Complaints as Accountability? The Case of Health Care in the United Kingdom

Susan Kerrison and Allyson Pollock
*Health Policy and Health Services Research Unit, School of Public Policy, University College London**

Few would disagree that health care systems should have robust complaints procedures. Health care services should be responsive to their users and when things go wrong patients should have a right to have their complaints addressed in a fair and impartial way. The debate about the NHS complaints procedure, implemented in 1996, has mainly concentrated on how the procedure fails to meet these objectives.[1] But in this paper we wish to shift the debate into a different dimension. We argue that since the 1980s, U.K. health services have been re-structured in a way that renders the traditional methods for monitoring, controlling and providing accountability increasingly ineffective.

Complaints from patients potentially provide one mechanism for both regaining transparency and extending accountability to service users. In a health care system where one of the most enduring criticisms is the lack of accountability to users,[2] this dual function makes complaints procedures almost unique. Scott[3] suggests that within public law there have been calls for the development of an extended notion of accountability to cope better with

* Our thanks to Colin Scott who commented on earlier versions of this article.

[1] See J. Hanna, "Internal Complaints Resolution" in D. J. Galligan (ed.) *Administrative Law* (1996); L. Mulcahy and J. Allsop, "A Woolf in Sheep's clothing? Shifts Towards Informal Resolution of Complaints in the Health Service" in P. Leyland and T. Woods (eds) *Administrative Law: Facing the Future Old Constraints and New Horizons* (1997); H. Wallace and L. Mulcahy, *Cause for Complaints: An Evaluation of the Effectiveness of the NHS Complaints Procedure* (Public Law Project, 1999); Health Service Commissioner for England, Scotland and Wales *Annual Report 1996–97* (1997); Health Service Commissioner for England, Scotland and Wales, *Annual Report 1997–98* (1998); Health Service Commissioner for England, Scotland and Wales, *Annual Report 1998–99* (1999); Health Service Ombudsman for England *Annual Report 1999–00* (2000); Select Committee on Health Sixth Report HC 549-I 1998–99 *Procedure Related to Adverse Clinical Incidents and Outcomes in Medical Care*; Select Committee on Public Administration Second Report H.C. 54, 1998–99; *Report of the Health Service Ombudsman for 1997–98*; Select Committee on Public Administration Third Special Report H.C. 816, 1998–99, Appendix 1 *Government Response to the Second Report from the Select Committee on Public Administration on the Report of the Health Service Ombudsman for 1997–98.*

[2] See R. Maxwell and N. Weaver, *Public Participation in Health* (1984); Greater London Council, *Accountability and Democracy in London's Health Services* (1986); W. Hutton, *New Life for Health: The Commission on the NHS* (2000); S. Harrison, M. Mort, "Which Champions, Which People? Public and User Involvement in Health Care as a Technology of Legitimation" (1998) 32:1 *Social Policy and Administration* 60–70; D. J. Hunter and S. Harrison, "Democracy, Accountability and Consumerism" in S. Illiffe and J. Munro (eds), *Healthy Choices: Future Opinions for the NHS* (1997).

[3] C. Scott, "Accountability in the Regulatory State" (2000) 27 J. Law & Soc. 38–60.

the transformation in public services. "Extended accountability" would include mechanisms such as grievance handling, internal audit and inspection. This paper examines whether current complaints mechanisms in U.K. health care can adequately contribute to extending the accountability of U.K. health care providers of all types, NHS and private.

Accountability is a term that defies easy definition. At its simplest, to be accountable is to answer for, or to explain one's conduct. Using this definition, Lloyd-Bostock and Mulcahy[4] suggest that complaints are a mechanism through which patients directly attempt to call health providers to account for conduct which has violated the complainant's normative expectations. However, in complex institutions of public life, public accountability operates in the main indirectly through elaborate mechanisms. Day and Klein[5] identify the key elements as political responsiveness and stewardship. The former is concerned with public involvement in decision-making, either through participation or representation, and the latter with fairness and rationality in administrative decision-making. Scott argues that as well as being subject to political control, public actors are also held to the democratic will through a requirement to exercise their functions in accordance with the principles of public law.[6] In principle, public law and parliamentary representation are the key mechanisms through which the public holds the NHS to account. However these two traditional mechanisms are now considered inadequate to deal with the re-structuring of the state. This has proceeded in two main ways. The first, referred to by Freedland[7] as "corporatisation", is the establishment of a contractual dichotomy between the procurers and the providers of public services, and the constitution of service providers as essentially corporate entities capable of being separately accountable for their own budgets. The second is a move away from direct provision of public services towards oversight of public services provided by others.[8]

Both these styles of governance are evident in U.K. health care after successive restructuring of the system. NHS trusts set up after the reforms of the early 1990s are public corporations which are operationally independent. Although they are accountable to the NHS Executive and the Secretary of State, they have freedom to take decisions about staffing and capital expenditure[9] within the constraints of their budgets. Primary care trusts introduced with the reform of the late 1990s are allowed to assume control of resources for patients on general practice lists, purchasing or providing all forms of care.[10]

[4] S. Lloyd-Bostock and L. Mulcahy, "The Social Psychology of Making and Responding to Hospital Complaints: An Account Model of Complaint Processes" (1994) 16 Law & Pol. 123–148.

[5] P. Day and R. Klein, *Accountability in Five Public Services* (1987).

[6] See Scott (2000) *op. cit.* n. 3.

[7] M. Freedland, "Government by Contract and Public law" [1994] P.L. 86–104.

[8] G. Majone, "The Rise of the Regulatory State in Western Europe" (1994) 17 *West European Politics* 77; M. Loughlin and C. Scott, "The Regulatory State" in *Developments in British Politics* 5, P. Dunleavy, I. Gamble, Holliday and G. Peele (eds), (1997).

[9] W. Barlett and J. LeGrand, "The Performance of Trusts" in R. Robinson and J. LeGrand (eds), *Evaluating the NHS Reforms* (1994).

[10] C. Ham, "The Third Way in Health Care Reform: Does the Emperor Have any Clothes" *Journal of Health Policy* (1999) 4:3 168–173.

