients from outside. In other circumstances, for example in an urban area with a number of well-funded purchasers and an overall under-supply of services, a provider which found that it had spare capacity because one purchaser had taken its contract elsewhere could sell that capacity to other

²² See above.

purchasers. Asset specificity might therefore be a problem in the NHS, but much depended on the parties' circumstances.

A third factor is personal relationships. Hard contracts do not involve wider personal relationships outside the scope of the transaction itself; soft contracts involve interactions at a number of levels (Macneil 1974). This was important in the NHS because the contracting system was introduced into a context in which many of the key actors were in relationships in other capacities and had known each other for some time. This suggested that NHS contracts would fit the soft model. In the social care context, for example, Lapsley and Llewellyn (1997) found that social workers knew each other and had shared values which rendered formal contracts entirely unnecessary.²³

A fourth factor is the extent to which it is possible to specify the exchange between the parties. Following Macneil (1974), we can distinguish hard contracts in which the parties measure their exchanges and expect precise reciprocation, from soft contracts in which they expect reciprocity over time but do not measure it exactly. The indications for the NHS were ambiguous. The purchaser's need to obtain as much treatment as possible within a limited budget was likely to lead to an attempt to specify the price and quantity of treatment covered by the contract relatively precisely (NHSME 1990a). But there were difficulties with this. Specifying the quantity of treatment was technically difficult in some areas, notably community services (Flynn *et al.* 1996). Specifying the type and quality of

²³ See also Flynn *et al.* (1996).

the treatment to be provided was even more challenging.²⁴ The NHS was shown by Day and Klein (1987) to be heterogeneous (providing a variety of services), complex (using a variety of skills), and uncertain (in the relationship between the services provided and their outcomes or objectives). This might require a soft contract, in which the parties set general standards and negotiated collaboratively during the life of the contract to decide exactly what the contract required.

A *fifth set of factors* relates to the *institutional framework* surrounding the contracts (Sako 1992; Deakin *et al.* 1997). In the NHS, central government policy and the arbitration system were probably the most important influences. Did they encourage or facilitate the development of long-term relationships? In the NHS, the policy element was ambiguous (Hughes *et al.* 1996). On the one hand, the government acknowledged that for many services, purchasers would have only one realistic provider and would therefore be in a long-term relationship (NHSME 1989; 1990a). On the other hand, the reforms were in part intended to introduce competition, so there was pressure for short-term relationships and changes of provider where possible.²⁵ The effect of the ‘legal’ system²⁶ for NHS contracts was also difficult to predict. Its applicability to the negotiation stage acknowledged that some relationships were inevitably long-term, and might require outside assistance to ensure their effective functioning (Hughes 1991). But its weakness more generally might make disputes more prevalent and long-term relationships more difficult to sustain (cf. Deakin *et al.* 1997).

²⁴ See Allen (1995); Flynn *et al.* (1996); Walsh *et al.* (1997).

²⁵ The ‘money follows the patient’ principle of Department of Health (1989).

²⁶ National Health Service and Community Care Act 1990, s. 4. See Chapter II.

Finally, the parties' *strategy* is relevant. Although the circumstantial factors discussed above are important, the parties' preference for one or other model is also likely to be influential. Because of the weakness of competition in the NHS, discussed above, the parties might have no choice about the duration of their relationship: contracting with one another might be inevitable. Here, the parties' willingness to work at developing a relationship of trust was vital (Lapsley and Llewellyn 1997). But it might prove difficult to sustain that trust in a 'compulsory' relationship: a point explored fully by Hypothesis 2. Moreover, a purchaser's ability to devote time to building relationships might also be relevant: large Health Authorities had more staff and more time to devote to meetings with providers than did fundholders, for example.

To sum up, it was difficult to predict which model would best describe NHS contracts. Several factors pointed towards the soft model. But we did note some ambiguities: the fact that long-term relationships might not be a matter of choice, for example. It was difficult to determine their significance without empirical evidence: the hypotheses will help us to explore them fully.

PART II:

RESEARCH HYPOTHESES

Our three hypotheses draw increasingly heavily on the models we have set out. Hypothesis 1 focuses on the constraints and pressures faced by the caller to account. These affected the caller's ability to implement either model of

accountability relationship. Hypotheses 2 and 3 explore in detail the contractual accountability process from provider to purchaser, bearing in mind the constraints and pressures identified by Hypothesis 1. Hypothesis 2 examines the quality of the relationship between the parties to the accountability process, drawing on the models' concern with trust. Hypothesis 3 asks whether the accountability process through NHS contracts was an effective means of achieving the broad goals of any accountability process: enabling the caller to account to set the standards it required and to secure compliance with them. This involves an examination of the models themselves, and the extent to which they were fully implemented in the NHS. For each hypothesis, we will also offer a set of principles with which to evaluate the empirical data.

Hypothesis 1: Pressures and Constraints

One of the remarkable features of the NHS contract as a mechanism of accountability was its potential breadth. It could be used to call the provider to account for any aspect of its performance:²⁷ there were no limits in the statute²⁸ or guidance²⁹ as to what could be covered. Moreover, each of the accountability tasks – standard-setting, monitoring and enforcement – could be performed using a variety of different techniques (some of which were described in Chapter II). In practice, however, it was unlikely that purchasers would examine every aspect of a provider's performance or use every available technique for doing so. This raised

²⁷ Assuming the provider could be persuaded to agree to the contract: see Hypothesis 3.

²⁸ National Health Service and Community Care Act 1990.

²⁹ Department of Health (1989); NHSME (1989; 1990a).

the question of how purchasers would choose the topics to be covered in the accountability process, and the techniques to be employed.

Our hypothesis attempted to explain purchasers' choices in terms of the pressures and constraints on their activities. Purchasers would be faced with pressure from the accountability mechanisms to which they themselves were subject ('onwards' mechanisms). Their behaviour in calling providers to account would be influenced by their own accountability to central government. Purchasers' actions would be constrained in two main ways. One constraint was that time and resources for the accountability process would be limited. Another constraint was that they might not have all the knowledge or skills required in order to tackle some topics or employ some techniques. We will examine each element of the hypothesis in turn.

Our first suggestion was that purchasers would be subject to *pressure from onwards accountability mechanisms*. Purchasers did not act on their own behalf when placing contracts with providers. They might therefore be called to account by those with a legitimate interest in their activities. This would be likely to shape their own behaviour when calling providers to account. For example, if purchasers were themselves called to account for long waiting times for treatment in their area, they would probably set and enforce standards on this topic in their contracts with providers.

We discussed the onwards accountability mechanisms applicable to purchasers in Chapter II. Although members of the public had a legitimate interest in

purchasers' activities, in at least three possible capacities (as taxpayers, and patients or potential patients), that interest was not reflected in strong accountability mechanisms from purchasers to the public.³⁰ It was not therefore to be expected that the views of members of the public would play a particularly strong role in shaping purchasers' approaches to calling providers to account. But purchasers were held to account more rigorously by central government.³¹ Purchasers were obliged to meet central priorities and targets (for example, NHSE 1995*b*). Performance was monitored through regular reports, and compliance was enforced by managerial sanctions.³² It was therefore to be expected that purchasers' accountability to central government would help to explain some of their choices when calling providers to account. Indeed, some writers have gone so far as to suggest that central government influence is one of the factors that should be incorporated into an explanatory model of the NHS contract: the 'administered contract', used by Hughes *et al.* (1996), is an example of this. Examining purchasers' own accountability takes us beyond the main focus of the study on provider/purchaser accountability, but the data showed that purchasers' actions could not be understood without an examination of the context in which purchasing took place.

In addition to the pressures of onwards accountability, purchasers were subject to two sets of constraints: of time and resources, and of skill and knowledge. These constraints were not explicitly raised in the literature, but soon became

³⁰ Chapter II; Longley (1990; 1993).

³¹ On the role of central government, see Hughes and Dingwall (1990); Hughes *et al.* (1996); McHale *et al.* (1997); Montgomery (1997*b*). The *appropriate* extent of central control is a matter for debate, and is beyond the scope of this thesis.

³² Within the statutory framework described in Chapter II.

apparent during initial interviews in which early formulations of the research hypotheses were tested. They would also help to explain purchasers' approaches to calling providers to account.



Time and resource constraints are an inevitable feature of any governmental activity. Purchasers had to ration their resources for accountability: their budgets for all activities were limited. For example, GP fundholders' main function was the provision of primary health care services to patients. Purchasing was a secondary role and could only be allowed to absorb the attention of a limited number of staff for limited periods of time. These constraints would help to explain various 'omissions' by purchasers, usually of particular techniques of accountability: for example, monitoring performance through visits to the provider's premises was often avoided because it was seen as unduly time-consuming. These 'omissions' occurred even on topics which were a high central priority. As we shall see in Chapter IV, this affected the parties' ability to implement to the full either the hard or the soft model of accountability, since both models required the investment of time and effort in particular activities.

Constraints of knowledge and skill would also help to explain the data. The 'purchaser/provider split'³³ was an unhelpful description of the reforms, in that it failed to emphasise the novelty of the purchasing role. Health Authorities and GP practices were expected to develop the new skills it required. By the time of the study in 1996-97, Health Authorities had six years' experience, and fundholders

³³ See Chapter II.

had up to six years' experience, depending on when they joined the scheme. Nevertheless, some gaps remained in purchasers' knowledge of particular topics, and skills in using particular techniques. For example, purchasers of both types rarely set standards on clinical quality issues. In part, this was because they were not encouraged to do so by central government. But it also reflected their limited knowledge of clinical issues. GPs' knowledge was inevitably general, and Health Authorities received varying degrees of assistance from their public health departments:³⁴ neither could match providers' specialist expertise. Purchasers' limited skills were also relevant to the techniques used. For example, whereas Health Authorities' contracting teams had accountancy and information skills, fundholders were less expert in these matters and felt less confident in negotiating prices with providers as a result.

The hypothesis to be tested can be formulated in the following way:

The choices that purchasers needed to make when shaping the accountability process were affected by the pressures (from 'onwards' accountability mechanisms) and constraints (of time, resources, skill and knowledge) purchasers faced.

Chapter IV explores in detail the role of the pressures and constraints we have identified, in the light of the study's empirical findings. Chapter IV also seeks to evaluate the findings using three principles of good accountability. These

³⁴ One Authority in the study had no public health input into contracting at all; another's Director of Public Health was heavily involved in contract negotiations.

principles form part of an attempt, brought together in Chapter VII, to develop our analytical model of an accountability process into an evaluative tool. The first principle relates to the pressures on purchasers from other accountability mechanisms. The second and third relate to the constraints they faced.

The caller to account should be subject to effective accountability mechanisms to all interested third parties. Purchasers, as we have seen,³⁵ did not act on their own behalf when calling providers to account. They could be seen as the delegates of central government and the public. The basic principle of accountability,³⁶ that a delegate should be subject to an accountability mechanism, ought therefore to have applied to purchasers. This was the case even though their main task was to call providers to account rather than to provide a particular service themselves: they could be called to account for their conduct of the contractual accountability process. Thus, one way of evaluating the findings was to ask whether purchasers were adequately accountable to *all* those with a legitimate interest in their activities. As we shall see, purchasers were subject to relatively rigorous accountability to central government. They could not therefore be described as ‘unaccountable’. But their accountability to the public was weak and unsystematic. Accountability to one stakeholder was not an adequate substitute for accountability to all relevant stakeholders.

Furthermore, purchasers’ accountability to central government was not without problems. It was arguable that the purchaser/government accountability

³⁵ See Chapter II.

³⁶ See Chapter I.

relationship was untransparent. (The principle of transparency is discussed fully under Hypothesis 2, below.) If so, this would cause problems for government's accountability to MPs, Parliament and the public. Those calling the government to account would find it difficult to discern the extent of the government's control over purchasers' activities. A clear idea of the scope of a body's responsibility is obviously essential to determining the scope of its accountability (Day and Klein 1987). We will examine whether the findings of this study about the extent of central government influence over purchaser behaviour were fully acknowledged in official descriptions of the reforms and in the accountability mechanisms applicable to central government.³⁷

The caller to account should be given sufficient resources in order to operate an effective accountability process. Did the constraints facing purchasers unduly impede their ability to call providers to account through contracts? An accountability process inevitably involves some costs. The decision to implement an accountability process implies a decision that those costs are justified. Adequate funding is needed to ensure that the constraints on the accountability process, such as limits on the resources and skills available to operate it, are kept to a minimum. This is not to say that funding should be unlimited: governmental resources for any activity are, of course, never infinite. Nor is it to say that accountability processes should necessarily be treated as a high priority for resource allocation: accountability is always secondary to the delivery of a particular public service. Chapter IV will offer some tentative comments, bearing

³⁷ Our comments will be tentative because the issues raised go beyond the main focus of our study.

in mind the limitations on our data,³⁸ about the sufficiency of resources given to NHS purchasers for accountability.

The caller to account should strive to maximise the accountability achieved within the resources available. Our third principle involves the specific application to accountability processes of more general ideas of public sector efficiency and effectiveness. These criteria are important for at least two reasons. Firstly, as we saw in Chapter I, they are key standards in the government's financial accountability (to the Comptroller and Auditor-General, and the Audit Commission, for example). They reflect the government's 'estate management' role (Day and Klein 1987), and are an aspect of securing the proper stewardship of public funds. Secondly, they reflect the common-sense proposition that the government should seek to maximise what can be achieved within available resources, because those resources are inevitably limited.

Hypothesis 2: Relationships and Procedure

Our second hypothesis focuses on the relationships between purchasers and providers during the accountability process. The discussion in Part I showed that predicting the shape of those relationships was not straightforward. A number of features of NHS contracting suggested soft relationships, but others indicated the hard model. The hypothesis, rather than attempting to predict which model might prevail, suggests that the contracting parties themselves might be faced with the

³⁸ The study was not designed to cost the contractual accountability process in any detail: see Appendix 1.

same dilemma. In turn, this would indicate that their relationships would be highly complex and fraught with tension. The models appear to be mutually exclusive, because of the different levels of trust they imply. It is hard to imagine a comfortable contractual relationship in which some aspects of the parties' behaviour imply high trust, and others low trust. The hypothesis can therefore be formulated as follows:

Accountability relationships between the contracting parties in the NHS displayed many features of the soft model but some features of the hard model. The latter undermined the high-trust relationship associated with the former.

A study of accountability relationships will advance our understanding of the practicalities of an accountability process quite considerably. Relationships were highly important to the parties: often, the manner of the other party when participating in a particular accountability task was as much a matter of concern as the outcome. Indeed, an undesirable outcome - a breach of contract, for example - was less likely to be resented by the purchaser where the provider was apologetic. We saw above that the nature of the parties' relationship was in part a matter of choice, although they were well-advised to make certain choices if certain conditions prevailed. In practice, that choice was often taken very seriously. Purchasers expressed clear policy preferences for either the hard or the soft approach. Finally, a knowledge of relationships was essential to obtaining a deep understanding of the day-to-day operation of the accountability process. It was not comprised of the parties' actions in isolation from one another, nor was it simply a

list of successes and failures. Instead, it was a complex interaction between them. Chapter V thus fills the gap between the purchaser's choices about the accountability process (Chapter IV) and the outcomes of that process (Chapter VI).

Our enquiries will also enable us to test the methodological value of studying relationships using the hard and soft models. We will be able to ask whether they help us to identify and explain the key features of the parties' behaviour. In particular, the models themselves may need further development in the light of the empirical data. For example, although the models link precise standards with low trust, we might want to question this assumption. In some contexts, notably finance, trust may be built by using clear terms which enable the parties to 'know where they stand'. This task is made all the more interesting by the potential we have predicted for NHS accountability relationships to be a complex blend of the two models.

More generally, the data enable us to explore the fundamental issue of the relationship between accountability and trust. Accountability may seem to be the very opposite of trust: it implies checking up on, rather than relying on, the body being called to account. But there cannot be an infinite regress of checks, and ultimately, the caller to account must trust some aspects of the body's explanation (Power 1997). The balance between trust and accountability is therefore highly complex. We may be able to offer some tentative comments about this complex issue on the basis of the empirical findings.

Finally, there was a crucial link between relationships and effectiveness. The parties often justified their choice of either model in terms of its perceived effectiveness. Moreover, theorists link the soft model in particular with achieving the purchaser's goals. We will explore effectiveness in Hypothesis 3 and Chapter VI, but that discussion is inextricably linked to the detailed analysis of the models in Chapter V. In part, therefore, Chapter V provides background to Chapter VI.

A detailed study of accountability relationships makes it possible to *evaluate* the findings in terms of crucial public law principles about relationships and the procedures governing them, namely fairness and openness. This enables us to develop specific applications of those principles for contractual accountability relationships, and thus to make a contribution to the 'public law contract' debate.³⁹

The good accountability process is characterised by its regard for principles of due process. The rules of due process are, at the highest level, designed to ensure fairness in government's interactions with citizens or with other public bodies (such as local authorities). Although they have not intruded very far into relationships within government itself,⁴⁰ it is arguable that they should apply equally strongly to such relationships. The 'new public management' reforms, as we saw in Chapter I, involved dividing public bodies into separate units. These units were to relate to one another more formally. This creates more 'space' for

³⁹ See Chapter II, and Harden (1992); Freedland (1994; 1998) Hughes *et al.* (1996); McHale *et al.* (1997); Vincent-Jones (1997).

⁴⁰ There is no evidence of a concern with procedural fairness in the Next Steps context: Greer (1994).

formal due process rules than did the hierarchical relationships which characterised the public sector prior to the reforms.

The usual justifications for due process rules⁴¹ are particularly strong in the case of accountability relationships, in which judgements are made about performance and (possibly) sanctions applied. On the instrumental level, fair procedures are those which help to ensure that the accountability process is effective (cf. Galligan 1996). They might include requirements about evidence, for example, so that judgements about performance are as accurate as possible. On the non-instrumental level, fair procedures can be seen as an important means of ensuring that the person or body being called to account is given an opportunity to participate in decision-making, for example.⁴² Although this argument is perhaps morally less powerful in relation to a corporation, such as an NHS Trust, it is nevertheless relevant. In particular, unfair treatment of the organisation may involve unfairness to individual members of staff.

But the principles of due process are not ‘self-executing’. They must be tailored to the context in which they are to apply and to the values they are intended to serve (Galligan 1996). In our case, the relevant procedure is the negotiation and operation of a contract, in accordance with either the hard or the soft model. Our due process principles must fit both the basic contract procedure, and the different versions of it expressed by the models.

⁴¹ See generally Bayles (1990); Galligan (1996).

⁴² See the discussion of ‘process benefits’ in Bayles (1990).

In theory, contracts derive a high degree of legitimacy from the fact that the parties have agreed to the obligations they impose (Bayles 1990). In practice, this value is realised more or less imperfectly. Contracting parties are usually constrained by external regulation, and by inequalities of bargaining power.⁴³ The latter raises a difficult issue for accountability. An effective accountability process requires that the caller to account should have the upper hand (Day and Klein 1987).⁴⁴ This extends to imposing standards, in the public interest, on the body being called to account, where the caller to account believes that its objections are unreasonable. In a contractual accountability process, where standard-setting normally proceeds with the consent of that body, this creates a difficulty. Ultimately, in pursuit of accountability, it may be justified for the purchaser to violate the consensual nature of the contract and to impose standards on the provider. This may not be unfair: it is arguable that the body being called to account is itself behaving unfairly by making unreasonable objections to the standards. Nevertheless, it acts as an important caveat to our models of procedural fairness. They apply to contractual accountability relationships outside these extreme circumstances.

The hard and soft models involve different approaches to the central value of consensus. Each model therefore requires its own version of procedural fairness. It is important to note that the literature from which the models are derived is not expressly concerned with fairness. Our argument, given above, is that the accountability relationship itself requires the application of due process principles.

⁴³ See generally Collins (1997).

⁴⁴ See Chapter I, and Hypothesis 3, below.

Our challenge is to identify a conception of fairness which fits most closely with each model. The approach is thus similar to Dworkin's 'interpretive' method (Dworkin 1986).

The soft model places a high value on consensus, both when the contract is being negotiated and during its life. Fair procedures in this context are those which promote agreement between the parties. This suggests a particularly collaborative form of negotiation, in which the purchaser allows the provider full opportunity to comment on any proposed standards, and shows that it is willing to take account of the provider's representations.⁴⁵ Similarly, where problems arise during the life of the contract, the purchaser is expected to hold meetings with the provider in order not only to hear its excuses, but also to take joint responsibility with it for solving those problems.

Fully participatory procedures bring with them particularly strong information requirements. Negotiations proceed on the assumption that all relevant information is held in common: the parties cannot share the responsibility for reaching an agreement which is fair to both of them without full disclosure. More importantly, the purchaser's rejection of deliberate monitoring activities is based on the assumption that the provider is entirely open with the purchaser about performance. It would therefore be unfair, under the soft model, for either party to conceal information from the other.

⁴⁵ A highly collaborative accountability process may be open to the claim that the caller to account has been 'captured' by the body it is meant to be calling to account. This is an issue for Chapter VI, although it is worth pointing out at this stage that there was no real suggestion of capture in the data.

The emphasis on collaboration and fully participatory procedures explains why the model's vague, general standards are not unfair, despite their failure to conform to the Rule of Law⁴⁶ requirement that standards should be a clear guide to conduct.⁴⁷ Fairness under the soft model requires that the provider be given regular opportunities to discuss the standards and negotiate their detailed application jointly with the purchaser. This obviates the need for the provider to be able to predict how the standards will be used.

The hard model, by contrast, places limited value on consensus. Obviously, the parties must agree to the extent that they sign a contract, but even the contract negotiation process is not expected to proceed in a particularly collaborative way. Instead, the purchaser sets out its requirements and the provider is expected to protect its own interests, where necessary, by raising objections and refusing to sign the contract. The model itself does not suggest any sharing of information, although in pursuit of fairness it might be appropriate to graft onto it a minimum requirement, for example, that neither party should conceal any information that would materially affect the other party's consent to the contract.⁴⁸ This would help to ensure that each party's consent was voluntary, in that it would not be based on false assumptions generated by the other party. It might also be appropriate to insist that the purchaser should consult the provider on the proposed standards and give it a reasonable opportunity to make representations, as a matter of fairness, instead of simply demanding its assent. This would serve the instrumental goal of

⁴⁶ Fuller (1969); Raz (1977).

⁴⁷ Under the hard model, this would be unfair, as we shall see below.

⁴⁸ Cf. Collins (1997) on the 'duty to negotiate with care'

enabling the purchaser to check the reasonableness of the standards, and the non-instrumental goal of promoting participation. These goals may perhaps go beyond the essential requirements of the hard model, but it will be argued in Chapter V that the public sector context may require extra attention to the requirements of fairness.

Once it has been agreed, the hard contract appears to fit a familiar procedural model which might be labelled ‘applying standards’ (Galligan 1996). The value inherent in the procedure is that issues should be decided in accordance with the standards. A number of specific principles are designed to ensure that the standards are applied in a fair and effective way, most of which fit quite closely with the hard model.⁴⁹ Firstly, the standards to be applied should be set out clearly and in advance, to meet the Rule of Law⁵⁰ requirement that those affected by rules should be able to use them as a guide to conduct. A hard contract is likely to satisfy this requirement, in that the parties strive to set out detailed, specific standards in the contract, and to avoid leaving issues for further negotiation. Secondly, the person applying the standards should seek to discover the facts as accurately as possible. The hard purchaser certainly strives for this, too, by policing the provider’s activities, checking up on its accounts, and using independent information where available.⁵¹ This requirement might also be used to create a matching obligation on the provider to supply information to facilitate the application of the standards. But it would not require the openness of the soft

⁴⁹ The rule against bias is not discussed here. Its application is often modified or disregarded in administrative (as opposed to judicial) contexts.

⁵⁰ See n. 46, above.

⁵¹ Advocates of the soft model would argue that these methods are flawed.

model, discussed above. Instead, the provider might be obliged merely to supply specified information on demand. Thirdly, the person applying the standards should take into account any arguments and representations made by the provider. Once again, this is difficult to apply to the hard model. On the one hand, it is a highly important aspect of procedural fairness, particularly where sanctions are likely to be applied, serving the values of accurate decision-making and participation by the affected party (Galligan 1996). On the other hand, the hard model may allow the purchaser to hold the provider liable regardless of its excuse. Under these circumstances there is little point in the purchaser hearing the provider's representations. Thus, the element of adversarialism in the hard model cuts across apparently straightforward principles of due process. Again, the public sector context may require us to modify the hard model in order to fit the requirements of fairness more closely. We will explore this debate further in Chapter V.

Chapter V seeks to apply the concept of due process to the empirical findings, in order to evaluate the extent to which NHS purchasers observed fair procedures. Applying the principles to the NHS data presents particular problems, because those data are highly complex and involve a mixture of the two models. The chapter will conclude by setting out some tentative procedural requirements for 'public law contracts',⁵² in the light of the NHS findings.⁵³

⁵² See n. 39, above.

⁵³ Public law principles regarding the award of contracts are not discussed in detail because the NHS data related to contract renewals. These took place as a matter of routine. It was arguably unfair that tenders were not sought, at least under the hard model, but this would have been time-consuming and unrealistic in many cases.

The good accountability process is transparent to interested third parties. We have already established that third parties had a legitimate interest in the NHS contracting process.⁵⁴ The need for purchasers to be able to account to others for their activities gave rise to certain procedural requirements in the accountability relationship from provider to purchaser. Those requirements can be captured in the concept of ‘transparency’, which means that as much public sector activity as possible should be conducted openly and in public, and should be accessible or explicable to those it affects. Transparency is a fundamental principle of public law, supporting specific rules such as the requirement to give reasons for decisions.⁵⁵ An activity (in our case, accountability from provider to purchaser) needs to be transparent in this sense in order that the accountability process for that activity can be effective (purchasers’ onwards accountability to central government).

What are the specific requirements of transparency in the accountability process from provider to purchaser? In principle, the purchaser should be able to demonstrate that the various accountability tasks are being performed, and how this is being done. Transparency favours formality and clarity. It is easier for third parties to understand the accountability process if there is a clear written statement of the standards to be applied and the procedures to be followed.⁵⁶ The purchaser can point to a document which explains the accountability process. The hard model of accountability relationship is likely to satisfy this requirement, since it

⁵⁴ Chapter II and Hypothesis 1, above.

⁵⁵ See *Doody v Secretary of State for the Home Department*, 1993 3 All ER 92, per Lord Mustill at 107.

⁵⁶ Some writers (not distinguishing between different models) saw this as one of the major advantages of public sector contracting: see, for example, Harden (1992: 71).

promotes contracts which are as precise and comprehensive as possible. Transparency also favours measurable or demonstrable action at each stage of the accountability process. For example, at the enforcement stage, a contractual term specifying a penalty clause for a particular breach is more transparent than an understanding that the purchaser will collaborate with the provider in order to promote compliance. Transparency requires not only that action be taken, but that the action should be seen to be taken. This also favours the hard model, with its emphasis on formal procedures for monitoring and enforcement. The collaborative, informal style of the soft model may have other features to recommend it, but it does make the process inaccessible to interested third parties.

The NHS data will be evaluated against this principle in Chapter V. We will focus in particular on the extent to which it is possible to compromise on transparency, given that (as we shall see below) the soft model may have other advantages. Once again, we will seek to generalise from the NHS findings to other public sector contracts, in pursuit of the emerging notion of the ‘public law contract’.⁵⁷

Hypothesis 3: Effectiveness

The third hypothesis focused on the crucial question of the effectiveness of the accountability process through NHS contracts. The first limb of the hypothesis predicted that:

⁵⁷ See n. 39, above.

The purchaser might not be able to make the accountability process through the NHS contract effective.

We will explain this limb of the hypothesis before turning to the second limb, which is concerned with the hard and soft models.

Our first task is to define an ‘effective accountability process’. In Chapter I, we noted, briefly, that although accountability processes may have very different specific purposes⁵⁸ (resolving grievances, ensuring financial propriety and efficiency, regulating standards of performance) they all have a common purpose at the highest level, encapsulated in the definition of ‘making someone accountable’. The general goals of any accountability process have been implicit in much of our discussion so far, and can be simply stated.

The primary aim of any accountability process is to ensure that the performance of the body being called to account conforms⁵⁹ to the standards set.⁶⁰ Ideally, the caller to account should be able to ensure that breaches of standards do not arise - that the body being called to account is generally inclined to comply or deterred from breaching.⁶¹ If the breach occurs, the caller should be able to persuade or

⁵⁸ The specific goals of the NHS purchaser will be discussed in Chapter VI.

⁵⁹ The complex, socially-constructed nature of compliance is highlighted in the literature on regulation. See, for example, Hawkins (1984). (Regulators are, of course, an important group of callers to account.)

⁶⁰ In some accountability processes - a political process, for example - the body may be obliged to give an honest, open account of performance, rather than to meet particular standards about that performance. Views may differ as to what constitutes a good performance, so the body is merely obliged to give information on which those calling to account may base their own personal judgements. See Chapter I.

⁶¹ Depending on whether a soft or hard approach is in use.

compel the remedying of that breach, or to obtain a satisfactory explanation for it. The purchaser's main aim is to overcome any temptation on the part of the provider to behave opportunistically: to pursue its own self-interest instead of complying with the contract's requirements. Where an excuse is offered for a breach, the purchaser may need to test the adequacy of the excuse before accepting it.

This primary goal of effective enforcement brings with it a number of other goals. One is the goal of effective monitoring: to obtain sufficient and accurate information in order to judge the performance of the body being called to account. This involves overcoming two problems. One is the inevitable information asymmetry between provider and purchaser, noted in Part I: that the provider is bound to have more information about its own costs, performance standards and so on than the purchaser. The second, related problem is that particularly where its performance is in breach of the contract's terms, the provider may be tempted to conceal some of that information from the purchaser.

Another goal is effective standard-setting: securing performance in accordance with the standards set will be of little value if the standards are themselves inadequate. The standards must reflect the specific goals of the accountability process: whether it is designed to secure improvements or to fix a minimum level of performance, for example. Unlike some other callers to account,⁶² NHS purchasers were able to set their own standards in addition to interpreting and

⁶² See Chapter I.

applying central standards, and to combine both minimum and more challenging terms in their contracts. Purchasers' ability to set the standards they perceived to be in the public interest was an important indicator of the effectiveness of their work. This involved overcoming the provider's resistance to particular standards, in order to obtain its agreement to them, and testing the provider's claims that particular standards could not be met, in order to ensure that they were genuine. In extreme circumstances, as we saw above,⁶³ it might require the purchaser to be able to impose standards on the provider, against its will, where the purchaser doubted the provider's excuses and believed that the standards were in the public interest.

In Chapter I, we explained that the caller to account would need to have the upper hand in the accountability process, in order to make that process effective and to counteract any resistance from the body being called to account (Day and Klein 1987). It is at this stage that our discussion links to the analysis, in Part I, of NHS purchasers' bargaining power. Superior bargaining power on the part of the purchaser might be sufficient to oblige the provider to assent to the purchaser's preferred contract terms and to comply with the contract.⁶⁴ This is because 'superior bargaining power' implies that the provider's desire to retain the purchaser's goodwill and custom is greater than the purchaser's desire to contract with the provider, and that the purchaser's demands are backed by threats (usually

⁶³ See Hypothesis 2.

⁶⁴ Arguably, the provider is under greater pressure to comply with the contract because it is under an obligation to do so (rather than, or as well as, being obliged) in Hart's (1994) sense. But this depends both on one's conception of the nature of contractual obligation (economic theories of contract give it no weight where performance would be inefficient: Goetz and Scott (1980)) and upon one's view of whether the legal system has a direct or indirect role to play in the enforcement of contracts (a matter on which socio-legal scholars have differed: compare Macaulay (1963) with Deakin *et al.* (1997)).

of exit) of which the provider is afraid.⁶⁵ This would render the purchaser's accountability process effective. But one of the difficulties with contract as a mechanism of accountability is that it does not guarantee that the purchaser will have the upper hand. Any distribution of power is possible. Moreover, as we saw in Part I, there was reason to believe that the NHS purchaser's bargaining position would be weak. The NHS 'internal market' might not be fully competitive. The purchaser's position was further weakened by problems with the 'legal' remedies available to it, and by the likelihood that the provider would have superior expertise.⁶⁶ This gave rise to our prediction that purchasers might not succeed in instituting an effective accountability process.

The second limb of our hypothesis brings the hard and soft models into the discussion. It was formulated as follows:

Where it could be fully implemented, the soft model was likely to be a more effective method than the hard model for the performance of the accountability tasks.

This reflects the claim often found in the literature that the soft model is likely to be more effective than the hard model. Although the soft model requires a substantial initial investment of time and effort in order to build a close and trusting relationship, it is perceived as a more effective alternative to the endless specifications, checking and sanctions of the hard model (for example, Sako

⁶⁵ Hart's (1994) sense of 'being obliged'.

⁶⁶ See Chapter VI.

1992). Such arguments are particularly common where the parties face severe difficulties in implementing the hard model (see Williamson 1979). For example, in a longer term contract, in which it is particularly difficult to provide for every eventuality in advance, it may be preferable to build a trusting relationship in which standards can be negotiated as the need arises (Macneil 1974).

But there is an important caveat in the formulation of the hypothesis, above. The soft model was expected to be more effective ‘where it could be fully implemented’. As we saw in the discussion of the models above, ‘full implementation’ of the models requires the purchaser to have superior bargaining power. Where that superior power is absent, the purchaser may still behave in persuasive or adversarial ways, but any failures to achieve its goals are more likely to be attributable to its weak bargaining position than to any flaw in the strategies suggested by the models themselves. Our ability to assess the relative effectiveness of the models was limited by the findings under the first limb of the hypothesis: that NHS purchasers were not always in the required bargaining position in order to implement the models properly.

For Hypotheses 1 and 2, it was possible to draw a relatively clear distinction between analysing and evaluating the data. For Hypothesis 3, such a distinction was impossible. To state, after analysis, that an accountability process was ineffective, was also to condemn it. The evaluative principle at work is uncontroversial and does not require explicit justification:

The good accountability process is effective. The caller to account should have sufficient authority to ensure that the process meets the general goals of making the relevant body accountable, and any more specific goals relevant to that particular accountability process.

This uses the same notion of effectiveness discussed above,⁶⁷ and highlights the need for an appropriate distribution of power in order to give rise to the required obligation on the part of the body being called to account. The concluding section of Chapter VI draws together the evaluative threads of the chapter, and assesses whether purchasers (as callers to account) and central government (as the designer and regulator of the contracting system) could have done more to strengthen purchasers' bargaining positions, and thus their ability to operate an effective process of accountability. Although this discussion relates closely to the NHS data, it is also a source of ideas of more general interest for the emerging notion of the 'public law contract'.⁶⁸

⁶⁷ The general goals of accountability were described above; the specific goals of NHS purchasers are explored in Chapter VI.

⁶⁸ See n. 39, above.

IV

Hypothesis 1: Pressures and Constraints

The choices that purchasers needed to make when shaping the accountability process were affected by the pressures (from 'onwards' accountability mechanisms) and constraints (of time, resources and skill) purchasers faced.¹

We saw in Chapter III that NHS contracts had a wide range of potential uses as mechanisms of accountability. Purchasers could conceivably set standards on any aspect of a provider's performance, and employ a variety of standard-setting, monitoring and enforcement approaches.² In practice, however, purchasers would select some topics on which to call providers to account, and some techniques to use in carrying out the various tasks involved in the accountability process. In choosing these topics and techniques, we predicted that purchasers would be influenced by pressures and constraints. Drawing on the literature and on pilot interviews, we identified three of the most important factors:

- pressure from onwards accountability mechanisms, particularly to central government
- constraints of time and resources
- constraints of skill and knowledge

¹ Chapter III.

² Assuming that providers could be persuaded to agree with them: see Chapter VI.

This chapter tests the hypothesis against the empirical data collected during the study. It will be shown that all three factors listed above were of assistance in explaining purchasers' choices of topics and techniques. Pressure from onwards accountability mechanisms to central government was particularly helpful in explaining why purchasers chose finance, waiting times and information as high priorities for the contractual accountability process. But it did not entirely explain fundholders' priorities: they had more discretion to pursue issues of their own choosing. Time and resource constraints primarily influenced purchasers' choices of techniques. Limits on the time available for accountability explained both the neglect of some techniques and the use of various devices intended to save time. Constraints of skill and knowledge were also relevant to the choice of topics and techniques, although they were usually present in conjunction with either or both of the first two explanations.

The findings had significant implications for our emerging notion of the 'good accountability process'. We introduced three evaluative principles in Chapter III to apply to the data. The first principle is concerned with the pressures facing purchasers; the second and third principles with constraints:

- the caller to account should be subject to effective accountability mechanisms to all interested third parties
- the caller to account should be given sufficient resources in order to operate an effective accountability process
- the caller to account should strive to maximise the accountability achieved within the resources available

The second section of this chapter tests the NHS data against these principles of good accountability. It will be seen that on the basis of this study's findings, the system of NHS contracts fell far short of what was desirable on the basis of the first principle: it was not clear that purchasers were adequately accountable to all relevant stakeholders, or that central government was fully accountable for the extent of its influence over purchasers. But purchasers stood up well to scrutiny on the basis of the third principle: they adopted a number of strategies to make the best use of their resources for accountability.³ We will present the study's findings before examining these evaluative issues in more detail.

FINDINGS AND EXPLANATIONS: HOW DID PURCHASERS RESPOND TO THE PRESSURES AND CONSTRAINTS THEY FACED?

Choosing the subject-matter of the accountability process

We predicted that one aspect of purchasers' responses to the pressures and constraints they faced would be to select some issues on which to focus when calling providers to account. Attention would be paid to setting standards on these issues, monitoring performance and enforcing compliance. Such prioritisation was inevitable given the potentially all-embracing nature of the NHS contract as a mechanism of accountability. The empirical study confirmed our expectations.

³ Our evaluation against the second principle is advanced very tentatively below: the study was not designed to provide detailed data on this point.

Purchasers of both types concentrated on the cost and quantity of treatment, waiting times, and the supply of data for contract monitoring.⁴ Our task in this section is to present findings on the subject-matter of the contractual accountability process, and to test whether the explanations suggested in our hypothesis (pressure from onwards accountability mechanisms, constraints of time and resources and constraints of skill and knowledge) were of assistance in explaining them. This will help us to make progress towards our general research goal: to develop a deep empirical understanding of the practicalities of implementing an accountability process. The section is organised using the parties' own descriptions of the issues that were covered or could have been covered - in their contracts.

*Finance and activity*⁵ were clearly the parties' highest priority. Contracts invariably included a clear specification of the price, and some description of the activity to be provided. The description of activity might be more or less precise. 'Cost and volume' contracts⁶ involved complex predictions of the overall number of treatments to be performed, broken down into specific targets for each specialty. 'Block' contracts, by contrast, were much less precise: they gave the purchaser's patients access to a particular facility (an accident and emergency service, for example) without giving guidance as to the quantity of treatment to be provided. (Data quality was one of the most important factors governing the

⁴ Purchasers sometimes expressed a desire to broaden their contracts to include 'neglected' issues, particularly of service quality. Such statements were treated with caution on methodological grounds. They often indicated a sense of embarrassment about the current position rather than a real intention to alter the focus of contracts.

⁵ NHS jargon for 'quantity of treatment'.

⁶ See NHSME (1990a) for a detailed discussion of contract types.

choice of contract type: where accurate activity figures were not available, it was not possible to move from block contracts to the more sophisticated cost and volume arrangements most purchasers and providers preferred.⁷) Attempts to specify the type of activity to be provided were rare. Rather than seeking to define what was meant by ‘orthopaedic services’ or ‘district nursing’, the parties relied on common understandings of these terms across the NHS.

Contracts containing specific activity targets were rigorously monitored and enforced. One Trust manager, pointing to a large file containing the local Health Authority’s contract, said:

And it contains within it a whole load of service specifications, and statements about penalties and incentives...it says things about Patients’ Charter,⁸ it talks about...what kinds of demands for monitoring are going to be made, but the four or five sheets in there which are the key are about the activity levels that we are undertaking to deliver and the cost of that.
(A7T)⁹

All the contracts studied contained obligations to report on the financial progress of the contract on a regular basis, usually monthly, often with the possibility of penalties if the data were late. Fundholders’ quarterly meetings and Health Authorities’ monthly meetings with their main providers were dominated by discussion of activity levels. Purchasers focused on whether the actual activity performed by the provider was ‘on target’, neither more nor less than the level fixed in the contract. The activity level was enforced through a system of refunds from the provider for ‘underperformance’ (not reaching the activity level) and extra payments from the purchaser for ‘overperformance’ (exceeding the activity level). The purchaser might refuse to make extra payments if the provider

⁷ See Chapter V.

⁸ Department of Health (1991; 1995).

⁹ Interview codes are explained in Appendix 2.

exceeded the activity level without seeking its prior permission. Thus, the provider might lose money if it failed to reach the targets, or if it exceeded them contrary to the purchaser's wishes.

