Accountability, public services and statistics

A meeting of the Northern group of Radical Statistics. Speaker - Peter Smith, report by Anthony Staines

Peter opened the discussion by talking about the meaning of accountability. Traditionally it is something which arises in a principal <-> agent situation. The principal, the funder, taxpayer, electorate, government etc.., relies on the agent to do something. The agent, local authority, police chief, district health authority, hospital etc... is held to be responsible for getting the task done. The principal has a need to 'control' the agent, or to make the agent accountable to the principal. The agent, of course, usually knows more about the task. They have, so to speak, inside information. It is difficult for most principals to know what is going on. At present accountability is a popular word.

The whole thrust of the relaunched citizens' charters is to make public service providers accountable. The poll tax, for example, was introduced to make local authorities more accountable to their payers. This begs several questions. Accountability is a two edged sword. It includes both giving an account (agent to principal) and holding to account (principal to agent). When giving an account what information should be given?; how should it be presented?; how should it be analysed and by whom? When receiving an account being able to hold the agent to account gives some point to the whole business.

In the private sector the main mode of accountability is 'voting with your feet'. Generally, though not always, you can shop around, you can make comparisons of the products and services available, you can gain experience of the services provided by several different providers. In the public sector, and in certain privatised quasi-monopolies, this is not so. The cost and difficulty of moving to a nicer water supply board, or county council, or electricity provider is usually entirely prohibitive. Most of us form a truly captive market for this type of service.

The role of performance indicators

Information can be a sort of proxy for having a real choice. It can provide a sort of 'experience' of what other councils, hospitals, passenger transport executives and so on are like. It can enable us to say that this service is good or poor. The difficulty here is that given very limited power, the incentive for an individual to look at the available information is limited. More precisely,

given the simple practical difficulties in accessing the 'publicly available' information, the costs of using it exceed the rather limited benefits likely to be obtained. Even if you discover that your local service is very poor, the average member of the public has little possibility of doing anything about it. Even service providers (agents) and specialists find it very difficult to use existing information effectively.

Performance indicators have been advocated as a solution. They are advertised as offering a simple quantitative way of making comparisons between the services provided in different areas. They are most extensively developed in the health service, although their use is being extended into other areas of the public service. Typical indicators are things like beds per person, nurses per person per bed, clinic visits per doctor per year and so on. Other measures used include exam league tables in education, poll tax levels compared with standard spending assessments in local government, and the percentage of crimes of a certain type detected in police work.

These measures have a role. They can be very useful for people working within the service, both in providing some measure of what they are doing, and in placing their work in a wider context. As a basis for dialogue and for considering changes in services they are of value, although this is not as simple as it might seem.

Not decision bases in isolation

There are a number of reasons why performance indicators are hazardous bases for decision on their own. Leaving on one side the multiplicity of indicators available for some services, they are susceptible to changes which have little to do with service provision. If one indicator is taken as a benchmark for service provision the organisation will concentrate on improving it. Thus waiting lists are seen as a problem in the NHS, and much effort has been diverted into reducing them. As a result other services have been restricted, for example waiting times for outpatient clinics are alleged to have risen. It isn't usually difficult, nor is it necessarily wrong, to make subtle alterations in the process used to produce the indicators, and so create an apparent improvement. Part of the decrease in waiting lists is due to removing the dead, the cured, and the moved away patients from them. This was worth doing, but it destroys the value of the indicator, and penalises those who had good lists to start with. Different ways of accounting for overheads and allocating costs and staff can produce significant changes in indicators.

The use of these national 'target' indicators also tends to promote a uniformity of service provision and delivery. In general this leads to a shift towards the mean, rather than the excellent. Furthermore one of the reasons

for having local management and local democracy is to enable local decisions on priorities and appropriate service provision. A more fundamental criticism of many indicators is that they reflect things which are outside the control of those providing the service. Thus local variation in poverty seems to account for far more variation in health, crime and educational attainment than doctors, schools or policemen. This means that the indicator is of limited use when assessing the service provider, though it may be of great value in deciding where to put extra resources. Most of the existing performance indicators have limited relevance to the outcomes of the services provided. In general they reflect inputs or sometimes processes. What is usually of real interest is the quality of the service, and this is not easy to measure.

It is also true that these measures will reflect aspects of the efficiency and competence of the service providers. This has been one of the most important reasons given for having these indicators. But they are not sufficient. For example if the DHA observes that hospital 1 has twice as many nurses per bed in the geriatric ward as hospital 2 what should they do? It is possible to castigate hospital 1 for profligate waste, and hospital 2 for gross under-provision of services. No quantity of performance indicators seems likely to overcome this kind of objection. It has been suggested that the main effect of publishing national indicators is to force everyone to move to the middle, removing both the very bad and the very good. In effect these indicators make local service providers more accountable to government, and arguably less able to respond to local needs than before.

Are improvements possible?

A substantial amount of effort has been invested in defining performance indicators. The health service has well over 400 of them. The Audit commission proposes that local authorities should have another 200 or so. Everyone is looking for performance indicators which work. Most systems of performance indicators focus on short term and cross-sectional measures for practical reasons. This can lead to an overly simplistic approach to policy formation, with periodic switches in purpose and direction. It seems likely that only a conscious direction of attention to longer term aims, and to a longitudinal analysis of policy, will improve this. It will not be cheap, but then good quality management information systems rarely are.

Clearly the future role of performance indicators need to be considered. One possible direction is to develop performance indicators further, to find better ones, and to extend the period of time considered in making policy. Another is to start looking at what 'consumers' want, to study customer satisfaction, and to ask people what they want from the services. It is unclear which of these is likely to be more effective, and it is also unclear what is meant by

effectiveness here. Effective for whom seems an important question.

Conclusions

Taking up the threads of the initial discussion of accountability, it now seems appropriate to ask this question - Who is the principal? To whom should service providers be accountable? It would appear from the discussion which took place that the local 'consumer' can be excluded, and that central accountability can replace local responsiveness. We feel that there is a need to develop local accountability, and to make the data which is at present available, actually accessible to non-specialists. It seems to us that no single number or set of numbers will capture all of the essentials of service provision. Surely when evaluating any service a hierarchy of assessments will always be needed. This could range from watching for single events which should never occur, (i.e. sentinel events), through assessments of satisfaction with services, up to global measurements like immunisation rates, death rates, and so on.

It seems to us that decisions about services will be most effective if there is very widespread and serious consultation both about service provision and service evaluation. This consultation will involve experts and politicians, but it must also involve the customers.

What has all of this to do with RadStats? Roughly we felt that our role would lie in making the statistics more accessible to people, and specifically in preparing some work on using data to help with local accountability. A small group has formed to do this. The Northern group will return to the subject of accountability at its September meeting, probably on the 24th, but check with me please. Anyone who would like to take part in this project should get in touch with me a.s.a.p Anthony Staines (0532) 443517 (work) (0532) 662584 (home) LRF6AS@UK.AC.LEEDS.CMS1B (e-mail) 17 Springfield Mt, Leeds, LS2 9NG. (s-mail).