Care which used to be provided by the NHS such as the long term institutional care of the elderly is now contracted out to the private sector to the extent that over half (52 per cent) of all the health care beds in England are now provided in the independent sector.[11] The *Partnership in Action*[12] proposals to establish care trusts in *The NHS Plan*[13] will mean that all services, with the exception of surgical procedures, have the potential to be provided in partnership with other agencies—both public and private—using the pooled budget of health and social services. The Department of Health will take progressively less central control with increasing power and responsibility being devolved to service providers, primary care trusts and NHS and local authority commissioning bodies. As a result of these reforms, a bureaucratic structure in which accountability was understood in terms of a disciplined response to the hierarchical line of command reaching upwards to the Secretary of State for Health has ceased to exist. The arrangement whereby a particular health authority would be responsible for the health and health care of the population within a defined geographical area has also ceased. Authority has now been delegated to a wide range of public and private actors and accountability is spread between different agencies, different sectors and different owners. As a result of the lessening of direct central control over NHS and other health care providers, parliamentary or even ministerial control over the health care system is becoming ever more tenuous.

This mode of governance requires a re-conceptualisation of the machinery of accountability. To this end Scott[14] has argued that accountability should now be viewed as operating though a web of interdependent "regulatory" organisations and frameworks which hold the regime in a broadly acceptable place through the opposing tensions and forces generated. Diagram 1 shows the complex web of regulatory agencies currently operating in U.K. health care. With implementation of *The NHS Plan* the number of these organisations is set to increase markedly. The current "regulatory" organisations use a variety of different mechanisms of control. After the introduction of the internal market, the emphasis was on the increasing use of contracts and other market mechanisms for controlling this fragmented system. The government elected in 1997 has increased emphasis on targets, standards, performance monitoring[15] and inspection, introducing a new inspectorate body, the Commission for Health Improvement. In recent years there have been attempts to increase user participation in the NHS through focus groups, citizens' juries and various requirements for public consultation, but at best these are considered to be

[11] Average number of beds available daily in NHS in England in 1999–2000—186,290. Data from "Bed Availability and Occupancy in England (Department of Health published annually). Registered beds in private or independent hospitals or nursing homes at March 31, 2000—202,100. Data from "Community Care Statistics" (Department of Health, published annually).

[12] Department of Health, *Partnership in Action: New Opportunities for Joint Working between Health and Social Services* (1998).

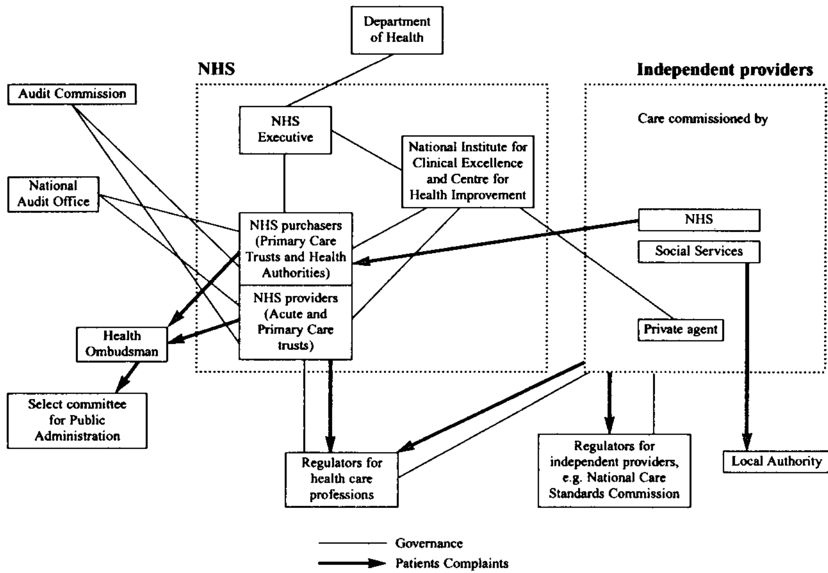
[13] Secretary of State of Health, *The NHS Plan. A Plan for Investment, a Plan for Reform* Cm. 4818–I (2000).

[14] C. Scott (2000) *op. cit.* n. 3.

[15] C. Ham (1999) *op. cit.* n. 10.

tokenistic.[16] However, with proposals to set up representative forums for all NHS trusts and health authorities and for increased lay representation on all NHS bodies, *The NHS Plan* sets the scene for increased involvement of patients. The question is, where do complaints procedures fit within these mechanisms of extended accountability? Complaints systems potentially provide a mechanism through which patients can directly call providers and care purchasers to account. But, we shall argue, such systems are undervalued.[17] They have grown up in a ramshackle way, have outmoded powers and are subject to constraints which severely limit their effectiveness in dealing with a transformed public health service. In short they have not been updated to take account of the transformation of public services.

Diagram 1. Regulatory Framework for Health Care in the United Kingdom



Clearly, a complaint will achieve most effect in increasing accountability if it is backed by the authority of some external agency, independent of the provider. This can give force to the complaint, legitimating the complainant's view. Equally, the agency's powers and authority over the provider are of considerable importance in determining not only whether the complainant is satisfied but also whether wider issues of public concern are addressed. Within the U.K. health care system there are three different types of bodies for health care complaints: the Health Service Commissioner or Ombudsman, public sector purchasers and regulatory agencies. The latter include regulators for the

[16] S. Harrison and M. Mort (1998) *op. cit.* n. 2.

[17] See Select Committee on Public Administration Second Report (1997–98 H.C. 352), *Report of the Health Service Commissioner for 1996–97*; Annual report of Health Service Ombudsman for England (2000) *op. cit.* n. 2; Department of Health, *A First Class Service: Quality in the new NHS* (1998).

profession and for independent providers. The rest of this paper will consider the extent to which these agencies are able to use complaints to hold providers to account.