Why were finance and activity such high priorities? A number of explanations can be offered. The basic bargain is an important component of any contract: without agreement on what is to be purchased and at what price, there is no contract in private law (Treitel 1995). Empirical studies of contractual relationships have found that the parties usually specify these crucial elements clearly, however informal the rest of their contract may be (Macaulay 1963). In this study, the importance of finance and activity was reinforced by the fact that all the contracts examined were renewals. The parties already had contract documentation from the previous year, which could be recycled, perhaps with some amendments. But because the provider's prices and the purchaser's budget changed from year to year, finance and activity were an area which had to be re-negotiated annually.¹⁰

The care with which finance and activity targets were monitored was not altogether surprising. It was natural that purchasers should wish to ensure that they were 'getting what they paid for'. This sentiment was particularly common among fund managers, who devoted much of their time to querying providers' (often inaccurate) invoices. But there was an important central influence here, too. Purchasers of both types were expected to remain within their annual budgets, and

¹⁰ See also Montgomery (1997*b*).

to achieve certain targets, notably the 'efficiency gain'.¹¹ Health Authorities monitored fundholders, and were themselves monitored by the regional office of the NHS Executive.¹² In order to meet their own financial targets, purchasers needed to ensure that they would not incur unexpected or unaffordable financial liabilities as a result of the contracts they had placed. Providers also had central financial targets to meet: they were under a statutory duty to break even each year and to achieve a return on their assets.¹³ They were as much concerned as purchasers to ensure that the contractual arrangements were clear and carefully monitored. These concerns were reinforced in a climate of financial stringency. At the time of the study, most Health Authorities and some fundholding practices could not afford to pay for more than the contracted level of activity. Providers did not wish to incur expense that would not be reimbursed; purchasers did not wish to incur liabilities they could not meet.

*Waiting times*¹⁴ were purchasers' next highest priority, after finance and activity. All the contracts studied contained terms specifying maximum waiting times for treatment, broken down into times for outpatient appointments and inpatient procedures,¹⁵ sometimes with variations between specialties. But matters were made more complicated by the link between waiting times and finance. To maintain a shorter waiting time in any given year, the provider would have to treat

¹¹ A Treasury requirement that more activity be carried out for the same money as the previous year, or the same activity for less money than the previous year, at a rate of around 2% (NHSME 1990a).

¹² See Chapter II.

¹³ National Health Service and Community Care Act 1990, s. 10.

¹⁴ Compare Audit Commission (1996) for a slightly earlier study of fundholder behaviour on this issue.

¹⁵ Inpatient waiting times were probably a higher priority than outpatient waiting times. This meant that although waits were important in both community and acute contracts, purchasers paid even more attention to them in discussions with their acute providers.

more patients than it would to maintain a longer waiting time. This led to disputes in some cases as to whether the purchaser had funded enough treatments to maintain the waiting time target it had set. For example, Authority A's main local acute provider had performed all the activity agreed in the contract before the end of the financial year. Once the contract had been completed, the provider was instructed to treat emergencies only until the next financial year. This meant that some non-emergency cases waited longer than the contractual target. The Authority was forced to relieve the provider of its liability to pay a penalty for waiting time breaches, because it was itself unable to pay for the extra treatments required to meet the target.¹⁶ By contrast, where a purchaser was well-funded, it would be able to maintain a shorter than average waiting time. For example, some fundholding practices paid providers to offer outpatient clinics on the practice premises. Waiting times usually improved because practices were able to buy enough sessions to meet demand, and because their patients did not have to join the queue of those already waiting to be seen at the main clinic. Thus, waiting time targets were a significant feature of contracts, but had to be understood in their financial context.

Contracts placed by purchasers of both types required providers to report their progress against waiting time targets on a monthly basis. Health Authority staff and fund managers checked these reports for signs of actual or likely breaches, and used contract monitoring meetings to ask the provider to account for problems. Fund managers also dealt with concerns about individual patients' waiting times

¹⁶ There was a dispute about whether the provider had done enough to treat patients nearing the maximum waiting time before the money ran out.

by telephoning the provider. Moreover, the standards were rigorously enforced. Most purchasers began by complaining to the provider and threatening more severe sanctions. All three Health Authorities (and some fundholders) used some form of contractual penalty clause for breaches of waiting times. For example, Authority A's contracts included a fine for each patient waiting longer than the maximum. Partial exit (taking some patients to another provider) was also a possibility. Waiting times were one of the main reasons given by fundholders for a decision to exit. More strikingly, Health Authorities were prepared to use partial exit for waiting times even though their use of that sanction more generally was rare.¹⁷ As one Health Authority manager explained:

We don't want to destabilise any Trust or any relationship, but we do have that ultimate sanction that we have the money, and if they don't agree with us, we've still got the money and we could go somewhere else. And at a very small level, particularly for management of waiting lists, that does happen. If you've got a specialty where the waiting lists are too long, we've got some resources to reduce it and the Trust we normally deal with hasn't got the capacity then we would look to place individual patients in other hospitals on a one-off basis to reduce the waiting list and to start moving the money around a bit.

(B1A)

The severity of the sanctions used to enforce waiting time guarantees was a good indication of their importance.

Why were waiting times a high priority? The role of central government was crucial. Waiting times were a politically sensitive issue. In the Patients' Charter, the government made a much-publicised commitment to achieving and maintaining a set of maximum waiting times across the NHS as a whole (Department of Health 1991; 1995). Prior to the study period, this commitment had been reinforced by extra funding for 'waiting list initiatives', to clear the backlog of patients who had already waited longer than the target time. By the

¹⁷ See Chapter V.

time of the study, the extra funding had been withdrawn, and purchasers were expected to maintain the Charter targets within their normal annual budgets. This was laid down as a priority for the NHS in successive editions of the annual *Priorities and Planning Guidance* produced by the NHS Executive (for example, NHSE 1995*b*). Moreover, it was rigorously enforced through the mechanisms explained in Chapter II: Health Authorities were given a target by their regional office (which might be more stringent than the Charter target) in their corporate contract. They were required to report their performance each month and to agree action plans with providers to remedy breaches. Even Authorities in financial difficulties were expected to meet the targets: Authority A had pleaded with its regional office to be given a more lenient target, but the regional office continued to demand fifteen months for inpatients, three months shorter than the Charter target itself. Fundholders were also affected by these pressures, to some extent. For the reasons given below, many fundholders were able to contract for waiting times well below the Charter maximum, so that the need to keep within the Charter was not a significant concern. But it remained important for those fundholders with less generous budgets. They were obliged to report any patients waiting longer than the Charter maximum to the Health Authority. Most practices wished to avoid the more intrusive monitoring of their performance by the Health Authority which might ensue if they appeared to be in difficulties.

For the more generously funded practices, waiting times remained a high priority even though the central influence was less obvious. A number of the GPs interviewed said that the prospect of improving waiting times had been a major factor in their decision to join the fundholding scheme. This could be interpreted

in a number of ways. One was that fundholding, as a new accountability mechanism, gave GPs the opportunity to call providers to account for this aspect of performance. It enabled GPs to address a long-standing problem over which they had not previously had any control. Another interpretation of GPs' statements was that they believed that fundholding would increase the amount of money available to be spent on their patients (compared with that spent on behalf of non-fundholders by the Health Authority). The data suggested that some practices had very generous budgets, making it financially possible for them to maintain very short waiting times. For example, one of the more active fundholders in Area B was working to a three-month target for all procedures, which compared favourably with an average of between six and nine months for other fundholders and between nine and twelve months for the Health Authority at the time of the study. Furthermore, there was evidence that many providers offered shorter waiting times to fundholders in order to retain their custom, fearing the use of partial exit noted above.¹⁸ But there is one important caveat here, which emphasises the extent of fundholders' discretion in respect of waiting times. Some practices were concerned about the development of a 'two-tier' service, in which fundholding patients were given priority over Health Authority patients. More general concerns were also expressed about the danger that the target might lead to the treatment of patients with minor ailments (who were nearing the target time) over patients with more urgent conditions. These fundholders chose not to strive for below average waiting times and did not enforce the contractual target rigorously where the provider had a good explanation for a breach.

¹⁸ See Chapter VI.

Finance, activity and waiting times were thus the highest priority issues addressed by the contracting process. But these did not exhaust the parties' concerns. As noted above, purchasers of both types were concerned with the timely and accurate *supply of data* from providers, particularly on activity and waiting times. Both Health Authorities and fundholders addressed data issues in meetings with providers, complaining if activity reports or invoices were late, incomplete, or apparently inaccurate. All three Health Authorities' contracts included penalty clauses for late activity and waiting list data, and Authorities A and C had invoked them on several occasions. Fundholders made less use of penalty clauses, but did place reliance on a national rule that there was no obligation to pay invoices that arrived more than six weeks after the end of the month in which the activity occurred (NHSE 1993). Some practices would routinely refuse to pay these invoices; many would do so occasionally, when a provider's record was particularly bad. This focus on the supply of data was closely linked to the fact that waiting times and activity were substantive priorities. Without adequate data, purchasers could not monitor and enforce the standards they had set on these issues. The supply of data therefore became a priority itself.

Purchasers of both types tackled some *service quality* issues in contracts. Very broadly, quality standards may concern inputs (the structural features of a service, such as staff or facilities); processes (the way in which the service is delivered);

and outcomes (whether the service achieves its goals) (Donabedian 1980).¹⁹ We will examine Health Authorities' approaches to quality first. All three Authorities' contracts contained large sections entitled 'quality'. The standards set concerned inputs, such as the number of trained nurses per shift, and processes, such as ensuring that outpatient clinics ran to time. They addressed the patient's experience in hospital, but rarely examined outcomes or any other aspect of the quality of the clinical care provided. All three Authorities required providers to supply quarterly or annual reports on their performance against quality standards, although only Authority C's contract contained a penalty clause for late reports. At the time of the study, Authority C was conducting a programme of regular site visits to providers to monitor quality issues, and Authority B was conducting occasional visits in a much less systematic way. Providers had noticed the decline in quality monitoring:

Certainly over the last twelve, eighteen months, they seem to spend far less time visiting and talking to us. You know, before, they used to phone three or four times a week, whereas now you often go three or four weeks without hearing from anybody.
(C6T)

It was apparent from the findings about monitoring in particular that quality issues (at least in terms of inputs and processes) had been a higher priority during the period prior to the study, but were declining in importance when the study took place. Enforcement (where any monitoring took place) was largely through persuasion, although there were some penalty clauses attached to certain easily measured targets,²⁰ such as numbers of cancelled operations.

¹⁹ For an introduction to the controversy surrounding 'quality' in health care, see Morgan and Potter (1995). For discussions of 'quality' in the public sector generally, see, for example, Gaster (1995); Kirkpatrick and Martinez Lucio (1995).

²⁰ These targets were derived from the Patients' Charter, discussed further below.

The focus on inputs and processes reflected, once again, the influence of central government. The Patients' Charter set a number of standards of this nature, including requirements that hospitals should signpost departments clearly and that staff should wear name badges.²¹ Authorities had been encouraged to adopt and elaborate upon these standards in their contracts, developing 'local' Charters in conjunction with providers. This gave purchasers some discretion: Authority C had used the Charter requirement that services should be accessible to everyone in order to set standards on accessibility for ethnic minorities, a central concern in its area, even though this was not mentioned in the Charter itself. The standards reflected the consumerist approach of the Charter initiative: part of its aim was to challenge a perceived lack of 'customer orientation' on the part of professional providers.²² The approach also fitted with the background and skills of many Health Authority quality managers. This was reflected particularly clearly in Area B. Here, the Authority had devised its own quality standards with less emphasis on the Charter. The standards covered inputs and processes, rather than outcomes or clinical issues, largely because the managers involved in drafting them were from a nursing background. They had a strong professional interest in the patient's experience of a hospital stay.

The declining importance of these standards could be explained in several ways. One reason was that the initial momentum of the Patients' Charter initiative had dissipated by the time of the study, five years after its initial publication.²³ a

²¹ National 'league tables' were used to publicise performance: see NHSE (1998).

²² Chapter I; Willett (1996).

²³ With the exception of waiting times (a Charter requirement but usually handled separately from other quality issues).

routine system of reporting on performance was in place, and everyone was aware of its requirements. Even for the NHS Executive, it had become a ‘baseline requirement’, taken for granted, rather than a current priority (NHSE 1995*b*). Another reason was that prior to and during the study period, Authorities were under pressure to reduce their management costs. Partly because quality issues were receiving less attention from the centre, Authorities had targeted their quality departments when making cuts. Authority B, for example, had reduced its quality team from three full-timers to two part-timers with other responsibilities. Finally, some of the standards were controversial. This made it more difficult for quality managers in both Health Authorities and Trusts to insist on them in the absence of a strong central impetus. It was argued that the focus on easily measured process issues neglected or even conflicted with more difficult, but arguably more important, clinical quality issues. One consultant summed up the issue in this way:

On the one hand, you could say that those are superficial, sort of just putting a gloss on the provision of the service; other people might say well, that’s the most important thing - you know, if you go to your general practitioner, however good a doctor he is, if he’s got a terribly scruffy, dirty waiting room and a receptionist who’s rude, however brilliant he is when you come to see him, that isn’t a quality service.
(A11T)

Many clinicians, and even some quality managers, had taken the view that the standards were superficial. These various factors meant that the quality sections of Health Authority contracts had become, to some extent, ‘dead wood’ by the time of the study.

Fundholders also had an interest in *service quality* issues.²⁴ Their approach differed in many ways from that of Health Authorities. Their contract documents

²⁴ Compare Audit Commission (1996) for a slightly earlier survey of fundholders’ approaches to quality standards.

were much shorter, containing a handful of key quality standards rather than a large quality section. There was some variety in the issues pursued by practices: one practice in the sample was attempting to persuade providers to send all correspondence on A5 paper,²⁵ a concern not shared, or at least not expressed, by any other practice. But there were common elements too: a number of the contracts studied contained requirements that patients should be seen on their first or second visit to outpatients by the consultant rather than by junior staff, and that patients should be given a supply of drugs when discharged. Most strikingly, GPs in all three areas had as their main priority the improvement of communications from hospitals. Contracts were used to set deadlines for the receipt of letters from consultants, detailing the treatment given to each patient seen either as an outpatient or an inpatient. The letters were essential to enable GPs to continue the patient's care appropriately on discharge. Moreover, GPs had an effective means of enforcing this requirement. The clinical letters were used to check the provider's invoices. Practices would refuse to pay invoices, at least in part, until letters had been sent evidencing all the treatment detailed on the invoice. One fund manager highlighted the change this had brought about:

Because these queries have been raised and GPs are saying, well, we're not paying for that until we've got a letter, it's made consultants really have to make sure they're communicating with GPs, so you're getting a lot more clinic letters.

(C9F)

This approach reflected GPs' pragmatism about the contracting process. They were wary of setting standards that could not be monitored or enforced. Even the most ambitious practices refused to set standards about the patient's experience in hospital, for example, because they would be difficult to monitor. Enforcing the

²⁵ To make it easier to file correspondence with patients' notes.

Patients' Charter was left largely to Health Authorities. Moreover, practices preferred to concentrate on a few realistic targets, waiting until some had been achieved before adding new ones. They were sceptical about the large quality manuals drafted by Health Authorities, and of Authorities' failure to link the standards set with clear monitoring and enforcement arrangements. Furthermore, GPs' quality standards reflected their own sense of priorities. Central government did not dictate that GPs should set standards on communications. They chose this issue for themselves. Fundholding gave GPs the chance to call providers to account for the inconvenience poor communications could cause. It is important to note, however, that some GP priorities in this area were partly generated by the NHS reforms themselves. The requirement that patients should be given a supply of drugs on discharge was, of course, important in terms of patients' well-being and convenience. But it also had financial implications: if providers breached the requirement, they could shift a cost onto GPs. The need to prevent 'corner-cutting' arose in part because both contracting parties were more aware of the financial implications of decisions. This led to an increasing specification of their respective responsibilities, discussed further in Chapter V.

These findings highlighted one obvious omission: *clinical quality*. Neither Health Authorities nor fundholders tackled this in a systematic way. Some effort was made by purchasers of both types, in response to the worsening financial climate, to make savings by eliminating the purchasing of particular procedures of doubtful clinical effectiveness, such as the removal of asymptomatic wisdom teeth. Health Authorities also made some use of standards 'parasitic' on providers' own accountability processes, which required providers to have complaints

procedures and medical audit systems in place, and to report their results on a regular basis (NHSME 1990a). But contractual quality schedules did not contain sets of standards about outcomes or even the process aspects of clinical care.

At first sight, this omission seems surprising, given the obvious importance of clinical quality in any evaluation of health care provision. But purchasers were given little central encouragement to tackle clinical issues, apart from the mention of ‘parasitic’ standards in the early guidance (NHSME 1990a).²⁶ Moreover, and perhaps most importantly, purchasers knew that clinical issues were addressed through other accountability processes. This was reflected in Health Authorities’ active, and fundholders’ passive, reliance on these other mechanisms. Even the more assertive fundholders in the sample saw their role as largely confined to non-clinical quality:

I think we should be using the power of purchasing to make sure that the quality is being improved and that people are being treated better as they go through - not treated clinically; I think clinically there’s good quality all over the place, but treated as people better as they go through the system. (C5F)

Even if purchasers had wanted to set clinical standards, they would have been subject to a further constraint. Neither GPs nor Health Authorities could match providers’ clinical expertise. GPs had general clinical knowledge, and Health Authorities might be able to obtain some assistance from their public health departments,²⁷ but this did not necessarily give them the confidence to tackle clinical issues. As one consultant put it:

I don’t think most of the GPs have any idea about whether treatment... is up to national guidelines: I don’t think they have time to read about guidelines in particular specialties, when you

²⁶ And with the exception of the very broad health improvement targets set out in Department of Health (1992), which were too general to be of much assistance in contracts.

²⁷ Their enthusiasm for the contracting process varied: the public health department in Authority B gave almost no assistance to contract managers, whereas Authority A’s director of public health was heavily involved in contract negotiations.

consider the breadth of work they have to cope with. You'd have to be a superman to keep up with what the guidelines were.

(B14T)

Finally, the use of contracting to address clinical standards would have been politically controversial, because of the challenge it would have posed to the medical profession's right to regulate itself (Allsop and Mulcahy 1996).

We have seen that the contractual accountability process tended to focus primarily on finance and activity, waiting times and the supply of information. All three of our possible explanations - time and resource constraints, limitations on skill, and the influence of accountability to central government - were useful in interpreting the findings. Accountability to central government stood out as the most important of the three, but with one important caveat. It applied more strongly to Health Authorities than to GP fundholders, with the latter having more discretion to pursue their own priorities.²⁸ The data on Health Authorities showed the extent of the impact a strong onwards accountability mechanism could have on a caller to account's behaviour, and the importance of acknowledging the central government role in Health Authorities' purchasing.²⁹ The data on fundholders showed how practices identified their own concerns and balanced their pursuit of those concerns with central priorities (cf. Audit Commission 1996). Finally, the findings highlighted the fact that setting substantive priorities, in response to pressures and constraints, was a key practical concern in the implementation of the accountability process.

²⁸ Other studies focusing on central influence have concentrated on Health Authorities: Hughes *et al.* (1996); McHale *et al.* (1997).

²⁹ See also Hughes *et al.* (1996; 1997); McHale *et al.* (1997).

Before we move on, it is worth pausing to note one respect in which these findings will be of relevance in later chapters. In Chapter III, we identified comprehensive contracts with the hard model of contractual relationship, and contracts that used broader standards and did not seek to address all issues in detail with the soft model. Our findings on priorities showed that most purchasers omitted a range of issues from the contractual accountability process. Does this mean that they were adopting the soft model? The answer is not entirely clear. Although much was omitted from contracts, this was not done with a sense that the gaps might be filled in at a later stage during negotiations between the parties. Instead, they were issues that the purchaser either had not thought about or had no intention of addressing through the contracting process. This type of ‘passive’ omission may not be what is meant by writers on the soft model. This is discussed fully in Chapter V, in which further evidence is presented. The evidence on priorities is inconclusive.

Choosing techniques for performing the accountability tasks

This section aims to introduce a second group of instances in which purchasers made choices as to the way in which they would call providers to account. Whereas the examples given above related to specific topics, and demonstrated the way in which some topics were a high priority while others were neglected, the examples in this subsection are less closely linked to subject-matter. Instead, they examine purchasers’ choices among the various techniques for the performance of the accountability tasks of standard-setting, monitoring and enforcement. For example, monitoring might be carried out in a variety of ways: through reports

from the provider, meetings, or visits to the provider's premises. Our focus is on whether the purchaser's choice of techniques was influenced by pressures (from accountability to central government) or constraints (of time or skill). Of course, there are some links between this discussion and substantive priorities, and these will be noted below, but many of the concerns raised applied regardless of the subject-matter at issue. We will see that all three of the factors identified in the hypothesis were helpful in explaining purchasers' approaches to the various accountability tasks.

Time and resource constraints were an important consideration in understanding purchasers' approaches to the monitoring element of accountability.³⁰ For example, some purchasers drew a distinction between standards that could be monitored during the day-to-day operation of the contracting process, and standards that required 'active' monitoring through special procedures. We have seen that fundholders often set standards requiring prompt clinical letters from providers. It was easy to monitor whether or not the letters had arrived: fund managers used them for routine checks on invoices, as explained above. But monitoring whether or not they had arrived within the deadline was more difficult. Extra effort was required to record the date of receipt of each letter and to compare it with the date on which the patient was discharged.

A fund manager explained:

But things like monitoring are we getting all the letters within fourteen days, without doing a real sort of in-depth exercise, taking time out and doing it, and as I say, we could do it for a week or a fortnight and see what we get, it would just be too - you'd just need another person doing it, whole time, to actually do it.

(C9F)

³⁰ Time and resource constraints were also relevant to contract negotiations, addressed in the discussion of skill and knowledge, below.

Thus, a distinction was drawn between contract monitoring that was coincidental to the fund manager's daily work, and monitoring that required extra time and effort. In this case, constraints on time and staffing meant that the standard was not routinely or even occasionally monitored.

A number of interviewees emphasised the amount of effort involved in certain methods of active monitoring. This could deter purchasers from using such methods. Site visits were an illustration of this problem. Visits made a number of demands on the staff involved: for example, there was a need to decide which services to inspect and which standards to monitor, to set aside time to conduct the visit, and to produce a report for the provider and other Health Authority staff. As we saw above, the quality managers in Area B were finding it difficult to continue with a programme of visits after substantial staff cuts. Of course, visits were designed primarily to monitor quality standards, which were themselves declining in importance, but nevertheless, the amount of effort involved in this monitoring technique was a factor in its neglect.³¹

But perhaps the most interesting evidence of the role of time and resource constraints in explaining purchasers' choice of accountability techniques was to be found by examining the 'time-saving' devices they adopted. In our examination of clinical quality issues above, we mentioned the possibility of relying on other accountability mechanisms to save time. Purchasers could also rely on, or work

³¹ We will see in Chapter V that the neglect of visits affected purchasers' ability to implement to the full either the hard or the soft approach to accountability. The hard model required cross-checking with several different information sources, and the soft model required sustained contact with the provider in order to build close relationships. Visits could support either of these goals.

with, other purchasers. One of the main time-saving methods for Health Authorities was the 'host purchaser' concept, introduced by the government's early guidance on contracts (NHSME 1990a).³² The idea was that each provider's local Health Authority (its host purchaser) would take primary responsibility for negotiating and monitoring detailed contractual terms (on quality standards, waiting times and so on) with that provider. Neighbouring Authorities would adopt these standards in their contracts, to make compliance less complex for the provider, and to reduce negotiating costs. Authorities' reliance on their neighbours' contract documents was relatively passive: they did not attempt to influence their content or to check that they were being monitored. Even if an Authority disapproved of its neighbours' standards, providers viewed the host purchaser arrangement as compulsory and were unlikely to make an exception to it. Authorities A and B welcomed the opportunity to save time. Authority C did not: its urban location meant that its contracts with neighbouring providers used a much higher proportion of its budget than did those for the other two Authorities in the sample.³³ Contract managers expressed some frustration at their inability to negotiate in detail with these providers.

For fundholders, the main time-saving device was the local fundholding group. The most developed group approach in the sample was in Area A. Most of the GPs in the area were members of the group, which appointed a team of representatives to work with each of the main local providers. The representatives

³² The guidance uses the term 'primary client' instead of 'host purchaser', but the latter was the usual expression among interviewees.

³³ Very roughly, Authority C's biggest out-of-county contract was worth 20% of its main local acute contract, whereas Authority B's biggest out-of-county contract was worth 2% of its main contract.

negotiated basic contract documentation, including quality standards, and various elements of the contract price, including the contract types (block, cost and volume, etc.) to be offered, and the percentage price change from the previous year. Individual practices could then negotiate their own activity levels (and any special requirements) within this deal, or negotiate their own contract outside the group arrangement if the provider permitted it. During the life of the contract, the representatives met regularly with the provider to monitor overall activity levels and to discuss any problems raised by practices, such as breaches of quality standards. These arrangements did not always run smoothly: practices often disagreed on particular issues which arose in negotiations with providers, and more fundamentally, as to the appropriate role of the fundholding group. But most acknowledged that it saved time, and that it enhanced their bargaining power in negotiations with providers, an important point to which we will return in Chapter VI.

Despite these advantages, joint approaches were not as well established as one might have expected. In Area B, for example, joint working between fundholders had shown much less impact than in the other areas studied. In part, the market rhetoric of the reforms was to blame: initially, purchasing had been portrayed as an individual activity (Department of Health 1989). Fundholders in particular would be able to pursue the interests of their own practice without regard to other considerations, and reforms making it easier for patients to change doctors suggested that competition between purchasers was intended (Department of Health 1989). As time went on, both purchasers and central government had come to the realisation that collaboration would save time (NHSE 1994). Nonetheless,

purchasers' comments on effort-saving devices sometimes had a confessional element: it was feared that they might be seen as a sign of weakness rather than as the most rational use of resources. As one fund manager put it:

But we do a lot of work on the [activity and finance], which in a way is where the real meat is. Because quality issues, they've got to declare it on their Patients' Charter reports,³⁴ and the Community Health Council³⁵ jumps up and down on them anyway, so to a large extent we're a little bit lazy, and we let them do that.
(A12F)

Arguably, the fund manager was entirely justified in concentrating on issues unique to the practice, and refusing to duplicate other accountability mechanisms. But he was aware that the impetus for time-saving had come from purchasers, rather than being sanctioned by the centre.

Constraints of *skill and knowledge* were also helpful in explaining purchasers' choice of certain methods of performing the accountability tasks.³⁶ Price negotiations were a good illustration of this. They were an important aspect of the contractual accountability process: although they resulted in an obligation for the purchaser to pay the agreed price, they also gave the provider a financial target within which it had to deliver the purchaser's contract, and in an indirect way made it accountable for the cost of the services it provided.³⁷ Health Authorities negotiated on price by examining in considerable detail the provider's 'quantum of costs', which set out all the cost elements the provider intended to include in calculating its prices for the year. Their aim was to ensure that cost increases were kept to a minimum. In part, their willingness to become involved at this level of

³⁴ See NHSE (1998).

³⁵ National Health Service Act 1977, s. 20 and Schedule 7; Community Health Councils Regulations 1996 (SI 1996/640); Montgomery (1997a). See Chapter II.

³⁶ Limits on skill and knowledge decreased over time, as purchasers became more experienced, but this did not necessarily give them an advantage, since providers shared a similar learning curve.

³⁷ For analysis, see the discussion of 'implicit standards' in Chapter II.

detail was explained by the fact that they had teams of finance and contracting staff who had the necessary skills to evaluate the data supplied by the provider.³⁸

Fundholders, by contrast, were much less likely to look at the detail of the provider's costs. Instead, they examined the overall percentage price change from the previous year's contract, and challenged the provider if a substantial increase was involved.³⁹ They lacked both the time and the expertise to become involved in detail:

They say where are we going to save the money from, and unless you spend a year or two years in there, doing an in-depth analysis, you couldn't tell them.

(A14F)

The fundholding group in Area A was experimenting with a novel approach to this problem at the time of the study. It had employed a part-time advisor with expertise in information to scrutinise data from providers on behalf of practices. By pooling their resources, practices had been able to 'buy in' the expertise they needed. But this strategy was obviously limited by resource constraints. The relevance of skill and knowledge was reinforced by the fact that where fundholders did feel they had some expertise, they were prepared to use it. Fundholders in Area A had challenged the community Trust over the proportion of the price paid to the Trust that was spent on management. They were supported by the Health Authority, but had taken the initiative themselves. Most practices employed nurses themselves ('practice nurses') and felt that the presence of a large Trust management structure to oversee the work of district nurses, health visitors and so on was unnecessarily bureaucratic. The Trust's managers

³⁸ The approach is further analysed in Chapter V, in terms of the hard and soft models of accountability relationship.

³⁹ See further Chapter VI.

questioned whether GPs understood fully what was involved in providing the service:

If you are buying something then you've got a perfect right to know what you're getting for it, but I still feel that perhaps the degree of probing largely happened because they were not aware of the complexity of the arrangement, that all they saw was what seemed to be - what is a large sum of money for a big block of service, and didn't or don't appreciate what it actually takes to provide that service, in general terms.

(A16T)

Nevertheless, because the GPs themselves felt they had some expertise, they were more willing to become involved in questioning the Trust's costs in some detail.

Our third factor affecting purchasers' choice of methods was the influence of *onwards accountability processes*, particularly to central government. This factor applied primarily to Health Authorities, and affected which model of the contractual accountability relationship - hard or soft - they adopted. (The models were introduced in Chapter III.) Many aspects of Health Authorities' circumstances, particularly the likelihood that they would be in long-term relationships with their providers, suggested that their contracts ought to fit the soft model. Moreover, Authorities used some soft methods, such as broad standards and persuasive enforcement. But where Authorities were to be called to account by the NHS Executive for their performance in a particular area, they were more likely to adopt the hard approach.⁴⁰ For example, waiting times were rigorously enforced through penalty clauses and even partial exit, rather than through persuasion as dictated by the soft model. This reflected a number of concerns among purchasers. They felt a need both to use all possible means to ensure that providers complied with central standards, and to be seen to be using

⁴⁰ Sometimes, the centre did seek to promote collaboration, but we shall see in Chapter V that the main example of this (in price negotiations) continued to involve overriding hard elements.

those means. They turned to stringent, formal methods because they did not wish to be criticised by the regional office. This issue will be explored in full in Chapter V, in our discussion of the hard and soft models.

Once again, all three elements of our hypothesis helped to explain purchasers' choices of particular methods of approaching the accountability tasks. Of the three, time and resource constraints were probably the most significant. They explained the neglect of some activities which were perceived to be time-consuming, and also accounted for the widespread use of 'effort-saving' devices. This acts as an important reminder of the need to ensure that any prescriptions we make for callers to account are realistic. Implementing an accountability process is itself a difficult and time-consuming task, and we should moderate our expectations accordingly.

Conclusion

Purchasers' choices of topics and techniques for their contractual accountability processes were affected by pressures from onwards accountability mechanisms, and by constraints of time, resources, skill and knowledge. We have learnt that Health Authorities were most clearly influenced by central government, selecting their substantive priorities and their model of the contractual accountability relationship in the light of their onwards accountability. Fundholders had more discretion on priorities: they seized their new opportunity to call providers to account in order to address long-standing grievances about service provision.

Nonetheless, purchasers of both types pursued the same issues - activity, finance, waiting times and data - with vigour. Time and resource constraints were most obvious when we examined the accountability techniques chosen by the parties. This factor showed their limitations - Authorities' rejection of site visits as too time-consuming, for example - and their strengths. Purchasers themselves found innovative ways of calling providers to account with the minimum of effort. Purchasers' skills tended to limit their activities, discouraging both types from pursuing clinical quality, and fundholders from pursuing detailed financial scrutiny, although we saw that the other factors also helped to explain these choices. Our understanding of the practicalities of an accountability process has been advanced considerably by these data. We have seen that calling to account can be interpreted as a series of choices made by a caller who is pushed and pulled in different directions, constantly prioritising and never able to do everything that accountability might ideally require. This sense of the difficulties of the caller's world will act as an important constraint upon our pursuit of the notion of the good accountability process, to which we will now turn.

EVALUATION: PRESSURES AND CONSTRAINTS IN THE GOOD ACCOUNTABILITY PROCESS

It is important to make clear at the outset that our notion of the good accountability process does not require that the caller to account should seek to address every conceivable issue with equal vigour, or to use every imaginable method for evaluating or enforcing performance. Some selection, of both issues

and techniques, is inevitable. There are, however, several ways in which the caller to account's choices, and the factors influencing those choices, can be evaluated. This section applies three evaluative principles to the NHS data, one relating to pressures and two to constraints. The principles were introduced in Chapter III, and were formulated as follows:

- the caller to account should be subject to effective accountability mechanisms to all interested third parties
- the caller to account should be given sufficient resources in order to operate an effective accountability process
- the caller to account should strive to maximise the accountability achieved within the resources available

We will explore the implications of these principles for the 'public law contract' in the conclusion.

The caller to account should be subject to effective accountability mechanisms to all interested third parties.

We have seen that central government and the public (in various capacities) had a legitimate interest in purchasers' activities. The central government interest was realised in the form of an accountability process from purchasers to the centre, via the regional offices of the NHS Executive for Health Authorities, and via Health

Authorities for GP fundholders.⁴¹ But one of the criticisms of the NHS reforms was that they did nothing to enhance the influence of the public over decision-making.⁴² Purchasers of both types were directed to consult on their purchasing plans,⁴³ but the study found no evidence of purchasers altering their plans as a result of the views expressed. Moreover, consultation was not a well-established feature of the contracting process: fundholders were not likely to engage in formal consultation (although they did become aware of some patients' views during the normal course of their work), and Health Authorities⁴⁴ approached it with varying degrees of enthusiasm.⁴⁵ This meant that a significant interested group was unable to call purchasers to account for their activities. What effect did this have on purchasers' choices?

For Health Authorities, the answer to this question was simple. Without accountability to patients, the only strong accountability mechanism to which they were subject was to central government. They therefore pursued central priorities with vigour, and gave only limited consideration to local needs when doing so. Their response to local needs tended to be confined to situations in which those needs complemented central requirements. For example, we saw above that Authority C's quality managers had worked on the accessibility of services to ethnic minority patients, in the light of an accessibility requirement in the Patients'

⁴¹ See Chapter II.

⁴² Chapter II, Longley (1990; 1993).

⁴³ Department of Health (1994) for Health Authorities; NHSE (1995a) for fundholders.

⁴⁴ Health Authorities' boards might also have provided some representative input, through their non-executive membership. But the reforms made boards less representative of local communities, by using 'business experience' as the main criterion for appointment (see Ferlie *et al.* 1996). In any event, their effectiveness has been shown to be limited (Day and Klein 1987; Ferlie *et al.* 1996).

⁴⁵ For critique of the position of Community Health Councils in the consultation process see Longley (1990; 1993).

Charter which referred to a variety of groups other than minorities, such as the elderly and disabled. The area had a relatively high proportion of ethnic minority residents and this was therefore an important local concern. By contrast, managers in Authority B felt unable to question or disobey a central requirement which was inconsistent with local needs. They were forced to spend more money on paediatric intensive care because of a national initiative, even though local provision was felt to be adequate and there was an ongoing programme of investment to ensure that the facilities were maintained:

I don't think our consultants here or us as purchasers would necessarily see paediatric intensive care as something we should be immediately putting more resources into. But we will be instructed that these services will be developed, therefore we will be expected to make a contribution towards the development of these services.

(B1A)

Where local needs posed a challenge to central requirements, they were not pursued. Stronger local accountability would have given greater legitimacy to Authorities' claims to represent local needs, and might have encouraged them to make such a claim more vociferously. This would have given them a role beyond that of simply acting as the agents of central government.

For fundholders, the position was rather different. They were one step removed from central government influence, in that central requirements were passed to them through the local Health Authority, which tended not to interfere unless a practice was in financial difficulties. As we saw above, practices used their contracts to call providers to account for a variety of issues that affected both GPs and their patients, particularly failures to write to the practice explaining the treatment given to patients during a hospital stay. This issue obviously improved the service offered to patients, by ensuring that their treatment could be continued

appropriately. But communications standards were GPs' priorities: they were not set in consultation with patients, and made GPs' lives easier as well as improving patient care. By contrast, one practice which had done a patient survey was turning its attention to a variety of standards about the process of inpatient and outpatient care, responding to criticisms made by patients about their experiences in hospital. Of course, such issues would be harder for GPs to tackle through contracts, because obtaining information for monitoring would be more difficult. But by the time of the study, it seemed that at least some practices ought to have moved on to these more challenging issues. A more formal and systematic accountability process to the public would perhaps have helped to prompt such a movement. Moreover, it would have brought the reforms more closely into line with the patient-centred rhetoric surrounding their introduction (Department of Health 1989; Hughes 1991).

Implementing purchasers' accountability to the public as well as to the centre would have brought its own difficulties. In particular, there would have been a need for guidance as to how conflicts between the demands of the various stakeholders were to be resolved (cf. Day and Klein 1987: 18). If central accountability was to 'trump' local accountability on all occasions, local accountability would have been devalued. Allowing local accountability to 'trump' might not have been acceptable: it was important that purchasers should be accountable to the centre for their financial performance, given that taxpayers' money was at stake, and for the procurement of services that met certain standards, given that some minimum standards were considered necessary across the service as a whole (Department of Health 1991; 1995; NHSE 1995*b*).

Moreover, as we have seen, the government was accountable for the NHS through political channels, and needed to maintain some control over performance at the local level in order to make such accountability meaningful. In a dual system, it would have been necessary to keep central guidance to a minimum - a notoriously difficult requirement⁴⁶ - in order to leave some space for local accountability to operate.

Despite the practical difficulties, the case for local accountability was certainly arguable on principle. Without it, an important group of stakeholders was denied a voice in the purchasing process. The case of purchasers and the public helps to highlight the importance of effective accountability mechanisms. Purchasers knew that they acted on behalf of patients and local communities, but did not seek to represent them in a formal way because there was no *obligation* to account to them.

Purchasers' accountability to the centre, although much more rigorous than their accountability to the public, was not without problems, as we noted in Chapter III. The accountability process from purchasers to the centre was insufficiently transparent. This cast doubt on whether the centre would be fully accountable for its influence: it was difficult for those calling the government to account to discern the extent of its role in purchasers' decision-making.

Throughout the study period, the NHS was a politically sensitive issue. The experiences of particular patients or hospitals due to shortages of beds in specific

⁴⁶ The problems of delegating power to semi-autonomous bodies were discussed in Chapter II.

areas such as paediatric intensive care, or more generally during the winter months, were given a high profile in the media,⁴⁷ forcing government to respond with promises of extra resources and greater managerial effort to address the difficulties. Towards the end of the study period, the general election campaigns of the major political parties focused on NHS issues, notably waiting lists or waiting times, and management costs (Webster 1998). The government was also subject to the usual channels of parliamentary accountability for the NHS, although these have some well-documented weaknesses (for example, Oliver 1991).

But this general political accountability did not necessarily mean that central government was clearly accountable for its influence over purchasers. Critics of the 'new public management' have argued that the apparent delegation of authority to semi-autonomous bodies, such as agencies or NHS purchasers, could be misleading (Bruce and McConnell 1995; Foster and Plowden 1996). In relation to the nationalised industries, for example, the government undermined the formal freedom of the industries with a stream of informal guidance. This allowed it to control their actions without being fully accountable for its influence: when problems arose, it could evade responsibility by reference to their formal freedom (Prosser 1986). A similar point could be made in relation to the NHS reforms. As we have seen, purchasers did have formal freedom: there were no limits in the statute or guidance as to what could be covered in contracts. The rhetoric surrounding the reforms emphasised the delegation of decision-making and local

⁴⁷ See for example Brindle (1996); Kennedy (1996).

discretion: decisions were to be taken ‘close to the patient’.⁴⁸ Moreover, the very use of the contract mechanism gave the impression that the parties’ accountability arrangements resulted from their own bargaining, in response to market forces. In practice, however, purchasers’ priorities and methods were strongly influenced by central guidance. This study has highlighted the extent of that influence. It was the major determinant of the topics covered in the contractual accountability process, particularly by Health Authorities, and also affected the methods they used to address those high-priority issues. Moreover, it is arguable that this guidance was deliberately concealed. For example, although Health Authorities’ purchasing plans were published and consulted upon, the NHS Executive’s crucial Priorities and Planning Guidance (NHSE 1995*b*) was not openly available or subject to consultation. This might have given the appearance that some national priorities used in purchasing plans had been set locally. The data from this study have emphasised the need to address the issue of concealed central influence as a matter of urgency, by researching other purported delegations of power and by evaluating the arrangements against the linked principles of transparency and accountability.⁴⁹ The implications of the findings for the ‘public law contract’ will be explored in the conclusion, below.

The caller to account should be given sufficient resources in order to operate an effective accountability process.

Our second evaluative principle reflects the fact that accountability inevitably

⁴⁸ Department of Health (1989); NHSE (1994). For discussion, see Hughes (1991).