The jurisdictions of these agencies have evolved in a piecemeal way, resulting in a complex web of appeal procedures. Diagram 1 illustrates that while the "regulatory web" for holding independent providers to account and the web of complaints procedures are broadly in alignment, this is not the case for NHS providers. Patients of independent providers have a right of appeal to the main agency with responsibility for oversight, the relevant industry regulator, and in the case of publicly funded patients, to the relevant purchaser. In contrast, the "regulatory web" for NHS providers and the web of NHS complaints systems are misaligned. For the NHS providers, accountability to users is both fragmented and fractured from the main systems for holding these providers to account. The agencies which act to increase the accountability of providers to the Secretary of State for Health are the NHS Executive and its regional offices, the Audit Commission, the National Audit Office, NHS purchasers and the new internal regulator, the Commission for Health Improvement. Patients have no rights of appeal to any of these bodies. Instead, NHS patients' complaints are diverted to two bodies with a complex and indirect relationship with NHS trusts, the Health Service Ombudsman and regulators of professions. These agencies have different powers over providers depending on whether or not the provider is part of the state, in other words, an NHS provider, or a private agency. For these purposes self-regulating professions and independent providers are categorised as non-state agencies. The fundamental principle at work is that appellate agencies are legally constrained from challenging the policies of state providers. Boyle,[18] in a review of tribunals, inquiries and appeals to ombudsmen, shows how complainants are given the opportunity to be heard and to make complaints of maladministration but not to challenge government policies or appeal the merits of a policy decision, for to do so would be to challenge the democratic will of Parliament, even though the NHS is now structured so that the ability of Parliament to exercise its will over the NHS is an increasing fiction. Boyle concluded that there is deep reluctance in the United Kingdom to create any institutions capable of exercising real control over the executive.

As a consequence of this principle, complaints systems in the United Kingdom are usually viewed through a framework of administrative law. Harlow and Rawlings[19] suggest that lawyers typically view public systems as functioning well but complaints procedures are needed to protect the client if administrators act unfairly. This view of the purpose of complaints systems as increasing the accountability of administrators by curbing the arbitrary use of administrative power led to development of the ombudsmen scheme.[20] A different view expressed by Lewis and Birkinshaw[21] in their review of

[18] A. E. Boyle, "Sovereignty, Accountability and the Reform of Administrative Law" in G. Richardson and H. Genn (eds), *Administrative Law and Government Action*, (1994).

[19] C. Harlow and R. Rawlings, *Law and Administration* (1997).

[20] Justice, *The citizen and the administration* (1961).

[21] N. Lewis and P. Birkinshaw, *When Citizens Complain: Reforming Justice and Administration* (1993).

government complaints mechanisms is that the enforcement of individual rights should provide a challenge to executive action. Although this is controversial in the United Kingdom, in other jurisdictions, for example France and Australia, complaints systems take on these constitutional dimensions.[22] For example, as well as providing individual justice, the Australian Administrative Review Council, which oversees administrative justice in Australian public services, regards complaints procedure as contributing to the oversight of government.[23] In the Council's view the aim of such a procedure is to ensure that the government acts within its lawful powers, to improve the quality of administration and to contribute to the accountability system for government decision-making.

Appellate agencies, whether they be the Ombudsman, purchasers or regulators, are not fettered in the same way when dealing with private health care providers or self-regulating professions. However, purchasers and regulators are constrained by the terms of the contract or by their legal mandate respectively. As services are increasingly provided by both "public" and "private" actors or by partnership between them, the stance, jurisdiction and relationship of appellate agencies with these hybrid providers are becoming increasingly muddled. As we shall see this is particularly true of the Health Service Ombudsman and the Commission for Health Improvement.

The Health Service Ombudsman

The Ombudsman and public providers

The office of Health Service Ombudsman or Health Service Commissioner was created under the NHS Reorganisation Act 1973. This Commissioner's powers and role have increasingly diverged from that of the Parliamentary Ombudsman. The Health Service Ombudsman can investigate complaints about failures in service, failure to purchase or provide a service a complainant is entitled to receive, and maladministration or administrative failure where hardship or injustice has been suffered. Critics have suggested that as the Ombudsman has no powers to initiate investigations and cannot investigate the merits of a decision, he has been relegated to the investigation of relatively trivial matters such as delay, misrepresentation and rudeness.[24] Instead, Harlow and Rawlings[25] have suggested, the Parliamentary Ombudsman's strength lies in the "big inquiry", exposing and analysing the systemic problems of government departments. In the case of the Health Service Ombudsman, this means the NHS, as this ombudsman is precluded from investigating the Department of Health.

A complaint cannot be considered by the Health Service Ombudsman unless the NHS complaints procedure has been exhausted. Of the 3,320

[22] See A. E. Boyle (1994) *op. cit.* n. 18; N. Lewis and P. Birkinshaw (1993) *op. cit.* n. 21.

[23] Administrative Review Council, *Administrative Review and Funding Programmes: A Case Study of Community Services Programs* (Report No. 37, 1994).

[24] A. E. Boyle (1994) *op. cit.* n. 18.

[25] C. Harlow and R. Rawlings (1997) *op. cit.* n. 19.

complaints received by the Health Service Ombudsman in 1998–99,[26] 49 per cent of complaints (1,616) were rejected for this reason and a further 133 were rejected for other reasons of jurisdiction. Investigations were initiated on 157 complaints—a small figure for a health service covering some 58 million people. The figures tend to belie the claim that the primary aim of the Ombudsman is to provide individual justice. Despite the increased jurisdiction, the chances of any NHS trust or health authority being investigated by the Ombudsman, shown in Table 1, are small. In 1998–99 fewer than one in 900 written complaints to NHS were fully investigated by the Health Service Ombudsman.