⁴⁹ See also the discussion in Longley (1990; 1993).

involves some costs. We saw above that NHS purchasers' choices were affected by resource constraints. Did this mean that they did not have sufficient funding to operate an effective accountability process? Our comments on this principle are limited. The empirical study provided some data on costs, but was not designed to calculate in detail either the sums actually spent by purchasers on accountability, or the sums required to make the contractual accountability process effective.

NHS purchasers (and providers⁵⁰) did argue that there was a shortage of resources to support the accountability process through contracts. As we saw above, the pressure placed on Health Authorities to cut management costs had led to a reduction in the number of staff devoted to quality, and hence to a drop in the amount of monitoring activity that took place. Fundholders claimed that with the services of a fund manager, perhaps some assistants and the part-time attention of a GP, there was inevitably a limit to what could be done beyond agreeing and monitoring a basic contract deal with a few important quality requirements.

Against this, many commentators criticised the reforms on the grounds that they had increased the administrative costs of the NHS, thus diverting money away from patient care.⁵¹ The amount of money spent on management⁵² rose during the period of the reforms (Webster 1998). This was most obvious at the fundholding level. Practices were given an allowance for fund management staff and computer systems. In order to be accepted onto the scheme, practices had to

⁵⁰ Providers claimed that (unlike fundholders) they had not been given extra resources for staff or computer systems to support the contracting process.

⁵¹ See Chapter II.

⁵² Audit Commission (1996) gives the cost of fundholding at £232 million, but does not give detailed costs for Health Authorities or Trusts.

demonstrate that they had used this money in order to prepare for the task of managing budgets and contracts. All the practices in the sample had taken on at least one full-time member of staff to operate the scheme. Of course, a mere rise in administrative costs did not necessarily mean that purchasers and providers had *enough* resources for accountability. But an argument that these costs should have been increased still further was unlikely to be acceptable.

The caller to account should strive to maximise the accountability achieved within the resources available.

Our third evaluative principle can be discussed more fully, because it relates closely to our data on purchaser behaviour. It assumes particular importance in the light of the suggestion, above, that callers to account could not easily have claimed more resources for accountability. There were a number of techniques for implementing the principle in the NHS: taking ‘short cuts’ within the purchaser’s own contractual accountability process; pooling resources with (or at least not duplicating the efforts of) other purchasers; and relying on other mechanisms of accountability. We will examine each in turn.

Taking ‘short cuts’

How could a purchaser take ‘short cuts’ within its own contractual accountability process? The government appeared to assume that the NHS reforms would create

a competitive market (Department of Health 1989).⁵³ Purchasers could therefore save time by relying on market forces to support the accountability process through contracts. This would work in a number of ways. Firstly, market forces would encourage providers to keep costs to a minimum, so that their services would be competitively priced. This would obviate the need for the purchaser to engage in detailed scrutiny of the way in which the provider had priced its services. Secondly, market forces would promote high quality services, short waiting times and good communications. If purchasers found that a provider's performance was poor on these issues, they might be tempted to go elsewhere: fearing a loss of business, providers would strive for better performance. Thirdly, there would be no need for purchasers to expend effort on persuading (or seeking to compel) providers to agree to, and then to comply with, particular standards. Once again, the need to attract and retain custom would encourage providers to be responsive. In short, purchasers would need to expend very little effort on the accountability tasks of standard-setting and enforcement: the market would do the work for them.

It was, however, a recurring theme in the data that market forces could not be relied on to offer this level of support to the contractual accountability process. Many commentators predicted that the NHS 'market' would not be fully competitive.⁵⁴ Purchasers would be reluctant to move their contracts between providers, for a variety of reasons. Their choice would be limited by the fact that patients would not wish to travel long distances for treatment (Barker *et al.* 1997:

⁵³ Although the White Paper avoided explicit use of market terminology.

⁵⁴ For example, Hughes (1991). For later assessments, see Chapter VI and, for example, Proper and Bartlett (1997); Walsh *et al.* (1997).

96). Moreover, they might be reluctant to destabilise providers financially (particularly in the case of large Health Authority purchasers) or to stop using consultants with whom they had a good working relationship (particularly in the case of GP fundholders).⁵⁵ These predictions were confirmed by the data from this study, examined in detail in Chapter VI. Thus, instead of having to fight for business, providers could comfortably rely on a steady flow of work from local purchasers which would continue from year to year. There was some contestability at the margins,⁵⁶ but this did not necessarily make providers more responsive to the purchasers posing the threat, nor was there clear evidence that it helped other purchasers who did not threaten to exit. This meant that purchasers had to be more active in order to compensate for the weakness of the market.⁵⁷ For example, where they could not rely on competitive forces to encourage the provider to comply with a particular standard, many purchasers sought to negotiate financial penalty clauses in contracts in the hope that they would deter breaches of the standard. The weakness of the market closed off the most obvious and important ‘short cut’ within purchasers’ own contractual accountability relationships.

Pooling resources

Our second technique of maximising the accountability obtained within the resources available was that purchasers should pool resources with, or at least not duplicate the efforts of, other NHS purchasers. Health Authorities sometimes contracted jointly for specialist services where their requirements, taken

⁵⁵ The importance of relationships is brought out very clearly in Flynn *et al.* (1996).

⁵⁶ See also Walsh *et al.* (1997).

⁵⁷ See Chapter VI.

individually, were so limited that it was not worth placing individual contracts. Most importantly, Health Authority purchasing generally followed the ‘host purchaser’ arrangement, described above, in which Authorities negotiated only on finance and activity levels with neighbouring providers, relying on the provider’s ‘host’ Health Authority’s contract for other terms and conditions (NHSME 1990a). Some of the problems with relying on other accountability mechanisms, discussed below, particularly the issue of checking their reliability, are relevant to the ‘host purchaser’ arrangement too.

Joint working was most significant among fundholders. There were fundholding groups in all three areas studied, although their roles differed. The group in Area A (discussed above) was most advanced as a forum for contract negotiation and routine monitoring. In Area B, GPs had begun to work together to negotiate contracts shortly before the study period, in response to a dramatic price rise at one provider. It was not clear whether the group would develop into a stable negotiating forum once this issue had been resolved. The group in Area C had worked very closely with the Health Authority to produce a set of joint quality standards, to be included in the contracts placed by both types of purchaser.

These joint approaches, particularly the sophisticated version found in Area A, had a number of advantages. Where the group conducted negotiations on issues of common interest, such as quality standards, they prevented unnecessary duplication of effort and allowed practices more time to concentrate on issues of individual concern, such as finance and activity. Group negotiations also saved time for providers: it was easier to deal with one negotiating team than with

twenty or thirty individual practices. Moreover, grouping together enhanced fundholders' bargaining power, as we shall see in Chapter VI. Providers were more likely to respond to a group demand to reduce prices or to meet a particular quality standard than they were to a demand from a single practice. Of course, there were disadvantages. Groups reduced diversity among purchasers and perhaps limited the potential for providers to be called to account against a range of standards. But their ability to save time (and to enhance effectiveness) seemed to justify this loss of variety.

Another strategy of pooling resources was to find ways of sharing information on best practice, to improve the overall standard of purchasing. Much of the impetus for this came from the centre, rather than from purchasers. The NHS Executive and some regional offices produced guidance documents collating examples of good practice in contracting, which were circulated to Health Authorities (for example, NHSME 1993). Audit Commission studies also highlighted areas in which some purchasers were being more effective than others (for example, Audit Commission 1993*a*; 1993*b*; 1996). Purchasers' attempts to share good practice were less systematic. In Area A, for example, there was evidence that more experienced fundholders played a role in advising potential entrants, and newcomers, to the scheme, but there were no formal arrangements for this. It was arguable that joint learning processes could have been more fully developed in the NHS: the data indicated wide variations in the skills of different fundholding practices (see also Audit Commission 1996).

Relying on other mechanisms

Our third technique for securing as much accountability as possible within the resources available was that purchasers could rely on other accountability mechanisms applicable to providers outside the contracting system. Where another forum existed to make a provider accountable for a particular aspect of its performance, the purchaser could either make use of the results that forum generated during the contractual accountability process, or ignore that aspect of the provider's performance altogether, on the assumption that it was being dealt with satisfactorily elsewhere. This enabled purchasers to concentrate their resources for accountability on issues that were not being addressed in any other way, and prevented a wasteful duplication of efforts. For example, the study showed that purchasers did not usually tackle clinical issues in contracts. One reason⁵⁸ for this was that other techniques, such as complaints, negligence claims, disciplinary procedures and medical audit, could be relied upon to address these issues (Allsop and Mulcahy 1996). This meant that purchasers did not need to find the time or the expertise to set and monitor clinical standards themselves. But the non-duplication principle was a ground for criticism of Authority B's quality standards. Their focus on the safety of staff and patients appeared to duplicate statutory standards⁵⁹ and professional norms.

The principle of non-duplication did, however, raise one dilemma: should the purchaser's reliance on other accountability mechanisms be active or passive? In

⁵⁸ Constraints of skill and knowledge and a lack of encouragement from central government to address these issues were also relevant, as we saw above.

⁵⁹ Health and Safety at Work Act 1974.

the clinical sphere, for example, Health Authorities' reliance on other mechanisms tended to be active, whereas fundholders' was passive. Health Authority contracts usually required providers to have complaints and audit procedures in place, and to report their results to the Health Authority. Providers sometimes suspected that little was done with these reports. It appeared that their suspicions were often justified, although there were exceptions: the public health department in Authority A, for example, made considerable use of the data. Fundholders, by contrast, tended simply to trust to the existence of clinical accountability procedures, concentrating instead on issues such as communications which had never before been addressed by any method of accountability. On the one hand, purely passive reliance saved the maximum possible time, and was perhaps appropriate where the purchaser lacked the expertise to evaluate the detailed results of a professional accountability process. On the other hand, active reliance would draw the purchaser's attention to any issues arising from other accountability mechanisms which should be addressed in its own contracts, and would allow the purchaser to check that its reliance on other mechanisms was justified. For example, requiring the provider to report on audits carried out would enable the purchaser to check that all departments were participating in the audit regime.

NHS purchasers thus performed well against the principle that they should strive to make the most of the resources available to them for accountability. Various efforts were made to avoid duplicating the work of other NHS purchasers and other accountability mechanisms, and to engage in some joint working where possible. This was particularly important given that purchasers could not always

rely on market forces to support the accountability process, thus making their task more onerous.⁶⁰

Conclusion

We have examined the NHS data using three evaluative principles expressing various ideas about the good accountability process. NHS purchasers did seek to maximise the accountability they obtained within available resources, thus fulfilling the third principle. But using the first principle to evaluate the accountability mechanisms applicable to purchasers produced more worrying results. Purchasers were accountable only to one of the third parties with a legitimate interest in their performance, namely central government. Accountability mechanisms to the public were not sufficiently strong to act as a countervailing pressure. This meant that Health Authorities tended to act solely as the agents of central government, without taking account of local needs. Fundholders had more discretion because they were subject to less detailed and intrusive accountability to the centre, but their priorities tended to reflect their own concerns with unsystematic input from patients. Moreover, it was not clear that central government was adequately accountable for its role in determining purchasers' priorities. The rhetoric of localised decision-making which accompanied the reforms could be used to disguise the continuing central influence demonstrated in the data. Purchasers as delegate callers to account did not fit into a rigorous but transparent chain of accountability mechanisms to all relevant stakeholders.

⁶⁰ See Chapter VI.

CONCLUSION

Several of the points we have made using the NHS data are likely to be of wider relevance to other mechanisms of accountability. The task of generalisation from an empirical study in a particular context must, of course, be pursued with some caution, but we can at least suggest some possible implications and avenues for further research.⁶¹

Ensuring that the accountability process is adequately funded, and making the best possible use of the resources allocated to it, are universal principles of good accountability. They may seem obvious, but it is important to articulate them because of the accountability failures which will ensue if they are not observed. For example, it is arguable that the Parliamentary Commissioner for Administration (who calls the government to account for its behaviour towards individual complainants) has only recently begun to accept these principles (Parliamentary Commissioner for Administration 1998). He has admitted that his resources do not allow for a thorough investigation of every case referred to him, and that it is desirable to use less time-consuming methods in appropriate cases in order to maximise the number of grievances handled within available resources. Moreover, the more specific principles developed above, relating to the way in which resource use was maximised in the NHS, could be of relevance in other similar contexts. For example, where a public body has a number of local offices

⁶¹ Chapter VII seeks to generalise from the study as a whole.

(such as branches of the Health and Safety Executive or the Environment Agency) it may be appropriate for these offices to work together on issues of joint concern.

This chapter has also examined the special considerations which apply within chains of accountability mechanisms: where the caller to account in one accountability mechanism is or should be subject to accountability mechanisms itself. These principles can be generalised to other systems of linked accountability mechanisms, for example in a hierarchy. Despite the attempt, as part of the ‘new public management’ reforms, to remove layers of hierarchy from government,⁶² many public services continue to have a hierarchical structure, particularly those with localised provision. Our data highlight the importance of recognising the influence of higher links in the chain of accountability over lower links, and of making those links transparent. For example, it is important to know whether a particular decision was taken by a prison governor, by the Prison Service Agency, or by the minister, in order to know who should be deemed responsible (during the minister and agency’s accountability to Parliament, for example) for its adverse consequences (Foster and Plowden 1996).

This aspect of our findings may have particular relevance for the emerging notion of the ‘public law contract’.⁶³ The data showed that the NHS contract was heavily regulated by central government,⁶⁴ particularly in terms of the topics covered and the model of relationship adopted by the parties (a finding which will

⁶² See Chapter I.

⁶³ See generally Harden (1992); Freedland (1994; 1998); Hughes *et al.* (1996); McHale *et al.* (1997); Vincent-Jones (1997).

⁶⁴ See also Hughes *et al.* (1996; 1997); McHale *et al.* (1997).

be confirmed in Chapter V). The proper extent of central regulation is beyond the scope of this thesis, although it may safely be said that even if the government attempted to relax its grip on public sector contracting, it would find the aim difficult to accomplish.⁶⁵ The needs of central political and financial accountability inevitably require the government to have some control over field-level purchasers.⁶⁶ The study did show that where central control was mediated through another layer in the organisational hierarchy, as it was for fundholders, its effects were weaker, but it was not clear that this relaxed approach would have continued had fundholding become the dominant form of purchasing.⁶⁷ Assuming that continuing central influence was inevitable, our discussion of accountability and transparency becomes particularly significant. Even if we cannot (or do not wish to) curb central guidance, we can strive to ensure, in any public law contract, that the guidance given to purchasers is transparent and that purchasers are not held responsible for decisions they did not take. This requires publication of the guidance and some skill in interpreting it. For example, this study showed that instructions to purchasers to treat particular issues as high priorities meant that they ignored all other issues, rather than (as one might have expected) dealing with them as lower priorities. Empirical studies have an important contribution to make to our understanding of how purchasers will respond to various types of guidance.

⁶⁵ Some of the problems of attempts by government to delegate to semi-autonomous bodies were discussed in Chapter I.

⁶⁶ This is likely to involve some constraints on the free play of market forces, although as we shall see in Chapter VI, market forces were in any event limited in the NHS.

⁶⁷ NHSE (1995a) shows signs of the centre tightening its grip over fundholders.

More generally, the data reinforce the importance of the basic principle of accountability: that all relevant stakeholders should be able to express their views to the delegate through effective accountability processes. In the absence of an accountability mechanism to a particular stakeholder, the delegate is unlikely to consider (or even be aware of) that stakeholder's concerns. In this chapter, we demonstrated the importance of this principle in relation to purchasers' accountability to the public. But it must be at the very heart of any understanding of good accountability. Chapter VI will demonstrate the importance of ensuring that the mechanism which is put in place is *effective*.

Finally, the data in this chapter have an important role in setting the scene for the next two chapters on purchaser/provider relationships (Chapter V) and on the effectiveness of the contractual accountability process (Chapter VI). For example, when we ask why purchasers did not adopt a particular strategy which might have improved relationships or made the contractual accountability process more effective, we may find that it was because the purchaser lacked the time or the skill to do so, or because the purchaser was subject to pressure from central government to behave in a different way. Purchaser behaviour in the remaining two chapters must be understood in the context of the various pressures and constraints analysed in this chapter. Our expectations must always be realistic.

V

Hypothesis 2: Relationships and Procedure

Accountability relationships between the contracting parties in the NHS displayed many features of the soft model but some features of the hard model. The latter undermined the high-trust relationship associated with the former.¹

We saw in Chapter III that contractual relationships could be described in terms of two models, hard and soft. They reflected different levels of trust between the parties. The hard model involved only the minimum degree of trust necessary to maintain a contractual relationship at all; the soft model involved a much higher degree of trust, sufficient to maintain the relationship over the longer term. In practical terms, the models involved very different approaches to the accountability tasks of standard-setting, monitoring and enforcement. These approaches can be summarised as follows:

Hard model:

- adversarial negotiations; comprehensive and precise standards
- monitoring through ‘policing’
- enforcement through sanctions, particularly exit

Soft model:

- collaborative negotiations; broad, general standards
- monitoring through shared information or trusting the provider to comply
- enforcement through persuasion

¹ Chapter III.

In Chapter III, we predicted that NHS contracts would fit the soft model. A variety of factors identified in the literature as indicators of the soft model seemed likely to be present in the NHS. These included:

- longer term contractual relationships
- personal friendships and shared professional values among staff in each contracting party
- the difficulty of specifying the exchange between the parties in a precise way, given the complexities of health care services

But our prediction was made with some caveats:

- central government regulation might push the parties towards a particular model, whether or not it was the best model for their relationship
- longer term contractual relationships might result from the lack of competition in the NHS ‘market’ rather than the purchaser’s deliberate choice
- the different elements within the NHS contract (finance, activity, waiting times, service specifications, etc.) partook of different degrees of complexity

Despite our acceptance of these ambiguities, the study’s findings were strikingly at variance with the predictions. Very broadly, fundholders adopted similar, hard approaches to negotiations, contract drafting and contract monitoring, but varied across the range from hard to soft when enforcing their contracts. Health Authorities tended to mix approaches even within the same contract, using both hard and soft standards and negotiating styles. But their monitoring tended to be soft, and to describe their enforcement strategies, an

‘intermediate’ model² had to be developed. The study thus revealed a rich and complex pattern of data, which is presented and explained in the first section of the chapter. The section has two aims: to advance our understanding of contractual relationships in the NHS, and to test the value of the hard and soft models as an analytical tool to be added to our basic model of an accountability process.

In the second section of this chapter, the findings will be evaluated using two fundamental principles of good accountability of a procedural nature.³ They were formulated in Chapter III as follows:

- the good accountability process is characterised by its regard for principles of due process
- the good accountability process is transparent to interested third parties

The discussion builds on our interpretation of these principles in Chapter III, and focuses in particular on problems highlighted by the empirical data. This will enable us to add an empirically-grounded procedural dimension to our notion of the ‘good accountability process’. Finally, the conclusion explores the significant implications of this aspect of the study for the emerging notion of the ‘public law contract’.

² There are some threefold classifications in the literature: Macneil (1978); Williamson (1979).

³ Effectiveness is also a crucial consideration: it was possible that one model might prove to be more effective than the other. This type of evaluation is performed in Chapter VI.

FINDINGS AND EXPLANATIONS: WHICH MODEL DID PURCHASERS ADOPT, AND WHY?

The findings are most conveniently organised around the components of the contractual accountability process: standard-setting; contract drafting; monitoring; and enforcement. There will be some cross-referencing between the various components: using a particular model for one element has implications for the other elements. The section will enable the reader to acquire a rich empirical understanding of the practicalities of an accountability relationship, bearing in mind the considerable importance of relationships to the parties themselves. It will help to fill the gap between the purchasing context discussed in Chapter IV, and the results of the process discussed in Chapter VI. Finally, the discussion will act as an exploration of the methodological value of the hard and soft models for classifying accountability relationships and drawing attention to the complex role of trust in accountability.

Standard-setting

Negotiations are the main standard-setting forum in a contractual accountability process.⁴ Standards are set directly when the parties agree the substantive terms of their contract, creating obligations for the provider. Standards are set indirectly when the parties agree the contract price. Although the payment of the price is an obligation for the purchaser, it acts as a financial target for the provider, and the

⁴ Standard-setting can also take place during monitoring and enforcement as standards are interpreted and applied to specific situations.

process of negotiating it forces the provider to explain and justify its financial performance.⁵ Both types of standard-setting negotiation can be approached in either a hard or a soft way. The soft model relies on a substantial measure of trust between the parties.⁶ They can be expected to share information and work collaboratively to ensure that the final agreement reached takes both their interests into account. The hard model involves a lesser degree of trust: only that minimum level which is required for the parties to contract at all. Each pursues its own interests during the negotiations, sharing as little information as possible and seeking the best deal it can get, regardless of the effects its behaviour might have on the other party.

Health Authorities

Authorities' negotiations contained evidence of both hard and soft approaches. Negotiations in which Authorities were pursuing their own requirements could fit either model; those in which they were pursuing central government requirements tended to fit the hard model.

Authorities' approaches to negotiating their own standards varied quite widely. For example, Authorities B and C adopted very different approaches to the negotiation of quality standards with their main local providers. Authority B used the hard model. Its managers prepared quality standards without consulting providers, and insisted that they sign contracts incorporating those standards.

⁵ See Chapter II.

⁶ Particularly when the parties are renewing their contract. (Most of the data in this study concerned renewals.)

Providers disputed the content of some of the standards, but signed up to them because it was not worth provoking a dispute on low-priority⁷ quality issues. Authority C adopted the soft model. The quality managers' preferred approach was to prepare detailed quality specifications for particular services. They tended to lead the process, producing initial proposals on the basis of the relevant literature and guidance, but consulted extensively with providers (through correspondence and meetings) before producing a final specification.

The reason for the difference of approach between the two Authorities seemed to lie in two factors. One was that the Authorities perceived their roles differently. Authority B's managers saw quality standards as a matter for the Authority: the purchaser should describe the services it wished to buy. Collaboration with providers would have limited the Authority's freedom to set out its own terms. Authority C's managers valued the provider's input: although the Authority should lead negotiations, providers' comments ensured that the standards were realistic and perhaps increased the chances of compliance. A second factor was the relationship between the contracting parties' quality managers. As we saw in Chapter III, personal ties are an important feature of the soft model: once friendships have been established, collaboration on the professional level is more likely.⁸ Authority B's managers did not have a good working relationship with their Trust counterparts, apparently for purely personal reasons, whereas Authority C's did, even though their organisations were often in dispute on other issues, such as finance. One of the Trust managers explained:

⁷ See Chapter IV.

⁸ Macneil (1974), and see Flynn *et al.* (1996) and Lapsley and Llewellyn (1997) for similar empirical findings.

But I think at the grass roots level, now I work very closely with the quality nurse advisor from the Health Authority, and we have a very good relationship. I mean, she's amenable to my suggestions and, you know, we try and work together to try and find a solution to things that we want to agree between us.
(C7T)

Where Authorities were negotiating central requirements, the position was very different. Hard strategies were the norm.⁹ Thus, for waiting times and other Patients' Charter requirements (Department of Health 1991; 1995), Authorities simply insisted that the standards be included in contracts: providers had no choice. Similarly, during price negotiations, Authorities demanded a contract deal which would enable them to remain within their own limited budgets, and to meet other central targets, notably the efficiency gain.¹⁰ Price negotiations merit a more detailed examination, because they demonstrate how strongly these central requirements pushed the parties towards the hard model. Attempts to promote a more collaborative form of price negotiations were unsuccessful.

The typical approach to price negotiations was for each party to begin by calculating its preferred contract deal. The provider's sum would cover its costs and perhaps allow for some service developments; the purchaser's sum would allow it to remain within budget and meet efficiency gains and other targets. The parties would engage in a bargaining process until a compromise could be reached between the two figures. In the event that they could not agree, they would resort to arbitration.¹¹ The process was essentially hard: each party pursued its own

⁹ A point noted briefly in Chapter IV.

¹⁰ A Treasury requirement that the NHS as a whole should either do more activity for the same money as the preceding year, or the same activity for less money. The figure was usually in the region of 2%.

¹¹ See Chapter II.

interests in getting a contract deal as close to its figure as possible. By the time of the study, the NHS Executive had adopted a policy of encouraging the contracting parties to negotiate more collaboratively.¹² In particular, the provider was to share with the purchaser its draft ‘quantum of costs’ to be used in calculating the price of its services.¹³ The approach seemed more in line with the soft model, in that it involved close negotiations between the parties and substantial sharing of information.¹⁴ But attempts to implement this softer approach failed.

One difficulty was that purchasers and providers were unwilling to collaborate to the required degree. Providers sought to retain some independence, and purchasers sought to keep their distance. As one Authority manager explained:

The Trusts would be very upset if we actually went along as a Health Authority and said we think that service is overfunded in your budget and you’ve got to cut it back. They would see that as that’s their management. And I think we’d see it as their management.
(B1A)

There were two reasons for this. One was historical. Before 1990, providers were directly managed by Health Authorities.¹⁵ Having acquired the formal independence offered by Trust status, they did not wish to undermine that independence by allowing Health Authorities to control all aspects of their operations. They therefore resisted the close involvement indicated by the soft model. (Drawing a satisfactory distinction between the role of the Trust and the role of the Authority was highly problematic: a theme to which we will return in the discussion of drafting, below.) The second related to trust. Although the soft

¹² Unpublished regional office guidance.

¹³ It will be remembered that the link between costs and prices was direct in the NHS, because Trusts were not allowed to profit or to cross-subsidise between services (NHSME 1990*b*).

¹⁴ This is, of course, less surprising in a not-for-profit context than it would be in business, because in the latter context firms would often be reluctant to reveal their profit margins. But see Sako (1992).

¹⁵ See Chapter II.

model treats close involvement as a sign of high trust, providers saw purchasers' involvement in their affairs as an indication of distrust. Purchasers were more likely to interfere where they perceived that a problem had arisen.

A second problem with quantum negotiations was that it was impossible to prevent hard elements from intruding into the process. Under a genuinely soft approach, the parties would have the same goal of achieving a deal that remunerated the provider fairly for its work (Sako 1992). Soft negotiations on NHS contracts could not mask the fact that while the provider sought remuneration (fair or otherwise), the purchaser's aim was to keep prices down so that it could meet its central targets. For this reason, the purchaser could be forced to ignore an entirely legitimate argument from a provider that a particular contract deal would not cover its costs or would lead to unwanted cuts in services. This gave Authorities a very strong reason for refusing to become involved in detail, despite central encouragement to do so. Providers would sometimes ask Authorities to make detailed proposals as to how targets might be met, as a way of demonstrating the problems they caused. Authorities were wary of the trap:

Certainly Trusts at times do get to the point of saying if it's so easy, why don't you tell us how to do it? And we avoid biting on that one.
(B1A)

If the Authority revealed that it could not suggest a way of meeting the targets, it would undermine its ability to insist on them in the contract. Authorities therefore fell back on the hard approach.

It was interesting to note that purchaser/provider relationships were damaged by these difficulties even though purchasers were not themselves the source of the targets.¹⁶ The following comment from a Trust manager was typical:

I think we've got a good relationship with them overall, in terms of service provision, and in talking to each other, but basically they want to give us less money every year, and get us to do more work every year, and you can imagine that at the end of the day that doesn't make for an easy relationship.
(B9T)

It seemed to be impossible for Trusts to separate the centrally-determined aspects of their negotiations with Authorities from their relationships with them more generally. This reflected the fact, noted in Chapter IV, that central requirements dominated the contractual accountability process between Health Authorities and their providers. Our expectation that Health Authorities' contracts would fit the soft model was, for the most part, proved wrong.

Fundholders

Fundholders' standard-setting tended to follow the hard approach. Fundholding groups used the hard model for price and quality negotiations; individual practices used the hard model for price negotiations.¹⁷

Fundholders' price negotiations had two key elements: deals and price comparisons. Price comparisons tended to be the work of fundholding groups. The approach was essentially hard: the group compared the current year's prices with

¹⁶ Authorities did share some of the blame, in that they could reduce the efficiency requirement for particular Trusts by imposing a higher requirement on others. Most Authorities differentiated in a limited way, but obviously this approach brought its own difficulties.

¹⁷ The setting of quality standards at the individual practice level was relatively rare and will not be covered here.

the previous year's prices and demanded a reduction if the figures showed an 'excessive' price rise. The second element of fundholders' price negotiations, at the individual level, was to seek favourable 'deals'¹⁸ from providers. Most, though not all, fundholders used 'cost and volume' contracts. They paid a sum each month in respect of an agreed level of activity. If this level was exceeded, the provider undertook to offer some activity at a marginal rate, discounted to reflect the fact that the provider could afford to do a certain amount of extra work without incurring further fixed costs. A 'good deal' was one which offered cheap marginal rates, and set the agreed level of activity in such a way as to make it very likely that the practice would exceed that level and obtain some activity at marginal rates.

The process of obtaining a good deal from a provider showed fundholders at their 'hardest'. Of course, some providers offered the favourable deal (often to placate fundholders adversely affected by price rises) and the practice simply accepted it. But in many cases, it was the fund manager's skill that was essential to securing a good deal. The skill lay in keeping the agreed activity level low enough so that the practice would be assured of some activity at marginal rates. One fundholder admitted:

You arranged your 110% of your contract to correspond with 90% of your predicted activity so that 90% of your predicted activity would take you up to 110% and then you would hope to get your 10% predicted activity at marginal rates.

(B13F)

Of course, providers tightened up on the deals available as time went on: they would be able to tell that a practice was not contracting for sufficient activity, and

¹⁸ As used here, the term does not refer to the 'one-off' initiatives described by Walsh *et al.* (1997: 100).

demand that it agree to a more realistic activity level. Nevertheless, fund managers saw it as their job to pursue the best deal available, even if it could not be repeated. They had little regard for the effect of such contracts on the provider, seeing it as the provider's responsibility to ensure that the contract could be afforded and to safeguard its own interests.

Why did practices adopt this hard approach? The practice's own activity data were readily available and most fund managers felt able to interpret it for the purposes of a deal. Nor was the approach time-consuming: detailed discussions of the kind employed by Health Authorities were not required. But it was a hard strategy which involved the pursuit of self-interest rather than a regard for what the provider could afford. Viewed in this way, it did reflect a lack of trust of providers. Fund managers felt that providers, characterised as large organisations with negotiating expertise, were well able to safeguard their own interests in negotiations. Moreover, many fund managers were able to give examples of cases in which providers had miscalculated prices or sought to impose unreasonable increases, thus undermining their trust even further. Finally, although GPs often had personal and professional bonds with clinicians, personal ties between practices and managers were less common, perhaps because time and resource constraints on both sides meant that they did not meet often enough to build such bonds.¹⁹ These various factors contributed to the low-trust character of price negotiations between fundholders and providers.

¹⁹ Nor were there necessarily any shared professional experiences or values on which to ground the relationship, in contrast with the links between GPs and consultants.

When negotiating substantive standards, fundholding groups' approaches were also hard.²⁰ The strategy was to demand compliance, reinforcing the demand with a threat of exit or some other sanction. For example, a manager at the community Trust in Area A recounted a particularly adversarial meeting with local GPs:

The GPs... swept in, sat down, and said right, unless you implement by April next year [a particular management structure for] community nursing, we are all going to go wholesale and buy from somebody else.
(A15T)

The very fact of a group approach could reflect a belief that the provider would not respond to individual requests, and that it was therefore somewhat recalcitrant. It was not surprising that this low-trust view was carried forward into the way in which the group's negotiating team approached discussions. Unlike Health Authorities' use of the model, it was not likely to be connected to central pressure to achieve particular targets: many fundholders could afford to maintain low waiting times, for example, and did not therefore negotiate in the shadow of the central target. Although hard behaviour damaged relationships with providers, practices continued to use the model because it was remarkably effective, as we shall see in Chapter VI.

To sum up, both fundholders and Health Authorities used hard negotiating strategies, but for very different reasons. Authorities were forced to do so by the need to implement central standards, regardless of the wishes of providers, through the contracting process. Fundholders adopted hard approaches partly for practical reasons, and partly because of low trust levels. On issues of real

²⁰ Individual practices' negotiations on quality standards, where they occurred, sometimes used the soft model.

importance, the parties' immediate interests diverged, trust levels were low and the hard model prevailed.

Contract drafting

Different types of negotiations, and different relationships, result in different contract documents, according to the models. A soft contract is informal, relying on common assumptions and understandings between the parties. It makes no attempt to be comprehensive or to cover all eventualities. It contains broad standards which can be worked out in more detail during the life of the contract, if necessary. Because the parties trust one another, they can feel confident that these further negotiations will proceed smoothly. A hard contract relies on formal standards, preferably ones which can easily be measured for compliance. It aims to set out as many standards as possible in advance, striving for comprehensiveness. Because the parties do not trust one another, formal documentation is required to set out their rights and responsibilities. In principle, it should not be possible to find both approaches combined in the same contract, because they express different trust levels.

Health Authorities

We examined the *comprehensiveness* of Health Authorities' contracts in Chapter IV. Finance, activity and non-clinical quality standards were described with care. On the other hand, clinical issues were omitted and attempts to specify in any detail the services covered by the contract were rare. Thus, despite some efforts at

comprehensiveness, the contracts could not function successfully without a substantial reliance on a ‘soft underbelly’ of assumptions and common understandings shared between the parties, and across the NHS as a whole. Our findings on this issue were not conclusive as to whether the hard or the soft model was in play. Here, we will examine two further indicators of the models: the extent to which Health Authorities became *involved in detail*, and the *drafting style* of the standards they included in their contracts.

Involvement in detail by a purchaser could denote either model: it depends, crucially, on the way in which that involvement takes place. Detailed contractual standards indicate the hard model; detailed discussions outside the contract indicate the soft model. All three Authorities in the sample became involved, at times, in the details of service provision: to achieve more control over a particular service, to respond to evidence of problems, or to address waiting time or funding crises, for example. These discussions took place outside the framework of the contract. But the data indicated that in the NHS, this was not a sign of the soft model. Providers resented it, taking the view that there should be limits on Health Authorities’ involvement in their operational management:

They’re quite at liberty to ask of any provider... what staffing levels are you going to put in to manage this facility, because that’s part of the quality, isn’t it, of the service that’s being provided... we’ve had instances of where they’ve overstepped that mark and got too involved in trying to specify which member and what grade of staff should provide a particular service, and we just politely tell them no, that’s not your business. You set the specification, we’ll decide how we’re going to deliver the service and agree that with them.

(B2T)

There appeared to be two main reasons for this view. Firstly, providers were keen to safeguard their new-found independence from Health Authority control, as we saw in our discussion of finance negotiations, above. This led to disputes as to

how the boundary between purchasing and provision should be drawn. Secondly, providers noticed that Health Authorities only became involved in detail when problems arose. They suspected that the involvement resulted not from a desire to collaborate, in accordance with the soft model, but from a lack of trust in their competence. This explained their ‘low-trust’ response.

The hard and soft models involve different *drafting styles*: precise standards under the hard model and broader standards under the soft model. Interestingly, Health Authorities used both styles, selecting a style to fit the subject-matter of the standard in question. For finance and activity, the preference was to have standards which were as precise as possible:

I mean the first year of the contracts we had here were pretty woolly, the second year was slightly better, the third year was really the first year that we very much tightened up... they’ve certainly been refined year on year, and are not getting simpler. They are getting more complex in terms of finance and activity.

(A2A)

The general trend was to use more sophisticated contract types, such as the cost and volume contract, to replace the simple block contracts employed in the early years of the reforms when data quality was poor.²¹ Moreover, there was a high level of planning for contingencies in many contracts. For example, where cost and volume contracts were in place, it was felt to be important to agree on what the marginal rates for extra payments or refunds would be before the contract came into force. As one manager put it:

It’s a question of agreeing these things before you start... rather than leaving it until later in the year when it looks like you might be overperforming or underperforming, because obviously whoever’s going to benefit financially is going to negotiate a higher or lower rate according to where they are.

(C4A)

²¹ See Chapter IV and NHSME (1990a) for further discussion of contract types.

The aim was to remove the possibility of opportunistic behaviour during subsequent negotiations.

At one level, the interpretation of these findings must be that they reflected a lack of trust between the parties. Increasing precision was designed to safeguard the purchaser against the provider's pursuit of its own interests. Financial issues could not simply be left to collaborative negotiations between the parties as the contract progressed, because those negotiations were unlikely to be genuinely collaborative in a low-trust environment. At another level, however, a more subtle interpretation may be possible. With some specification of rights and responsibilities, the parties may have been hoping to build a trusting relationship rather than simply reflecting a low-trust relationship. This could be done by sharing risk more fairly, and ensuring that each party's position was clearly set out in a binding way. In a genuinely soft relationship, the parties would trust to their negotiations. But in the NHS, on the difficult and important issue of finance, this would have required an enormous leap of faith. Some specification could give the parties a sense of security, enabling them to relax into a trusting relationship. Of course, if the contract became ever more specific, one might reasonably take this as a sign of ever-declining trust. At the time of the study, however, many Health Authority contracts had reached a level of specificity with which both parties were reasonably satisfied. Moreover, there was no real suggestion in the data that trust had declined over the period during which the sophistication of contracts had increased. Moreover, two further factors outside the realm of the models themselves may also have some explanatory force. One is the simple fact that the contracting process was new to the parties in 1990, making it inevitable that

contracts should increase in sophistication over time as the parties acquired better data and new skills. Another is the influence of central government: both parties needed to be able to demonstrate, by using carefully drafted contracts, that they had reached agreements that would enable them to comply with their financial duties. Thus, the link between precise financial standards in contracts and low trust levels was not entirely straightforward.

Outside the realm of finance, Health Authorities used hard and soft contractual standards. Where the subject-matter of the standard lent itself to precise specification, the hard model was used. For example, Authorities set very specific targets for the supply of activity data and quality reports from Trusts, requiring them by a specific working day of the month, rather than using a vague term such as ‘promptly’. Both parties benefited from knowing exactly what was expected: disputes could arise over the meaning of ‘promptly’, but not over the fifteenth working day of the month. This use of the hard model was a simple and uncontroversial way of reducing the potential for disputes as to interpretation, thus helping at least to safeguard, and even to build, trust between the parties.

But various types of soft standard were also in use. One type was a broad, general term open to different degrees of compliance by providers. One of Authority C’s contracts stated:

The Trust will ensure that there is a strong consumer focus to all services they (*sic*) provide, both for the external and internal customer. They should have in place systems to gain and evaluate consumer feedback, and mechanisms to ensure that the views of consumers are acted upon.

Another type provided that work would be done on a particular issue by the parties during the life of the contract. One of Authority A’s contracts contained this term:

During 1996/7 the Trust will work with [the] Health Authority to continue to implement Changing Childbirth²² recommendations and specifically to agree and implement an ongoing programme for the provision of breast feeding support and promotion.

Both types of standard acknowledged the parties' long-term relationship: not everything needed to be settled before the contract was signed. Standards of the first type required further negotiations in order to apply them to particular circumstances; standards of the second type acknowledged that despite the formal status of contracts as annual, the parties were in reality in an ongoing relationship in which negotiations continued throughout the contract year and into subsequent years.²³ Both types also reflected the difficulty of setting precise contractual standards on these complex quality issues. It was easier to state a general principle in the contract, leaving its application to be worked out in discussions about particular aspects of the provider's services.

But whilst all the Health Authority contracts sampled contained soft quality standards, reflecting the difficulty of setting more precise standards on some issues, not all Authorities could boast about their relationships with providers. This made it difficult for them to harness the benefits of the soft model. For example, an out-of-county Trust in Area A had been asked by its host Health Authority to improve the management of pressure sores:

And we say 'Well, what do you want us to do?' 'Oh, just send us a six-monthly report.' 'Well, do you want us to include anything in particular in it?' 'Oh, no, just tell us what you're doing.'
(A3T)

Although the Trust was happy to be given some discretion, managers felt that the

²² Department of Health (1993).

²³ A truly soft relationship is probably one of ongoing discussions with no formal point at which agreement is reached. But in the NHS, there was a sharper distinction between contract negotiations and the life of the contract because the parties were obliged by the NHS Executive to sign contracts by a certain date each year, and because annual budgets created a fixed point at which finances would inevitably change.

Authority was not taking the issue seriously: it had chosen the soft approach because it could be used to avoid having to do any detailed work on the problem. As a result, the Trust did not feel motivated to comply. By contrast, soft standards were working well in Area C. The Health Authority held regular discussions with the provider to ensure that both were happy with the way in which the standards were being developed.

Fundholders

Fundholders' contracts offered an interesting contrast. As we saw in Chapter IV, fundholders' contracts were not *comprehensive*. Their coverage of issues was limited to certain key areas: activity and finance, waiting times, and quality issues pertaining to the relationship between fundholder and provider, such as communications. Their omission of some issues, such as clinical quality, reflected both the constraints discussed in Chapter IV and a willingness to trust providers' clinical staff. This trust was based on a variety of factors: shared professional values, past experience and the presence of other accountability mechanisms, for example. Moreover, clinical issues could be separated in fundholders' minds from other (administrative) aspects of the provider's or even the clinician's service that were of poor quality. One fundholder said:

Clinically, I think the service was good whichever provider we used, but this one didn't bother to write to us, so we said... we'll go somewhere else.
(C13F)

The comprehensiveness factor taken alone would suggest that fundholders' contracts fitted the soft model. *Involvement in detail* was inconclusive: as we saw in Chapter IV, were reluctant to become involved in detail, whether through the

contract or outside it, largely because of the constraints of time and resources they faced.

However, GPs' approaches to *contract drafting* invariably fitted the hard model. There was a gradual movement, similar to that in the Health Authority data, towards more sophisticated contract types involving some activity measurement. The fundholding group in Area A, for example, was seeking to collect data over the course of the study year in order to move to cost and volume contracts for mental health provision. Fundholders' quality standards were also drafted in a hard way. To some extent, this reinforces the point made with regard to the Health Authority data that the subject-matter of the standard was usually deemed to be more important than the relationship between the parties in determining the drafting of the standard. Because fundholders tended to concentrate on issues such as waiting times and prompt communications, which could easily be specified in numerical terms, their standards were precisely drafted, regardless of whether their approach to negotiating and enforcing the standards was hard or soft.

Nevertheless, there was more evidence for fundholders than for Health Authorities to support the idea that hard standards did denote a lack of trust between the parties. Many such contracts 'hardened' over time, as practices encountered instances in which the provider disappointed their implicit expectations. (It will be remembered that reliance on such expectations is a key part of the soft model). For example, a provider in Area C had sent some patients to a private hospital for treatment, because it was struggling to meet contractual

waiting time targets. It then sought to invoice practices at the private provider's (higher) prices. There was no contractual term permitting the provider to pass on these charges, and practices which refused to pay were not challenged. But at least one practice in the sample had included a term in the following year's contracts to make certain that the question would not arise again: the practice would be liable only for the NHS provider's published prices. In the administrative sphere, fundholders did not trust providers: relationships with managers were less well-established and were not grounded in shared professional values. They responded with increasingly hard contractual standards. This contrasted sharply with their approach to clinical issues.

Thus, fundholders' and Health Authorities' contracts were mixed. Fundholders used the hard model for drafting, but their contracts were not comprehensive or particularly detailed. This could be interpreted as an expression of high trust in providers on clinical issues, and low trust on administrative issues. Health Authorities' contracts were more comprehensive than fundholders', but still omitted a number of topics. These omissions were not a clear indication of high trust on the relevant issues. Their contracts contained a mix of hard and soft drafting, largely reflecting the subject-matter of the standards. Moreover, although Authorities became involved in detail outside the framework of the contract, this was not seen as an indicator of a soft relationship by the parties. The data revealed a highly complex picture.

Monitoring

The level of trust in the relationship between a pair of contracting parties is bound to affect the way in which they monitor each other's performance. The purchaser in a low trust relationship is likely to seek out opportunities to check up on the provider's performance, and to find monitoring methods which do not rely solely on the information the provider supplies. The purchaser in a high trust relationship may not engage in any explicit 'monitoring' activity at all: it may simply trust the provider to perform well. Alternatively, the parties may be in a very close relationship, in which they share information openly: this too may obviate the need for explicit monitoring, since the provider will inform the purchaser of problems as a matter of course. The findings revealed evidence of both approaches, although as with contract drafting, the chosen approach did not necessarily reflect the parties' relationship exactly. The factors discussed in Chapter IV, particularly time and resource constraints and priorities, had an overriding explanatory force which applied regardless of the parties' preferred model.

Fundholders

We saw above that fundholders tended to set only hard standards: if they were following the model in a consistent way, we would expect to find hard monitoring methods in use. The study confirmed this expectation. Firstly, fundholders relied on their own sources of information to identify problems and to check reports received from the provider. For example, because practices kept their own records

of patients waiting for treatment, they could examine the provider's monthly waiting list reports to ensure that they tallied. Secondly, fundholders cross-checked different sources of information from providers. We saw in Chapter IV that fund managers checked invoices against clinical letters, both to ensure that consultants wrote to the GPs about patients' treatment, and to ensure that the provider's invoices were accurate.

Why did GPs adopt these monitoring strategies? The obvious theoretical explanation is that they did not trust providers. The data supported this to some extent. No wise fund manager would pay an invoice without checking its accuracy first:

They send out invoices for what they think they'll invoice for. They're invariably wrong... I've sent back several thousand pounds worth of invoices yesterday just to the acute [Trust].
(B10F)

Moreover, as we saw in Chapter IV, GPs perceived standard-setting and monitoring as linked activities, refusing (unlike Health Authorities) to set standards which could not easily be monitored. This could also be taken as a sign of low trust: providers could not be relied upon to meet standards unless their performance was scrutinised. But attitudes did vary among fund managers. They were not all as critical as (B10F) above:

We check the waiting list reports... we have found that we've got someone on our list, but the hospital hasn't got them listed, through an admin error really, perhaps a secretary has forgotten or something.
(C9F)

It was inevitable that in a hospital dealing with large numbers of patients and purchasers, some mistakes would be made. Moreover, although providers (like fund managers) complained about the time-consuming nature of dealing with queries, they accepted that practices might legitimately check the information they

supplied. The fact that checks were a routine part of the contracting process meant that their impact as an expression of low trust was much reduced.

Health Authorities

As we saw above, Authorities used a mixture of hard and soft standards in their contracts. But although that finding appears to point towards a mixture of hard and soft approaches to monitoring, the prediction seems problematic. The soft model involves purchasers and providers in high-trust relationships. Because of their close bonds they can be expected to share information and to be open and honest with one another. Policing would be harmful, because it would imply that the purchaser did not trust the provider. How then could a Health Authority combine policing its hard standards with building up close relationships in order to monitor its soft standards? The data on monitoring revealed that this was not the most important issue in this area: in fact, limits on Health Authorities' access to information sources other than the provider, and limits on their time and resources, were probably more important than relationships in determining the form taken by monitoring.

Finance and activity were subjects on which Health Authorities invariably set hard standards. To some extent, a hard approach was continued into the monitoring stage: Trusts usually supplied Health Authorities with detailed data on each patient treated, and then with aggregate totals for the month. Authorities checked the totals against the specific information to ensure that they were correct, raising any ambiguities in the data at meetings. They could also check the data

against commonsense expectations. The community Trust in Area B was quizzed about activity figures for minor casualty which showed the number of patients treated in a small town to exceed that for the second biggest town in the district. Surprising figures were often the result of an administrative error or a change in the way the data were being collected, rather than a 'real' change in activity levels. But Health Authorities' ability to implement hard approaches here was limited by their lack of access to independent information. Unlike fundholders, they did not have their own records of how many patients had been referred to the hospital. Of course, non-fundholding GPs could in theory have supplied the information, but the sophisticated computer systems for recording such data were usually owned only by fundholding practices.²⁴ Thus, even though Health Authorities appeared to be as desirous of checking their data as fundholders were, they were not in a position to carry out so many checks. In fact, the only area in which Health Authorities could perform some truly hard monitoring on their hard standards was in relation to communications. The Health Authority could itself monitor whether activity and quality reports had been received on time, and whether all the required information had been supplied.

Quality was an area in which Health Authorities tended to use a mixture of hard and soft standards, looking at both specific, numerical quality targets and also at general principles applicable to all aspects of the provider's work. The basic monitoring method was regular reporting from the provider. Quality managers sought to supplement the reports with meetings and site visits. Unlike cross-checking in the financial sphere, the aim was to build up close relationships in

²⁴ Fundholders were given extra money for computers.

accordance with the soft model. For example, managers who carried out site visits did not visit unannounced, to minimise the provider's opportunity to prepare for the visit (a hard approach). Instead, they would give ample warning of their intentions:

It wasn't a sort of drop-in, ha-ha, caught-you-out visit, it was arranged well in advance. We could involve anyone we wanted within that area, who we felt needed an input into the quality review visit.
(C7T)

Quality managers felt that this approach was important, usually taking the view that policing strategies would destroy trusting relationships. For example, the manager in Area B was resisting pressure from the Authority's chief executive to use surprise site visits, because she believed that this would make providers uncooperative and impair her ability to gather information.²⁵ Interestingly, soft approaches in the realm of quality could co-exist comfortably with much harder approaches to finance, because the personnel involved were different. Quality managers in Trusts and Authorities could collaborate even though their colleagues working on finance had a highly adversarial relationship. Organisational complexity could thus account for the apparent contradiction in some Authorities' relationships with providers.

But two factors often overrode this desire to use multiple monitoring methods in a soft way. Firstly, time and resource constraints and Health Authority priorities overrode quality managers' monitoring plans. Although quality often appeared on the agenda at contract monitoring meetings, it was rarely discussed, and then not in detail, because it was a low priority when compared with finance and activity.

²⁵ Compare the findings of studies of regulatory agencies, for example, Hawkins (1984).

Staffing levels affected managers' ability to conduct site visits, as we saw in Chapter IV: at the time of the study, only Authority C was carrying out a regular programme of visits. Secondly, even where visits did take place, managers admitted that they were more likely to monitor hard standards than soft ones. One manager gave this example:

I mean how would you monitor respect for privacy and dignity? We do, we actually look at privacy, we look and we try and observe are there any instances where curtains haven't been pulled round patients' beds, and things like that, so we do observe, but it's much more difficult. (C2A)

Ironically, although quality managers conducting site visits appeared to be taking a soft approach, their main focus was on hard standards. Visits were one forum in which an attempt might have been made to implement the soft model's ideal of further negotiations in which the parties worked out the meaning of a vague standard in greater detail. Purchasers were in part distracted by the ease of monitoring harder standards, and in part afraid of the controversy they might cause by probing into the meaning of softer standards.

Interestingly, the outcome of this for Health Authorities seemed to be that whether they had a high or low trust relationship with providers, they were forced to adopt an approach to information-gathering in which they took most of what providers told them 'on trust', in a rather more passive sense than that denoted by the soft model.²⁶ They attempted to monitor quality in a soft way, but were generally thwarted by time and resource constraints which made it difficult for them to use multiple monitoring methods in order to build relationships. They sought to monitor finance, activity and waiting times in a harder way but were

²⁶ Lorenz (1988) argues that this is not 'genuine' trust.

thwarted by their inability to have access to information which was not controlled by the provider. Often, they had no choice but to accept the provider's reports, whether or not they were inclined to trust the provider. We shall see below that this could in itself be a source of tension in relationships, particularly where the provider claimed that it could not meet a contractual term, because Authorities lacked the means to test such claims. By contrast, fundholders had better access to information (at least on the standards they set) and could monitor in a hard way, even though this did not necessarily, or entirely, reflect a low trust attitude towards providers. The shape of monitoring was less clearly determined by trust levels than one might have expected.

Enforcement



At the enforcement stage, the hard model is characterised by a willingness to use exit.²⁷ It may not always be possible for the purchaser to send all its patients to another provider, but if the intention is to move as many patients as possible, even a partial exit may fit the hard model. The soft model relies not on sanctions but on persuasion: the purchaser appeals to the desire of both parties to maintain a close and trusting relationship. These pure versions of the models were rare in the NHS, in part because of the weakness of the institutional factors (the market and the 'legal' system) which would normally support the models in the private sector markets in which they have been developed. This created severe problems of effectiveness, which are explored in detail in Chapter VI. Many purchasers

²⁷ A purchaser might exit without finding the current provider to be in breach of contract, perhaps because another provider has offered a better deal, but such cases are not our concern: we are interested in exit as an enforcement response.

employed what we will term an ‘intermediate’ model, in which they used sanctions such as penalty clauses. These fell short of exit and thus did not fit the hard model, but went beyond the persuasive approach of the soft model. It will be seen that all three Health Authorities used the intermediate approach in most cases, with some examples of hard or soft strategies in specific situations. Fundholders varied far more widely, with some using the hard approach, some the soft approach and some the intermediate approach. Our focus in this chapter is on the relationships associated with the use of these different types of enforcement.

Hard model

This approach was rare. As we shall see in Chapter VI, Health Authorities’ use of exit was highly constrained. But some of the more assertive fundholding practices in the sample were able and willing to use exit. They deliberately opted for the hard model, perceiving that their role was to pursue the interests of their own practice (and its patients) at all costs, without regard to the effects of their actions on providers. Breaches of high priority standards such as waiting times were commonly cited as reasons for exit.

It may seem rather strange to consider the relationship implications of exit since, obviously, it terminated the parties’ contract. But this oversimplifies the position, for two reasons. Firstly, even those purchasers with a choice of providers had only a limited choice. They might wish to return to the losing provider at some time in the future. This would be difficult if relationships had been severely damaged by the original exit. Secondly, purchasers were not always able to take

all their patients elsewhere. Some might remain with the losing provider (for example, if they had been seeing the same consultant for some time), making it important that some degree of trust should be maintained. In fact, the data revealed that it was possible to exit without damaging relationships. The out-of-county provider in Area A had lost two fundholder contracts at the time of the study, because of poor waiting times caused by a high rate of emergency admissions, but reacted very differently to the two cases. One of the practices had a history of aggressive finance negotiations with the provider, and was highly critical of the waiting times problem. The provider characterised the practice as self-interested and unsympathetic:

It's all about cutbacks and reductions every year, it's all about shifting work away, for no other reason than point-scoring, as I see it.
(A3T)

The other practice had been far more supportive, accepting the provider's excuse and emphasising its reluctance to move the contract. The practice argued that its actions were intended to obtain the best treatment for its patients rather than to punish the losing provider:

This practice... says... we can see it's all to do with emergencies... we would love to be able to keep work with you.. but really, you know, if there are marked differences, then obviously we'll have to take that patient away.
(A3T)

Trust managers made it clear that if the practices wished to move their contracts back in the future, the first would be unwelcome whereas the second would be accepted. The manner in which the exit was carried out - whether sympathetic or aggressive - was crucial to its effect on relationships. Once again, the data showed that the alleged link between the hard model and low trust was not as straightforward and inevitable as we had expected.

Soft model

The soft purchaser persuaded the provider to comply and was prepared to consider its excuses. We suggested in Chapter III that NHS contracts might fit this model, given the likelihood that many pairs of contracting parties would be in a long-term relationship and given the presence of other factors that indicated the soft model. The data revealed, however, that clear cases of the soft model were rare. Many purchasers used sanctions, such as penalty clauses, which took them into the intermediate model, discussed below.

There appeared to be three different sets of reasons for adopting the soft model. Firstly, there were purchasers who believed that it would be an effective way of achieving their goals. This was the most varied category. Authority C's quality managers used the soft model, believing that progress would best be made by building close relationships with providers' staff and persuading them to improve their practice.²⁸ Fundholders who opted for the soft approach seemed less dependent on personal relationships. Instead, they sought to attain the status of a 'valued customer' of the provider, so that when problems arose, persuasion would be sufficient to achieve change. Two practices in Area A and one in Area C fell into this category. By a carefully calculated use of exit and penalties, they had impressed on providers their seriousness about achieving high standards through their contracts.²⁹ For example, a provider had allowed some patients from one of

²⁸ Cf., for example, Hawkins (1984) in the context of regulatory enforcement.

²⁹ This is similar to the 'negotiated compliance' behaviour of regulatory agencies: Fenn and Veljanovski (1988); Ayres and Braithwaite (1992). For empirical evidence see, for example, Richardson *et al.* (1983); Hawkins (1984); Hutter (1988); Rowan-Robinson *et al.* (1990). It also reflects the need for effective persuasion to be backed by threats, discussed in Chapter VI.

these practices to wait for longer than the contractual target for treatment. The practice had sent the patients to another hospital for treatment. On subsequent occasions when patients were nearing the target, the fund manager telephoned the hospital and was able to obtain prompt dates for their operations. It was clear on the evidence that this did not indicate an adversarial, low-trust relationship. Instead, the provider treated the practice as a favoured customer, giving it advance notice of new developments and involving the fund manager in internal projects to review its services.

A second set of reasons for adopting the soft model was more overtly political. Some fundholders were reluctant members of the scheme. Their reasons for joining varied: some had been pressured to do so by the Health Authority; others felt that while they remained outside the scheme, their patients were losing out. But once they had joined, they did not wish to make use of elements of the scheme that they felt were inappropriate in the NHS. In particular, they rejected the ‘market philosophy’ of the reforms and did not wish to use exit or even intermediate sanctions. As one fundholder put it:

Somebody is actually going to have to say look, we can’t risk leaving all of this to the vagaries of the marketplace - we’ve got to look at the consequences of what we’re doing.
(B13F)

A couple of practices in the sample eschewed sanctions on this ground.

A third version of the soft model was the soft ‘default’ model. Some purchasers appeared to adopt the soft model where they did not use intermediate or hard sanctions, for example because they did not have a choice of providers, or because they believed that sanctions would be ineffective. This left them with the option of

using persuasion, or simply accepting whatever terms and conditions the provider offered. One practice in Area B fell into this category, taking the view that an individual practice could not change a provider's behaviour and that effort expended on contracting would be wasted. But it was arguable that the practice's version of the soft model (not using sanctions) was not that envisaged in the literature (more active persuasion). Instead, the practice tended to modify its expectations to what the provider was prepared to offer, failing altogether to enforce an accountability process against that provider.

The soft model's implications for relationships seem as obvious as the hard model's. It is premised on the existence of a high-trust relationship, and does not involve any activity that is likely to reduce the level of trust. Indeed, the purchaser's decision to persuade rather than use sanctions could be thought to build trust. But all three versions of the model were problematic. On the one hand, the first version depended upon an underlying awareness on the provider's part that the purchaser might complain or use sanctions if persuasion failed (cf. Dore 1983). Some use of the intermediate model was often necessary in order to ensure its success.³⁰ On the other hand, the second and third versions did not appear to involve the full collaboration and joint working to address the problem implied by the pure model itself. This seemed to be because these versions of the models were not necessarily linked to high-trust relationships. Purchasers did not try to help; instead, they merely refrained from punishing the provider.

³⁰ As we shall see in Chapter VI, the purchaser could not rely on competition to supply underlying threats.

Intermediate model

This model involved using sanctions but without bringing the parties' relationship to an end. Perhaps the most severe of these intermediate sanctions was partial exit, in which the purchaser would send some patients to another provider as a temporary measure, with an intention of returning when the provider's performance improved. Other measures included penalty clauses (see NHSME 1990*a*), or refusing to pay invoices in whole or in part. The intermediate model was the normal approach of Health Authorities, at least in relation to high-priority standards, and was common among fundholders.

Health Authorities tended to use the intermediate model as a last resort. As we shall see in Chapter VI, they lacked a realistic prospect of exit. This would appear to suggest long-term relationships and therefore the soft model, but in practice most Authorities felt that for a variety of reasons, they needed some form of sanction.³¹ One argument was that the sanction was a last resort when persuasion failed:

We would much rather talk it through and try and sort it out and agree an action plan to put the problem right, than take money out of the contract... but nonetheless... you've got to have some ultimate sanction.

(A2A)

There was a general sense that a contract that relied solely on persuasion to achieve compliance left the Authority rather exposed to the provider's whims. The presence of a penalty gave the Authority a greater degree of reassurance. Moreover, the use of penalties also reflected Authorities' priorities, which in turn

³¹ Again, this reflects the need for persuasion to be backed by threats (see Dore 1983), reflecting similar findings in regulation. See, for example, Hawkins (1984).

reflected the concerns of central government. All three Authorities used or had used penalty clauses for waiting times and other Patients' Charter standards, which were clearly derived from the centre, and for the supply of information for contract monitoring. Where the issue was a high priority, Authorities did not feel that they could rely on persuasion alone. This contrasted with the position for quality, a low priority area usually left to the soft model.

Most fundholders (other than those using the default or political versions of the soft model) adopted an intermediate approach, using penalties for their own high priority standards. Like Health Authorities, they used penalty clauses, but they also had a range of other less formal techniques for imposing sanctions. One such strategy was refusing to pay invoices, for example where clinical letters had not been received in respect of items of activity.³² Another strategy was partial exit. Several practices had moved some patients to another provider in protest at poor communications or waiting times, moving them back when the losing provider's performance improved. Practices explained that their use of these techniques was designed to highlight the importance of the standard in question, and to draw the provider's attention more sharply to their requirements:

Just negotiating [the penalty clause] somehow heightened the issue... basically if you put money on it, if you show that you're prepared [to act]...
(A12F)

Although such sanctions were often a response to the fact that persuasion had failed, they could, as we saw above, make future attempts to achieve compliance through persuasion more successful (cf. Hawkins 1984).

³² Discussed above under monitoring.

What were the relationship implications of the use of penalties by purchasers? Negotiating for a penalty clause to be included in the contract might imply that the purchaser anticipated problems and did not trust the provider to comply. Empirical studies of contracts between businesses have shown that such clauses are avoided for precisely this reason (Macaulay 1963). The findings tended to support this view. Providers often drew attention to the fact that contracts never contained incentives, and argued that their own willingness to work on improving performance was not enhanced by the presence of penalties:

They didn't act as a spur, and by penalising us, it wasn't going to be able to make us do something that we were really struggling to do any quicker than we would do by the sheer determination that we were going to try and get it right.
(C7T)

Nevertheless, purchasers included penalties because they were afraid of being left without a remedy in the event of a breach. As we shall see in Chapter VI, the weakness of the institutional support for contracts contributed to this, because it meant that purchasers could not rely on the market or the legal system to safeguard their rights.

One might expect that *invoking* a penalty would cause even more damage to relationships. But the data revealed a strong link between the effectiveness of penalties and their impact on relationships (Davies 1999). If they prompted the desired compliance, the relationship could survive. If they did not prompt compliance, relationships deteriorated. The effectiveness issues touched on here will be explored in more detail in Chapter VI. Penalties seemed to prompt compliance where the provider was clearly to blame for the breach, did not have a good excuse for its failure and could easily put the problem right. This meant that

fundholders' penalties for clinical correspondence were often effective (although some departments were quicker to respond than others):

We said if you don't write to us we don't know what's going [on] - we'll go somewhere else. It actually suited us to send our patients back there, so when they sorted it out, most of them have gone back. It does sharpen the minds, especially if you tell them you're doing it.
(C13F)

The decision to exit did not appear to have caused any relationship difficulties: the provider had responded to the problem and the purchaser had rewarded it by bringing its business back. Providers were able to acknowledge that some sanctions were fair: one manager in Area A admitted that her Trust had been slow to modernise its management structure and should have anticipated purchasers' demands for change. Purchasers' resort to sanctions had been understandable:

I would say probably that the Trust needed that kick, really, from our purchasers.
(A15T)

Where penalties failed, relationships did suffer. Authority C had used penalties to tackle breaches of Patients' Charter standards on waiting times at its main local provider. The provider claimed that a high rate of emergency admissions made it impossible to meet the standards, and produced good evidence for its claims:

And we did it for a couple of quarters, and then [the Trust's Chief Executive] wrote across and said I'm really cheesed off with these penalties, because you know full well the problems we've got in terms of capacity, we're stuffed to bust with medical emergency admissions, we haven't got any beds, you won't give us any more money to open any more beds, you know, it's a bit over the top to keep penalising us on these sorts of things. And we sort of said yes, fair do's, it's perhaps not an appropriate thing to carry on doing.
(C4A)

The damage to relationships was enormous. The provider's staff resented the Authority's behaviour and felt that their goodwill and honesty had been called into question. The Authority had been forced to stop applying the penalties, and eventually to remove them altogether from the next year's contract, to prevent the problem arising again. But the most significant problem with penalty clauses was

that they were often used by purchasers who lacked any real prospect of exit if their penalties failed. Where penalties were used as a stepping-stone on the way to exit, as they were by some fundholders, it did not matter that they damaged relationships. The practice would simply respond by terminating the relationship altogether. But for Health Authorities and other fundholders, penalties that failed could be a source of extreme discomfort in a relationship they were bound to continue.

Enforcement was a complex area. Health Authorities adopted a relatively uniform approach, using intermediate strategies in high priority areas and softer strategies in low priority areas. There was greater variety among fundholders: each practice tended to adopt the same approach in most situations, but that approach could be any one of the three possibilities. The soft approach both reflected and built on a positive relationship, but was rarely encountered in practice because it depended, crucially, on the provider valuing the purchaser's custom. The use of sanctions could sometimes be necessary to achieve that 'valued customer' status. The hard approach terminated the parties' relationship for the time being, but interestingly, relationships of trust could be maintained if it was used fairly. The intermediate approach was the most problematic. Although sanctions did not damage relationships if they were fairly applied, they could destroy trust where the provider argued that it was not to blame for the breach. This caused particular difficulties where the purchaser was forced to remain in a relationship with the provider even after the sanction had been used. In short, fairness was the crucial factor in maintaining relationships here, whatever the model in use.

Conclusion

Summarising the model adopted by each type of purchaser is a difficult task. Broadly, fundholders used the hard approach for most aspects of their negotiations and for contract monitoring. Their contracts were drafted in a hard way but were far from comprehensive. Their behaviour varied most widely at the enforcement stage: hard, soft and intermediate approaches were used by different practices. Fundholders' use of the hard model often reflected relatively low-trust relationships with providers, particularly on administrative matters, although trust in providers' clinical competence remained high. But the findings were not straightforward: we saw, for example, that some practices refrained from hard enforcement methods on policy grounds, either believing that persuasion would be more effective or that sanctions were not appropriate within the NHS.

Health Authorities' relationships were more mixed.³³ They used both models for negotiation and drafting. Their monitoring fitted a weak version of the soft model, in which they were unable to carry out sufficient checks in order to implement the hard model. To enforce their contracts, they used soft and intermediate approaches. Several factors explained the findings. One practical problem was that Authorities could not easily have implemented the hard model, given their limited choice of alternative providers and their limited access to independent information for hard monitoring. Another important factor was the

³³ Cf. Turpin (1989) on the tension between adversarialism and collaboration in government procurement.

influence of central government: we saw that central pressure to achieve certain standards pushed Authorities towards the hard model when those standards were at stake. But trust levels were also relevant. On the one hand, there were cases in which high trust between staff facilitated the effective use of the soft model, particularly for quality. On the other hand, for high priority central standards, the pressure on Authorities was so great (and the standards so difficult to meet) that they could not simply trust providers to comply, and felt a need to resort to enforcement methods such as penalties. Not surprisingly, these mixed approaches were a source of considerable tension in relationships.

Our understanding of accountability relationships in the NHS has been significantly advanced by the study. The hard and soft models proved to be a useful addition to our armoury of analytical tools: they helped to organise our thinking about the data and to explain some of the findings. This was the case even where it was the *non-implementation* of a particular model that accounted for the findings. For example, we saw that use of the soft enforcement model was constrained by the need for effective underlying threats.³⁴ But the discussion has highlighted the need for some caution when applying the models. In particular, the links between particular features of the models and trust levels were more complex than we predicted. For example, a purchaser's apparently soft involvement in detail could denote low trust. Hard standards could simply reflect their subject-matter, and act as a means of building trust by preventing disputes about interpretation. It is therefore worth checking, when using the models, that the

³⁴ See further Chapters IV and VI.

assumed link between a particular model and a level of trust is in fact present in the contract being studied. But the models were undeniably useful as a means of classifying and understanding contractual accountability relationships.

Finally, the data have demonstrated the complex relationship between accountability and trust (cf. Power 1997). Purchasers' accountability relationships did not eliminate the need for some reliance on providers: contracts did not contain (and could not have contained) a complete set of standards covering all aspects of performance. Moreover, we saw that within the accountability relationship itself, trust could play either a major or a minor role. Under the soft model, it enabled the parties to use collaborative methods for each component accountability task. Under the hard model, it could not be eliminated entirely: we saw that even during hard monitoring, there could not be an infinite regress of checks on the explanations proffered by the provider.

EVALUATION: PROCEDURAL FAIRNESS AND TRANSPARENCY IN THE GOOD ACCOUNTABILITY RELATIONSHIP

Chapter III drew attention to the fact that an accountability process, like any other governmental activity, should be subject to the familiar procedural requirements of due process and transparency. That chapter also introduced some of the difficulties of applying these requirements to contracts: the reader is referred to that discussion for a general background to what follows. We will concentrate here on

the ways in which the empirical findings can be used to advance our initial interpretation of the procedural principles.³⁵

The good accountability process is characterised by its regard for the principles of due process.

Evaluating the findings against the due process principle is a highly complex task. As we saw in Chapter III, fair procedures must be matched to the context in which they are to apply,³⁶ and to the values they are intended to serve (Galligan 1996). Given that we are concerned with a *contractual* accountability relationship, we must seek procedures which promote consent, at the most general level: contracts derive their legitimacy from the fact that the parties agree to the obligations they impose (cf. Bayles 1990). (We noted the limits of this principle in Chapter III: genuine accountability may require that the caller to account should be able to impose standards on a recalcitrant provider, even though this would involve setting standards without the provider's consent.) But in designing fair procedures, we must also take account of the different versions of a contractual accountability relationship described by the models. The soft model emphasises consensus throughout the contract; the hard model requires limited consensus during

³⁵ This explains the omission of the awarding of contracts and dispute resolution from our discussion of procedural fairness. Although fairness is important in both activities, the study did not yield enough relevant empirical data to advance our understanding of them. The reader is referred to n. 54, below for discussions of fairness in the former and to Harden (1992: 76) for fairness in the latter.

³⁶ One important aspect of the context is the balance of bargaining power between the parties. It is arguable that the party with superior power is under a particularly strong obligation to treat the other party fairly. We will return to this point in Chapter VI, in which bargaining power issues in the NHS are discussed in full.

negotiations and approximates more closely to a formal process of applying standards³⁷ once the contract has been agreed.

Consensus

The influence of central government requirements has been a constant theme of the empirical material. Such requirements posed a serious threat to the value of consensus in NHS contracts, and therefore to their procedural fairness. On the one hand, it could be argued that central requirements were simply the basic background of regulatory rules against which contracting took place. These non-consensual rules did not wholly undermine the value of mutual agreement in the contract; they simply limited the sphere in which that agreement was able to operate. On the other hand, central requirements in the NHS did not take the form of rules to regulate contracting. They were obligations not for both parties, but for purchasers alone, to be included in those purchasers' contracts with providers.³⁸ This undermined the value of consensus in the contract because technically, it obliged one contracting party to impose standards on the other, even though the ultimate source of those standards was the centre. The harm this could cause was discussed in detail above: providers resented the imposition of standards and trusting relationships between the parties were damaged. Obviously, some central regulation of contracts was inevitable:³⁹ there were limits to the extent to which the government was prepared to leave minimum standards in the NHS to the vagaries of the bargaining process. But by regulating one party rather than both,

³⁷ See Galligan (1996).

³⁸ Contrast the absence of binding 'external standards' discussed in Bayles (1990: 177).

³⁹ The appropriate extent of central regulation is a matter for debate.

the government undermined purchasers' attempts to observe procedural fairness by obtaining providers' agreement to the various aspects of the accountability process.

Fairness and the models

How closely did purchasers themselves conform to the requirements of due process in the contractual accountability relationship?⁴⁰ At the contract negotiation stage, purchasers using the hard model did not pay much regard to fairness. They used an extreme version of the model which was not justified, in the cases studied, by an unreasonable refusal on the part of the provider to negotiate or agree to standards. (We noted above that in extreme circumstances, accountability might require the imposition of standards without the provider's agreement.) It involved imposing standards, without engaging in any consultation with providers as to the content of the standards or taking account of providers' representations: Authority B's quality negotiations were a case in point. Moreover, there was some evidence that purchasers failed to share information which would affect the provider's agreement: for example, fundholders withheld information about the implications of particular financial deals. These findings may simply express the hard model's vision of each party seeking to protect its own interests during negotiations.⁴¹ But they raise two possible concerns about fairness. Firstly, purchasers did not take

⁴⁰ During monitoring, due process obliged providers to share information (under the soft model) or to supply information when required (under the hard model). It also obliged purchasers to seek out accurate information on which to base a judgement as to providers' performance. These issues are dealt with in Chapter VI: they raise crucial issues about effectiveness as well as having implications for due process.

⁴¹ Bayles (1990) argues that the requirements of fairness in negotiations are minimal, although he does accept that some intervention may be necessary to preserve the voluntariness of the agreement.

account of whether the provider was able to look after its own interests before adopting this strategy.⁴² For example, Authority B secured agreement to its quality standards because the provider did not wish to put its main contract at risk by provoking a dispute. Similarly, fundholders undermined providers' ability to look after their own interests by concealing relevant information. Secondly, as we shall see in the discussion of enforcement, below, it is not clear that the pursuit of self-interest by one public body to the disadvantage of another public body is appropriate behaviour, given that both should be governed by considerations of the wider public interest.

Drafting created particular due process problems for Health Authorities. Their use of a mixture of hard and soft standards raised the twin dangers of inconsistency and confusion. The problem of inconsistency would arise where an Authority using a mixed approach attempted to apply a soft standard in a hard way. This would be unfair to the provider, because it would not necessarily have been able to use the standard to guide its conduct: soft standards failed to meet the hard model's requirement of clear and precise standards set out in advance. The converse situation demonstrates the danger of confusion. A provider, confronted with a hard standard in a contract also containing soft standards, might expect that standard to apply subject to collaborative negotiations. It might be surprised to discover that the standard was not open to debate, but applied exactly as set out in the contract. Procedural fairness here depends on a clear understanding by both parties as to the way in which the standards will be applied. In particular, if the

⁴² This illustrates the point in n. 36, above, that the obligations of procedural fairness are particularly strong where one party has superior bargaining power.

standards are to be applied in different ways, it must be possible to divide up the contract clearly into a hard part and a soft part. To some extent, Authorities did succeed in doing this. Hard standards were applied in a hard way in the financial sphere; soft standards were applied in a soft way for quality. The contractual relationship could be split because different members of staff dealt with these issues. Although the study found no clear evidence of these problems, the danger was obvious.

It was at the enforcement stage that procedural fairness presented the greatest number of pitfalls for purchasers. As we saw above, persuasion, even in its strongest form, usually denoted the absence of sanctions rather than the presence of any very active involvement on the part of the purchaser. In particular, it was not clear that purchasers were willing to share the responsibility for problems or to help the provider to solve them. This suggests that the value of collaboration was not implemented to the full during soft enforcement in the NHS.

Intermediate enforcement (which, in terms of procedural fairness, seemed closer to the hard model) presented two problems. One was that fairness would appear to require that the provider be given advance warning of the penalty to be imposed. Health Authorities usually satisfied this requirement because they relied on contractual penalty clauses. These were agreed between the parties and included in the contract from the outset. Fundholders used a range of less formal methods, including refusals to pay invoices or partial exit. It was arguable that these methods were unfair where the provider was not warned of the action to be taken. In practice, many providers did become aware of impending sanctions

because purchasers did not resort to the sanction without threatening to do so first. But this occurred because it was a useful tactic for purchasers, rather than because they acknowledged the need for due process in their dealings with providers.

The second difficulty with intermediate enforcement also afflicted hard enforcement through exit. Purchasers did not always give providers a hearing before using the sanction, or take notice of the representations they made. To punish the provider without giving it a chance to put its case seemed of the essence of a procedural impropriety. Did purchasers have any justification for their behaviour? One argument was that some purchasers held providers liable for breaches regardless of whether or not they had a good excuse. In such cases, giving the provider a hearing would have been pointless. The main difficulty with this position was that purchasers did not always make their stance apparent to providers when the contract began. Most purchasers were prepared to listen to excuses, thus placing a burden on those who did not do so to inform the provider of their practice. Another argument was that providers' excuses were not always genuine. The only way to test them was to apply a sanction, and wait to see if the provider abandoned the excuse. This strategy seemed unfair. Although providers' excuses were sometimes unconvincing, this was not invariably the case. Giving providers a hearing would have allowed purchasers to identify reasonable explanations supported by evidence before even applying a sanction. This would have prevented the difficulties encountered by Authority C in the penalty clause example given above.

The findings raised two more general issues of due process in NHS contracts: the problem of mixed models, and the vexed question of fairness within the hard model. The hard model was adopted by fundholders (with some variations at the enforcement stage) and by Health Authorities for issues such as finance and waiting times. We have identified some senses in which the hard model fits familiar procedural principles: for example, standards are set out clearly and in advance, in order to guide the behaviour of those subject to them. But there are other aspects of the hard model which are more difficult to square with traditional notions of procedural fairness. Was it fair to conceal information, to disregard excuses or to impose sanctions without advance warning? The hard model treats all these actions as normal market behaviour. We suggested in Chapter III that the requirements of procedural fairness might override some of the extremes of the hard model. The suitability of those extremes in public sector contracts can be questioned on two levels.

Firstly, does its fairness depend on whether each party is *capable* of defending its own interests?⁴³ Procedures are particularly important where there is a power imbalance between the parties. We expect government to observe fair procedures partly because citizens are not in a good position to defend themselves from an arbitrary or improper use of power unless they are given an opportunity to put their case, for example.⁴⁴ If accepted, this view would cast doubt on whether it was appropriate, for example, for a Health Authority to pursue self-interest as against its main provider, dependent upon it for the bulk of its income. Secondly, is the

⁴³ See n. 36, above.

⁴⁴ See, for example, the discussion of legal representation in Galligan (1996).

unconstrained pursuit of self-interest appropriate in a *public sector* market? This more fundamental objection strikes at the heart of market-based reforms. On the one hand, it could be argued that promoting the pursuit of self-interest was the purpose of the reforms (see Chapter I). They played on public choice notions of bureaucratic self-interest by creating smaller agencies with divergent interests. Competition between these agencies would promote improvements in service quality and efficiency. Notions of fairness might impede the free play of competitive forces by giving weaker agencies an opportunity to justify their failures rather than face the market consequences of a poor performance. On the other hand, it could be argued that this type of self-interest is illusory. The various agencies' short-term interests did perhaps diverge: the purchaser's desire to stay within budget might not have been compatible with the provider's desire to break even. But purchasers and providers also showed signs of 'benevolence', and did not always pursue their 'own interests' at all costs.⁴⁵ This could suggest a longer-term view of self-interest, in which the parties to an ongoing relationship acknowledged that making a gain one year would make subsequent years' negotiations more difficult (implying either the soft model or a constrained version of the hard model). More fundamentally, it may suggest that a wider public interest was also at stake (implying at least a partial rejection of the public choice argument). On this view, procedural fairness could have played a central role in promoting that wider public interest, by ensuring that NHS contracts did not unduly disadvantage either party.

⁴⁵ This study identified a number of examples: providers' maintenance of high clinical standards, for example, and purchasers' use of the soft model even where it was not in their immediate interests to do so. See also the discussion in Barker *et al.* (1997).

How might the hard model be tempered by principles of procedural fairness? Firstly, self-interest should not be pursued where one party is clearly less able than the other to protect its interests.⁴⁶ In these circumstances, the stronger party should assume some responsibility for ensuring that the deal struck is fair to the weaker party, at least by using a consultative version of the hard model, or even by moving to a fully collaborative soft approach. Secondly, the contractual relationship should be governed by some traditional principles of procedural fairness in the application of standards and the use of sanctions. The parties should be obliged to supply relevant information on request, and the purchaser should be obliged to give the provider an advance warning of sanctions and the opportunity to make representations. Observance of these principles of fairness would help to maintain relationships and to ensure that standards and sanctions are accurately and appropriately applied. Importantly, the data showed that sanctions prompted compliance without harming relationships where they were perceived by providers to be fairly applied: where the provider had been warned about the sanction but had no good excuse for its breach, for example (Davies 1999). This suggested that providers linked fairness with traditional due process, rather than with the pursuit of self-interest by each party. Fair procedures were more central to good accountability relationships - even under the hard model than the NHS contracting parties appeared to realise.

The second general issue raised by the NHS data was the problem of mixed models. This was particularly relevant to Health Authorities. It raises the question

⁴⁶ See Brown and Bell (1998) for related principles of French administrative law, in the context of the government's contracts with private bodies.

of how we might describe the requirements of procedural fairness in a contract in which more than one model is in play. One possibility would be to argue that a mixed contract is inherently unfair: it is open to the problems identified above and should therefore be avoided. But this would restrict the parties' freedom of action: mixed standards were arguably a sensible response to concerns about varying levels of complexity and priority in the issues to be covered. Fairness in the mixed approach seems to require the observance of two key principles. Firstly, it should be possible to separate clearly the issues to be treated in a soft way from the issues to be treated in a hard way. Health Authorities did this when they used hard standards for finance and waiting times, which were dealt with by finance staff, and soft standards for quality, dealt with by quality staff. They were thus divided by subject-matter and by the members of staff responsible. This minimised the risk of inconsistency in the application of the standards. Secondly, the purchaser should ensure that the provider is aware of how the mixed approach is to be used. This should address the danger that the provider might mistakenly assume, for example, that all the contract's terms were open to negotiation, despite the presence of some hard standards. But this would have required a much stronger awareness of the need to observe the principles of due process than was apparent in the behaviour of most NHS purchasers.

The good accountability process is transparent to interested third parties.