Table 1. Written complaints to the NHS and complaints investigated by the Health Service Ombudsman

	1993–4[(2)]	1994–95[(2)]	1997–98[(2)]	1998–99[(2)]
Total NHS written complaints (England, Wales and Scotland[(1)])	97,860	112,607	139,675	140,676
Complaints received by Health Service Ombudsman	1,384	1,782	2,660	2,869
Investigations started by Health Service Ombudsman (as % of all complaints received by Health Service Ombudsman)	203 (15%)	233 (13%)	120 (4%)	157 (5%)
Ratio of Health Service Ombudsman investigations to NHS written complaints	1 in 500	1 in 500	1 in 1,164	1 in 900

Sources: Health and Services Commissioner Annual Reports 1993–94, 1994–95, 1997–98, 1998–99. Complaints statistics from Department of Health, Information and Statistics Division of the NHS in Scotland, and the National Assembly for Wales[27]
Notes: [(1)] *Total NHS complaints statistics unavailable for year 1995–96 and 1996–97.*
[(2)] *Statistics for 1993–94 and 1994–95 exclude family health services complaints. These are included in statistics for 1997–98, 1998–99 to reflect the expansion in jurisdiction of both NHS complaints procedure and of the Health Service Ombudsman.*

[26] Health Service Ombudsman for England, *Annual Report* 1998–99 *op. cit.* n. 1.

[27] Department of Health, *Handling Complaints: Monitoring the NHS Complaints Procedures* (published annually); National Assembly for Wales, *Health Statistics Wales* (published annually); Information and Services Division of the NHS in Scotland *NHS Complaints in Scotland* (published annually).

As the public cannot appeal directly to the Health Service Ombudsman but must first exhaust the NHS complaints procedure, the NHS procedure screens complaints and acts as "gate-keeper" to ombudsman review. There are obvious concerns as to whether the procedure works to suppress complaints of public importance or enables them to come to the attention of the Ombudsman.

Overall the procedure is structured in such a way that the suppression of complaints is the more likely result. The Secretary of State for Health has described the system to the Select Committee on Health "as a bit of a shambles"[28] and this Select Committee, the Select Committee on Public Administration, the Health Service Ombudsman annual reports for 1997, 1998, 1999, 2000, user organisations such as the National Consumer Council, Association of Community Health Councils and the research community have all criticised the procedure for its lack of thoroughness, impartiality and formality.[29]

Implemented in 1996, following the recommendations of the Wilson Committee,[30] the internal NHS procedure is in two stages and covers all NHS trusts and authorities, and care by independent providers funded by the NHS. The first stage "local resolution" aims to provide a quick, informal response to complaints at the "front line". The second stage is a review by an independent panel. The complainant can only move to this if a convenor agrees. The procedure owes much to the twin pulls of informality in dispute resolution[31] and a managerial philosophy, popular in the early 1990s, Total Quality Management.[32]

Informal procedures are characterised as having a non-bureaucratic structure and make minimal use of legal professionals. They tend to avoid formal law in favour of substantive and procedural norms which are vague, unwritten, "commonsensical", flexible and ad hoc. Critics of informal dispute resolution such as Fiss,[33] argue the danger in such procedures is that they do not take into account the imbalance of power between disputing parties. In the context of attempts by patients to hold the NHS to account, this critique has considerable significance. It is argued that informal disputes procedures allow the state to decide which complaints get aired, by whom, to whom, in what form and forum, how they are processed and what remedy is granted. The relaxation of procedural safeguards associated with formal adjudication typically operates in the interests of stronger institutional litigants rather than the disadvantaged, leaving the former free to engage in coercive or manipulative actions. Abel comments, that, "[i]t denies the latter the swords of formality while assuring

[28] Select Committee on Health Sixth Report (H.C. 549-I), para. 20.

[29] See n. 1 and National Consumer Council, *The NHS Complaint Procedures: The First Year* (1997); Association of Community Health Councils for England and Wales, *The NHS Complaints Procedure: ACHCEW's Memorandum to the Public Administration Committee* (1996).

[30] Department of Health, *Being Heard: the Report of a Review Committee on NHS Complaints Procedures* (1994).

[31] L. Mulcahy and A. Allsop (1997) *op. cit.* n. 1.

[32] J. Hanna (1996) *op. cit.* n. 1.

[33] O. Fiss, "Against settlement" (1984) *Yale Law Journal* 1073 at 1085–1086.

the former that they can continue to invoke formality as a shield".[34] When the same state agency is both the body which initially hears the complaint and the subject of the complaint then the effect is to compromise attempts to ensure that complaints of public interest reach the public arena, weakening the complaints procedure as a mechanism of accountability.

Stacey,[35] who reviewed submissions to the Wilson committee for the Select Committee on Health concluded:

> Our view was that the managerial model adopted . . . had led to attention to procedures which might in practice be more concerned with cooling out aggrieved patients than understanding the basis upon which the complaint was made or ensuring social justice for the complainants and staff alike.

These echoes of Abel's criticisms of informalism have been borne out in subsequent investigations and research. The Select Committee on Public Administration[36] was concerned that the procedure was too informal and that a degree of formality was required to ensure proper respect for it and to ensure it was fair and impartial. Mulcahy and Allsop, in a study of complaints in primary care, summed up the move towards informalism as creating a situation where:

> The pursuit of public discussion of issues has been left to the small percentage of complainants prepared to pursue their case beyond the first stage of the procedure. The complainant is hindered at every threshold by discretionary powers granted to state agents to decide whether the issue ought to be pursued.[37]

In pursuing claims patients are often supported by community health councils who act as independent patients' advocates. In *The NHS Plan*, community health councils will be abolished to be replaced by a patient advocacy service with advocates employed by the NHS trusts—an arrangement that is likely to add further weight to the criticism that the NHS complaints system lacks impartiality.

The influence of the Health Ombudsman on the NHS

Despite these criticisms, issues of public concern have managed to reach the attention of the Health Service Ombudsman. The Ombudsman has investigated and found failures by the NHS to follow government policies, for instance, in the regulation of nursing homes and in care provided at death and for the bereaved.[38] He has also identified unintended consequences of

[34] R. L. Abel, "The contradictions of informal justice" in R. L. Abel (ed.) *The politics of informal justice Vol. 1: The American Experience* (1982), p. 296.

[35] M. Stacey, *The NHS Complaints Procedure Three Years On*, Opening address to the Public Law Project Complaints Forum, March 25, 1999 London.

[36] Select Committee on Public Administration Second Report (1998–99 H.C. 54) *Report of the Health Service Ombudsman for 1997–98*, para. 25.