It will be recalled from Chapter III that transparency involves two main elements: clear and comprehensive documentation, and demonstrable monitoring and

enforcement procedures.⁴⁷ Both types of purchaser included some transparent elements in their contracts. Neither pursued transparency as an express goal, but interestingly, Health Authority contracts were more transparent on issues for which the Authority was obliged to account to the NHS Executive. This helped to confirm the rationale for the principle, as a support for onwards accountability processes.

Fundholders' contracts tended to conform to the hard model, with some exceptions. This meant that they scored reasonably highly on the scale of transparency: as we saw in Chapter III, the hard model has obvious advantages in this regard. Fundholders' contract documents set out the required standards clearly and in advance, leaving little for further negotiation. Moreover, fundholders' monitoring was highly transparent, since it often involved the use of their own sources of information: they could demonstrate from their own records the provider's rate of compliance with waiting time targets, for example. But there were untransparent elements. One was that the contracts, as we saw above, were far from comprehensive. Many issues were disregarded altogether, or addressed through unspoken assumptions. This meant that although the contracts themselves were accessible to an outsider, they did not express the totality of the parties' relationship. There were also problems with enforcement. Some practices used soft enforcement, which was inherently untransparent. Some used exit, but this was not provided for in advance and its nature as punitive or otherwise was not always made clear. Finally, some used intermediate sanctions. These were

⁴⁷ Harden (1992) sees these features as one of the benefits of the use of contract in the public sector, but does not distinguish different models of contractual relationship in his discussion.

demonstrable punishments but were not always included in the contract. In particular, fundholders were more likely than Health Authorities to use partial exit or non-payment of invoices, rather than penalty clauses set out in advance.

Health Authorities used a mixture of the two models. This meant that their contracts were untransparent to the extent that the soft model was in use. For example, Health Authority contract documents were dependent upon a range of unspoken assumptions, and contained some broad standards which were difficult for the outside observer to understand. Moreover, they used softer monitoring methods (for quality standards) and because of their poor access to information, could not demonstrate as clearly as could fundholders that providers were meeting the standards set. Persuasive enforcement strategies were also common, particularly for quality, making it difficult for Authorities to show that they were acting on breaches.

The softer side of Health Authorities' contracts highlighted one of the inherent problems of 'new public management' reforms, mentioned in Chapter I. Where power is devolved to a semi-autonomous body, which remains subject to controls by another body, confusion may result as to their respective roles. This confusion may lead to disputes between the two bodies as to the correct balance between autonomy and control. It may also be untransparent to outsiders. As we saw above, providers resented perceived instances of 'interference' by Health Authorities, which usually took place during detailed discussions outside the framework of the contract document. Although the parties usually had a sense of what would constitute illegitimate involvement by a purchaser, they did not (with

limited exceptions) use the contract document to attempt to set out their respective roles. This created particular problems where a breach of contractual standards could be attributable to the purchaser as much as to the provider, as in the case of waiting times, where funding levels affected the provider's ability to meet targets. It also reflected the familiar problem (experienced in the law of negligence, in the nationalised industries and in relation to Next Steps agencies⁴⁸) of drawing a clear distinction between policy (for purchasers) and operations⁴⁹ (for providers).

Central guidance merely re-stated the difficult distinction:

The contractual process will give hospitals...increasing freedom to manage the delivery of services as they think best. The changing role of [Health Authorities] from service managers to service purchasers will increasingly mean that they will concentrate on *what* services their residents need, without specifying in detail *how* every service is to be provided.⁵⁰

This was an area in which a greater focus on transparent contract drafting would have served the useful function of clarifying responsibilities both for the parties themselves and for outsiders.⁵¹

In some areas, however, Health Authorities deliberately opted for the hard model. Waiting time standards were set out clearly in the contract, with penalty clauses to be invoked in the event of a breach. Activity levels and remedies for over- or under-performance were also carefully defined.⁵² Their use of the hard model was linked to the need to meet targets dictated by central government. In part, the model helped Authorities to demonstrate, when asked by the regional

⁴⁸ See Chapter I.

⁴⁹ Literally!

⁵⁰ NHSME (1989: 2.11), emphasis in original.

⁵¹ The soft model solves this problem by insisting that the parties' responsibility is joint. But this was unlikely to work in the NHS, given that providers (and purchasers) were keen to maintain some separation between their roles, as we saw above.

⁵² Some of the practical limitations on Authorities' implementation of the hard model were noted above.

office, that they were doing everything within their power to ensure that the standards were met. This confirmed the link between transparency and accountability. When Authorities were to be called to account for their performance against particular targets, they made their efforts to achieve those targets transparent. Instead of persuading providers to treat patients promptly, Authorities demanded that providers should treat patients within a specified time limit or face a financial penalty.

Thus, NHS contracts were reasonably, though not entirely, transparent. The principle of transparency gives us a reason for preferring the hard model where the caller to account is subject to onwards accountability mechanisms. But there are two difficulties with expressing this as a strong preference. Firstly, the soft model may have other features to recommend it: the parties themselves might prefer more collaborative relationships, and it has been argued that the soft model is more effective than the hard model (a claim which will be explored in Chapter VI). Secondly, we have seen that the hard model can be difficult to implement, particularly at the drafting stage. The findings showed that some issues did not lend themselves to precise specification as required by the model. Nevertheless, evaluation using the principle of transparency has demonstrated a major advantage of the hard model, and an important argument in favour of employing at least some hard elements in contracts.

In conclusion, we have seen that NHS contracts did observe some aspects of procedural fairness, and were at least partially transparent. We have noted some of

the complexities of applying those principles to contractual accountability relationships, and some of the steps which might have been taken to bring NHS relationships more closely into line with the principles. The conclusion, below, seeks to generalise from the NHS findings.

CONCLUSION

Our analysis of the empirical findings in terms of relationships, and our evaluation of those findings in terms of procedure, should help us to make some progress towards the emerging notion of the ‘public law contract’, introduced in Chapter II.⁵³ We have linked the key ideas of contract, accountability, due process and transparency. This has given rise to a number of general principles which might be of relevance to other public sector contracting contexts. The generalisations made here do, of course, require further research to test their validity.

One crucial finding from this study is that it is important to consider not only the award of the contract but also its subsequent management. English public law has begun to address the award of contracts,⁵⁴ partly prompted by EC developments, but detailed principles have not yet been developed to govern behaviour during the contract’s life.⁵⁵ As we have seen, this involves various

⁵³ See also Harden (1992); Freedland (1994; 1998) Hughes *et al.* (1996); McHale *et al.* (1997); Vincent-Jones (1997).

⁵⁴ See Turpin (1989); Arrowsmith (1992); Craig (1994); and Brown and Bell (1998) for the position in French law.

⁵⁵ Harlow and Rawlings (1997) recognize the importance of this aspect of government contracts, which they term ‘contract technology’.

administrative activities (applying standards to facts; applying penalties and so on) to which due process principles ought to be applied, in the ways suggested above. Without detailed empirical work, this important point might not have become apparent. Of course, the relative unimportance of contract awards in the NHS might in itself be unusual,⁵⁶ but this does not diminish the value of examining the behaviour of contracting parties during the life of a ‘public law contract’ for its conformity to the principles of due process.

Another very general lesson from this study is that the core contractual value of consensus should be observed in the way that ‘public law contracts’ are regulated. As we saw above, the NHS practice of regulating the purchaser rather than both parties blurred the distinction between central regulation and those aspects of the parties’ relationship that were open to joint negotiation. This undermined purchasers’ attempts to behave fairly by seeking the provider’s agreement to the standards set, whether in the limited way suggested by the hard model or in the fuller sense of the soft model.

Most importantly, this study has shown how familiar procedural principles of due process might be applied in a way which is sensitive to the special needs of the contractual accountability relationship and to the different forms it might take, under the hard and soft models. We have modified some common assumptions about fairness to fit the models: for example, we acknowledged that standards did not need to be clear and precise - despite the usual Rule of Law requirement - under the particular circumstances of the soft model. We have modified some

⁵⁶ It will be recalled that all the NHS contracts studied were renewed as a matter of routine.

aspects of the models to meet the demands of fairness: in particular, the hard model's extremes of concealing information and punishing without warning were rejected on due process grounds. Our conclusions on fair procedures under each model can be summarised in the following way:

Soft model:

- collaborative negotiations (as far as the need for some purchaser domination allows); an obligation on both parties to share information during negotiations; no requirement to set out clear standards in advance (but no ban on doing so where the parties feel that clarity is desirable)
- an obligation on the provider to share information for the purposes of monitoring
- an obligation on the purchaser to take account of the provider's explanations and excuses at the enforcement stage, and to take joint responsibility with the provider for solving the problem which has led to the breach of standards

Hard model:

- relatively collaborative negotiations with no deliberate concealment of relevant information; clear and precise standards set out in advance as a guide to conduct
- an obligation on the provider to supply relevant information on request for the purposes of monitoring
- an obligation on the purchaser to give advance warning of any sanctions to be applied, and to give the provider a hearing at which to offer its explanations and excuses

Our discussion also highlighted one factor governing the choice between the two models: transparency. This is particularly important where the caller to account does not act on its own behalf, and needs to be able to explain its conduct towards the body being called to account during an onwards accountability process to an interested third party. We have seen that hard contracts are naturally transparent: they favour the use of clear contract documentation and demonstrable monitoring and enforcement methods. Soft contracts, on the other hand, do not necessarily fulfil this value. They may include some clear standards: as we saw, such standards might be used where the issue to be addressed lent itself to precise specification. But the requirements of due process under the soft model do not create an obligation to use clear standards (because the parties' ongoing negotiations render them unnecessary) or demonstrable action (because collaboration is more difficult to demonstrate). One way to solve this dilemma is to use the mixed contract, partially hard and transparent and partially soft. But this has its own procedural complexities: as we saw above, it is important that the parties should be able to separate the different elements of the contract and to be clear about how the mixed approach is to function. Implementing transparency is not straightforward, but we have at least illustrated some of the factors to be considered when approaching that task.

We would expect any accountability mechanism to involve respect for procedural fairness. This is most obvious in mechanisms such as complaints procedures, in which individuals may be criticised and punished for falling short of required standards, but it is also relevant where the mechanism is a contract.

This study has highlighted the importance of developing the procedural dimension of the 'public law contract', and has begun to address some of the difficulties of achieving a fit between familiar procedural principles and contractual processes of accountability.

VI

Hypothesis 3: Effectiveness

The purchaser might not be able to make the accountability process through the NHS contract effective.

Where it could be fully implemented, the soft model was likely to be a more effective method than the hard model for the performance of the accountability tasks.¹

Our third research hypothesis cast some doubt on whether purchasers would be able to institute an *effective* accountability process through their contracts. In order to measure effectiveness, we identified some general goals of accountability which purchasers might be expected to pursue:²

- during contract negotiations, the goal of setting the standards they believed to be in the public interest, normally by agreement with the provider but with the possibility of imposing standards where the provider's objections were unreasonable
- during the life of the contract, a primary goal of obtaining performance in accordance with the standards set, supported by the goals of obtaining information in order to monitor performance, and a reasonable explanation if standards were not met

The first limb of our hypothesis predicted that purchasers would find it difficult to achieve these goals. The purchaser would be unlikely to succeed unless its

¹ Chapter III.

² Within the constraints identified in Chapter IV.

bargaining position was superior to that of the provider. But purchasers' bargaining positions would be weak, for the following reasons:

- the NHS 'internal market' was likely to lead to some contestability at the margins, rather than full competition (Walsh *et al.* 1997). Purchasers who were unhappy with a particular provider might not be able to move their contracts elsewhere. This would impair their ability to negotiate the terms they required and to enforce them during the contract's life. The provider could resist the purchaser's requirements in the knowledge that it would not lose the contract
- the 'legal system' surrounding NHS contracts would offer some support to purchasers at the contract negotiation stage, by enabling them to invoke arbitration where a provider sought to impose terms.³ But its use was discouraged by the NHS Executive.⁴ During the life of the contract, it was of no assistance to purchasers because providers knew that it was unlikely to be invoked
- NHS providers would usually have greater expertise and information about their services than purchasers, giving them a bargaining advantage at the contract negotiation stage and during monitoring

The first section of this chapter examines the study's data on effectiveness. It is divided into two subsections, one on negotiating the contract and the second on enforcement. Our predictions were largely confirmed by the findings.

The second element of the hypothesis was that the soft model would be a more effective means of performing the accountability tasks than the hard model, where

³ National Health Service and Community Care Act 1990, s. 4, and National Health Service Contracts (Dispute Resolution) Regulations 1996 (SI 1996/623).

⁴ Interview data. See also McHale *et al.* (1997).

it was fully implemented. This was based on the view expressed in the literature that, for example, minimising the problem of information asymmetry through building a trusting relationship was more likely to be successful than seeking to combat the problem through policing (Dore 1983). Some attempt will be made to examine the study's findings for evidence of this, in the first section of the chapter. But such analysis is limited by the fact that wherever the purchaser's bargaining power was weak, the models could not be said to be fully implemented. The models are derived from studies of competitive markets.⁵ Where - as in parts of the NHS - a market is not fully competitive, the purchaser may not be able to take its business elsewhere. The provider knows that it will keep the contract, even if it refuses to agree to some standards or breaches those it has agreed. The models' fundamental assumption, that the provider would be responsive to the purchaser, was not always present. Our evaluation of the models themselves was therefore limited.

The first section of the chapter, though analytical, has close links with evaluation. The clear distinctions drawn in Chapters IV and V between analysis and evaluation are impossible here. An ineffective accountability process is obviously a bad accountability process. But the second section of the chapter is more explicitly focused on reform, and examines two important questions: what could have been done, firstly by purchasers themselves, and secondly by central government, to make the accountability process through NHS contracts more effective? Our findings indicated a number of problems, some of which were easier to solve than others. Perhaps the most striking difficulty was the general

⁵ For example, Dore (1983); Sako (1992).

failure on the part of the system's designers to acknowledge that the public sector context might require a different understanding of the familiar private law notion of a contract: excessive reliance was placed on market forces to support purchasing, despite their obvious weakness in many areas. The implications of this for the emerging concept of the 'public law contract'⁶ are explored in the conclusion.

WAS THE CONTRACTUAL ACCOUNTABILITY PROCESS EFFECTIVE?

Before we turn to the data, some methodological caveats are in order. Firstly, purchasers' difficulties were generally easier to spot than their successes. In interviews, purchasers drew attention to problem areas, and to successes that had been achieved after a struggle: they could take credit for their efforts. But it was important not to ignore cases in which providers complied without the need for purchasers to exert any obvious pressure. These 'hidden' successes were likely in those instances in which the purchasers' demands *were* backed by an effective threat of exit, for example. Thus, cases in which purchasers were at their most powerful were not always immediately obvious in the data. Secondly, some caution must be exercised when explaining the findings. As we shall see, it was not always possible to make a direct link between particular cases of purchaser weakness and particular features of the purchaser's situation. Although we may be able to suggest likely explanations, we cannot always assert a cause and effect

⁶ See Chapter II and Harden (1992); Freedland (1994; 1998) Hughes *et al.* (1996); McHale *et al.* (1997), Vincent-Jones (1997).

relationship with confidence.

Could purchasers set the standards of their choice?

This section examines effectiveness during the standard-setting component of accountability. As we saw in Chapter I, genuine accountability (as opposed to the volunteering of accounts by the public body) requires the caller to account to have a substantial degree of control over the process (Day and Klein 1987). Where the caller to account's role includes the setting of standards, the caller should be able to set the standards it believes to be in the public interest. The specific goals of the accountability process will help to define that public interest: whether it is in essential minimum standards, or in more stringent standards aimed at improving performance, for example.

Applying this principle to a contractual accountability process is not straightforward. As we saw in Chapter V, consent is a key element of the concept of contract. Where the purchaser, as caller to account, wishes to set a standard in the public interest,⁷ but the provider disputes that standard, a conflict arises between the consensual nature of the contract and the purchaser's right to control the accountability process. In order to uphold accountability in these circumstances, we must accept that where the purchaser believes that the provider's objection is unreasonable, the purchaser may legitimately violate consensus and impose a standard on the provider against its will. Effective

⁷ There is, of course, a risk that the purchaser might seek to impose a standard that is not in the public interest. The provider would have to seek protection from the NHS Executive against such behaviour.

accountability therefore requires that the purchaser should have sufficient power to force the provider to agree to standards, as a last resort.⁸ This demonstrates the need for modifications to the concept of contract to meet the special requirements of the public sector context.

But this does not mean that the provider should have no input into the content of the standards. Although accountability might require some limitation on the value of consensus, this limitation should, in principle, be kept to a minimum. Otherwise, one of the main advantages of using contracts is lost. Wherever possible, the purchaser should seek the provider's agreement to the standards it wishes to set. This may be done either in the limited way suggested by the hard model (asking the provider to sign up to a contract, with some bargaining over terms) or in the fuller sense suggested by the soft model (negotiating collaboratively with the provider to reach an agreement which fully satisfies both parties). Seeking agreement serves a number of instrumental goals. For example, it enables the caller to account to draw on the expertise of those being called to account, to check that the standards set are not misguided or impossible to meet. It may also help with compliance, by giving those being called to account a sense that the standards are fair and reasonable and that they have some 'ownership' of their content. Consultation with firms on proposed standards is commonplace in regulation, for example (Hawkins 1983).

To sum up, the purchaser's goal at the standard-setting stage is to set the standards it believes to be in the public interest, normally by agreeing them with

⁸ This involves going beyond even the hard model of negotiations.

the provider (using either the hard or the soft model) but with the possibility of imposing them on the provider against its will in extreme circumstances. This could be translated into more specific goals for the NHS purchaser, falling into two main groups. One related to the purchaser's obligations under the contract, primarily the obligation to pay the contract price. Purchasers sought a 'good deal' from the provider: one which offered reasonably-priced services (by comparison with other providers or with the same provider's previous year's contract) and enabled the purchaser to meet its financial targets (remaining within its budget and achieving efficiency gains, for example). The other group of purchaser goals related to the provider's obligations. The purchaser might wish to set a variety of standards for the provider, particularly on the high priority issues discussed in Chapter IV: waiting times, information, quality and so on. Because the negotiations observed in the study were contract renewals, price (which changed each year) tended to be more important than the provider's obligations (for which the previous year's documentation could be re-used).

We predicted that purchasers would experience some difficulty in achieving these goals at the contract negotiation stage. We will consider five factors which affected purchasers' bargaining positions. The first three factors were predicted in the hypothesis; the last two emerged during the study itself. They were: competition; conciliation and arbitration; expertise; joint purchasing arrangements and pressure from central government. Some comments will be offered on the hard and soft models, but it will be seen that purchasers were not usually in the required superior bargaining position in order to implement the models fully.

Competition

We will begin by examining the purchaser's perspective on competition. Was there a realistic possibility of moving contracts to other providers (using 'exit' (Hirschman 1970)) if the current provider did not offer or agree to an acceptable contract deal? Our argument is that whether or not the purchaser wished to *use* exit (thus, whether the hard or the soft model was in play) its availability affected the provider's attitude towards that purchaser. Where exit was not a possibility, the provider was less likely to treat the purchaser as a valued customer or to take heed of its requests. Even persuasion needed some underlying threat, however remote, to render it effective. Most purchasers identified a number of obstacles in the way of exit.

Moving providers brought with it numerous administrative complications which deterred some purchasers. A Health Authority, for example, needed to consult with GPs and ensure that they were in agreement with any proposed contract change. Otherwise, they might not refer to the hospital holding the contract.⁹ Obtaining their support could involve complex negotiations. Similarly, fundholders had to persuade patients to accept a referral to a hospital which was perhaps further away than the main local provider. But these factors could be overcome by the determined purchaser. Authority C had persuaded its GPs to accept a change in the contract for plastic surgery, and one practice in the sample

⁹ The Health Authority could refuse to authorise an 'extra-contractual referral', where a GP sought to refer to a Trust with which the Authority had no contract, but most Authorities were keen to avoid confronting GPs in this way (see generally Montgomery 1997a).

had adopted a deliberate policy of informing patients about waiting times at local providers and encouraging them to choose for themselves.

Other constraints were more difficult to overcome. Health Authorities had a duty to ensure that core services were provided to their patients (NHSME 1989; 1990a). There was a natural flow of emergencies to local hospitals that was difficult to change, and contracts had to be in place to pay for that care. There was more flexibility in relation to non-emergency work, but this was only a part of Health Authorities' contracting portfolios.

Most importantly, purchasers might not have a wide choice of providers. Area C offered the greatest choice in the study, being situated in a large conurbation with its own district general hospital and numerous neighbouring providers, including a large teaching hospital. Areas A and B had one major provider at the centre, which had to compete only for the custom of patients who lived on the borders. This meant that exit was most easily available to purchasers of both types in Area C, and to fundholders on the borders of Areas A and B. Where the purchaser was situated close to the local provider, exit was not a realistic option.

One GP gave a startling illustration of the point:

Even where the waiting list has been a year [at the local provider] and six weeks [at a provider an hour's drive away], about 90% of the patients did not wish to travel for that investigation, which basically says that people don't - in this area, because of the geography, there isn't a suitable alternative for most services.

(B4F)

Even where it might be expected that competition would be stronger, there were problems. One fund manager in Area C found that transport caused difficulties for her patients. While there were convenient buses to the local provider, it was much

more difficult to travel by public transport across the city to other providers. Patients who did not have their own transport were reluctant to use those providers. Of course, it was possible that patients were more willing to travel than purchasers believed. Nevertheless, purchasers' behaviour meant that providers' contracts were relatively secure. The study confirmed the view of many commentators that the NHS 'market' was one of limited contestability at the margins, rather than full competition.¹⁰

There are, however, two important qualifications to this statement. So far, we have concentrated on the purchaser's perspective on competition, and on the obstacles to moving contracts. But the study found that from the provider's perspective, contracts could sometimes seem more insecure than they did to purchasers, in two respects. Firstly, some providers feared that fundholders would exit, even though their threats to do so were not always realistic. Secondly, providers were keen to get contracts signed even when they were unlikely to lose them.

A striking illustration of providers' fear of fundholders' exit threats occurred in Area B, when the community Trust attempted to impose a substantial price increase. Practices responded by negotiating as a group (discussed below) and by threatening to exit. One fund manager admitted that this was not entirely realistic:

We did then threaten them with going [elsewhere], but it's extremely difficult with community services to actually move who you're going to have as your provider.¹¹ So that was a bit of an empty threat in a way.

(B8F)

¹⁰ For example, Barker *et al.* (1997); Walsh *et al.* (1997).

¹¹ Flynn *et al.* (1996) found similar evidence that fundholders were reluctant to move community contracts, preferring local provision by trusted staff.

Interestingly, the Trust had nevertheless been quite strongly affected by the threat. One manager (B2T) described it as ‘real’ and explained that he had ‘managed to talk them round’. Similarly, in the realm of finance, providers’ negotiations with fundholders were sometimes conducted against a background of competition. This enabled individual practices to obtain good deals from providers which were anxious to win or retain their custom. The study showed that fundholders who were adversely affected by providers’ price changes were often able to obtain compensatory discounts in their contract. One Trust manager explained:

There are ways in which we can obviously help to offset some increases... ‘Well, OK, we’ll keep you happy - we’ll give [you a deal whereby if you buy this much activity], we’ll do so many cases for you for free, how about that?’ And they’ll say, ‘OK, fine’.
(C8T)

The reference to ‘keeping the purchaser happy’ is particularly telling: for many (though not all) providers in the sample, this was a guiding principle of their negotiations with fundholders. The fact that many fundholders’ exit threats were at least plausible could make the need to get them to sign contracts seem particularly pressing. Thus, fundholders could use exit threats as a bargaining tool to give them the upper hand in negotiations.

Our second qualification to the argument that competition was weak was that providers were often keen to get contracts signed, even though they were unlikely to lose them. There were several reasons for this. Although it was realistic to assume that most purchasers (of both types) would renew their contracts with their main providers, formal guarantees of renewal, such as longer-term contracts, were relatively rare. At the beginning of each contract year, providers were in a position of considerable financial insecurity. Services were priced on the assumption that a certain amount of activity would be carried out, but providers could not be sure

that the assumption was justified until contracts were signed. In order to agree contracts and make their financial positions more stable, providers might be willing to make concessions, thus giving purchasers an important bargaining advantage.

Authority B's quality standards were a good example of provider concessions of this kind. The Authority's main acute provider objected to some of the standards, but signed a contract incorporating them, because obtaining the purchaser's income was its overriding goal. Quality standards were insufficiently important to be the subject of a dispute, and an approach to the regional office would have met with little sympathy. The following quote from a Trust manager sums up the basic principle underlying these concessions:

If they want to purchase... us with [particular standards] ...and they think that's appropriate, then if we didn't, we would try to argue it with them, but if they were absolutely adamant, at the end of the day, they're the piper, and they're calling the tune.
(B11T)

In short, the provider had more to gain by agreeing to some purchaser demands than by resisting them.

But the provider's desire to reach agreement did not operate where it had overriding objections to the standards. For example, many purchasers thought that providers should be able to offer flexible terms and conditions, tailoring contractual arrangements to the individual purchaser. This was an important issue for fundholding practices requiring arrangements other than those agreed by the local fundholding group, and for Health Authorities contracting with providers outside their 'host' area. Some providers argued that flexibility was unethical:

space forbids us to consider the arguments in detail here.¹² More commonly, they argued that flexibility was impractical. These claims were defeated by the fact that many providers *were* prepared to offer a choice of waiting times, and to accept different sets of contract documentation if the purchaser's requirements were not too difficult to meet.¹³ Nevertheless, where a provider insisted that flexibility was impossible, there was very little the purchaser could do to impose its preferred standards. Although purchasers could force concessions where the provider did not have serious objections to the standards, there were numerous counter-examples showing the extent to which purchasers could be dependent upon the provider's co-operation.

To sum up, we have seen that competition offered only limited support to purchasers in the NHS. It was a realistic option only for fundholders in conurbations or on administrative borders and, to a limited extent, for the urban Authority C. Fundholders did benefit from the fact that providers were unnecessarily afraid that they might exit, and purchasers of both types benefited from providers' desire to reduce their financial uncertainty by signing contracts, even where exit was unlikely. Nevertheless, Authorities A and B and many of the fundholders in the sample conducted their contract negotiations without the support of a competitive market.

¹² Essentially, they related to the creation of a 'two-tier' system in which the patients of fundholding practices were treated more quickly than the patients of non-fundholders. This was felt to infringe the fundamental principle of equitable access to health care according to need. See Chapter II.

¹³ For example, providers were unwilling to agree to different reporting obligations, because collating reports in a large organisation was a complex task and had to be made a matter of routine.

Conciliation and arbitration¹⁴

The NHS conciliation and arbitration arrangements were an acknowledgment by the centre that the ‘internal market’ would not be fully competitive and that purchasers might need some assistance where a provider sought to abuse its monopoly position. Their existence did help purchasers (as we shall see below) but not in the way we expected.

Conciliation¹⁵ did not offer a strong or accessible remedy for abuse of monopoly power. Firstly, its use was discouraged by the NHSE’s regional offices. Both purchasers and providers were told that to use it would be seen as a sign of management failure, a threat that was taken very seriously by all concerned.¹⁶ This had deterred Authority B and its providers altogether. Nor was there any evidence of fundholders resorting to this remedy.¹⁷ Although Authorities A and C had used conciliation, both were quick to point out that they had used their best endeavours to solve the problem themselves beforehand. Secondly, conciliation decisions tended to offer the parties a compromise that pleased no-one. No real consideration was given to the need to protect the party with the weaker bargaining position from the other: management action to award some items to each party was preferred to a process of adjudicating on the relative merits of the parties’ claims. Purchasers and providers were highly critical of conciliation,

¹⁴ National Health Service and Community Care Act 1990, s. 4; National Health Service Contracts (Dispute Resolution) Regulations 1996 (SI 1996/623). See Chapter II, and Hughes *et al.* (1997).

¹⁵ The study found no examples of statutory arbitration, so ‘conciliation’ is used to denote the informal conciliation and arbitration process operated by regional offices.

¹⁶ Interview data. See also NHSME (1990a); Hughes *et al.* (1997).

¹⁷ The fundholding group in Area A did discuss threatening a provider with conciliation, but resolved the dispute without doing so.

perceiving it as a ‘fudge’ rather than a genuine remedy. (Of course, the original central plan to use pendulum arbitration might have been equally unsatisfactory, providing too ‘strong’ a remedy where both parties’ cases had merit, and acting as an even greater deterrent to the use of dispute resolution (NHSME 1989).)

These factors reduced the value of conciliation as a remedy. Paradoxically, however, this could be turned into a bargaining advantage. Where the purchaser had a better case or a stronger nerve than the provider, it could obtain concessions by threatening conciliation and manipulating the provider’s desire to avoid involving the regional office. One of Authority C’s providers, with which the Authority had a relatively small contract, had increased its prices by an amount well beyond what the Authority had expected. The provider was unable to explain and justify its prices to the Authority’s satisfaction, and eventually offered a compromise. The Authority’s contract manager said:

After a war of attrition I think we justified it to a certain extent because they gave us a contract with a discount to recognise that there was a big gap. So I mean after several weeks of hanging in there, I think we did a reasonable deal.
(C4A)

The Authority’s refusal to sign the contract gave the provider the choice of offering a compromise or taking the risk of conciliation (exit was not an option). The provider’s case was poor, and the contract was not financially significant. Arbitration was therefore unattractive, and the provider chose to compromise instead. Of course, in other cases, the balance of advantage might lie with the provider.

Expertise

Expertise gave a bargaining advantage to whichever party possessed it.¹⁸ Sometimes, purchasers gained the advantage through superior negotiating skills. More commonly, the provider's superior knowledge of the services to be supplied gave it the best position. This created two linked problems for purchasers. The first was to find ways of harnessing the provider's knowledge in order to set achievable but challenging standards. The second was to ensure that the provider's input did not enable it to dominate the accountability process, for example by making false claims that standards could not be met in order to persuade the purchaser to remove them from the contract. Obviously, it was not always easy to tell whether the purchaser had struck the right balance between these goals.

Knowledge did sometimes favour purchasers. Fundholder negotiations on cost and volume contracts were an example of this. Because fundholding practices had more information about their own activity needs than providers had, they could fix activity levels so as to make it likely that they would obtain discounts. One practice in Area A had committed a high level of activity to the local Trust, in return for a promise of very low marginal rates (only 25% of the provider's published prices) once the activity level was exceeded. Trust managers had agreed to the deal on the assumption that they would not have to offer much activity at the reduced rate. But the fund manager knew that the practice was bound to exceed the agreed activity because it was situated in a rapidly expanding town and

¹⁸ See also the discussion of skill and knowledge as a constraint on purchasing, in Chapter IV.

had a growing list of patients. Her superior information gave a more reliable insight into the likely effect of the agreement. Moreover, she used this information in a hard way to agree a contract that would benefit the practice, without regard to its effect on the provider.

There were two dangers for purchasers in this hard use of superior knowledge. Firstly, providers' knowledge and negotiating skills were likely to improve over time: they would be increasingly capable of responding to the purchaser's hard approach in a hard way themselves. In the case just given, the Trust had refused to offer a similar deal in subsequent years. The fund manager explained:

We ended up getting something like £55,000 worth of activity for only £10,000. And they won't let us do that again - can't think why! So they didn't see us coming last year - unfortunately they have done this year!

(A10F)

This meant that the benefits accruing to purchasers from hard approaches were not usually sustainable over the longer term. Secondly, if purchasers' demands became too onerous, they might outweigh the value to the provider of the purchaser's custom. Even providers that were willing to make some concessions to purchasers were not prepared to seek agreement at all costs. For example, a provider in Area C was proposing, at the time of the study, to take a strict negotiating stance on cost and volume deals with fundholders. In preceding years, the Trust had been too generous, allowing fundholders to fix low activity levels that would guarantee them a proportion of work at marginal rates. This had left the Trust in deficit. Managers were prepared to take the risk that some fundholders might exit as a result of the new policy:

Because some of them are deliberately buying less, knowing that they'll spend more, and they'll get it free or they'll get it cheap. You know, we're saying we can't afford to do that any

longer...and if you're not happy about that, then don't have a contract. Just be a cost-per-case.¹⁹ We'll take the risk that you can't better the performance, or you're not that vindictive as to take the work away.
(C10T)

Managers had realised that they needed to safeguard the Trust's financial interests more assertively, even if this might place some contracts in jeopardy. This demonstrated an important limitation of the hard model: over-use could render it ineffective.

But expertise was usually a factor in the provider's favour. This raised a dilemma for the purchaser. As we saw in Chapter V, the hard model was associated with the imposition of standards on the provider without consultation. This reflected the purchaser's pursuit of self-interest regardless of the provider's views, and its deliberate attempts to dominate the relationship. Although this allowed purchasers to pursue their own preferred standards, it deprived them of the opportunity of drawing on the provider's expertise. In relation to the detail of service provision, the provider's knowledge was usually far superior to the purchaser's. The study found a number of cases in which a purchaser had set standards using the hard model, and then changed them after taking account of the provider's views. For example, during a site visit to an Accident and Emergency department, one Health Authority quality manager had discovered that some of the Authority's quality standards were misguided, and all were much less stringent than those set by the consultant for the department to monitor itself. She agreed with the consultant that he would report the results of his own auditing as a more meaningful measure of performance.

¹⁹ In effect, a series of single-treatment contracts in which each treatment purchased was paid for at the provider's published price, with no obligation on the purchaser to refer or the provider to accept future work.

But moving to a softer approach in which the provider was consulted on the content of proposed standards was not straightforward. Here, the difficulty lay in ensuring that the purchaser retained the upper hand. Effective accountability presupposes some domination on the part of the caller to account (Day and Klein 1987). Some input from the provider was consistent with this. Indeed, the provider might even take the lead in suggesting appropriate standards. But the purchaser had to retain at least a veto over the provider's ideas if the appropriate balance of power was to survive. There were two weaknesses in the position of most purchasers in this respect. Firstly, purchasers lacked the information to judge whether the provider's claims were correct, particularly where it argued that a standard could not be achieved. Secondly, even if a purchaser disputed a provider's claim, it was often impossible to impose its own view of what the standard should be.

One situation in which it was difficult for purchasers to judge providers' claims was in relation to waiting times. This did not matter where the parties had a genuinely soft relationship. The purchaser trusted the provider and was inclined to believe its claims. One fund manager explained his policy on outpatient waiting times:

We were determined to only have in quality clauses that were realistic. It's pointless having in three weeks if we know they're only going to do nine. We'd rather have in one that they feel they can achieve, and that we can then measure against and say look, you know, you should have achieved this, why didn't you, rather than expecting something totally unrealistic.
(A12F)

This demonstrated a high level of trust: the purchaser accepted that the provider would give an honest assessment of what could be achieved. But problems arose

where the purchaser did not trust the provider. It had no obvious means of verifying the provider's claim that a particular standard could not be met. For example, one criticism was that providers did not make enough effort to expand their capacity to meet demand. A fund manager complained that her local provider seemed to be unable to increase its level of service if its waiting time for clinics became unacceptably high. She was not sure whether there was a legitimate explanation - difficulties in recruiting more staff, for example - or whether the provider was simply being incompetent or inefficient. The more positive attitudes of other providers in the area made the latter seem more likely, but the purchaser could not be certain.

This raised the question of whether the purchaser in this situation could act on its views by imposing a standard on the provider, thereby retaining the upper hand. Those few purchasers who were able and willing to use exit did not have to make the attempt: regardless of their view of the provider's excuse, they could simply take their business elsewhere. But the study did not find any clear examples of situations in which a purchaser successfully imposed standards on a provider in the face of real opposition from that provider to their content (with the exception of the central standards discussed below). This undermined purchasers' ability to set the standards they believed to be in the public interest, where the provider unreasonably refused to agree to them.

Joint purchasing

This factor affected only GP fundholders. While individual fundholding practices often found it difficult to achieve their goals through contracts, their bargaining power was enhanced if they grouped together to negotiate with the provider. (Sometimes, an individual practice was seeking special treatment for itself, rather than an improvement in the service for everyone.²⁰ Some providers agreed to such requests, particularly where they valued the practice's custom; others raised both ethical and practical objections to 'bespoke' terms and conditions.) Our focus here is on the ability of fundholding groups - as opposed to practices acting alone - to achieve overall improvements in the deal offered by a provider to *all* practices in the area.²¹

A striking illustration of this occurred in Area B, when the community Trust sought to change its pricing structure for mental health services. A local GP explained:

[It] disadvantaged some practices enormously. But looking across the group, it actually disadvantaged everyone to some more or less extent. There was nobody who gained out of it, which meant that the whole cost of the service had increased enormously. And the group acted together on that and was able to resist that price change.
(B4F)

By acting as a group, GPs had been able to secure significant concessions from the provider. The time of the dispute had been a worrying one for the provider:

They get together and they exercise that purchasing power, and there was sort of quite a shaky period really last year...
(B2T)

²⁰ Similarly, a non-host Health Authority might seek standards other than those agreed by the provider with its host purchaser.

²¹ Group approaches had other advantages. They reduced transaction costs for both purchasers and providers, and could act as a force for equity in their locality. Their main disadvantage was that they reduced the scope for innovation by individual practices, but this was already reduced where an individual purchaser could not achieve change acting alone.

The fact that all the GPs in an area were refusing to make a financial commitment to the Trust by signing contracts was enough to prompt serious reconsideration of the Trust's proposals, even though (as we saw above) the GPs' exit threats were not realistic. Similar successes were reported in the other study areas. Of course, providers could turn group approaches to their advantage. By insisting that all requests for changes to contracts were fed through the group, providers could exploit disagreements between GPs. For example, the group might not pursue an issue which was seen as a low priority by some practices. Nevertheless, group approaches usually enhanced fundholders' ability to set the standards they required.

Central government pressure

Our final factor was central pressure. We saw in Chapter V that this pushed purchasers towards the hard model during negotiations, because they were obliged to insist that providers agreed to contracts which met or included central standards. Central pressure also enhanced purchasers' authority: if a standard was nationally required, providers were bound to accept it, even if they strongly disputed its validity. For example, the efficiency gain was taken as given by all parties to contract negotiations, although they complained bitterly about the requirement. Even more strikingly, the Patients' Charter was taken as read by all contracting parties (Department of Health 1991; 1995). It was included in contracts as a matter of course, almost without the need for any negotiation to take place at all. But central pressure was perhaps a 'false friend' to purchasers here. In relation to

finance, central standards were met by the very act of agreeing the contract in conformity with them. In relation to Patients' Charter standards, including them in the contract was no guarantee that the provider would meet them during the contract year. We shall see below that there were instances of cheating or 'creative compliance' with central standards imposed on providers during negotiations.

Conclusion

Purchasers faced three main obstacles when pursuing their goal of setting the standards they required. Firstly, whichever model they used, they lacked a means of making providers responsive to their demands. Often, they could not make a plausible direct threat of exit (under the hard model) or indirect threat of exit (under the soft model) if their requirements were not met. Conciliation did not provide a means of addressing this problem. Secondly, where the purchaser consulted the provider on proposed standards, it could be difficult to scrutinise the provider's input, given the disparity of information and expertise between the parties. Thirdly, with the exception of standards required by central government, there were no clear examples of purchasers being able to impose standards on a provider where they believed that the provider's objections to the standards were unreasonable. Of course, there were exceptions to this negative picture. Fundholding groups overcame the first difficulty because of their purchasing power and because providers were afraid (often unnecessarily) of fundholders' exit threats. Purchasers in soft relationships overcame the second difficulty: they trusted providers to offer only honest excuses. Nevertheless, purchasers struggled to achieve the goals of effective accountability at this stage in the process.

It is possible that providers would have been more responsive had there been a greater degree of competition (or NHS Executive intervention to compensate for its absence). But we cannot say for certain whether this would have provided a complete solution, or indeed any solution, to the problem of purchaser power. It also limits our ability to comment on the hard and soft models. We have seen some cases in which they worked well: the soft model enabled purchasers to trust providers' claims that proposed standards were unreasonable; the hard model could prompt the provider to make short-term concessions to the purchaser's advantage. But it is the absence of purchaser power which explains why, for example, the needs of individual fundholders could be ignored: they could not implement either model fully where the provider was not inclined to respond to their requests.

Could purchasers obtain compliance with the standards set?

Once the contract had been signed, the parties moved on from the standard-setting²² element of our analytical model of accountability, to monitoring and enforcement.²³ The purchaser's primary accountability goal here was to obtain performance in accordance with the standards set: in a word, compliance.²⁴ This gave rise to two further goals. Firstly, in order to assess whether performance was

²² Although the focus turned to monitoring and enforcement, standard-setting continued as part of the process of interpreting standards and applying them to fact situations.

²³ See Chapter I.