[37] L. Mulcahy and J. Allsop (1997) *op. cit.* n. 1, p. 134.

[38] Health Service Commissioner for England, Scotland and Wales, *Annual report 1996–97*, Select Committee on Public Administration Second Report (1997–98, H.C. 352).

government policies, for instance, in the discharge of elderly patients from hospital and the operation of the NHS complaints procedure itself in the annual reports for 1997, 1998, 1999 and 2000. Less frequently, the Health Ombudsman has raised issues where government policies are unfair, such as the decisions taken by health authorities about funding of long term care.[39] In this case, the Ombudsman report resulted in the Department of Health reformulating policy and issuing guidance.

But although issues do reach the public arena and the attention of the Select Committee on Public Administration through the Ombudsman' reports, neither the Ombudsman nor the committee have the powers to make NHS bodies or the government reform or change policy. The inherent weakness in the select committee system is that there is no legal duty on the government to respond to select committee reports, let alone explain why they are or are not accepting their recommendations.[40] Successive committees have been concerned about their ability to hold the NHS to account.

In the 1997–98 session, the new committee reviewed the effects of their predecessors' recommendations from 1994–95 onwards, commenting:

> This Committee's predecessors have made recommendations relating to the management of the NHS almost every year since 1976. Nevertheless, year after year, the results of investigations by the Ombudsman reveal the same failings. Our predecessors wrote in 1996 that despite the circulation of the Ombudsman's report within the NHS, "in certain areas such as complaints handling, records management and dealing with bereavement there is as yet no obvious improvement". What we say in this report shows that this is still true.[41]

In the most serious of cases, the committee has insisted that the Secretary of State use his powers to discipline the NHS. For example, in one case, three elderly patients died after being removed from hospital to a nursing home against the advice of the clinician.[42] The Select Committee criticised the motives and integrity of the health authority chair. They sought the resignation of members of NHS boards to demonstrate accountability. But this appeared extremely difficult for the committee to achieve and it took the zeal of a new government to force the resignations. The Committee commented:

> The Board of an NHS trust or authority is accountable to the Secretary of State and the Secretary of State has the power to dismiss the Chairman, the non executive members of a board and he has powers to issue directions. These powers are rarely used, but they exist. The Ombudsman told us that he could not think of a case where the powers had been used in response to one of his Office's investigations.[43]

[39] W. Reid, *Resolving Complaints and Promoting Openness: Can the Ombudsman Help?* (The Nuffield Trust, 1998), p. 5.

[40] C. Graham, "Is there a crisis in Regulatory Accountability" in R. Baldwin, C. Scott and C. Hood (eds), *Regulation* (1998).

[41] Select Committee on Public Administration Second Report (H.C. 352), para. 105.

[42] W. Reid *op. cit.* n. 39, p. 26–27.

[43] *op. cit.* n. 41, para. 101.

Delegation of power and authority from the Department of Health to the peripheral front line providers as envisaged in *The NHS Plan* will add to these problems.

The Health Ombudsman and private agencies—health care professions and private providers

Initially the Ombudsman's jurisdiction was confined to NHS bodies such as health authorities and NHS trusts, and it excluded matters involving clinical judgment, and services provided by general practitioners. It has now been extended to include these areas and matters arising from arrangements between health service bodies and bodies outside the NHS, such as private clinics which provide services for patients funded by NHS.[44] The inclusion of these "private" actors has resulted in a rather muddled situation. The Health Service Ombudsman can now investigate the merits of a clinical decision, in other words a matter relating to clinical judgment or policy, but he still cannot challenge state actors or policies by investigating the merits of an administrative decision. Complaints about arrangements between two private parties, for example patients who purchase care privately from private providers, remain outside the Ombudsman's jurisdiction.

The extension of the Ombudsman's role to include appeals from those who receive publicly funded services from independent providers and about clinical decision making has created a paradox. The Ombudsman scheme was set up in order to provide increased parliamentary oversight into the action of the executive and to curb what was seen as the burgeoning discretionary power of administrators within the civil service.[45] The Ombudsman has little direct authority over independent providers or self-regulating health care professions and much depends on the Ombudsman's relationship with the regulators. In the case of the medical profession, the Ombudsman can only disclose information in serious cases which have been the subject of an investigation or a report. There is no legal duty on the General Medical Council to respond to the Health Service Ombudsman or the select committee reports.[46] But there is a further issue: in the 1997–98 report, the Health Ombudsman predicted that in the future the majority of complaints investigated fully would involve clinical matters, and in 1999–2000, 77 per cent of the complaints investigated fell into this category.[47] Unless the Ombudsman succeeds in dramatically increasing the number of investigations then the frequency with which the Ombudsman investigates administrative matters will be reduced. This major change will move the Ombudsman even further from the function of providing a check on administrators. With the Ombudsman's investigatory powers directed towards matters of clinical judgment, the select committees will now have even less information about the actions of the executive. The effect may well be to direct the Ombudsman's attention into areas where he has little real

[44] V. Harpwood, "The Health Service Commissioner: An Extended Role in the New NHS" (1996) 3 *European Journal of Health Law* 207–229.

[45] See N. Lewis and P. Birkinshaw *op. cit.* n. 21.

[46] *op. cit.* n. 40.

[47] See Health Service Commissioner Annual Report 1999–2000.

influence while at the same time reducing his capacity to investigate the executive, removing it further from scrutiny.

Whither the Health Ombudsman?