²⁴ Perhaps the most important literature on compliance in the public law sphere is found in the analysis of regulatory agency behaviour: Fenn and Veljanovski (1988); Ayres and Braithwaite (1992). For empirical evidence see, for example, Richardson *et al.* (1983); Hawkins (1984); Hutter (1988); Rowan-Robinson *et al.* (1990). Comparisons between this literature and the behaviour of NHS purchasers will be made where appropriate.

adequate, the purchaser required information about that performance. This involved (among other things) securing compliance with contractual terms obliging the provider to supply information for monitoring through reports, meetings and other arrangements. Secondly, where the provider could not comply with one or more of its substantive obligations, the purchaser might wish to obtain a reasonable explanation for the breach.²⁵ We will examine each of these goals in turn,²⁶ beginning with the goal of obtaining information about performance, logically prior to enforcement.

Obtaining information for monitoring

As we saw in Chapter V, purchasers were dependent upon providers to supply information for contract monitoring. This was particularly true of Health Authorities: unlike fundholders, they did not have much information of their own on which to base judgements about performance. It seemed reasonable to predict that providers would be more forthcoming with information where their performance was good, than where it was poor. Assessing the effectiveness of monitoring during the study raised methodological difficulties.²⁷ The researcher was in a better position than the purchaser, in that providers did sometimes admit that the information supplied to purchasers was misleading or inaccurate. But the only way to evaluate purchasers' monitoring efforts conclusively would have been to obtain parity of information with the provider: this was impossible in a small study concerned with a range of other issues as well as monitoring. Nevertheless,

²⁵ We shall see that some purchasers were not interested in providers' excuses.

²⁶ The NHS-specific elements of these goals will become apparent during the discussion.

²⁷ See Appendix 1.

some comments can be made on the basis of the study's findings. The data revealed that providers were more willing to supply information than we expected.

There were cases in which providers successfully concealed a poor performance from purchasers.²⁸ Some providers deliberately submitted false reports, in which they claimed that they were meeting a standard when they were not. Examples are given in the discussion of compliance, below. The risk that the purchaser would uncover the falsehood was often slight, because Health Authorities in particular lacked access to independent information against which to verify reports. This information asymmetry was even more apparent in cases in which purchasers were unable to detect *accidental* errors in reports. For example, Authority C had directed fundholders to stop referring to a particular hospital, because its contract appeared to be overperforming substantially, exposing the Authority to a liability to make further payments. A few weeks later, the provider discovered that a computer error had caused it to send out inaccurate reports: the contract was, in fact, on target. Finally, purchasers' monitoring tended to concentrate on high priority standards: activity levels, waiting times, the supply of data, and clinical communications (for fundholders).²⁹ This made it unlikely that breaches of low priority standards would be detected.

Nevertheless, two points can be made in favour of purchasers' monitoring. Firstly, they did identify breaches of contract, either through providers'

²⁸ In breach of the principles of procedural fairness, under either model, discussed in Chapter V. The principles apply particularly strongly to the party with superior bargaining power: here, the provider, given its access to information.

²⁹ See Chapter IV.

admissions or their own monitoring efforts, or a combination of the two. It will be remembered that fundholders had access to information of their own on activity and waiting times, in particular. Health Authorities were more dependent on the provider, but were able to identify irregularities in reports and tease out further information at meetings, for example. The discussion of compliance, below, is ample illustration of the kinds of breaches purchasers were able to identify. Secondly, one of the study's most surprising findings (of particular significance for Health Authorities) was that Trusts were often willing to admit to cases in which they had failed to meet a contractual term, provided that they were given the chance to say why their performance fell short of the standards. One manager welcomed site visits because they gave an opportunity to account for breaches:

They need to come here and get a feel for what we're doing and what the place is like, to understand perhaps some of the difficulties, the areas why we're not able to achieve, and they very much realise that... we can't do it all, but as long as you explain why you can't do it...
(C7T)

Providers were prepared to admit to a breach where they could offer an excuse, in the hope that the purchaser would accept their explanation and be lenient. (Where excuses were not accepted, concealment was more likely, as we shall see below.) Given that most purchasers would hear excuses, access to information appeared to be less of a problem than we expected.

Obtaining compliance with the standards set

'Compliance' is used here as an umbrella term. Where no breach of contract has occurred or been threatened, securing compliance simply involves maintaining this situation of performance in accordance with the contract. Where a breach is threatened, the purchaser's goal will be to secure compliance by preventing that

breach from taking place. Once a breach has occurred, securing compliance may involve putting the breach right, where appropriate, and ensuring that similar breaches do not arise again.

The soft and intermediate models offer different strategies for performing these tasks. The soft model seeks to persuade the provider to conform to the contract; the intermediate model employs sanctions to deter breaches or to secure corrective action. The discussion below examines whether purchasers were able to implement the models, and if so, whether the models were effective. The hard model will not be examined in detail here, for two reasons. One is that examples of full exit were rare, because of the constraints on moving contracts discussed above. The second reason is that the impact of full exit on the losing provider was not the purchaser's main concern.³⁰ It might be portrayed as a punishment for poor performance, but the purchaser was not concerned with any improvements that its actions might generate: it was moving elsewhere and would not benefit. More commonly, full exit was presented as market behaviour – moving to another provider offering a *better* performance – rather than as a sanction. Since it was neither punitive nor aimed at securing compliance, it was not an enforcement response and is not therefore relevant to our discussion.

But before we turn to the models, we will examine *the normative force of the contract itself*. This discussion focuses on the first element of compliance, identified above: the general goal of ensuring that contracts were met. Could the

³⁰ The hard model may correspond, loosely, to the 'sanctioning' behaviour described by Hawkins (1984); with the intermediate and soft models as different versions of 'compliance' behaviour.

purchaser obtain compliance simply by including a term in the contract? In practice, it was not always easy to separate the contractual term from the action the purchaser took (or was thought by the provider to be likely to take) in the event of a breach. But some comments can be made on the power of contractual terms *per se*. We shall see that NHS contracts were not perceived as binding by the parties, even where providers had agreed to the obligations they imposed.³¹ It will be argued that the general weakness of the purchaser's bargaining position was a major factor in explaining this.

Many NHS contractual terms were routinely met. They set standards which providers would meet in the normal course of events, or in response to other regulatory regimes. But including a term in the contract did not guarantee compliance. One GP said this about his contractual term requiring prompt clinical letters:

You get a proportion that are, but there's a proportion that aren't, and the sort of comment is 'Well, we just can't manage that. We'll try and work on it.' But there isn't any great sense of 'It's imperative'.
(C13F)

Interviews with providers reinforced this finding. One of the more extreme examples occurred when one Trust could not³² meet a contractual deadline:

They said you can't do this, it says in here, you can't do it. I said well, tough. So all I did was just Tippex it out and put a new date in.
(B11T)

This sense that contracts were not 'binding' could be attributed to the weakness of

³¹ The extent of this varied from 'full agreement' under the soft model to a lesser consent under the hard model. In some cases - central standards, for example - the argument that the obligations were voluntarily accepted by the provider did not apply.

³² The Trust in question was an ambulance Trust that had undertaken to publish its prices by a certain date. Its argument was that compliance was impossible because the government had changed the date of the Budget. It did not wish to issue prices until after the Budget, so that any rise in fuel costs could be reflected in its prices.

competition, and other factors, such as ‘legal’ remedies, in the NHS.³³ Contractual obligations did not bind because there were no real consequences of a failure to comply with them: the provider would not necessarily lose the contract, and there was no threat of ‘legal’ action in the form of NHS conciliation or arbitration. Moreover, all parties were well aware that the contracts were not enforceable in private law. Although most did not believe that court action was appropriate in the NHS, this gave another reason for thinking that contracts did not matter.

The view that NHS contracts lacked normative force was further demonstrated by some of the factors providers took into account when a question of compliance arose. One such factor was the provider’s view of whether the purchaser was serious about the standard. We saw in Chapter IV that purchasers were guided by their sense of priorities. Providers felt they could ignore low priority standards because the purchaser might not monitor or enforce them. For example, the acute provider in Area B made little effort to work to the Authority’s quality standards, in part because it was not clear that the standards would be monitored or that the purchaser would act on breaches. By contrast, a fund manager in Area A reported that negotiating for a standard to be included in the contract requiring the provider to give adequate supplies of discharge drugs, and setting out a penalty clause in case of breach, had been sufficient to prompt compliance:

We don’t need [the penalty] any more, and we never actually had to use it, but just negotiating it somehow heightened the issue.
(A12F)

Here, the provider had perceived that the purchaser was serious about the issue: it

³³ This reinforces the conclusions of studies emphasising the role of institutions in the contracting process (Deakin *et al.* 1997).

had gone to the effort of negotiating a penalty clause in the hope of addressing a long-standing grievance. The findings cast doubt on whether there was any value in including low priority standards in contracts. It also highlights, once again, the weakness of purchasers' bargaining power: although a provider in a competitive market might assess the risk of being punished for a breach, one would not expect it to focus solely on a handful of standards which would definitely be enforced.

Our second factor was the provider's view of the standard. Particularly where the hard model of negotiation was in use, providers might consent to standards with which they did not fully agree, either because it was not worth provoking a dispute, or because some, but not all, staff in the Trust accepted the standards. Most commonly, problems arose because managers signed up to standards which clinicians did not accept. When the time came for compliance, the lack of agreement to the standard might override the fact that the provider was contractually obliged to meet it. Most Health Authority contracts replicated the Patients' Charter standard that patients should be seen within 30 minutes of their appointment time in outpatients. Many consultants breached the standard because they overbooked their clinics in order to see patients as soon as possible after referral. It was impossible to keep to appointment times when too many patients were at the clinic. Despite pressure from purchasers and sometimes from quality staff in their own Trust, some refused to attempt to meet the standard, arguing that patients would prefer an earlier date for the consultation, even if they had to wait longer on the day of the appointment. Where a standard clashed with powerful professional norms, it was unlikely that the contractual requirement would win the

battle. (This case highlighted the need to match hard negotiations with hard enforcement, a point considered further below.)

By contrast, where a term coincided with the provider's view of good practice, it was likely to be met. For example, one fundholding practice had included a term in its contracts requiring one of the local Trust's community psychiatric nurses (CPNs) to attend a certain percentage of practice meetings. The term had been met. Once the idea had been suggested through the contracting process, it had been taken up by the CPNs who found it helpful to have more contact with the rest of the primary health care team. The fact that the practice had attached a financial incentive to the standard - negotiating in a hard way rather than seeking the Trust's full consent through the soft model - turned out to be irrelevant.³⁴

Once again, this finding highlighted the weakness of the purchaser's bargaining position. A provider concerned about losing the contract or facing legal redress would not perceive compliance as a matter of choice. Even if it did, it would take account of the fact that a contractual obligation was at stake. The need to avoid breaching contracts, *per se*, did not feature in the deliberations of NHS providers.

Under the circumstances, purchasers did not simply expect to achieve their goals by putting standards in the contract. The *soft model*, introduced in Chapter V, involved the use of persuasion by the purchaser to secure compliance. Two

³⁴ The incentive was that the practice would guarantee to spend a high percentage of the current year's contract sum with the provider in the following year. The provider had asked for the incentive to be removed: it could not cope with this longer-term approach to contracting.

issues will be considered. Was the soft model fully implemented by NHS purchasers, and if so, did it work?

The first difficulty with implementing the soft model was that it relied, as we argued in Chapter III, on the purchaser having superior bargaining power. Unless the provider valued its relationship with the purchaser and wished to maintain it, there was nothing on which persuasion could ‘bite’. Some purchasers were able to use the market in this way. A fundholder in Area A had taken two patients who were nearing the contractual maximum waiting time to the local private provider for treatment. On subsequent occasions, a telephone call to the provider to point out that some patients were nearing the maximum time was enough to encourage the provider to give them a date for their operation. On these occasions, persuasion worked, because the provider knew that it was reinforced by an implicit threat of exit.³⁵ Other purchasers, who simply tried to persuade providers to meet standards in the absence of any threats, rarely succeeded.

A second difficulty with implementing the soft model was that it required a considerable investment of effort. One illustration of this was the ‘communication gap’ between management and service delivery staff identified by many GP fundholders in particular. On finding a breach of contract, the practice would complain to the provider’s managers. The managers would accept the practice’s complaint and apologise, but performance would still not improve. One fund manager, whose contract provided for a three-month waiting time, said this:

³⁵ Cf. Dore (1983) on soft contracts in competitive markets. The approach is similar to ‘negotiated compliance’ in regulation (cf., for example, Hawkins 1983).

They seem to have a big, big problem with communications, that they've got a layer of business managers and contracts managers - there's a level that we talk to regularly, and who are very aware of what we're saying in terms of our contract, and what we want...the reality is that the consultants are acting to a six-month waiting list and that's what's happening.
(B10F)

Not unreasonably, many practices saw this as an issue for providers themselves to address. But at least one had come up with an innovative solution. A practice in Area A required the lead clinician of every department to sign the practice's contract. The fund manager believed that compliance was improved by ensuring that clinicians, as well as managers, were aware of the contract's requirements:

If you make them all sign up then yes, they come back with fiddly bits like... one of them picked up some very small point relating to his specialty... but it makes them read it... it's worth it, because it means that they do tend to then perform what they've said they'll perform.
(A12F)

Using persuasion effectively required this level of effort. The practice had entered into the spirit of the soft model, and had sought to build a genuinely close relationship with the provider. This involved relating to clinicians as well as to contract managers. But cases in which the soft model was implemented in this way were rare.

Nevertheless, there was a place for the soft model in the enforcement of contractual accountability relationships. It was a useful and effective means of dealing with minor infringements of the contract which could easily be remedied by the provider (and for which it had no good excuse). For example, persuasion was effective where administrative errors led to breaches. One practice in Area A found that its outpatient waiting times occasionally rose beyond contracted levels when the consultant had been unavailable and no cover had been arranged. Usually, telephoning the hospital manager to ask for an extra clinic to be arranged was sufficient to put the problem right. But for more serious breaches, purchasers

placed little faith in persuasion, turning instead to more stringent enforcement methods.

As we saw in Chapter V, some purchasers were prepared to use *intermediate sanctions*, such as penalty clauses or refusing to pay invoices. But did these sanctions work? The data were highly complex, and a number of explanatory factors could be identified. One was the ease of compliance with the standard: providers were more likely to respond to a sanction where they could put the problem right. This factor was linked to providers' use of excuses, and will be discussed below. We will consider two other factors here: the provider's perception of the purchaser's sanction, and the role of central government.

The provider's perception of the purchaser's sanction was the most important consideration. If the sanction was seen as a significant harm, the provider was more likely to respond. Thus, financial penalties would fail where the provider felt it could survive the loss of the sums involved. One provider had lost money because it sent out late invoices to fundholders, who were not obliged to pay them.³⁶ The provider responded by instituting a complex system of checks to ensure that as much activity as possible was billed promptly. The sanction had brought about a change in the provider's administrative practices because the provider had incurred the cost of performing the activity, and was not obtaining necessary reimbursement. But financial sanctions had to be of a significant sum in order to make an impact on the provider. One fund manager in Area C, who had

³⁶ National rules stipulated that invoices had to arrive within six weeks of the end of the month in which the activity took place (Richardson and Taylor 1995).

tried penalty clauses without success, believed that provider could simply afford to pay the penalty: the sums involved were not large enough. Of course, penalties did have some effect, even if the sums were small: providers complained about the hard purchaser attitude they represented, and at least resented the loss of any money. But this was not necessarily sufficient to prompt compliance.

Similarly, partial exit had to appear as a significant sanction if the provider was to react to it. One fundholding practice had taken its patients to another provider in protest at a particular orthopaedic surgeon who failed to send clinical letters after seeing patients. This strategic use of exit, coupled with a clear complaint about the service, prompted improvements and achieved the practice's goal. Given that the complaint could easily be resolved, it was not worth losing the purchaser's trade. But although partial exit might seem to be a relatively severe sanction in any circumstances, providers gave two reasons for being able to withstand it.³⁷ These highlighted the weakness of the purchaser's position particularly clearly.

Firstly, a provider which was already overworked would probably welcome some loss of business. Where demand exceeded supply, some reduction in demand would enable the provider to manage its workload more easily. This meant that purchasers' use of partial exit as a sanction for poor waiting times was not necessarily perceived as a sanction by the provider, as one Trust manager explained:

³⁷ A third possibility was the rule that prices reflected costs: if the provider was not doing the work it would not incur the costs, and would not suffer loss. But most providers did not make this assumption. It was usually difficult to make savings that would compensate entirely for the lost income, because prices covered a proportion of the hospital's fixed costs.

We're trying to do something about it...[but] I said to [GPs] if you wish to, you know, send them to [a neighbouring provider], feel absolutely free. Because it takes the pressure off our waiting list, and our dermatologists will never be under-employed.
(C14T)

Secondly, providers felt that they could withstand the loss of some contracts where the sums involved were not substantial. A single fundholder's contract would not necessarily make much impact on a large provider:

GP fundholders certainly threatened to take work away, and some of them did, but that's like a sting on the side of an elephant, to an extent.
(A7T)

This cast doubt on the argument that contestability at the margins could be an adequate substitute for competition.³⁸ Precisely because only a few purchasers could exit, providers felt that they could withstand the loss of one or two fundholders' contracts. Fundholders could compensate for this by acting as a group: although threats that all the GPs in the area would exit were not always entirely plausible, the community Trusts in both Areas A and B had been prompted to tackle management and pricing issues respectively in response to such threats. Nevertheless, this acted as a further factor to weaken the position of the purchaser.

The provider's view of the purchaser's sanction was not the only factor relevant to the success of that sanction. Special considerations applied where central standards were at stake. On the one hand, central pressure could help purchasers to secure compliance. It raised the profile of the standard, and exposed providers to the threat of incurring the NHS Executive's wrath as well as that of the purchaser. For example, providers were well aware of the compulsory and unquestionable

³⁸ See, for example, Barker *et al.* (1997: 96).

nature of their obligation to report their Patients' Charter performance to Health Authorities in particular. As one manager vividly explained:

There would be punishments, penalties, if the Patients' Charter standards weren't recorded and we didn't monitor them and submit that information. Heads would roll.
(C7T)

Purchasers commonly employed penalty clauses to enforce these information requirements, but pressure from the centre clearly enhanced the effect of the penalties.

On the other hand, central pressure could be counterproductive. In relation to the substantive Patients' Charter targets, particularly on waiting times, providers might be tempted to submit false reports or to comply 'creatively' with the standards. One of the community providers in the sample submitted false reports in relation to the Patients' Charter standard on appointment times for district nurses. It reported a high rate of compliance with the requirement that patients should be given appointments within two-hour time bands and seen at the promised time, but in practice, simply told patients whether the nurse would call in the morning or the afternoon, giving a precise appointment time only when required. The Authority's quality manager had discovered the truth during a casual conversation with a nurse who was unaware of her role at the Authority. (This highlights the weakness of Authorities' monitoring efforts in the face of deliberate attempts to deceive on the part of the provider: normal monitoring had failed to uncover the problem.) Another response was 'creative compliance' (McBarnet and Whelan 1991; 1997). This involved interpreting the standard in a way which made it easier to meet. Allegations of this were common in relation to the Patients' Charter requirement that patients should be given an initial assessment within five

minutes of arrival in the accident and emergency department. It was claimed that although the standard was meant to apply to an assessment of the patient's needs by a trained nurse, many Trusts were counting a contact with the receptionist as sufficient. This made it easier for short-staffed departments to meet the standard.

Why did providers respond in this way to central standards? Providers were placed under very severe pressure to meet these targets. Purchasers attached penalty clauses to breaches of Patients' Charter targets. The NHS Executive added to this pressure by publishing providers' results in annual league tables (NHSE 1998). This could lead to adverse publicity for poor performances. Moreover, both providers' excuses were ignored. Purchasers disregarded excuses because they were under pressure from the centre to secure compliance with the standards at all costs.³⁹ The NHS Executive disregarded excuses in the sense that the published league tables gave no opportunity to providers to explain that a breach of waiting times was due to a high rate of emergency admissions, for example. Finally, the standards were difficult to meet, particularly where funds were not available to clear waiting list backlogs or to employ more staff. These combined pressures tempted providers to cheat. Not all succumbed, but the study found evidence that some did.

In conclusion, we have seen that purchasers were not particularly successful in achieving their primary accountability goal of obtaining performance in accordance with the standards set. Purchasers had few sanctions against providers,

³⁹ There was some suggestion that the pressure on purchasers from the NHSE was so severe that they were prepared to 'turn a blind eye' to, or even encourage, cheating by providers.

making it difficult for them to opt for the hard model. Many purchasers were unable to take their entire contract to another provider. Conciliation and arbitration were not realistic options during the contract's life. Nor was the intermediate model particularly effective: partial exit and financial penalties were ignored by some providers. Where stringent sanctions were available, providers might be tempted to cheat rather than comply. Finally, the soft model was undermined by the fact that because competition was weak, purchasers could not reinforce their persuasion with more serious threats. All this contributed to the general sense, noted at the beginning of the section, that NHS contracts were not 'binding'. Purchasers did obtain compliance with some standards: where the provider would have met them as a matter of course, where the provider believed them to be legitimate, or where they were easy to meet, for example. But this left purchasers exposed to providers' whims.

Obtaining a reasonable explanation for a breach

We have argued that the purchaser's primary goal at this stage of the accountability process was to obtain compliance with the standards set. But we identified a further goal, to come into play where the provider breached the contract. This was to obtain a reasonable explanation for the breach.

Not all purchasers accepted this goal. We saw above that central government did not do so in relation to core Patients' Charter standards: compliance was expected at all costs. Moreover, those purchasers with an option of exit, particularly fundholders, disregarded providers' excuses. If the purchaser could

obtain a better performance elsewhere, it was not concerned with the provider's reason for breaching. But apart from these special cases, purchasers were prepared to consider providers' excuses. This approach had advantages: as we saw above, in relation to central standards, and more generally in Chapter V, providers felt that purchasers who listened to excuses treated them fairly. A sense of fair treatment helped to preserve relationships (as discussed in Chapter V) and to encourage honesty (suggested by the discussion of central standards, above).

The purchaser's first challenge was to obtain the explanation. In practice, this was less difficult than one might have anticipated. As we saw above, in relation to information, providers were willing to admit to breaches where they were able to offer an excuse. Sometimes, providers would even forewarn purchasers that a breach was imminent: a fundholding practice in Area A gave examples of this for waiting times in outpatient clinics. The provider would contact the practice to explain why the waiting list had risen, and what action was being taken to put it right. Other providers were less forthcoming. They waited until the purchaser had identified the breach through routine monitoring, and then sought to account for it with an excuse. Nevertheless, purchasers rarely had difficulty in obtaining an explanation.

The purchaser's second challenge was to determine whether the excuse was reasonable. In soft relationships, this posed no difficulties. The high level of trust between the parties meant that the purchaser would assume that the provider was being honest when it gave an excuse. But such cases were rare: only one or two fundholding practices in the sample could claim to have this type of relationship

with providers. Under the hard model, the purchaser was naturally suspicious of the provider's claim and would seek to verify it. In some cases, this was relatively easy. For example, one practice in Area C explained that it had accepted the provider's failure to meet a six-month waiting time in orthopaedics because of well-publicised local and national shortages of consultants and an enormous demand for the service: it was apparent that the provider could not avoid the breach.

In other cases, it was much harder for the purchaser to judge the excuse. There were examples of disputes about waiting times between the Health Authority and its main local provider in all three sample areas, in which the Authority believed that the provider could improve its performance but the provider put forward a variety of excuses, including shortages of funds, ward space and staff, coupled usually with a high rate of emergency admissions. All three Authorities faced the same problem: given that the provider had better access to information about its performance, how was the Authority to verify the excuse? Authority C tried to solve this problem by using a penalty, assuming that if the provider's excuse was not genuine, it would improve its performance if faced with a financial loss. But as we saw in Chapter V, this strategy caused considerable damage to relationships. The other Authorities continued to debate the issue with the provider. Such debates were a constant source of tension: there was no authoritative means of deciding which party's view of the situation was correct.

Recourse to conciliation or arbitration might have served a useful function in these cases. It could have resolved the parties' dispute, enabling them at least to

attempt to rebuild their relationship. (Private businesses are, of course, reluctant to litigate (Macaulay 1963), but unlike NHS purchasers they are more likely to have the option of exit.) In the NHS, however, conciliation and arbitration were not commonly used once a contract had been agreed: they were intended primarily for disputes during contract negotiations,⁴⁰ and their use was firmly discouraged, as we saw above. The study unearthed only one example of a conciliation case during the life of a contract. Authority C sought to invoke a contractual penalty clause entitling it to a payment for every day's delay in receiving activity data from a provider. The provider refused to pay, arguing (implausibly) that the clause was unclear. The regional office directed that the provider pay the Authority a sum of money by way of a penalty, but considerably less than the sum to which the Authority would have been entitled under the contract. Although neither party was entirely satisfied with this compromise, it did enable both to claim a partial victory. It solved the immediate dispute and provided a starting-point for a renewal of trust between them. But apart from this example, conciliation was not a remedy to which purchasers felt they could turn when a provider offered an excuse they were not prepared to accept.

To sum up, it was relatively easy for purchasers to achieve their goal of obtaining an explanation from a provider where it had breached a standard. But it was more difficult for the purchaser (outside a soft, trusting relationship) to be sure that the excuse offered was reasonable. This drew attention to some of the (now familiar) weaknesses in the position of many purchasers: their inferior access to information and their inability to exit from a provider they did not trust.

⁴⁰ National Health Service and Community Care Act 1990, s. 4.

Conclusion

Our prediction, that purchasers would experience difficulties in rendering the accountability process effective, was proved correct. At the standard-setting stage, purchasers' main goal was to agree a contract which included the standards they wished to set for the provider's performance. Negotiations proceeded in a hard way - they were rarely collaborative - but providers were not usually responsive to purchasers' demands. Providers knew that they had nothing to fear by refusing to agree: many purchasers could not exit, and resort to conciliation was unlikely. Moreover, providers' expertise and superior access to information made it difficult for purchasers to scrutinise arguments that particular standards could not be met. Even where purchasers contested those arguments, they were not usually able to impose the standards of their choice, unless the relevant standards were backed by central pressure. Of course, purchasers did succeed in setting some of the standards they required. For example, fundholders could obtain concessions where the provider was afraid that they might exit, and Health Authorities could do so where the issue at stake was not worth disputing. Nevertheless, purchasers were often in a weak position.

During the life of the contract, purchasers' main goal was to secure compliance with the standards set: to enforce their contracts effectively. Again, they experienced difficulties. Providers did meet many contractual terms as a matter of course, but NHS contracts did not carry a strong sense of obligation. Providers were aware that breaches would not necessarily lead to a loss of the contract, and

that they were unlikely to lead to conciliation or arbitration. Purchasers' enforcement efforts using the soft model were successful only where relatively trivial breaches had occurred, or where the provider valued the purchaser's custom (perhaps because there was an effective underlying threat of sanctions). Purchasers' enforcement efforts using the intermediate model - to which they often resorted in an attempt to alleviate the weakness of their position - depended on their being able to cause a significant harm to the provider by their sanction. As we saw, some providers felt able to disregard financial penalties and even partial exit. Finally, we saw that purchasers had more success in their goals of obtaining information for monitoring and obtaining reasonable explanations for breaches. But providers' superior access to information was again apparent: purchasers found it difficult to verify providers' accounts where they were not inclined to believe them.

EVALUATION: IMPROVING EFFECTIVENESS

This chapter has, as a whole, been strongly evaluative. It was impossible to present data on effectiveness without making apparent the value judgement that an ineffective accountability process was an inadequate one. The remainder of this section is, however, more explicitly focused on criticism and reform. It examines whether purchasers, as callers to account, and central government, as the system's designer and regulator, could have done more to improve the effectiveness of the accountability process through NHS contracts.

Purchasers could work to enhance their own authority. The data provided some examples of this, notably the joint negotiations by fundholders acting in groups. Moreover, it was clear that some purchasers made greater use of their opportunities than others. This raised issues of skill and effort, discussed in Chapter IV. For example, one of the more successful fundholders in the study drafted its own contracts and made use of a variety of techniques - partial exit, penalty clauses and persuasion - in order to acquire its status as a 'favoured customer' at the local provider. Other practices were less enthusiastic and less assertive. As we saw in Chapter IV, there were limits on the effort most purchasers were prepared to invest in their task. Demanding high levels of enthusiasm from all purchasers would probably have been unrealistic.

More importantly, there were some possible reforms to the contracting system which might have enhanced purchasers' bargaining positions, and thus their ability to achieve the goals of effective accountability. The government placed considerable reliance on competition to make providers responsive to their purchasers (Department of Health 1989). It was expected that providers would perform well in order to maximise their income, drawing on public choice notions of bureaucratic self-interest. But data from this study showed that reliance on competition was misplaced. It helped only a minority of purchasers. It would have been difficult to tackle this problem directly - it was caused, in large measure, by the geographically-specific nature of health care provision - but steps could have been taken to compensate for its weakness, had that weakness been acknowledged.

One such step would have been to enhance the role of conciliation and arbitration, particularly during the life of the contract. Although the study highlighted numerous cases of disputes between purchasers and providers about compliance with contracts, there was only one example of resort to conciliation. Obviously, we cannot predict with confidence the effect of introducing a more vigorous dispute resolution procedure. But at least two potential benefits can be identified.⁴¹

One advantage lay in the authoritative resolution of disputes. The purchaser's ability to demand agreement to or compliance with a particular standard would have been enhanced where arbitration had upheld the purchaser's view that the provider's objections were unreasonable. Even if the purchaser lost the case, there was some merit in putting an end to the parties' disagreement and giving them an opportunity to rebuild their relationship. Of course, the parties might not have invoked a dispute resolution procedure, had it been more widely available. Studies of contracts between businesses have shown that they were unlikely to resort to litigation unless their relationship had already been destroyed beyond repair (Macaulay 1963). But the NHS context might require a slightly different view. Because the parties (unlike businesses in a competitive market) could not take their contract elsewhere, third party intervention was sometimes welcome to tackle otherwise intractable problems. As one Trust manager explained:

⁴¹ In addition to its benefits from the perspective of purchaser authority, a stronger system of dispute resolution might also have saved some of the transaction costs involved in the 'self-help' enforcement methods used by purchasers, such as negotiating for penalty clauses.

We don't view conciliation and arbitration as setting us up as enemies... what it means is, the system has defeated us, we have nowhere else to go, we have tried every single thing we can try... and we need an outsider.
(A7T)

Another potential advantage of a stronger dispute resolution procedure was that it might have helped to combat the general sense, discussed above, that contracts were not binding and did not therefore deserve any real attention or respect. Purchasers did not have strong grounds for confidence in the contracts they had agreed: they knew that compliance depended on their own enforcement efforts, and on the provider's goodwill. This put purchasers in a weak position: given the limits on what they could do to enforce contracts, they were left largely at the mercy of the provider. Deakin *et al.* (1997) have shown that institutional support for contracts may reduce the prevalence of disputes by giving the parties grounds to trust one another. A stronger system of conciliation and arbitration might have been able to perform this function in the NHS.

Reforms to conciliation and arbitration were not the only way in which purchasers' ability to achieve their goals might have been enhanced. Another possibility was reform of the system of multiple purchasers, and therefore multiple callers to account.⁴² It was arguable that by giving a purchasing role to a large number of small purchasers, particularly through the fundholding system, the effect was to spread purchasing power too thinly, thus undermining purchasers' authority. But it was difficult to draw a firm conclusion. On the one hand, the data showed that providers did feel able to ignore requests from individual fundholding

⁴² The criticisms we shall discuss here relate only to purchasers' ability to achieve their goals. There were others, including, for example, the argument that the administrative costs of the system were too high.

practices, and even to ignore their decisions to remove contracts. Although fundholders could wield considerable bargaining power by uniting to tackle a particular problem, this placed a further barrier in the way of action and could be used by providers as an excuse for refusing to consider practices' individual needs. On the other hand, it was easier for smaller numbers of GPs, at the practice level, to make and implement an exit decision: some felt that fundholding groups were unwieldy and difficult to bring to a consensus. Moreover, the very fact that a single practice's impact on the provider was relatively small had advantages. It meant that the GPs were less likely to feel compelled to take account of 'political' considerations, such as the need to keep a particular hospital open. Health Authorities' softer attitudes towards providers were in part prompted by the greater damage they could do by altering a contract. Moving to larger purchasing units would have had advantages in terms of bargaining power, but these might have been cancelled out by a loss of the flexibility required to assert that bargaining power.

CONCLUSION

The implications of these findings for our emerging notion of the 'public law contract' are unclear.⁴³ The proposition that the purchaser, as caller to account, should have sufficient authority to make the contractual accountability process effective is uncontroversial. But how relevant is it outside the NHS context?

⁴³ Davies (1999) explores the wider implications of these findings for the socio-legal literature on regulatory enforcement.

When the government contracts with a private party, the usual concern is with securing fair treatment of that private party, given the government's greater bargaining power. The government is portrayed as a formidable negotiator (McCrudden 1999c), and during the life of the contract, it may be able to vary the terms of the contract or bring it to a premature end, as a result of a change in policy.⁴⁴ Thus, the NHS findings are the reverse of what we might expect in other instances of the 'public law contract'. NHS contracts may be unique in this respect.

But perhaps we should at least re-examine our assumptions about 'public law contracts'. Other internal markets - in the BBC, for example - might reveal similar results.⁴⁵ Where a production company has control of very popular programmes or presenters, for example, perhaps it is difficult for the purchaser to call that company to account through the contract because its bargaining power may be considerable.⁴⁶ Moreover, the same problems may exist even when central government is the purchaser. It may be difficult for the government to achieve effective accountability in respect of a large company providing highly specialised services, for example in information technology. Instances in which such contracts have failed to yield the desired performance for government, for example in air traffic control, have been well publicised.⁴⁷ If correct, this would suggest that the

⁴⁴ See generally Turpin (1989); Arrowsmith (1992); Craig (1994); and Brown and Bell (1998) for the position in French law.

⁴⁵ See generally Coffey *et al.* (1997).

⁴⁶ The point is speculative and subject to empirical confirmation.

⁴⁷ Environment, Transport and Regional Affairs Select Committee (1999); Peston and Skapinker (1998).

balance of power in the ‘public law contract’ needs very careful examination. In some cases, government power may need to be kept in check. In other cases, government power may need to be enhanced, to ensure that the contract can be used as an effective mechanism of accountability. We have identified ways in which this could have been done in the NHS; other contexts may require different measures. The ‘post costing’ clauses used in procurement contracts, to enable the government to ensure that the contractor does not make an excessive profit from the transaction, offer one example of how government might seek to enhance its bargaining position (Turpin 1989).

The importance of ensuring that the caller to account in a contract can perform its functions effectively should not be underestimated. NHS purchasers’ experiences shaped their perceptions of what could be achieved through contracting. Those who had achieved much, through a combination of their own determination and favourable circumstances, were enthusiastic. One fundholder commented:

I think what it’s done is it’s made them listen, because previously...everything was based around making a hospital work...So having the money does make a big difference, because then they have to look at things from a primary care point of view. And they have to understand that they are there to do a job for us, and that the patient doesn’t live in hospital.
(C5F)

Not surprisingly, those whose experiences had been less favourable took a very different view. The following comment was from a lead GP who had little choice (for geographical reasons) but to contract with one of the least responsive providers in the sample:

If I were to go to the provider and say I want to contract in a certain way, they really can’t handle that... so we don’t really have to be very imaginative in terms of contracting, because it’s a waste of time.
(B4F)

A failure to achieve the goals of accountability, because the caller to account lacks the required authority, may lessen that caller to account's willingness to work at the accountability process. This may produce a vicious circle in which little effort is made (see Chapter IV) and little is achieved. It was soul-destroying for those it affected, and led to an obvious reduction in accountability. In short, power is a crucial component of effective accountability. It is too crucial to be left to chance.

VII

Conclusions and Prospects

Chapter III identified two broad research aims, one analytical and one evaluative. The analytical aim was to test the value of focusing on the individual accountability mechanism and breaking it down into its three component activities of standard-setting, monitoring and enforcement. It was hoped that this approach would give us an insight into the practicalities of operating an accountability process, identifying some of the problems the parties might encounter, and some of the possible solutions to those problems. Chapters IV-VI demonstrated the complexities of 'operationalising' accountability through the NHS contract. Moreover, because the three tasks identified in our analytical model were common to all mechanisms of accountability, the approach was intended to facilitate generalisation. The potential for such generalisation is further explored in this chapter.

The other, evaluative, aim of the study was to develop a notion of the 'good' accountability process. Chapter III drew on the public law literature to identify a set of evaluative principles, which were applied to the NHS data in Chapters IV-VI. This enabled us to obtain a realistic sense of the extent to which our ideal model of good accountability might be implemented in practice. This chapter will review that model and examine the possibility of generalising the evaluative results from the NHS to other accountability processes.

These evaluative findings may be particularly relevant to the ‘public law contract’.¹ It is sometimes argued (for example, Harden 1992) that the increasing use of contract by government requires a response from public law. The present study has provided both theoretical arguments and empirical detail which may contribute to the development of such a response. By interpreting the NHS contract as a mechanism of accountability, we have provided a link between contract and familiar principles of public law. This link is reinforced by the incorporation of a number of other public law principles into our notion of good accountability: due process, transparency, making effective use of resources, and so on. But there is an important caveat. It is not entirely clear which contracts the concept of the ‘public law contract’ is intended to embrace. NHS and other contracts internal to government are potential candidates (McHale *et al.* 1997). Government’s contracts with private parties, either for procurement or under other schemes such as the ‘private finance initiative’ (Freedland 1998), would also appear to fit. But the conditions in which these various contracts operate may each be quite different (Vincent-Jones 1997): it is not clear that results from the NHS will always be directly relevant to government’s contracts with private parties, for example. The generalisations offered are thus tentative: they suggest avenues for further research rather than firm conclusions.

In this chapter, three lessons will be derived from the data, corresponding to the three hypotheses the study set out to test. Firstly, the accountability process must

¹ See generally Harden (1992); Freedland (1994; 1998); Hughes *et al.* (1996); Mchale *et al.* (1997); Vincent-Jones (1997).

be viewed in context by assessing the constraints and pressures facing purchasers as callers to account (discussed in Chapter IV). Secondly, accountability must be understood as a relationship, raising important issues of procedural fairness and, in some circumstances, transparency to third parties (Chapter V). Thirdly, accountability mechanisms must be rendered effective (Chapter VI). The next three sections explore these themes.

ACCOUNTABILITY IN CONTEXT: PURCHASERS' CHOICES

Focusing on the individual accountability mechanism showed the importance of understanding that mechanism in context (see Chapter IV). When choosing how to set about the accountability tasks, callers to account are affected by a variety of pressures and constraints. The NHS data showed that purchasers were affected by:

- pressures from central government (because they were themselves accountable to central government for their actions)
- constraints of time and resources
- constraints of skill and knowledge

The relevance of these issues is not demonstrated by a focus on categories of accountability (see Chapter I), central though they are to the experiences of those charged with 'operationalising' accountability.

Some pressures and constraints are inevitable: they would arise in any accountability process. Nevertheless, we identified various ways in which their potentially deleterious effects might be mitigated. This produced a set of realistic principles of good accountability which are likely to be of relevance to many other accountability processes.

Minimising the constraints on callers to account

The constraints facing callers to account could be confronted in two ways. One was to argue that the constraints themselves were too great: that the accountability process was under-resourced. The other was to accept that the allocated resources were adequate, and to seek ways of deriving maximal accountability from them. The study had implications for both these arguments.

We did not examine the *level of resources* allocated to the contractual accountability process in the NHS in any detail: in methodological terms, it was beyond the scope of the study. But further research on resources could usefully be conducted. On the technical level, there is a need for accurate costing of accountability processes by those with accounting expertise. It would be necessary to separate the cost of accountability from the cost of each participant's other activities.² This would be most complex for the body being called to account: Trusts' participation in accountability was obviously secondary to their role of providing care. On the political level, there is a need for debate about the right

² Audit Commission (1996) gives the cost of fundholding at £232 million, but does not give detailed costs for Health Authorities or Trusts.

proportion of public funds to be spent on accountability. As we saw in Chapter I, accountability is essential in a democracy. It clearly imposes a cost on a public service, and if it is to be effective, it must be adequately resourced. But it is inherently secondary to the performance of particular public functions. The dilemma faced by the NHS was that more money spent on accountability meant less money to spend on patient care. Political debate on the appropriate funding of accountability would be of relevance to all public services.

The study also had implications for the second argument about constraints: that ways should be found of *maximising the accountability achieved within available resources*. By examining best practice in the NHS, it was possible to identify a number of techniques for doing this. Some of these techniques might be applicable to other accountability mechanisms. We will examine the need for different accountability mechanisms to fit together without overlapping, and the need for callers to account to share information and resources.

One crucial general principle is to ensure that every accountability mechanism fits with other mechanisms operating in the same area. Taken together, there should be no gaps in the mechanisms applicable to a particular body (so that it can be called to account for all its activities) and no unnecessary overlap between mechanisms (in order to make efficient use of public resources). The former principle is emphasised by the categories of accountability employed in Chapter I; the latter was highlighted by this study. NHS contracts were particularly likely to lead to unnecessary duplication in the accountability mechanisms applicable to Trusts. This finding can be expressed as a general proposition that accountability

mechanisms are likely to lead to duplication in two situations. One is where a new mechanism is superimposed onto an existing set of accountability mechanisms: these may already offer adequate scrutiny of some issues. The other is where a mechanism is potentially very broad in scope. As we saw, NHS contracts could be used to address any conceivable issue about the provider's performance. These problems are unlikely to be confined to the NHS. In any public service delivered by professionals, for example, numerous accountability mechanisms may operate: to professional bodies, to the public agency as employer, to central government from the public agency, and to other public agencies with regulatory roles. Non-duplication is an important criterion of wise resource use in these circumstances.

The NHS data enabled us to explore some of the considerations to be taken into account when ensuring that accountability mechanisms did not duplicate one another unnecessarily. Firstly, callers to account should not be left to resolve the problem themselves: they should be given proper guidance by the system's designers. This principle was not met in the NHS. Purchasers were left in a state of confusion: when they omitted issues from the accountability process, they expressed feelings of regret or guilt, even though their actions were often justifiable in terms of the principle of non-duplication. Secondly, the skills of a particular caller to account should be considered when deciding on the appropriate scope of the accountability process he or she is to operate. For example, even though purchasers had a legitimate interest in all aspects of provider performance, they did not necessarily have the expertise to set and monitor proper clinical standards. Thirdly, non-duplication might involve active or passive reliance on other accountability mechanisms. Passive reliance involves assuming that the

other mechanisms are effective. It leads to the maximum saving of time, but may turn out to be unjustified. Active reliance involves the caller in one mechanism striving to reinforce other mechanisms. For example, the NHS purchaser could reinforce medical audit (itself an accountability mechanism) by requiring the provider to report on the results of audits. This enabled the purchaser to check the adequacy of audits without duplicating them itself.

Non-duplication was not the only way of maximising resource use for accountability. The NHS data also showed that where there was more than one caller to account, they could achieve more by sharing information and pooling their resources to work together on issues of joint concern. This might apply to any large public organisation divided into regional or local offices, each with similar accountability tasks to perform. For example, larger regulatory agencies may have several offices enforcing the same legislation in different localities. These offices may have much to learn from one another. Moreover, there may be an advantage in joint working where common issues arise. The NHS data showed that this could be used to avoid duplication (as the ‘host purchaser’ concept demonstrated) and to enhance effectiveness (amply illustrated by the success of fundholding groups).

Minimising the pressures on callers to account

The study provided data on the issues facing callers to account who did not act on their own behalf. These findings can, of course, only be generalised to other contexts in which the caller to account is also a delegate. Despite the efforts of

‘new public management’ reformers to ‘flatten out’ public sector hierarchies (Foster and Plowden 1996), many public organisations remain highly complex, with many layers of management between the service deliverers and the final callers to account: lay board members, ministers, MPs or the public, for example. Delegate callers to account may therefore be quite common even after the ‘new public management’ changes.

One problem evident from the NHS study was that purchasers were not subject to strong accountability mechanisms to patients or local communities. It is often argued in the literature (for example, Longley 1993) that strong central control of purchaser behaviour, coupled with government’s accountability to Parliament and to the electorate for its NHS policy, was an inadequate substitute for direct accountability from purchasers to the public at the local level. The principle that a delegate should be accountable to all relevant stakeholders was, in itself, nothing new. But data from the study highlighted two more subtle points.

First, the data showed that a body could not be relied upon to represent the interests of a relevant stakeholder in the absence of effective accountability to that stakeholder. Although fundholders and Health Authorities might claim to represent local needs, Chapter IV showed that this was not a high priority. In particular, local needs were not pursued where they clashed with central requirements (which *were* enforced through an effective accountability process). This reinforced our basic argument that accountability requires some formal process involving the various accountability tasks identified in Chapter I.

Secondly, the NHS findings also drew attention to the fact that accountability to one stakeholder was not necessarily an adequate substitute for accountability to all relevant stakeholders. NHS purchasers were accountable, in that they were obliged to explain and justify their activities to central government: this did not, however, compensate for the absence of local accountability. For example, the data implied that a purchaser responding to local needs would have challenged some of central government's preferred standards. Of course, this raises the difficulty of how conflicts between accountability to different stakeholders should be resolved. Additional research could usefully be conducted on this issue.

Another insight provided by the NHS study into the pressures facing callers to account related to transparency: it was vital for the proper accountability of central government to ensure that its role as the source of those pressures was clearly identifiable. Many actions taken by purchasers - their focus in contracts on finance and waiting times, for example - could be explained by reference to their need to account to the centre for their performance against those targets. It would have been unfair to hold purchasers responsible for this choice of priorities. In order to avoid such unfairness, a transparent chain of accountability mechanisms - from provider to purchaser to central government - was required. This would have enabled the final caller to account in the chain of accountability mechanisms to identify the level in the chain at which any given decision was taken, and to ensure that the responsible person was called to account for it. But the NHS study illustrated the potential for confusion, particularly where one layer in the chain (central government) claimed to have given a substantial degree of autonomy to

lower layers in the chain (purchasers). The study showed that despite a rhetoric of delegation, central government retained a substantial degree of influence over purchasers' activities. This adds further weight to the arguments in the literature that, both in the NHS (Hughes *et al.* 1996) and more generally,³ claims by central government to have delegated power should normally be treated with some suspicion.

ACCOUNTABILITY AS A RELATIONSHIP

By examining the individual accountability mechanism, rather than focusing generally on categories of accountability, it became possible to understand accountability as a relationship between the caller to account and the body being called to account. This enabled us to augment our analytical model of accountability, and to develop evaluative principles to apply to the data and to the 'public law contract' more generally (see Chapter V).

Depending upon the level of trust in the parties' relationship, the core tasks of standard-setting, monitoring and enforcement might be approached in rather different ways. Drawing on the contracts literature, we set out two different models of the accountability relationship: hard and soft (Chapter III). Their elements can be summarised as follows:

³ Oliver (1991); Greer (1994); Zifcak (1994).

Hard model:

- adversarial negotiations; comprehensive and precise standards
- monitoring through ‘policing’
- enforcement through sanctions, particularly exit

Soft model:

- collaborative negotiations; broad, general standards
- monitoring through shared information or trusting the provider to comply
- enforcement through persuasion

These models assisted the analysis of the NHS data in a number of ways. They provided a means of categorising different approaches to accountability. They enabled us to link particular types of behaviour with particular levels of trust in relationships, and to identify ways in which an approach to one accountability task (standard-setting, for example) fitted with approaches to the other accountability tasks (monitoring and enforcement). The models could perform a similar function in future studies of other ‘public law contracts’. Of course, some caution must be exercised. Some of the models’ assumptions did not hold true of the NHS data. For example, we questioned the supposed link between formal standards and low trust levels. A clear agreement on the price to be paid for the contract (where both parties felt that the price was reasonable) was, in itself, not necessarily a ground for, or a sign of, distrust. This might well be of more general application, contrary to the suggestion in the literature that formality is invariably linked to low trust (Fox 1974).

Procedural fairness

Focusing on accountability as a relationship opened up the possibility of a familiar public law response: to ask whether that relationship conformed to principles of procedural fairness. This proved to be a challenging question to answer. As we noted in Chapter V, the rules of due process are not 'self-executing'. Their detailed application must be worked out afresh in each situation, by identifying the values to be served and matching the procedures to those values (Galligan 1996). Chapter V resulted in the development of a procedurally fair hard model and a procedurally fair soft model of the contractual accountability relationship:

Soft model:

Values to be served:

- full consensus and collaboration at contract negotiations and during the life of the contract (although accountability itself may require a breach of these goals where the purchaser believes that the provider's refusal to agree to a standard is unreasonable)

Fair procedures:

- collaborative negotiations (as far as the need for some purchaser domination allows); an obligation on both parties to share information during negotiations; no requirement to set out clear standards in advance (but no ban on doing so where the parties feel that clarity is desirable)

- an obligation on the provider to share information for the purposes of monitoring
- an obligation on the purchaser to take account of the provider's explanations and excuses at the enforcement stage, and to take joint responsibility with the provider for solving the problem which has led to the breach of standards

Hard model:

Values to be served:

- limited consensus or consultation at the contract negotiation stage; the accurate application of standards during the life of the contract

Fair procedures:

- relatively collaborative negotiations with no deliberate concealment of material information; clear and precise standards set out in advance as a guide to conduct
- an obligation on the provider to supply relevant information on request for the purposes of monitoring
- an obligation on the purchaser to give advance warning of any sanctions to be applied, and to give the provider a hearing at which to offer its explanations and excuses

Because of the need to match fair procedures to their context and to the values being served, it is not possible to generalise very widely from a discussion of one set of such procedures. But it may be possible to generalise from the NHS findings

to other *contractual* accountability processes. This is one of the areas in which the study may have a contribution to make to the emerging notion of the ‘public law contract’.

One general consideration is that principles of procedural fairness should be developed for and applied to *all* the different activities taking place during the contractual relationship: choosing a contracting partner, standard-setting through contract negotiations, monitoring performance and enforcing the contract’s terms. Existing legal provisions for government contracts, for example, tend to concentrate on the choice of contracting partner, through rules governing tendering procedures, and on variations to the contract during its life, due to changes in government policy.⁴ But the study showed that contractual relationships involved many other activities in which fairness was also appropriate. This is an important first step in designing fair procedures for the ‘public law contract’.

A second general consideration in designing such procedures is that fairness should acknowledge the differing characters that can be taken by contractual relationships, as described under the hard and soft models. It was therefore essential to develop two different models of procedural fairness for the contractual accountability relationship. Developing these models brought out the complex interaction between context, values and fair procedures (Galligan 1996). The need to match procedures to values was illustrated by the fairness requirements of the

⁴ See generally Turpin (1989); Arrowsmith (1992); Craig (1994); and Brown and Bell (1998) for the position in French law.

soft model. To lawyers, familiar with the Rule of Law ideal,⁵ clear standards set out in advance seem to be of the very essence of fairness. That the soft model might not involve such standards did not, however, render it unfair. The value of consensus promoted by the model pointed in the opposite direction: to vague standards and continual negotiation. If the parties specified standards clearly, there would be less need for negotiation and less need for them to relate to one another. This could ultimately reduce or even destroy the consensus between them.

However, achieving a fit between context, values and procedures did not always involve accepting all elements of the models as set out in the literature. There were some aspects of the hard model that were difficult to reconcile with any concept of fairness. At the negotiating stage, a purchaser using the hard model might conceal information that would affect the provider's consent to the standards (see Chapter V). Our requirement of fairness - that the parties should not conceal material information during negotiations - was designed to avoid the harm this aspect of the hard model might cause. Likewise, our interpretation of hard negotiations as an opportunity for consultation on the content of the standards involved a stricter notion of fairness than the model itself suggested. We justified this by reference to the importance of fair procedures in public law. It was appropriate to modify some of the extremes of market behaviour in order to implement this central value.

The empirical data also reminded us, once these models of procedural fairness were established, that they were but models. NHS contracts were in practice far

⁵ Fuller (1969); Raz (1977).

more complex, and often contained a mixture of both hard and soft elements. Some issues lent themselves to precise specification; others were easier to express as general standards. Some high-priority, high-profile issues were liable to be enforced using every available sanction; lesser priority issues might be left to persuasion. This finding seemed unlikely to be unique to the NHS. Where the parties have a mixed contract and are working with one or other model, the requirements of procedural fairness are those applicable to the model they are using. But the potential applicability of both models gives rise to special procedural requirements. Firstly, the issues to be addressed in a hard way should be clearly separable from the issues to be addressed in a soft way. Otherwise, the purchaser might be tempted to behave unfairly by seeking to apply soft standards using a hard approach, disregarding the parties' original intention to collaborate in the detailed negotiation of the standards. Secondly, the purchaser should ensure that the provider is aware of the way in which the mixed contract is to operate. For example, without proper discussion of the issue, the provider may assume that all the contract's standards are open to negotiation, whereas the purchaser may intend that only the softly-drafted standards should be so treated.

Finally, the NHS findings underscored the importance of observing procedural fairness in a contractual relationship. Particularly in relation to sanctions, the provider's perception of the fairness of the purchaser's conduct was crucial to the parties' subsequent relationship. Fairness should therefore be given careful consideration in all 'public law contracts'.

EFFECTIVE ACCOUNTABILITY

The category approach to accountability, described in Chapter I, is concerned with effectiveness. It assumes that an effective accountability regime obtains if government is subject to some accountability mechanisms in each category. In turn, this presupposes that those mechanisms are effective. But, as we saw, it does not provide a way of exploring the effectiveness of *individual* mechanisms, or even of identifying the issues which might arise when trying to make a mechanism effective. Our focus on the individual accountability mechanism helped to remedy that failing. By breaking accountability down into a set of component tasks it became possible to identify a detailed set of goals for the caller to account when performing each of those tasks. These goals gave us a more precise notion of effective accountability. Drawing on related literature, from areas such as contracting and regulation, it then became possible to identify the practical problems that were likely to arise during the course of that accountability process. These could be tested empirically. A brief summary of purchasers' goals and the empirical findings (which were discussed fully in Chapter VI) is given below.

During contract negotiations, purchasers' goals were to:

- set the standards they believed to be in the public interest, normally by agreement with the provider but, in extreme circumstances, by imposing them⁶

⁶ This would inevitably breach the consensual nature of contract: see below, and the discussion of fairness, above.

In practice, the study found that:

- purchasers were in a weak bargaining position
- purchasers' ability to set their chosen standards depended on a variety of factors, including the provider's opinion of the standards and of the importance of the purchaser's custom
- purchasers could impose standards on providers only where the standards were required by central government
- purchasers found it difficult to judge the honesty of providers' claims that standards were unreasonable, because providers had superior access to information

During the life of the contract, purchasers' goals included:

- a primary goal of obtaining performance in accordance with the standards set
- obtaining information in order to monitor performance
- obtaining a reasonable explanation if standards were not met

In practice, the study found that:

- purchasers were in a weak bargaining position and their contracts did not create a strong sense of obligation among providers

- purchasers' ability to obtain compliance with their contracts depended on a variety of factors, including the provider's view of the standards and of the purchaser's possible methods of enforcement
- purchasers did obtain information in order to monitor performance but were not always in a good position to assess its honesty
- providers were willing to admit to breaches where they could offer excuses, but again purchasers found it difficult to assess the honesty of those excuses
- demanding compliance using stringent sanctions and without regard to excuses could prompt the provider to cheat

Good accountability is, obviously, effective accountability. What were the most important lessons which could be learnt from the NHS data for application to other accountability processes? Perhaps the most significant general feature to emerge from the data was the damaging nature of ineffective accountability processes. In such cases of ineffectiveness, NHS purchasers tended to lose faith in the accountability process. This led to a vicious circle in which the purchaser put less effort into accountability, and obtained fewer successes. Ineffectiveness was therefore self-reinforcing. This demonstrates the importance of realistically estimating the likelihood that any given accountability process will be effective.

Our discussion of procedural fairness, above, focused on the relevance of the NHS findings to the development of the 'public law contract'. At first sight, the findings on effectiveness do not seem so helpful. Where the government contracts with a private party, the usual concern is with regulating the government's power

and protecting the private party.⁷ The government has enormous spending power in some sectors, making firms willing to agree to all manner of terms and conditions in order to win contracts. That is why contract is an effective tool of social regulation (McCrudden 1999c). In the NHS, we saw that although some purchasers could achieve their goals, many were in a weak bargaining position and consequently found providers unresponsive. Now the NHS may be unique in this respect. Our findings on this issue may be of no wider relevance to the ‘public law contract’, because the usual distribution of bargaining power in ‘public law contracts’ favours the purchaser. It is, however, at least worth exploring the possibility that the NHS findings may suggest avenues for further research on bargaining power in these contracts.

The NHS was not the only ‘internal market’ in the public sector: other examples included the BBC internal market and the market for social care (although both of these markets included a greater proportion of private providers than did the NHS).⁸ Where one government agency contracted with another, it was not inevitable that the purchaser would have superior power. Moreover, it may be rather simplistic to assume that the government is invariably in the best position even when negotiating with a private party. Select Committee reports⁹ have been critical of the government’s negotiation and management of some contracts, particularly for the installation and operation of new computer systems. Those reports suggest that government is not always well-placed to call some suppliers to

⁷ See n. 4, above.

⁸ See, for example, Coffey *et al.* (1997) on the BBC, and Wistow *et al.* (1996) on social care markets.

⁹ For example, Environment, Transport and Regional Affairs Select Committee (1999).

account effectively through contracts. For example, the supplier of computer systems may have greater expertise, and once it has begun to install the system, the government may become dependent upon it and unable to move to another supplier. This can enable the supplier to impose terms, including price increases, or to evade penalties for late delivery of different stages of the project.

It is thus possible that other public sector purchasers may be in a weak bargaining position. Our findings on NHS bargaining power may therefore be of wider significance to other cases of the ‘public law contract’. The discussion below summarises the most significant NHS findings and identifies topics for further research.



One difficulty with using contract as a mechanism of accountability is that contract does not in itself guarantee the distribution of power appropriate to accountability. We saw in Chapter I that the caller to account should have superior power, enabling it to set and enforce the standards it believes to be in the public interest. In a market, though, any distribution of bargaining power is possible, depending upon the competitiveness of that market. The designers of the NHS contracting system placed considerable reliance on competition as a means of giving purchasers the authority they required to negotiate and enforce their contracts. In practice, however, the ‘internal market’ was not fully competitive and purchasers were left in a weak position. Thus, where a system of contracts is intended to promote accountability, careful consideration must be given to the purchaser’s bargaining position, whether this is to be secured through competition or through alternative means. The study also noted that one such alternative, in the

NHS, might have been stronger ‘legal’ support for contracts. Some purchasers suggested that this would have enabled them to resolve otherwise intractable disputes, and that it might have added weight to their demands for contract compliance. Their suggestion reflected the findings of recent studies on the role of institutions in promoting successful contractual relationships (Deakin *et al.* 1997).

The study’s related findings on the hard and soft models of contractual accountability are likely to be of particular importance to our understanding of the ‘public law contract’ where the purchaser is in a weak bargaining position. The central argument of Chapter VI was that, although the models suggested different strategies for approaching the contractual accountability relationship, they could not provide a remedy for the purchaser’s initially weak position. In fact, the models assumed that the provider valued the purchaser’s custom, because they had been developed in relatively competitive private sector markets (cf. Sako 1992). The failure of the hard model in those circumstances was obvious: it relied directly on the possibility of exit to another supplier where the purchaser was dissatisfied.

The failure of the soft model was less obvious: it relied on persuasion as an enforcement strategy and did not at first sight appear to be affected by the absence of more serious threats. In practice, however, successful persuasion depended upon the provider’s *valuing* the purchaser’s custom. Where the provider was not liable to lose that custom, it might well take it for granted (or appear to do so in the purchaser’s eyes). Studies of regulatory agency action have produced similar findings. Much is made of the fact that regulatory agencies prefer negotiating strategies to stringent enforcement through prosecution (Hawkins 1984). Yet on

closer inspection, those negotiating strategies depend on underlying threats. Such threats are particularly well illustrated by cases of ‘bluffing’ (Hawkins 1984: 149), in which regulators persuade a firm to comply by allowing its staff to think that the penalty for non-compliance is higher than that provided for in the legislation. If the regulators admit that the penalty is small, their persuasion will have no leverage. The NHS findings brought out this point very clearly. Persuasive strategies are no substitute for actual bargaining power, although they may provide an effective way of exercising that power (a point we could not test in the NHS).

The weakness of the soft model (and the unavailability of the hard model) in the NHS led some purchasers to turn to the intermediate model at the enforcement stage. This recourse might well be replicated in other studies of ‘public law contracts’ where purchasers had bargaining power problems. The intermediate model had its own disadvantages. Acknowledging that the purchaser could not exit, the model sought to compensate by giving the purchaser other lesser sanctions, in the hope of prompting the provider to comply. The NHS data showed that those sanctions were often insufficient to have the desired effect. One ‘scenario’ was provider refusal to co-operate. Paradoxically, because providers were unlikely to lose entire contracts (or many contracts) they felt able to disregard purchasers’ attempts to punish them. The purchaser’s trust in the provider would thus be destroyed, but, *ex hypothesi*, the purchaser could not usually resolve the issue by taking its business elsewhere. In fact, intermediate sanctions were only effective when the provider was prepared to acknowledge that the purchaser had been right to use the sanction. The difficulty of using the

intermediate model effectively is an important lesson for operators of other contractual accountability processes.

A further complexity with the use of contract as a mechanism of accountability lies in its consensual nature. The need to reach agreement has both advantages and disadvantages. Its main advantage is that it makes consultation with the provider, particularly on proposed standards, a central part of the accountability mechanism itself, rather than a matter simply of good practice. Consultation is thought to have a number of advantages, some of which were demonstrated by the study. These include ensuring that the standards set are appropriate and realistic, by drawing on the provider's expertise, and promoting compliance, by giving the provider a sense of 'ownership' of the standards. But most importantly, the study highlighted the difficulty faced by the purchaser in retaining control of the negotiating process whilst consulting with the provider. This difficulty arose because of the information asymmetry between the parties. Purchasers did not always accept providers' claims that standards could not be met, but nor did they necessarily have any means of checking those claims. This gave purchasers the choice either of accepting the provider's view (with a possible loss in accountability) or of rejecting it and seeking to impose a standard. The latter alternative might damage relationships, and in any event, the purchaser could not be sure that the standard was in the public interest. Evaluating input from the body being called to account is likely to be a difficulty for the caller to account in most accountability processes, including non-contractual ones.

In accountability terms, the main disadvantage of the consensual nature of contract is that agreement may need to be disregarded in order to preserve effective accountability. Where the caller to account is certain that a standard is in the public interest, and that the refusal to agree of the body being called to account is unreasonable, the caller may legitimately impose the standard regardless of the body's views. The imposition of a standard breaches the consensual nature of the contract, but is necessary in order to ensure that the caller to account retains control of the process. It is most likely to be a major issue in contractual accountability mechanisms where, unlike the NHS, the purchaser does have superior power. Nonetheless, the NHS study did produce some relevant data. Central standards were imposed by the purchaser on the provider in pursuit of central government's perception of the public interest, regardless of the provider's views. They gave rise to problems of enforceability. On the one hand, they might be ignored by the provider if the purchaser's enforcement methods were insufficiently stringent. Central standards sometimes clashed with professional norms, and as we saw, purchasers could not easily counteract those norms. On the other hand, if they were very strictly enforced, using sanctions and requiring compliance at all costs, the provider might be tempted to cheat or to comply 'creatively' (cf. McBarnet and Whelan 1991; 1997). Moreover, because of the information asymmetry between the parties, purchasers' monitoring efforts might be of no avail to detect these problems. In short, accountability might require a violation of consensus. For this to be worthwhile, however, the imposition of standards had to be matched with careful enforcement.

CONCLUSION

We began with two broad research aims: to test the value of studying accountability by focusing on the individual accountability mechanism, and to develop a notion of the good accountability mechanism. It is hoped that some progress has been made towards both these goals. Focusing on the individual accountability mechanism helped to identify the practical problems of implementing accountability: the constraints and pressures faced by callers to account, the complexities and tensions of the accountability relationship, and the difficulties of making the process effective. By breaking the individual accountability mechanism into its component parts, it was also possible to develop a detailed conception of the good accountability process, in which the harmful effects of constraints and pressures on the caller to account were minimised, the relationship was governed by principles of fairness, and the caller to account was given sufficient authority to make the accountability process effective. The study's findings could be generalised to other accountability processes, and in particular to the 'public law contract'.

This study's novel analytical and evaluative approach to research into the individual accountability mechanism awaits further testing and refinement in other empirical contexts. On the theoretical level, the approach has perhaps served to deepen our understanding of both the central public law concept of accountability and the notion of good accountability. On the practical level, moreover, it has produced a range of empirically-grounded ideas about the design and

implementation of good accountability processes. Perhaps most importantly, it has suggested a new way for public lawyers to respond to calls for ‘more accountability’: by ensuring that *all* accountability processes are *good* ones.

Appendix 1

Methodology

When this research project began, in 1995, it was apparent that a specially-designed empirical study of NHS contracts, as mechanisms of accountability, would be required in order to fulfil the research aims. Some empirical material from other studies of NHS contracts was available, but it was not focused on accountability and did not provide enough relevant, detailed information on which to base conclusions. A brief account is given here of the research methods employed.

SAMPLING

To gain a rounded view of the contracting process it was essential to study a sample of all three types of organisation involved: Health Authorities, GP fundholders and Trusts. It was preferable to study the Trusts with which the Health Authorities and fundholders in the sample had placed contracts, in order to obtain purchaser and provider perspectives on the same contract.

The choice of research subjects was governed by practical and theoretical considerations. On a theoretical level, although it was not possible to take a statistically significant sample, the reliability of the results was enhanced by choosing bodies facing different circumstances and seeking common patterns

amongst them (see Hutter 1988). On a practical level, factors such as the travelling time to the study area, the researcher's knowledge of the area, and any personal contacts that might facilitate access, were also relevant. The total sample size was governed by the amount of time available for empirical work (discussed below).

The Health Authorities chosen faced very different conditions, both in terms of access to providers and in terms of the nature of their populations. It was thought that an Authority's choice of providers would affect its behaviour in the market. For example, Authority C's access to several providers helped to explain its interest in partial exit as a sanction. The nature of an Authority's population might have influenced the issues it sought to address through contracts. In practice, there were few significant variations, although Chapter IV did note Authority C's special interest in ensuring that services were accessible to members of ethnic minority groups.

Authority A was in a relatively densely populated area with a large teaching hospital as its monopoly provider. The county was relatively wealthy, as were parts of the main city, but there were pockets of deprivation within the city and outside. Authority B was in a rural area with a very small District General Hospital and a variety of other hospitals some distance away. There were variations in wealth, although they were not stark, and an above average proportion of elderly people in the population. Authority C was in a densely populated urban area, with a choice of potential providers. The area was very deprived, with high rates of associated conditions such as lung cancer and

coronary heart disease. The population was ethnically diverse, in contrast to that in Areas A and B.

In each area, a sample of three or four fundholding practices was chosen. Once again, the practice's potential choice of providers was a significant criterion in selecting the sample, because of the need to examine market behaviour. This depended upon the practice's geographical location: studies sometimes take a thirty-minute travelling time as an indicator that a provider is reasonably accessible (cf. Propper and Bartlett 1997). For example, in Area B, one of the practices chosen was in the same city as the main local provider, whereas the other two were half-an-hour's drive away on the county boundary. These two practices also had the option of using a neighbouring provider, some forty minutes' drive away in the next county. Another important criterion was the date at which the practice had joined the fundholding scheme: the 'wave' in which it had gone fundholding. The sample therefore included a spread across the first (1991-92) to fifth (1995-96) waves. This ensured that the study included practices with different levels of experience (and confidence) in dealing with the contracting process. It also included practices with varying degrees of enthusiasm for the scheme: early wave practices were often ideologically committed to fundholding, whereas more recent practices tended to be more reluctant participants.

Finally, a sample of Trusts was chosen, three in each area. One of these Trusts was based outside the district being studied (two were out-of-county in Area C), whereas the others were within the district. This affected the nature of Health Authorities' relationships with them quite considerably, given the 'host purchaser'

concept described in Chapter IV. It also provided an insight into competitive behaviour: the efforts of the out-of-county provider in Area B to win the custom of fundholders on the county border were of considerable interest. The study concentrated on acute and community providers in each area (usually the in-county community provider, the main in-county acute provider and an out-of-county acute provider). Studying both acute and community provision gave the opportunity of comparison between the two types of service: for example, it demonstrated the fact that central regulation tended to focus on acute care, particularly given the high priority of in-patient waiting times. But broadening out the sample to include other types of provider (mental health, learning disabilities and so on¹) would have made the study difficult to manage. Concentrating on two services enabled the researcher to build up some understanding of the current issues affecting those services, any specialist terminology in use and so on.

Common patterns did emerge across all three areas. This suggested that the research results were reliable and generalisable. Where there were differences in the results for each area, these could often be explained by reference to an area's specific features, as we saw above in relation to Authority C. Moreover, there was no reason to think that the areas chosen were not typical of the NHS as a whole. Interviewees occasionally made reference to bodies not in the sample – a Trust manager might refer to other Health Authorities, for example – and these references often helped to confirm the reliability of the findings.

¹ An ambulance provider was studied in Area B, by way of further comparison.

Within each practice, provider or Authority, a sample of staff was chosen for interview: Appendix 2 contains a full list of the interviews conducted.² The aim was to identify those most closely involved with contracting, although some more ‘marginal’ staff were also interviewed to obtain broader perspectives and to check that their involvement in contracting was indeed limited.

In the three Health Authorities, the interviewees were selected in order to give a picture of the various specialisms within contracting (quality, finance, information and so on) and to include both junior and senior staff. More interviews were carried out in Authorities A and B than in Authority C, because better access was obtained to staff in those Authorities. Interviewees were selected gradually, beginning with staff involved in access negotiations, and moving on to others identified during initial interviews or meetings. It was important to be sensitive to each Authority’s special features, in terms of departmental organisation, job titles and roles. For example, so-called ‘commissioning’ managers in Authority C performed the functions of ‘contracting’ managers in the other two Authorities (whose ‘commissioning’ managers had a different role). Similarly, Authority A’s public health department (unlike B’s or C’s) was heavily involved in contracting, making it appropriate to interview public health staff in that Authority but not in the others.

Identifying relevant staff in fundholding practices was rather easier. Each practice usually had a fund manager, responsible for day-to-day administration, and a GP designated as the ‘lead’ partner for fundholding purposes. These two

² Interview methodology is discussed below.

people were most heavily involved in the contracting process, and interviews with both were sought wherever possible. One or two interviews and some informal conversations were held with non-lead GPs as more ‘marginal’ research subjects.

NHS Trusts usually had a small team of contracting staff. Often, each member of staff would take responsibility for particular contracts: the main local Health Authority, or certain fundholders, for example. It was therefore possible to identify staff responsible for dealing with the purchasers in the sample (although care was taken when interviewing to avoid breaching the guarantee of anonymity given to purchasers³). Once again, interviews were conducted with staff involved in different aspects of contracting, including finance and quality, and at different levels of seniority. Some ‘marginal’ interviews were also conducted with managers of particular services within the provider, and with a small sample of clinicians.⁴

ACCESS

Access negotiations can be one of the most difficult and time-consuming aspects of an empirical study (Buchanan, Boddy and McCalman 1988). Fortunately, access for the purposes of this study did not present major difficulties. One Health

³ See ‘ethical issues’, below. Health Authorities sometimes helped with access to providers, and therefore accepted that providers would be aware of their participation in the research. It was nevertheless essential, during interviews, to avoid asking questions in a way that would reveal one contracting party’s views to the other. Fundholders’ contracts could be discussed in general terms and were less problematic for anonymity.

⁴ This study found that clinicians played a less significant role in contracting than that implied by Audit Commission (1996).

Authority, one Trust and a couple of fundholding practices refused to participate, but suitable substitutes were found. The NHS had the advantage of offering a wide choice of potential research sites. The quality of access inevitably varied: some participants were extremely interested in the research and supplied extra documents, for example. Others simply met the terms of the request for access.

In order to obtain access, it was necessary to identify and negotiate with 'gatekeepers': 'Gatekeepers are those individuals in an organisation that have the power to grant or withhold access to people or situations for the purposes of research' (Burgess 1984: 48). For the Health Authorities, initial permission was obtained from the Chief Executive. The details of the research were then worked out in discussions with the relevant Executive Directors and more junior staff. In Trusts, permission was usually obtained from the relevant Executive Director or a senior member of the contracting team. Access to clinicians often had to be negotiated separately, by making direct contact with the clinicians themselves. This illustrates the point that access to one part of the organisation does not guarantee access to all parts of that organisation (Burgess 1984). In fundholding practices, the lead fundholding GP was asked for an interview and for permission to contact the fund manager.

In approaching potential research subjects, it was important to present the research carefully: 'Informants should not be subjected to a theoretical treatise or a research design...Instead, a clear indication should be given of those aspects of the setting on which you intend to focus and those individuals with whom you intend to work most closely' (Burgess 1984: 50). The access letter used for the study

contained a simple, half-page explanation of the research, and identified the precise nature of the assistance sought: the documents to which access would be required, and the likely duration of interviews, for example. It was essential to anticipate potential participants' concerns. The letter therefore emphasised the researcher's independence, and the independence of the researcher's source of funding,⁵ and explained the guarantee of anonymity offered to all participants.

Three factors helped the researcher to obtain access. Firstly, the guarantee of anonymity was essential: very few people would have been willing to participate (or to be frank) without that guarantee. Secondly, the researcher used personal contacts in two of the three areas. Such contacts made it easier to develop a relationship of trust with the research participants: trust required careful fostering where contacts were absent. Thirdly, some participants assisted in obtaining access to other potential participants. For example, Health Authority staff identified the staff they dealt with in Trusts, and supplied lists of fundholding practices, giving information relevant to the selection of a balanced sample. Sometimes, they agreed to be named in the initial access letter, a practice which often elicited a positive response. In these circumstances, it was very important to stress the independent nature of the research. There was always a danger that the researcher would be perceived as linked to the organisation which had assisted in obtaining access. This could be dealt with by ensuring that all participants received the access letter, described above, and by reassuring them in person that the researcher was not connected with any local health service bodies.

⁵ All Souls College, Oxford.

TIMING

The requirement to complete the entire research project in three, or at most four, years' full time study limited the total amount of time available for empirical research. The empirical study began in the summer of 1996 and ended at Easter 1997. There were two main reasons for selecting this period.

Firstly, it allowed the researcher to begin observing and interviewing during a contract year (the NHS financial year began in April) and to conclude the study with observation of contract negotiations for the 1997-98 contracting round. This ensured that data could be collected about contract monitoring and contract negotiations, to fulfil the research aim of studying all the accountability tasks: standard-setting, monitoring and enforcement. It also meant that the study began at a relatively quiet period of the NHS year. This facilitated access in that potential research participants were less busy and more likely to agree to be interviewed. Moreover, it accustomed the research subjects to the presence of the researcher at meetings while those meetings were relatively uncontentious. When sensitive contract negotiations began, the researcher was a familiar figure and participants were reasonably relaxed in her presence.

Secondly, studying the contracting system relatively intensely over a limited period of time helped to reduce one of the main difficulties with research in the NHS, and indeed, in many fields of socio-legal study. This is that the research

topic is a 'moving target' which may be radically altered by new legislation or changes in guidance. For the purposes of a case study of accountability, up-to-date findings were not the main priority. Instead, a manageable time-slice of data was required, in order to test theoretical ideas. The research period chosen helped to minimise the risk of major policy shifts: in particular, the research ended with the 1997 general election, which brought a change of government and some immediate alterations in government policy towards the NHS.

METHODS OF DATA COLLECTION

Three main research methods were employed: document analysis, participant observation and interviewing. The use of multiple methods, or 'triangulation' (Campbell and Fiske 1959), is commonly seen as a valuable technique on theoretical grounds, because it enhances the reliability and validity of the research. The possibility of bias is reduced if the researcher can show that different methods yield results which complement one another. Moreover, the flaws attaching to any particular method will not attach to the research as a whole, and may even be overcome by another method (Hutter 1988). Multiple strategies may also help to overcome practical problems. For example, interviews can be used to follow up points which the researcher finds difficult to understand during periods of observation (Hawkins 1984).

Document analysis

The most important documents for the study were the NHS contracts themselves. These were in the public domain (NHSME 1990*a*), although they were not usually published by the parties. Staff were not always aware of their public nature, and a certain amount of negotiation was sometimes required in order to obtain access to them.

The contracting process also generated a number of other documents, such as purchasing strategy plans and regular performance reports from providers. Many such documents were examined during the course of fieldwork. They were often handed round at meetings or supplied during interviews. Contract negotiations took place partly through correspondence, in which offers and counter-offers were made and details finalised. All three Health Authorities gave access to correspondence files.

One Health Authority was particularly helpful in providing access to its library of official documents: Health Service circulars and guidance, and NHS Executive 'executive letters'. Individual members of staff in that Authority (and other participants) also supplied copies of official documents to which they commonly made reference.

These various documents were used in two main ways. Firstly, they were a vital source of data in themselves. Contracts contained the parties' formal statements of their accountability relationship. Providers' reports were their formal

contribution to the monitoring stage of accountability. Central documents gave a formal statement of the rules within which contracting was to take place. It was, however, important to be aware that the parties' formal statements on these various matters might not reflect their practices. Secondly, therefore, documents could be used as a starting-point for interview questions and informal discussions in which the researcher sought to discover the degree of 'fit' between the formal documents and the parties' day-to-day activities.

Observation

The researcher using pure observation watches research subjects unobtrusively in order to see how they behave in particular situations (Adler and Adler 1994). At the other end of the spectrum, the *participant* observer joins the research subjects' activities and engages them in conversation, in addition to watching their behaviour (Becker 1958). In the sociological literature, observation is often used to research the way of life of particular groups (see Whyte 1943). It may be a useful technique in the socio-legal context, provided that the activity to be observed occurs with sufficient frequency (as does a 'way of life') for the method to be an efficient way of gathering data.

Observation was used in this study primarily for contract monitoring meetings and contract negotiation meetings. These were a rich source of 'observable' data. Observation was time-consuming, and could not be conducted in all three study areas. Instead, the researcher concentrated on Areas A and B. Authority B's contract monitoring meetings with its main acute and community providers were

observed, as were most of the negotiation meetings for the 1997-98 contracting round between the Authority and those providers. Limited access was obtained to negotiation meetings between Authority A and its main acute provider. The researcher also attended meetings for monitoring and negotiation between fundholding practices and the main acute and community providers in Areas A and B. Observation was, however, not a helpful technique outside the context of meetings. At other times, the work of the research subjects involved reading reports or writing letters, for example, so that their activities and thoughts were not accessible to the observer. The interview was a more efficient way to gather data in most circumstances.⁶

The type of observation used in this study was somewhere between the participant and unobtrusive poles. The researcher merely watched the relevant meetings, speaking to staff only before and after the formal proceedings. But the research did not involve the covert observation sometimes used by sociologists in public spaces: obviously, everyone attending the meetings was aware of the researcher's presence.

One of the problems with observation as a method is that the presence of an observer may affect the behaviour of the research subjects. This can be minimised by staying in the field for longer periods of time (Burgess 1984).⁷ However, in this study, the researcher's ability to stay in the field was reduced because the activity to be observed was a small part of the research subjects' daily work, and because

⁶ Interviews were used to explore the role of meetings in the contracting process, in order to ensure that they were a significant forum for negotiation and monitoring.

⁷ And by refusing to take a dominant role in their decisions or actions (Hawkins 1984).

the remainder of that work could not sensibly be observed. Nevertheless, a number of factors did suggest that this version of observation would be sufficiently reliable as a source of data. One consideration was that the researcher had a variety of contacts with the research participants outside meetings. These contacts enabled the researcher to build a rapport with them. Many took part in formal interviews. Most could be engaged in informal conversations while travelling to meetings or waiting for them to begin. Moreover, because the study of contract documents and correspondence usually took place at the research participants' offices, the researcher was able to take part in normal office life for several days or even weeks, providing further opportunities to build relationships.

In relation to Health Authority meetings, it was also possible to enhance the reliability of observation by attending meetings on a regular basis from the outset of the study. Fundholders' meetings with providers were less frequent (quarterly rather than monthly) making it more difficult for the researcher to establish a routine presence at those meetings. But this meant that fundholders were not in a relaxed, familiar relationship with providers: the presence of a researcher did not therefore seem to constitute so great an intrusion. Finally, providers' staff were more likely to become used to the presence of a researcher, because several meetings between the provider's negotiating team and different practices were observed.

These various factors contributed to a sense that the researcher's presence did not affect the participants' behaviour unduly. They discussed controversial or sensitive issues in a full and frank way, and relied upon the researcher's integrity

and discretion in dealing with those issues. Occasionally, the researcher was asked not to note particular items: these usually related to named individuals and were rarely of direct relevance to the research. But for the vast majority of issues, the need to get on with the meeting meant that the researcher was hardly noticed.

Observation and interviews complemented each other well (cf. Adler and Adler 1994). The interviews helped to validate the findings of observation by reducing the possibility that the researcher's interpretation of what took place at meetings was misguided or biased. Observation helped to validate the interview data, because it enabled the researcher to identify some instances in which an interviewee had deliberately or accidentally given a misleading answer to a question. For example, interviewees did sometimes exaggerate the degree of collaboration (or adversarialism) in their contract negotiations.