The Cabinet Office and Department of Health appear to have a different view about the purpose of complaints procedure and the Ombudsman role from that of the Select Committees for Health and Public Administration. The former are interested in increasing the move towards informalism while the latter wish to strengthen the formality of procedures, increasing their potential for imposing accountability. The NHS complaints procedure has been the subject of regular reports to the Select Committee on Public Administration and the Select Committee on Health.[48] In 1999 the Health Select Committee[49] recommended changes which would distance the procedure from authorities or trusts, give panels powers to summon witnesses and take evidence and recommend disciplinary action; trusts and health authorities would be required to make a formal response to the panel and any major concerns would be reported to the Commission for Health Improvement. Rather than accept the recommendations of the Ombudsman and the two select committees, the Secretary of State preferred to wait for the outcome of a Department of Health funded evaluation. As the Select Committee for Public Administration pointed out, the government has placed little value on complaints as a means of gaining information about patients' views and instead prefers to use surveys to guide policy:

> In announcing a new national survey of patient and user experience the White Paper makes the point that the NHS does not have systematic information on what patients feel about the care it offers. We point out that the Health Service Ombudsman regularly reports to Parliament on the worryingly low standards of care received by an increasing number of patients . . . [50]

In his latest annual report for 1999–2000, the Health Service Ombudsman expressed concern that the Department of Health had decided not to summarise and circulate completed Ombudsman cases within the health service. He noted that "the NHS collectively. . . devotes little attention to . . . the lessons that could be learnt from the over 100,000 formal complaints a year that it receives".[51]

In 1998, a Cabinet Office review of public sector ombudsmen was set up at the instigation of the ombudsmen themselves.[52] The ombudsmen wanted the review to address the problem that public services are increasingly provided

[48] See n. 1.

[49] Select Committee on Health Fifth Report (1998–99 H.C. 281-I); Select Committee on Health Sixth Report (1998–99 H.C. 549-I).

[50] Select Committee for Public Administration Second Report (1997–98 H.C. 352), para. 109.

[51] Health Service Ombudsman for England, *Third Report for Session 1999–00 Annual Report 1999–00* (2000), para. 1.16.

[52] P. Collcutt and M. Hourihan, *Review of the Public Sector Ombudsman in England: A Report by the Cabinet Office* (2000). For comment see M. Seneviratne [2000] P.L. 582.

by partnerships between agencies. The current legislation defines the ombudsmen's jurisdictions and powers in ways which make it difficult to deal with complaints which span central and local government or relate to services managed by multi-agency providers. The review recommended that the current Health Service Ombudsman, the Parliamentary Commissioner for Administration and the Commission for Local Administration should be amalgamated into an ombudsman commission with generic responsibility for publicly funded services. The Cabinet Office recommended that the prime focus of the new commission should be providing redress for individual complainants. In future, complainants would not be required to exhaust the NHS system before approaching the Ombudsman. Providing a check on the executive by investigating systemic problems was secondary. However, the Cabinet Office, ignoring the view that many of the problems with the NHS complaints procedure are attributable to informality, also embraced the move towards informalism: it recommended new legislation which would require the new commission to focus on complainants' needs by itself, attempting to resolve as many complaints as possible by informal means. Success in resolving complaints would be used to measure the commission's performance, and investigations should only occur when resolution proved impossible.

The effect of this new approach would be to change the role of the Ombudsman from an officer of Parliament providing a check on the executive, into a conciliation service mainly concerned with mediating between NHS practitioners and their patients. The logic may be clear. In an autonomous free floating "high trust" NHS as outlined in *The NHS Plan*, there is no role for parliamentary scrutiny. But the dangers are that complainants raising issues of public concern will either be mollified by the providers who wish to avoid investigation or, if persistent, pressurised by providers into withdrawing. For instance, the Association of Community Health Councils in England and Wales reports several cases where the threat of action for defamation, injunctive proceedings or libel actions have been used by health care practitioners in an attempt to silence patients.[53] In some cases such actions were supported by the NHS trust that employed the health care professional. The Cabinet Office's report concluded that:

> If the institution of public sector ombudsmen is to thrive in the future the Commission must be in the forefront in encouraging dialogue and discussion about issues which adversely affect the citizen and which lead to complaint. This is not to say that it should principally be concerned with systemic weaknesses in organisations under jurisdiction . . . or that it becomes some form of commission on public administration. Rather than being closely involved with public sector development, the new Commission can influence and persuade, and by involving Parliament when appropriate can contribute to the process of bringing the executive to account.[54]

[53] See M. Chester, *Fair Comment. How the threat of defamation undermines the complaints system* (Association of Community Health Councils in England and Wales, 2000).
[54] *opt. cit.* n. 52, para. 5.28.

Hitherto, as we have shown, the Ombudsman's influence and persuasion have had little effect on bringing the NHS to account.

Health care purchasers and independent providers

The logic of the market philosophy of the late 1980s was that contracts would be used by purchasers to hold providers to account. Accountability in this context means compliance with the terms and conditions of the contract. This may not always include a requirement for the provider to operate in terms of public service values of fairness, rationality or public involvement or responsiveness.[55] In line with the market philosophy, public sector purchasers were made appellate bodies for complaints about independent providers; for publicly funded patients, a further appeal to the relevant ombudsman was allowed when the purchaser's procedure was exhausted; and for all patients an appeal to the industry regulator is possible. In the case of NHS providers, purchasers were given no complaints handling functions. Nevertheless there was a requirement to use the information from the complaint as part of their purchasing intelligence, although the arrangements for this were sketchy.

With the reforms of the 1990s, the commissioning function was fragmented between health authorities, primary care groups and local authorities.[56] Adherence to this market philosophy then gave rise to complaints systems of labyrinthine complexity. The result is illustrated in Diagram 1. For example, in the same independent nursing home, residents may be receiving care purchased by many different agencies and funded by three different sources. In 1999, local authorities funded around 44 per cent of the places in nursing homes, the NHS 10 per cent and private individuals 36 per cent.[57] In order to complain, a resident must know who is commissioning the service—the health authority, a primary care group or the local authority—and whether the provider is part of the NHS, the local authority or independent. If the complaint is unresolved then depending on the type of purchasing agency, the complainant can appeal to either the Health Service Ombudsman or the Commission for Local Administration. However these avenues of appeal to public sector purchasers are not open to more than a third of nursing home residents—some 56,000 people who purchase care from their own funds. These residents, often very vulnerable, are provided with no specific avenue of appeal to pursue complaints about their contract with a private provider.

Even if the complainant does fall inside the purchaser's jurisdiction, the response to the complaint may be far from straightforward. The imperatives of government policies influence the contracting relationship, and this in turn complicates the purchaser's response, bringing the complainant up against hidden constraints. First of all the complainant must know whether the

[55] *op. cit.* n. 7.