Interviewing

The interview was a central method of gathering information from those involved in the contracting process (cf. generally Fontana and Frey 1994). Some fifty formal interviews (detailed in Appendix 2) were conducted with key staff in Health Authorities, fundholding practices and providers. These interviews were supplemented by countless informal conversations when travelling to meetings or examining documents, for example. These were also a vital source of data. In particular, they could be used to overcome one of the difficulties with the formal interview: that further questions might arise when the researcher began to analyse

an interview transcript. These questions could be put during subsequent informal discussions.⁸

In order to encourage a free flow of conversation and therefore information, each interview was semi-structured: it was approached with a list of topics to be covered in whatever order seemed appropriate. This flexible method allowed the researcher to explore the research subject's interests and expertise, and to follow up relevant lines of enquiry not included in the list. The use of a closed questionnaire was rejected because it would not have accommodated the exploratory nature of the research. There was an important interaction between interviewing and the other two research methods, document analysis and observation. The contract documents and meetings provided material for interview questions: issues could be explained or their significance or implications explored. These two methods also helped the researcher to learn NHS 'jargon', in order to ask questions in language meaningful to the research subjects (cf. Fontana and Frey 1994).⁹

Obviously, it is crucial when interviewing to encourage the interviewee to be as open and forthcoming as possible. Many researchers find that the people they wish to interview welcome the chance to discuss their life or work (see, for example, Hutter 1988), particularly if they are reassured by a guarantee of confidentiality and a clear explanation of the research. The experience of this study was similar.

⁸ Where necessary, permission was obtained at the end of each interview to contact the participant again, for example by telephone, if follow-up questions arose.

⁹ Some terminology was potentially controversial: for example, questions about rationing could only be asked using the NHS euphemism, 'priority-setting'.

These forms of reassurance were given in the letter requesting access and repeated at the beginning of the interview. Moreover, many NHS managers (much vilified in the Press) were glad of an opportunity to discuss the difficulties and challenges of their work. As with meetings, participants discussed many controversial issues in a frank way. On occasions, they did seek to present a 'party line' about an issue,¹⁰ but further questioning often elicited more open responses.

Interviews raise a number of questions of self-presentation (Fontana and Frey 1994). Two strategies were used in this study. One was that of the 'learner', asking expert interviewees to explain their work to the lay outsider. Managers often responded well to this strategy. The second involved a claim to some theoretical and practical knowledge of NHS contracting, as a result of academic study. Recourse was had to this approach where the first role elicited unhelpful answers. For example, a busy GP might engage more readily with an expert researcher, raising difficult and interesting issues, than with someone requiring time-consuming explanations. In both roles, it was important to avoid bias in the interview. The researcher's reactions may encourage the respondent to put forward particular lines of argument, if she appears to approve, or discourage discussion of some topics if she seems surprised (Burgess 1984). With the permission of the interviewees, interviews were tape-recorded. This helped the researcher to concentrate on the flow of the conversation and on observing her own (and the interviewee's) reactions. It also provided an accurate record of the formal interviews. Quotations in the text were all taken from formal interviews, because

¹⁰ For example, Chapter IV noted the tendency of some interviewees to claim that they planned to extend the coverage of their contracts to low-priority areas. Further questioning (and other data sources) revealed that this was a defence against potential criticism rather than a genuine intention.

the subject's exact words could be used. Fieldwork notes were kept of informal discussions.

ETHICAL ISSUES

The Socio-Legal Studies Association's 'Statement of Ethical Practice' (SLSA 1993) was used as a source of guidance on research ethics. Two main ethical issues arose in the study.

One was the obligation to ensure that the research was based on the informed consent of the participants: 'This implies a responsibility on the socio-legal researcher to explain as fully as possible, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is to be disseminated' (SLSA 1993, 3.2). As noted above, this was fulfilled by means of a carefully-drafted access letter. The key points were reinforced during informal conversations and at the beginning of interviews.

A second important obligation is that of ensuring that the identities of those participating in research are kept confidential, and that they are not identifiable in the research report although they are not named (SLSA 1993, 3.3). The study has been written up with this obligation in mind. For example, the controversial topic of 'creative compliance' (McBarnet and Whelan 1991; 1994) has been described (in Chapter VI) without reference even to the area in which it took place, in case an attempt might be made to identify those responsible. Confidentiality must also

maintained within the research setting: the researcher must resist pressure from managers to supply information about their staff, for example (Bryman 1988*b*). It was inevitable (and accepted by the participants to whom it applied) that some staff would know that others were being interviewed, but care was taken to ensure that the researcher did not reveal what had taken place during those interviews. In particular, it was important to avoid questioning which was obviously related to information supplied in other interviews. But no direct requests for information in breach of confidence were encountered.

METHODOLOGICAL LIMITATIONS

Any empirical study is bound to have limitations. Some issues may be beyond the scope of a single researcher with limited time. Others may present problems of research design - they may be difficult to investigate - or of expertise they may require skills the researcher cannot easily acquire. It is important to identify any limitations clearly in the research report: Chapters IV-VI noted points at which relevant data were less reliable or unavailable. Three significant limitations affected this study. They will be described briefly here.

One was that it proved impossible to examine conclusively the accuracy and honesty of the information supplied by providers to purchasers for the purposes of monitoring. This would have required the researcher to obtain parity of information with the provider, for example by working with the provider's staff when compiling reports for purchasers. This would have been a difficult task. For

example, the researcher could not merely have worked with the staff producing the reports: the ‘front-line’ workers collecting the data might have had an interest in deceiving management as to their performance. Given the limited time allowed for empirical research, and the need to address a range of issues as well as monitoring, it was not possible to embark on this line of investigation. Moreover, some data could be obtained by other means: providers did sometimes admit that the information they were supplying to purchasers was not accurate.

A second limitation was that it proved impossible to explore fully the ‘onwards’ accountability mechanisms applicable to purchasers. It quickly became apparent that Health Authorities, in particular, were influenced by the pressures to which they were subject from central government. To place the contractual accountability relationship from provider to purchaser fully in context, it would have been desirable to investigate this and other ‘onwards’ accountability mechanisms. Again, however, the need to design a manageable empirical study and to complete it in the time available meant that this aspect of the research could not be pursued. Some relevant data were gathered during the study: central accountability was commonly discussed in interviews and some meetings were observed at which NHS Executive staff were present. Moreover, central guidance was an important part of the initial document analysis. These data were sufficient for a study in which the primary purpose was to investigate NHS contracts themselves.

A third limitation was that it was not possible to produce a detailed costing of the contractual accountability process, in order to assess whether adequate

resources were available to callers to account. This meant that we could not comment fully on one of the public law principles of good accountability developed for the study. The main reason for not pursuing this issue was that the researcher did not possess the required accounting expertise.

ANALYSING THE DATA

There was a complex interaction in the study between devising research questions, collecting data, and analysing those data (cf. Huberman and Miles 1994¹¹). When writing up the research report, it is difficult to convey this interaction: the various processes are more easily presented as a sequence of separate tasks. Some brief comments will be offered here to dispel that image.

The research questions for the study were expressed as hypotheses. This did not reflect any particular claim that socio-legal research is closely analogous with research in the 'hard' sciences. Rather, it reflected the researcher's preference for the hypothesis as offering a clear and focused expression of the issue to be investigated. Initial formulations of the hypotheses were based on the relevant literature. Some pilot interviews and informal conversations were then conducted, which provided an opportunity to check the relevance and usefulness of the hypotheses. It was at this stage that Hypothesis 1, in particular, was developed more fully: the literature had suggested the significance of central government

¹¹ The authors also give a useful discussion of the problems of data management.

influence (for example, Hughes *et al.* 1996), but it was the initial interviews that drew attention to the role of time and skill constraints.

When the study began in earnest, the researcher's task was not merely to collect data, but to engage in a continuous process of analysis of those data. In practice, there were natural gaps in the fieldwork period during which analysis of the interview transcripts and fieldwork notes so far collected could take place. This continuous analysis was essential in guiding the study. It helped to ensure that the fieldwork remained focused on the research questions. It also enabled the researcher to identify issues to be clarified or theoretical ideas to be tested in the next round of fieldwork: '[T]he next interviews and observations become informed by analytic questions and hypotheses about categories and their relationships' (Strauss 1987: 26). The initial hypotheses became increasingly refined as the study progressed.

The data were coded following the method of 'grounded theory' suggested by Glaser and Strauss (1967). Put simply, coding involves examining the data line-by-line, and thinking of categories and concepts which fit the data and allow them to be organised into clusters. The codes constitute the essential building blocks of the theoretical conclusions which will be drawn from the data. As the discussion above indicates, there is a natural progression from developing research hypotheses to drawing conclusions from the data. Many codes are likely to relate to the hypotheses. But it is important not to become too wedded to the hypotheses. The researcher might be tempted to use the data selectively in order to support the hypotheses, rather than to interpret it carefully. Alternatively, the researcher might

miss valuable findings which were not predicted at the outset. Coding encourages a detailed examination of the data and should help to prevent these pitfalls.

Appendix 2

Interview Codes

The list below details all the formal interviews carried out for the study. The interviewees are not named, because anonymity was promised to all research participants (see Appendix 1). Instead, each interview has a code with three elements: the initial letter denotes the study area (A, B or C); the number identifies the individual interview; and the end letter describes which of the three types of contracting party the interviewee worked for (A for Health Authority, T for Trust, F for fundholding practice). Where an interview is cited in the text, the code is given to enable the reader to identify at a glance the area and contracting party. The list below adds the following information: the seniority and main responsibilities of each interviewee; the location (within or outside the participant Health Authority's district) and function of the Trusts in the sample; and cross-references between interviews with the same person or within the same organisation.

A1A	Health Authority Chief Executive
A2A	Health Authority Executive Director, contracting
A3T	Trust 3 (out-of-county acute), senior contract manager and junior contract manager
A4A	Health Authority Executive Director, public health

A5T	Trust 2 (in-county community), Executive Director, contracting
A6T	Trust 1 (in-county acute), junior contract manager
A7T	Trust 1 (in-county acute), Executive Director, contracting
A8T	Trust 2 (in-county community), Executive Director, nursing
A9A	Health Authority junior contract manager
A10F	Fund manager (same practice as A13F)
A11T	Trust 1 (in-county acute), consultant
A12F	Fund manager
A13F	Fundholding GP (same practice as A10F)
A14F	Fundholding GP
A15T	Trust 2 (in-county community), junior contract manager
A16T	Trust 2 (in-county community), junior contract manager
A17F	Fundholding GP
A18A	Health Authority senior public health manager
A19F	Fund manager
B1A	Health Authority senior contract manager
B2T	Trust 2 (in-county community), Executive Director, contracting
B3A	Health Authority junior manager, information
B4F	Fundholding GP
B5T	Trust 3 (out-of-county acute), senior contract manager
B6A	Health Authority junior contract manager (same interviewee as B15A)
B7A	Health Authority quality manager

B8F	Fund manager (same practice as B13F)
B9T	Trust 1 (in-county acute), contract manager
B10F	Fund manager (same practice as B12F)
B11T	Trust 4 (in-county ambulance), Executive Director, contracting
B12F	Fundholding GP (same practice as B10F)
B13F	Fundholding GP (same practice as B8F)
B14T	Trust 1 (in-county acute), consultant
B15A	Health Authority junior contract manager (same interviewee as B6A)
C1A	Health Authority contract manager (same interviewee as C4A)
C2A	Health Authority quality manager
C3A	Health Authority contract manager
C4A	Health Authority contract manager (same interviewee as C1A)
C5F	Fundholding GP
C6T	Trust 2 (out-of-county acute), quality manager
C7T	Trust 1 (in-county acute and community), quality manager
C8T	Trust 1 (in-county acute and community), contract manager
C9F	Fund manager (same practice as C13F)
C10T	Trust 3 (out-of-county acute), contract manager
C11F	Fund manager
C12T	Trust 2 (out-of-county acute), contract manager
C13F	Fundholding GP (same practice as C9F)
C14T	Trust 1 (in-county acute and community), Executive Director, medical

C15T Trust 1 (in-county acute and community), consultant

Bibliography

Adler, P. A., and Adler, P. (1994), 'Observational Techniques', in Denzin and Lincoln (1994).

Allen, P. (1995), 'Contracts in the National Health Service Internal Market', *Modern Law Review*, 58: 321-342.

Allsop, J., and Mulcahy, L. (1996), *Regulating Medical Work: Formal and Informal Controls* (Buckingham: Open University Press).

Arrowsmith, S. (1992), *Civil Liability and Public Authorities* (Winteringham, South Humberside: Earls Gate).

Ashburner, L., and Cairncross, L. (1993), 'Membership of the 'New Style' Health Authorities: Continuity or Change?', *Public Administration*, 71: 357-375.

Atiyah, P. S. (1979), *The Rise and Fall of Freedom of Contract*, (Oxford: Clarendon Press).

Audit Commission (1993a), *Practices Make Perfect: the Role of the Family Health Services Authority* (London: HMSO).

----- (1993b), *Their Health, Your Business: the New Role of the District Health Authority* (London: HMSO).

----- (1995a), *Briefing on GP Fundholding* (London: HMSO).

----- (1995b), *Code of Audit Practice for Local Authorities and the National Health Service* (London: HMSO).

----- (1996), *What the Doctor Ordered: a Study of GP Fundholders in England and Wales* (London: HMSO).

----- (1998), *Local Authority Performance Indicators 1996-97* (London: The Stationery Office).

Ayres, I., and Braithwaite, J. (1992), *Responsive Regulation: Transcending the Deregulation Debate* (Oxford: Oxford University Press).

Baldwin, R., and McCrudden, C. (1987), *Regulation and Public Law* (London: Weidenfeld and Nicolson).

Barker, K. (1993), 'NHS Contracts, Restitution and the Internal Market', *Modern Law Review*, 56: 832-843.

-----Chalkley, M., Malcomson, J. M., and Montgomery, J. (1997), 'Contracting in the National Health Service: Legal and Economic Issues', in Flynn and Williams (1997).

Barron, A. and Scott, C. (1992), 'The Citizen's Charter Programme', *Modern Law Review*, 55: 526-546.

Bayles, M. D. (1990), *Procedural Justice: Allocating to Individuals* (Dordrecht: Kluwer Academic Publishers).

Beale, H., and Dugdale, T. (1975), 'Contracts Between Businessmen: Planning and the Use of Contractual Remedies', *British Journal of Law and Society*, 2: 45-60.

Becker, H. S. (1958), 'Problems of Inference and Proof in Participant Observation', *American Sociological Review*, 23: 652-660.

Belcher, A. (1995), 'Codes of Conduct and Accountability for NHS Boards', *Public Law*: 288-297.

Brindle, D. (1996), 'Warning of 'Meltdown' in NHS Market as Trusts Resist Squeeze', *The Guardian*: 7th May.

Brown, L. N., and Bell, J. S. (1998), *French Administrative Law*, 5th edn. (Oxford: Clarendon Press).

Bruce, A., and McConnell, A. (1995), *Changing Regimes of Accountability in Local Government and the NHS* (Glasgow: Policy Analysis Research Unit, Glasgow Caledonian University).

Bryman, A. (ed.) (1988a), *Doing Research in Organizations* (London: Routledge).

-----(1988b), 'Inside' accounts and social research in organisations' in Bryman (1988a).

Buchanan, D., Boddy, D., and McCalman, J. (1988), 'Getting In, Getting On, Getting Out and Getting Back' in Bryman (1988a).

Buchanan, J. and Tullock, G. (1962), *The Calculus of Consent: Logical Foundations of Constitutional Democracy* (Ann Arbor: University of Michigan Press).

Burgess, R. G. (1984), *In the Field: an Introduction to Field Research* (London: Allen and Unwin).

Campbell, D., and Fiske, D. (1959), 'Convergent and Discriminant Validation by the Multitrait - Multimethod Matrix', *Psychological Bulletin*, 56: 81-105.

Campbell, D., and Vincent-Jones, P. (eds.) (1996), *Contract and Economic Organisation: Socio-Legal Initiatives* (Aldershot: Dartmouth).

Coffey, D., Nolan, P., Saundry, R., and Sawyer, M. (1997), 'Regulatory Change in the British Television Industry: Effects on Productivity and Competition', in Deakin and Michie (1997).

Collins, H. (1996), 'Competing Norms of Contractual Behaviour', in Campbell and Vincent-Jones (1996).

----- (1997), *The Law of Contract*, 3rd edn. (London: Butterworths).

Craig, P. P. (1990), *Public Law and Democracy in the United Kingdom and the United States of America* (Oxford: Clarendon Press).

----- (1994), *Administrative Law*, 3rd edn. (London: Sweet and Maxwell).

Davies, A. C. L. (1999), 'Using Contracts to Enforce Standards: the Case of Waiting Times in the National Health Service', in McCrudden (1999a).

Day, P., and Klein, R. (1987), *Accountabilities: Five Public Services* (London: Tavistock).

Deakin, S., Lane, C., and Wilkinson, F. (1997), 'Contract Law, Trust Relations, and Incentives for Co-operation: a Comparative Study', in Deakin and Michie (1997).

----- and Michie, J. (eds.) (1997), *Contracts, Co-operation, and Competition: Studies in Economics, Management, and Law* (Oxford: Oxford University Press).

Denzin, N. K., and Lincoln, Y. S. (eds.) (1994), *Handbook of Qualitative Research* (California: Sage).

Department of Health (1989), *Working for Patients* (Cm 555; London: HMSO).

----- (1991), *The Patients' Charter* (London: HMSO).

----- (1992), *The Health of the Nation: a Strategy for Health in England* (Cm 1986; London: HMSO).

----- (1993), *Changing Childbirth* (London: HMSO).

----- (1994), *Managing the New NHS: Functions and Responsibilities in the New NHS* (London: Department of Health).

----- (1995), *The Patients' Charter*, 2nd edn. (London: HMSO).

----- (1997), *The New NHS: Modern, Dependable* (Cm 3807; London: The Stationery Office).

Dicey, A. V. (1885), *Lectures Introductory to the Study of the Law of the Constitution* (London: Macmillan).

Doig, A. (1995), 'Mixed Signals? Public Sector Change and the Proper Conduct of Public Business', *Public Administration*, 73: 191-212.

Donabedian, A. (1980), *The Definition of Quality: Approaches to its Assessment* (Ann Arbor: Health Administration Press).

Dore, R. (1983), 'Goodwill and the Spirit of Market Capitalism', *British Journal of Sociology*, 34: 459-482.

Dworkin, R. (1986), *Law's Empire* (London: Fontana Press).

Enthoven, A. C. (1985), *Reflections on the Management of the National Health Service: an American Looks at Incentives to Efficiency in Health Services Management in the UK* (London: Nuffield Provincial Hospitals Trust).

Environment, Transport and Regional Affairs Select Committee (1999), *The Future of National Air Traffic Services* (Third Report; HC 122; London: The Stationery Office).

Erskine May, T., McKay, W. R., and Limon, D. (1997), *Erskine May's Treatise on the Law, Privileges, Proceedings and Usage of Parliament*, 22nd edn. (London: Butterworths).

Fenn, P. and Veljanovski, C. (1988), 'A Positive Theory of Regulatory Enforcement', *Economic Journal*, 98: 1055-1070.

Ferlie, E., Ashburner, L., and Fitzgerald, L. (1995), 'Corporate Governance and the Public Sector: some Issues and Evidence from the NHS', *Public Administration*, 73: 375-392.

-----and Pettigrew, A. (1996), *The New Public Management in Action* (Oxford: Oxford University Press).

Flynn, R., and Williams, G. (eds.) (1997), *Contracting for Health: Quasi-Markets and the National Health Service* (Oxford: Oxford University Press).

-----and Pickard, S. (1996), *Markets and Networks: Contracting in Community Health Services* (Buckingham: Open University Press).

----- (1997), 'Quasi-Markets and Quasi-Trust: The Social Construction of Contracts for Community Health Services', in Flynn and Williams (1997).

Fontana, A., and Frey, J. H. (1994), 'Interviewing: The Art of Science', in Denzin and Lincoln (1994).

Foster, C. D., and Plowden, F. J. (1996), *The State under Stress: Can the Hollow State be Good Government?* (Buckingham: Open University Press).

Fox, A. (1974), *Beyond Contract: Work, Power and Trust Relations* (London: Faber and Faber).

Fredman, S., and Morris, G. S. (1989), *The State as Employer: Labour Law in the Public Services* (London: Mansell).

Freedland, M. (1994), 'Government by Contract and Public Law', *Public Law*: 86-104.

----- (1996), 'The Rule against Delegation and the Carltona Doctrine in an Agency Context', *Public Law*: 19-30.

----- (1998), 'Public Law and Private Finance: Placing the Private Finance Initiative in a Public Law Frame', *Public Law*: 288-307.

Fridman, G. H. L. (1996), *The Law of Agency*, 7th edn. (London: Butterworths).

Fried, C. (1981), *Contract as Promise: a Theory of Contractual Obligation* (Cambridge, Massachusetts: Harvard University Press).

Fukuyama, F. (1995), *Trust: The Social Virtues and the Creation of Prosperity* (London: Hamish Hamilton).

Fuller, L. L. (1969), *The Morality of Law*, rev. edn. (New Haven: Yale University Press).

Galligan, D. J. (1986), *Discretionary Powers: a Legal Study of Official Discretion* (Oxford: Clarendon Press).

----- (1996), *Due Process and Fair Procedures: A Study of Administrative Procedures* (Oxford: Clarendon Press).

Gambetta, D. (ed.) (1988a), *Trust: Making and Breaking Cooperative Relations* (Oxford: Basil Blackwell).

----- (1988b), 'Can We Trust Trust?', in Gambetta (1988a).

Gaster, L. (1995), *Quality in Public Services: Managers' Choices* (Buckingham: Open University Press).

Glaser, B., and Strauss, A. (1967), *The Discovery of Grounded Theory* (Chicago: Aldine).

Glennester, H., Matsaganis, M., and Owens, P., with Hancock, S. (1994), *Implementing GP Fundholding: Wild Card or Winning Hand?* (Buckingham: Open University Press).

Goetz, C. J., and Scott R. E. (1980), 'Enforcing Promises: an Examination of the Basis of Contract', *Yale Law Journal*, 89: 1261-1322.

Greer, P. (1992), 'The Next Steps Initiative: an Examination of the Agency Framework Documents', *Public Administration*, 70: 89-98.

----- (1994), *Transforming Central Government: the Next Steps Initiative* (Buckingham: Open University Press).

Hailsham of St Marylebone (Lord) (1976), *Elective Dictatorship* (London: British Broadcasting Corporation).

Hammond, A. H. (1998), 'Judicial Review: the Continuing Interplay between Law and Policy', *Public Law*: 34-43.

Harden, I. (1992), *The Contracting State* (Buckingham: Open University Press).

----- (1993), 'Money and the Constitution: Financial Control, Reporting and Audit', *Legal Studies*, 13: 16-37.

----- and Lewis, N. (1986), *The Noble Lie: the British Constitution and the Rule of Law* (London: Hutchinson).

Harlow, C. and Rawlings, R. (1997), *Law and Administration*, 2nd edn. (London: Butterworths).

Hart, H. L. A. (1968), *Punishment and Responsibility* (Oxford: Clarendon Press).

----- (1994), *The Concept of Law*, 2nd edn. (Oxford: Clarendon Press).

Hart, K. (1988), 'Kinship, Contract and Trust: the Economic Organization of Migrants in an African City Slum', in Gambetta (1988a).

Hawkins, K. (1984), *Environment and Enforcement: Regulation and the Social Definition of Pollution* (Oxford: Clarendon Press).

----- (ed.) (1992), *The Uses of Discretion* (Oxford: Clarendon Press).

Hinton, P., and Wilson, E. (1993), 'Accountability', in J. Wilson and P. Hinton (eds.), *Public Services and the 1990s: Issues in Public Service Finance and Management* (Wirral, Merseyside: Tudor).

Hirschman, A. O. (1970), *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States* (Cambridge, Massachusetts: Harvard University Press).

Hirst, P. (1995), 'Quangos and democratic government', *Parliamentary Affairs*, 48: 341-359.

HM Government (1991), *The Citizen's Charter: Raising the Standard*, (Cmnd. 1599; London: HMSO).

HM Treasury (1991), *Competing for Quality: Buying Better Public Services* (Cm 1730; London: HMSO).

----- (1995), *Government Accounting: a Guide on Accounting and Financial Procedures for the Use of Government Departments*, consolidated edn. (London: HMSO).

----- (1997), *Partnerships for Prosperity - the Private Finance Initiative* (London: Treasury Taskforce: Private Finance Projects Team).

Hodgson, K. (and Hoile, R. W.) (1996), *Managing Health Service Contracts* (London: W. B. Saunders).

Hopwood, A. (1984), 'Accounting and the Pursuit of Efficiency', in Hopwood and Tomkins (1984).

----- and Tomkins, C. (eds.) (1984), *Issues in Public Sector Accounting* (Deddington: Philip Allan).

House of Commons Public Service Committee (1996), *Ministerial Accountability and Responsibility* (Second Report, HC 313; London: HMSO).

House of Commons Social Services Select Committee (1987-88), *The Future of the National Health Service*, (Fifth Report, HC 613; London: HMSO).

Huberman, A. M., and Miles, M. B. (1994), 'Data Management and Analysis Methods', in Denzin and Lincoln (1994).

Hughes, D. (1991), 'The Reorganisation of the National Health Service: the Rhetoric and Reality of the Internal Market', *Modern Law Review*, 54: 88-103.

----- and Dingwall, R. (1990), 'Sir Henry Maine, Joseph Stalin and the Reorganisation of the National Health Service', *Journal of Social Welfare Law*: 296-309.

- and McGuire, A. (1992), 'Legislating for Health: the Changing Nature of Regulation in the NHS', in R. Dingwall and P. Fenn (eds.), *Quality and Regulation in Health Care: International Experiences* (London: Routledge).
- McHale, J. V., and Griffiths, L. (1996), 'Contracts in the NHS: Searching for a Model?', in Campbell and Vincent-Jones (1996).
- (1997), 'Settling Contract Disputes in the National Health Service: Formal and Informal Pathways', in Flynn and Williams (1997).
- Hunt, D. (1995), 'Worthwhile Bodies', *Parliamentary Affairs*, 48: 192-206.
- Hunt, P. (1995), 'Accountability in the National Health Service', *Parliamentary Affairs*, 48: 297-305.
- Hutter, B. M. (1988), *The Reasonable Arm of the Law? The Law Enforcement Procedures of Environmental Health Officers* (Oxford: Clarendon Press).
- Hviid, M. (1996), 'Relational Contracts and Repeated Games', in Campbell and Vincent-Jones (1996).
- Jacob, J. M. (1991), 'Lawyers go to Hospital', *Public Law*: 255-281.
- JUSTICE-All Souls Committee (1988), *Administrative Justice: Some Necessary Reforms* (Oxford: Clarendon Press).
- Kay, J. A., Mayer, C. P., and Thompson, D. (1986), *Privatisation and Regulation: the UK Experience* (Oxford: Clarendon Press).
- Kennedy, D. (1996), 'Dorrell Orders New Intensive-Care Beds for Children', *The Times*: 30th May.
- Kirkpatrick, I., and Martinez Lucio, M. (1995), *The Politics of Quality in the Public Sector* (London: Routledge).
- Klein, R. (1995), *The New Politics of the NHS*, 3rd edn. (London: Longman).

- Lapsley, I., and Llewellyn, S. (1997), 'Statements of Mutual Faith: Soft Contracts in Social Care', in Flynn and Williams (1997).
- Levitt, R., Wall, A., and Appleby, J. (1995), *The Reorganized National Health Service*, 5th edn. (London: Chapman and Hall).
- Lewis, N., and Longley, D. (1994), 'Ethics and the Public Service', *Public Law*: 596-608.
- Longley, D. (1990), 'Diagnostic Dilemmas: Accountability in the National Health Service', *Public Law*: 527-552.
- (1993), *Public Law and Health Service Accountability* (Buckingham: Open University Press).
- Lorenz, E. H. (1988), 'Neither Friends nor Strangers: Informal Networks of Subcontracting in French Industry', in Gambetta (1988).
- Loughlin, M. (1992), *Administrative Accountability in Local Government* (York: Joseph Rowntree Foundation).
- Macaulay, S. (1963), 'Non-Contractual Relations in Business: a Preliminary Study', *American Sociological Review*, 28: 55-67.
- Macneil, I. R. (1974), 'The Many Futures of Contracts', *Southern California Law Review*, 47: 691-816.
- Macneil, I. R. (1978), 'Contracts: Adjustment of Long-Term Economic Relations under Classical, Neoclassical, and Relational Contract Law', *Northwestern University Law Review*, 72: 854-905.
- Madison, J., Hamilton, A., and Jay, J. (1788), *The Federalist Papers* (London: Penguin, 1987, ed. I. Kramnick).
- Marshall, G. (1986), *Constitutional Conventions: the Rules and Forms of Political Accountability* (Oxford: Clarendon Press).

Martin, J. E. (and H. G. Hanbury) (1997), *Modern Equity*, 15th edn. (London: Sweet and Maxwell).

McBarnet, D., and Whelan, C. (1991), 'The Elusive Spirit of the Law: Formalism and the Struggle for Legal Control', *Modern Law Review* 54: 848-873.

----- (1997), 'Creative Compliance and the Defeat of Legal Control: the Magic of the Orphan Subsidiary', in K. Hawkins (ed.), *The Human Face of Law: Essays in Honour of Donald Harris* (Oxford: Clarendon Press).

McCahery, J., Picciotto, S., and Scott, C. (1993), *Corporate Control and Accountability: Changing Structures and the Dynamics of Regulation* (Oxford: Clarendon Press).

McCrudden, C. (ed.) (1999a), *Regulation and Deregulation: Policy and Practice in the Utilities and Financial Services Industries* (Oxford: Clarendon Press).

----- (1999b), 'Social Policy and Economic Regulators: Some Issues from the Reform of Utility Regulation', in McCrudden (1999a).

----- (1999c), 'International Economic Law and the Pursuit of Human Rights: A Framework for Discussion of the Legality of 'Selective Purchasing' laws under the WTO Government Procurement Agreement', *Journal of International Economic Law*, (forthcoming).

McEldowney, J. F. (1991), 'The National Audit Office and Privatisation', *Modern Law Review*, 54: 933-955.

----- (1994), 'The Control of Public Expenditure', in J. Jowell and D. Oliver (eds.), *The Changing Constitution*, 3rd edn. (Oxford: Clarendon Press).

McHale, J., Hughes, D., and Griffiths, L. (1997), 'Conceptualizing Contractual Disputes in the National Health Service Internal Market', in Deakin and Michie (1997).

- Miller, F. (1992), 'Competition Law and Anticompetitive Professional Behaviour Affecting Health Care', *Modern Law Review*, 55: 453-481.
- Montgomery, J. (1997a), *Health Care Law*, (Oxford: Oxford University Press).
- (1997b), 'Control and Restraint in National Health Service Contracting', in Deakin and Michie (1997).
- Morgan, P., and Potter, C. (1995), 'Professional Cultures and Paradigms of Quality in Health Care', in Kirkpatrick and Martinez Lucio (1995).
- Morgan, R. (1993), 'Prisons Accountability Revisited', *Public Law*: 314-332.
- National Health Service Executive (1993), *GP Fundholding Cost per Case Activity* (FDL(93)77; Leeds: NHSE).
- (1994), *Developing NHS Purchasing and GP Fundholding: Towards a Primary Care-Led NHS* (Leeds: NHSE).
- (1995a), *An Accountability Framework for GP Fundholding* (Leeds: NHSE).
- (1995b), *Priorities and Planning Guidance for the NHS: 1996-97* (Leeds: NHSE).
- (1998), *The NHS Performance National Guide 1996-97* (Leeds: NHSE).
- National Health Service Management Executive (1989), *Contracts for Health Services: Operational Principles* (London: HMSO).
- (1990a), *Contracts for Health Services: Operating Contracts* (London: HMSO).
- (1990b), *NHS Trusts: a Working Guide* (London: HMSO).
- (1993), *Good Practice and Innovation in Contracting* (Leeds: NHSME).
- Nelken, D. (1987), 'The Use of Contracts as a Social Work Technique', *Current Legal Problems*, 40: 207-232.

Normanton, E. L. (1971), 'Public Accountability and Audit: a Reconnaissance', in Smith and Hague (1971).

Ogus, A. I. (1994), *Regulation: Legal Form and Economic Theory* (Oxford: Clarendon Press).

Oliver, D. (1991), *Government in the United Kingdom: the Search for Accountability, Effectiveness and Citizenship* (Milton Keynes: Open University Press).

-----(1994), 'Law, Politics and Public Accountability: the Search for a New Equilibrium', *Public Law*: 238-253.

Olson, M. (1965), *The Logic of Collective Action* (Cambridge: Harvard University Press).

Osborne, D. and Gaebler, T. (1992), *Reinventing Government* (Reading, Mass.: Addison Wesley).

Øvretveit, J. (1995), *Purchasing for Health: a Multidisciplinary Introduction to the Theory and Practice of Health Purchasing* (Buckingham: Open University Press).

Parker, R. S. (1976), 'The Meaning of Responsible Government', *Politics*, 11: 178-179.

Parliamentary Commissioner for Administration (1998), *Parliamentary Commissioner for Administration: Annual Report 1997-98* (HC 845; London: The Stationery Office).

Peston, R., and Skapinker, M. (1998), 'MPs to Probe Cost of Air Traffic Centre: Aviation Budget for New Swanwick Facility Has Risen From £350m to £475m', *Financial Times*: 17th September.

Power, M. (1997), *The Audit Society: Rituals of Verification* (Oxford: Oxford University Press).

Propper, C., and Bartlett, W. (1997), 'The Impact of Competition on the Behaviour of National Health Service Trusts', in Flynn and Williams (1997).

Prosser, T. (1986), *Nationalised Industries and Public Control: Legal, Constitutional and Political Issues* (Oxford: Basil Blackwell).

Radford, M. (1991), 'Auditing for Change: Local Government and the Audit Commission', *Modern Law Review*, 54: 912-932.

Ranade, W. (ed.) (1998), *Markets and Health Care: a Comparative Analysis* (London: Longman).

Raz, J. (1977), 'The Rule of Law and its Virtue', *Law Quarterly Review*, 93: 195-211.

Rhodes, R. A. W. (1997), *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability* (Buckingham: Open University Press).

Richardson, G., Ogus, A., and Burrows, P. (1983), *Policing Pollution: A Study of Regulation and Enforcement* (Oxford: Clarendon Press).

Richardson, T., and Taylor, B. (1995), 'Contracts', in S. Henry and D. Pickersgill (eds.) (1995), *Making Sense of Fundholding* (Abingdon: Radcliffe Medical Press).

Ross, S. (1973), 'The Economic Theory of Agency: The Principal's Problem', *American Economic Review*, 63: 134-139.

Rowan-Robinson, J., Watchman, P., and Barker, C. (1990), *Crime and Regulation: A Study of the Enforcement of Regulatory Codes* (Edinburgh: T. & T. Clark).

Sako, M. (1992), *Prices, Quality and Trust: Inter-Firm Relations in Britain and Japan* (Cambridge: Cambridge University Press).

Sanderson, R. (1656), *Twenty Sermons Formerly Preached* (London: printed by R. Norton for Henry Seile).

Simon, H. A. (1947), *Administrative Behavior* (New York: Macmillan).

Simpson, J. A. and Weiner, E. S. C. (1989), *The Oxford English Dictionary*, 2nd edn. (Oxford: Clarendon Press).

Smith, B. L. R. (1971), 'Accountability and Independence in the Contract State', in Smith and Hague (1971).

-----and Hague, D. C. (eds.), *The Dilemma of Accountability in Modern Government: Independence versus Control* (London: Macmillan).

Socio-Legal Studies Association (1993), *Statement of Ethical Practice*.

Spurgeon, P. (ed.) (1993), *The New Face of the NHS* (Harlow: Longman).

-----Smith, P., Straker, M., Deakin, N., Thomas, N., and Walsh, K. (1997), 'The Experience of Contracting in Health Care', in Flynn and Williams (1997).

Stewart, J. (1995), 'Appointed Boards and Local Government', *Parliamentary Affairs*, 48: 226-241.

Stewart, J. D. (1984), 'The Role of Information in Public Accountability', in Hopwood and Tomkins (1984).

Stinchcombe, A. L. (1985), 'Contracts as Hierarchical Documents', in A. L. Stinchcombe and C. A. Heimer, *Organization Theory and Project Management: Administering Uncertainty in Norwegian Offshore Oil* (Oslo: Norwegian University Press).

Strauss, A. L. (1987), *Qualitative Analysis for Social Scientists* (Cambridge: Cambridge University Press).

Taggart, M. (1992), 'The Impact of Corporatisation and Privatisation on Administrative Law', *Australian Journal of Public Administration*, 51: 368-373.

Thynne, I., and Goldring, J. (1987), *Accountability and Control: Government Officials and the Exercise of Power* (Sydney: Law Book Company).

Treitel, G. H. (1995), *The Law of Contract*, 9th edn. (London: Sweet and Maxwell).

Turpin, C. C. (1989), *Government Procurement and Contracts* (Harlow: Longman).

----- (1995), *British Government and the Constitution: Text, Cases and Materials*, 3rd edn. (London: Butterworths).

Vickers, J., and Yarrow, G. K. (1988), *Privatisation: an Economic Analysis* (Cambridge, Mass.: MIT Press).

Vile, M. J. C. (1967), *Constitutionalism and the Separation of Powers* (Oxford: Clarendon Press).

Vincent-Jones, P. (1994), 'The limits of contractual order in public sector transacting', *Legal Studies*, 14: 364-392.

----- (1997), 'Hybrid Organisation, Contractual Governance, and Compulsory Competitive Tendering in the Provision of Local Authority Services', in Deakin and Michie (1997).

----- (1998), 'Responsive Law and Governance in Public Services Provision: A Future for the Local Contracting State', *Modern Law Review*, 61: 362-381.

Walsh, K., Deakin, N., Smith, P., Spurgeon, P., and Thomas, N. (1997), *Contracting for Change: Contracts in Health, Social Care, and Other Local Government Services* (Oxford: Oxford University Press).

Webster, C. (1988), *The Health Services since the War, i. Problems of Health Care: the National Health Service before 1957* (London: HMSO).

----- (1996), *The Health Services since the War, ii. Government and Health Care: the British National Health Service 1958-1979* (London: The Stationery Office).

----- (1998), *The National Health Service: a Political History* (Oxford: Oxford University Press).

Weir, S. (1995), 'Quangos: Questions of Democratic Accountability', *Parliamentary Affairs*, 48: 306-322.

West, P. A. (1997), *Understanding the National Health Service Reforms: the Creation of Incentives?* (Buckingham: Open University Press).

Whyte, W. F. (1943), *Street-Corner Society: the Social Structure of an Italian Slum* (Chicago: University of Chicago Press).

Willett, C. (ed.) (1996), *Public Sector Reform and the Citizen's Charter* (London: Blackstone Press).

Williamson, O. E. (1979), 'Transaction-Cost Economics: the Governance of Contractual Relations', *The Journal of Law and Economics*, XXII: 233-261.

Wistow, G. and Barnes, M. (1993), 'User Involvement in Community Care: Origins, Purposes and Applications', *Public Administration*, 71: 279-299.

-----Knapp, M., Hardy, B., Forder, J., Kendall, J., and Manning, R. (1996), *Social Care Markets: Progress and Prospects* (Buckingham: Open University Press).

Woodhouse, D. (1994), *Ministers and Parliament: Accountability in Theory and Practice* (Oxford: Clarendon Press).

Zifcak, S. (1994), *New Managerialism: Administrative Reform in Whitehall and Canberra* (Buckingham: Open University Press).

Statutes

Parliamentary Commissioner Act 1967	34, 42
Health and Safety at Work Act 1974	161
National Health Service Act 1977	37, 48, 62, 63, 143
Local Government, Planning and Land Act 1980	20
Local Government Finance Act 1982	39
National Audit Act 1983	13, 34
Local Government Act 1988	20
National Health Service and Community Care Act 1990	23, 24, 45, 47, 48, 50, 51, 53, 55, 56, 88, 92, 94, 125, 230, 242, 271
Local Government Act 1992	36
Health Authorities Act 1995	45, 48, 49, 63
Audit Commission Act 1998	13, 39, 42
Human Rights Act 1998	13

Statutory Instruments

National Health Service Contracts (Dispute Resolution)	
Regulations 1996 (SI 1996/623)	51, 230, 242
Community Health Councils Regulations 1996 (SI 1996/640)	63, 143
National Health Service (Fund-holding Practices) Regulations	
1996 (SI 1996/706)	49, 50, 55, 62
Health Authorities (Membership and Procedure) Regulations	
1996 (SI 1996/707)	63
National Health Service (Functions of Health Authorities and	
Administration Arrangements) Regulations 1996 (SI 1996/708)	48, 55, 62



Cases

<i>Ridge v Baldwin</i> , 1964 A.C. 40	13
<i>R v Brent LBC, ex p. Gunning</i> , 1985 84 L.G.R. 168	42
<i>Doody v Secretary of State for the Home Department</i> , 1993 3 All ER 92	111
<i>R v Lord Chancellor's Department, ex p. Hibbit and Saunders</i> ,	
1993 C.O.D. 326	72
<i>R v Legal Aid Board, ex p. Donn & Co.</i> , 1996 3 All ER 1	72