[56] The NHS and Community Care Act 1990 introduced GP fund holders and under the same Act local authorities were given responsibility for commissioning community care which includes residential and nursing home care. The Health Act 1999 introduced primary care groups as purchasers of all forms of care.

[57] W. Laing and I. Buisson, *Laing's healthcare market review 1999/2000* (Laing and Buisson, 1999).

contract has been breached. But in many cases, patients are likely to be unaware of the terms of the contract. For example, the Office of Fair Trading[58] found that in the care homes sector—a sector with over half a million places—fewer than one in five of residents were aware of being a signatory to a contract. Two thirds of residents did not know or did not remember what sort of areas were covered by their agreement with the home. Secondly, the contract must be clearly defined and the purchaser must be willing to enforce the contract or sanction the provider as a result of the complaints. But health authority purchasers may face a conflict of interest between the imperatives of government policy and the requirements of good contracting. For example, the Health Service Ombudsman's investigation of East and North Hertfordshire Health Authority[59] found that in order to comply with policy imperatives to close an NHS hospital speedily, the authority precipitously transferred 60 elderly mentally ill patients to a private nursing home where its own registration unit had concerns about the quality of care. Subsequently a number of them died. The Ombudsman investigated a complaint by a relative and reported to the Select Committee for Public Administration. He found that the Health Authority had failed to agree a contract which would have "empowered it to have responded more quickly and firmly to any problems".[60] The Health Authority also failed to enforce the contract and to apply any sanction for failing to meet the specification of the contract. In such circumstances it would seem unlikely that any complaint would prompt enforcement action.

The fragmentation of purchasing function and the resultant confusion of responsibilities means that gaps can appear where there appears to be no oversight of particular activities. For example, local authorities do not believe they have responsibility for monitoring the specifications in their contracts which relate to health care. A recent investigation by the Commission for Local Administration,[61] found that the London Borough of Bexley refused to investigate a complaint about individual nursing care provided by a nursing home from whom they purchased care. Bexley Council argued that local authorities have neither the responsibility nor the expertise to ensure that contracts they make in relation to nursing care are properly enforced. The Commission for Local Administration agreed that there was considerable confusion but concluded, along with the Department of Health, that local authorities were responsible for monitoring this aspect of the contract. But the case highlights a large chasm. No agency currently appears to accept the responsibility for monitoring this major area, and consequently no agency will accept responsibility for a related complaint.

Complainants may raise matters of public concern, but there is a danger that purchasers are most responsive to imperatives of government policies. Disputes between the purchaser and provider about whether a matter is covered by the

[58] Office of Fair Trading, *Old People as Consumers in Care Homes*, 1998, OFT 242.
[59] Health Service Commissioner (1997) *op. cit.* n. 36.
[60] Select Committee for Public Administration Second Report (1997–98 H.C. 352), para. 53.
[61] Commissioner for Local Administration, *Report on an Investigation into Complaint No. 97/A/4002 against the London Borough of Bexley.*

contract and who is responsible for the matter under the terms of contract and situations where the purchaser and the provider do not have any interest or incentive to remedy the complaint, all reduce the likelihood of the purchaser taking any action as a result of the complaint. For all of the above reasons, the Australian Review Commission[62] in a report on complaints procedures in contracted-out services, argued that it was inappropriate for purchasers to deal with complaints about these services. In any of the situations described above, appealing to the purchaser would prove a poor mechanism for holding independent providers to account.

The regulators and "private" agencies—independent providers and health care professionals

Patients of independent providers have a further avenue of appeal, to the relevant industry regulator. As illustrated in Diagram 1, the regulatory agencies are the only agencies which deal with complaints about care purchased privately. Similarly, all patients can appeal to regulators for the relevant health care profession. But regulatory agencies in U.K. health care have complicated attitudes to complaints handling. The agency's core function is to protect the public by ensuring that the services of the individual health care professionals and private providers meet specific minimum quality standards. These quality standards may not have a direct relationship with public service values. Regulators are not primarily concerned with individual justice, complaints or the systemic problems of the NHS, but with modifying and controlling the behaviour of the providers they regulate. Complaints handling is just one of many potential mechanisms which could be used to achieve these ends. The main agencies responsible for the regulation of practitioners are the General Medical Council and the U.K. Central Council for Nursing and Midwifery. Nursing homes and private hospitals are required to register with local health authorities. The Human Fertilisation and Embryology Authority has responsibility for the registration of clinics providing fertility treatment and undertaking embryo research.

The Acts[63] which establish and provide the legal mandate for these four main authorities have a common form.[64] This requires that before a practitioner registers or a health facility receives a licence to operate, they must fulfil conditions laid down by the relevant regulatory authority. The main sanction the agency has is to remove the practitioners from the register or to remove the facility's licence. These are draconian powers and are seldom applied. For example, in 1999, health authorities in England instigated proceedings for closure for 40 out of a total of 5,700 nursing homes.[65] None of the health care

[62] Administrative Review Council *Report to the Attorney-General—The Contracting Out of Public Services*, Report No. 48 (1998).

[63] Registered Homes Act 1984; Care Standards Act 2000; Human Fertilisation and Embryology Act 1990; Medical Act 1983; Nurses, Midwives and Health Visitors Act 1977.

[64] A. Ogus, *Regulation: Legal Form and Economic Theory*, Chap. 10.

[65] Department of Health, *Survey of Local Authority Social Services and Health Authority Inspection Units* (2000).

regulatory agencies has a legal mandate for resolving or adjudicating on general disputes between users and providers. Their interest in complaints lies in the information they provide about whether a registered practitioner or a licensed provider adheres to the terms of the registration or licence. Some regulatory agencies have little interest in complaints. For example, the Human Fertilisation and Embryology Authority does not publish data about the number of complaints it receives, but reports that it receives fewer than five written complaints per year.[66]

In general, the effect of the legal mandates is that complainants are cast into the role of the "public spirited" individual reporting a problem rather than a citizen attempting to hold a provider directly to account. This has led to a mismatch between the actions of regulators and the expectations of the public. In 1999 health authority inspection units received some 2,500 complaints about nursing homes.[67] But the Office of Fair Trading[68] found great dissatisfaction from relatives with the way that inspection units handled complaints about nursing homes. Some investigations were conducted without reference to the complainant, the findings were notified to the body or person against whom the complaint was made ahead of the complainant, it was up to the discretion of the individual inspector whether a settlement was negotiated between the home and the complainant, and any settlement reached was not binding on the home.

Complainants encounter similar problems with the General Medical Council who similarly have no mandate for dealing with general disputes between doctors and their patients. A *Which* survey[69] found patients who brought complaints to the General Medical Council were likely to be dissatisfied, because only a small number of complaints resulted in action being taken against the doctor. In 1997, the General Medical Council received 2,500 complaints.[70] Of these, 45 were serious enough to go before the Professional Conduct Committee and 11 doctors were struck off. As well as its conduct procedure, the General Medical Council now has procedures for judging whether a doctor has seriously deficient performance and health procedures. But these fall short of giving the General Medical Council a general function in resolving disputes. A patient cannot be expected to know that the General Medical Council is only interested in complaints against doctors which fall into particular categories rather than all disputes. Thus complainants with relatively minor complaints will be turned away. Given the regulator's legal mandate, none of these actions are unreasonable. They would be in an agency where complaints were part of an overall framework of accountability.

Reform of regulation for both the medical profession and the nursing homes is under way. It has been argued that the General Medical Council should

[66] Personal communication with the Human Fertilisation and Embryology Authority.
[67] *op. cit.* n. 65.
[68] *op. cit.* n. 58.
[69] L. Beecham, "Patients' Complaints: GMC could do better" [1999] B.M.J. 1319:1022.
[70] General Medical Council, *Annual Review 1998*.

reform by expanding the complaints procedure to adjudicate on all complaints,[71] but this has not been taken up. Instead the General Medical Council will introduce revalidation which will involve appraisal by colleagues, employers and patients. The Care Standards Act 2000 will transfer the responsibility for regulation of nursing homes and private hospitals to a new National Care Standards Commission in 2002. The Act also contains the powers for the Commission for Health Improvement (CHI) to inspect private hospitals and care homes and for the National Care Standards Commission to take on the function of CHI. But the Act does not give the National Care Standards Commission a general responsibility for dispute resolution and it is not clear which commission will handle complaints. Similarly, there are no duties placed on the National Care Standards Commission to involve the public in the formulation of policies or inspection processes beyond the simple provision of information.

Conclusions

The NHS used to be a wholly state-funded organisation with a highly centralised structure where care was provided by state owned and managed providers. The intent was to provide a universal service to the population within a defined geographical area. In *The NHS Plan* the intention is for power and authority to be devolved to a series of primary care trusts, public-private partnerships or private providers. Providers will be within an extended web of accountability involving the National Care Standards Commission, the Commission for Health Improvement, NHS regional offices, the Audit Commission, the National Audit Office and various other bodies with regulatory functions proposed in the plan. But within this framework complaints systems have been neglected and devalued. Patients will have no rights of appeal to these agencies, so the potential to use complaints as the eyes and ears of the agency in what is now a fragmented and diverse system is lost. So is the potential of these agencies to increase their own legitimacy in the public eye by responding to patients' complaints.

As currently organised, complaints systems in health services are severely hampered as a mechanism of accountability. Such systems in U.K. health care have grown up in a ramshackle way. The Health Service Ombudsman was introduced to curb administrative power, purchasers became appellate bodies for complaints as a result of the market philosophy of the late 1980s, and health regulators use complaints primarily to collect information about compliance with terms of registration or licensing. As a result, these agencies have a hotchpotch of powers and jurisdictions which are maze-like in their complexity. The danger is that complaints of public concern may be lost. Moreover all agencies are fettered in some way by outmoded legal frameworks. The Ombudsman's powers were designed to protect the state from any challenge to its policies. Now semi-autonomous NHS trusts and private agencies providing care in partnership with the NHS are still protected by these mechanisms while

[71] I. W. B. Grant "GMC's current proposals for revalidation are flawed" [1999] B.M.J. 319:53.

being freed from some of the constraints and oversight of central government. As a consequence of increased use of private providers, regulatory agencies will be at the forefront of debates about public policy and the enforcement of standards. The lack of legal mandate for general dispute resolution may leave regulatory agencies open to criticisms that they are not responsive to issues of public concern.

The one development that may require the NHS to begin to address some of these issues is the implementation of the European Convention on Human Rights by the Human Rights Act 1998. This will require increased formality in areas where the dispute relates to Convention rights. Article 6 of the Convention requires a fair and public hearing by an independent and impartial tribunal empowered to consider the merits of decisions affecting civil rights and obligations. It must be independent of the parties and the executive, it must hold its proceedings in public, pronounce its decision publicly and ensure a fair hearing of both parties. Neither the NHS complaints procedure nor the Health Service Ombudsman scheme, whose style is investigative, fit these criteria. As the Act will also apply to independent agencies who carry out public functions then independent sector hospitals or nursing homes may also be subject to such a procedure. Boyle[72] suggests that large areas of discretionary decision-making by public bodies are excluded from Article 6(1) by the narrow interpretation given by the European Court to "civil rights and obligations" and its distinction in this context between private rights to which the Article does apply and public rights to which it does not. Nevertheless, many of the Convention articles such as Article 2 (the right to life) and Article 3 (protection from inhuman and degrading treatment) may apply to health care activities. It remains to be seen whether this problem will be approached piecemeal, with appellate bodies set up only to deal with appeals relating to Convention rights, or whether the Human Rights Act will provide a platform for a more radical reform of health care complaints systems. With the proposals to change the role of the Health Ombudsman into a mediation service, the signs are not positive. Apart from the public, Members of Parliament and their select committees appear to be the only group who still see complaints as important in promoting transparency and accountability in health care. It may be left to them to grasp the nettle and demand radical reform.

[72] *op. cit.* n. 18, p. 100.