From 'Major Decisions' to 'Everyday life'. Direct Accountability to Clients

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Abstract

In this chapter we will discuss two models for democracy: the 'Major Decisions Model' and the 'Everyday Life Model'. In the Everyday Life Model, citizens involved in an accountability process can say whatever bothers them in their dealings with a health care organization. In the Major Decisions Model, citizens involved in an accountability process have to disregard their personal experiences and are rather asked to discuss major strategic plans and decisions on the organizational agenda. In the literature, the Major Decisions Model is generally seen as preferential, because it directly connects citizens to crucial decision-making. However, in some circumstances the Everyday Life Model might be wiser to adopt as it builds directly on the genuine daily experiences of clients in health care settings.

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1. Introduction

A parent-teacher evening at a primary school usually follows an agenda consisting of topics such as the school's annual budget, teacher recruitment policy, new equipment for the school yard, finding a new location for physical exercise lessons, or the choice of a new method to teach arithmetic. These are interesting topics, even if some are more directly relevant to life in the classroom than others. However, many parent- teacher evenings are interrupted because assertive parents do not stick to the agenda but want to discuss a recent incident in class instead: "My Emily fell from the climbing rack last Wednesday. How did that happen? Is there enough supervision during morning breaks?" "Our George suffers from dyslexia. Yet he was forced to take the exact same test that his classmates had to in the same amount of time. I feel it's about time that we discuss the position of special needs children at this school." These interruptions are generally not approved of. Parents are admonished to stay on topic and to discuss specific questions relating to their own children at a later date.

In this chapter we will discuss two models for democracy: the 'Major Decisions Model' which is followed by the school board and the majority of parents in the parent-teacher example and the 'Everyday Life Model' that guides the interventions of the unruly parents. In the Everyday Life Model, citizens involved in a decision-making procedure or an accountability process can say whatever bothers them in their dealings with the organization. In the Major Decisions Model citizens involved in a decision-making procedure or an accountability process have to disregard personal experiences and discuss major plans and decisions on the organizational agenda. Both models figure in two bodies of literature: the

literature on democratic participation and the literature on accountability. In both bodies of literature, the Major Decisions Model is preferred overall, and with good reason, as we will show. However, the Everyday Life Model has more going for it than the example above and the bulk of the literature suggest. Thus we will explain why and under what circumstances it might be wiser to adopt the Everyday Life Model and what this would entail. We will use empirical studies from Dutch health care to support our claims, but we are certain that a large part of the argument will be applicable to other countries as well.

The chapter proceeds as follows: in the next two sections we will discuss the two bodies of literature in relation to the idea of the two models of democracy. In the fourth and fifth section we look at the Dutch health care sector focusing on patient participation (democratic participation) and accountability toward patients. We show where, how and why the Everyday Life Model might do more for patients than the Major Decisions Model. In the last section we present a general guideline for decision makers who have to choose one model or the other.

2. Major Decisions vs Everyday Life

Accountability and democracy are often modeled on a 'major decisions' basis. Scholars and policy entrepreneurs generally suggest that accountability and democracy should be organized in such a way as to affect the major organizational decisions within social service providers (see Damgaard & Lewis, 2014). This approach is inherently logical; if decision makers are to render an account of substantial decisions to their clients it seems only fair to focus on the major issues at stake. However, we will show that the Major Decisions Model sets a very high (if not unrealistically high) cognitive and practical standard for clients. A contrasting model focuses on 'everyday quality', seeing clients as 'everyday makers' (Bang & Sørensen, 1999) of health care outcomes. In this model, accountability focuses on decisions

relating to seemingly 'little things' that accompany daily life with a medical condition. In order to illustrate the contrast between both models, consider the excerpts from research below. The first quote comes from a client serving at a client-representing body within a health care institution:

> *"Managers have to deal with a multitude of interests. They must ensure healthy financial management, keep their employees satisfied, ascertain compliance with the standards imposed by the health care inspection, etcetera. With all of these important interests it is easy to forget about the interests of clients, which of course should not happen as they constitute the raison d'etre of the organization. We guard this specific perspective." (taken from Bons, Boerwinkel, Honig & Den Dulk, 2008)*

The implication of the quote above is that clients should have a say in all major organizational decisions, ensuring that the client perspective is treated on par with financial, regulatory, and organizational concerns. However, this assumes a) that the perspective of clients can be applied unambiguously and successfully to major organizational policy decisions and b) that clients have the knowledge and skills to do so. These assumptions can both be challenged, as the underlying notes from an observation of a meeting with a representative body in an elderly home illustrates:

> *"A policy advisor came into the meeting and held a presentation about quality indicators, protocols and assessments. The clients do not seem to understand her presentation. At one point she mentions a policy that needs to be implemented in a couple of years, and, while she shows herself to be an ardent supporter of this policy, one of the clients softly mutters "Well, by that time we may not be here anymore." The ensuing discussion mostly engages the policy advisor and the senior manager. The*

clients just nod their heads, with a strained look on their faces, while they gloss

through their documentation. When the policy advisor leaves, one of the clients asks:

"What, actually, is a protocol?" (taken from Van Bloemendaal, 2006).

3. Democratic participation

Scholars of democracy agree that the case for direct, participatory democracy (as opposed to indirect, representative democracy in which citizens merely elect their political representatives) dates back to classical Greece on the one hand and the work of Jean Jacques Rousseau on the other (Held, 2006). Direct democracy was revived in the 1960s and 1970s, notably in the work of Carol Pateman (Pateman 1970). In a series of articles on the topic, Michels and co-authors make an inventory of the claims made by the advocates of participatory democracy (Michels and De Graaf, 2010; Michels, 2011; Hendriks and Michels, 2011; Michels, 2012). In this literature, it is stated that democratic participation gives citizens a say in collective decision-making; it improves civic skills and fosters civic virtue; it makes people feel more at home in their political community; it enhances the legitimacy of decisions because decisions have been made collectively; and it enhances the quality of debate and deliberations, thus possibly leading to better decisions in other ways as well.

Many advocates of one or another form of participatory democracy make reference to the so-called ladder of participation developed by Sherry Arnstein (1969). The ladder posits that democratic participation is a step-by-step process, starting with citizens being merely informed or consulted, and ending with citizens setting the agenda and making important policy decisions. Ending up higher on the ladder is better for democracy in all of the aspects mentioned by Michels and her colleagues: it gives citizens more of a say in collective decision-making and more of a chance to practice civic skills and develop civic virtue.

Moreover important decisions are rendered more legitimate and better informed when citizens have a high degree of influence. The metaphor of the ladder, so dominant in the literature (cf Damgaard &Lewis 2014; Cornwall 2008; Michels & De Graaf 2010), strongly suggests that the way to go is ever upward. The more citizens are involved in decision-making and the more important the topics on which they are allowed to weigh in, the better. Deciding on the annual budget gives citizens an opportunity to learn new skills: to understand budgeting, to set priorities, to deliberate about cutbacks and their consequences, and to discuss new opportunities when there is money available to do so. Budget decisions make one keenly aware of one's responsibility: people may lose their job because of these decisions. Deliberating upon such major issues may indeed foster civic virtue. Of course, citizens may feel that they are not yet up to the task of presiding over budgets, but they can learn. In fact, that is one of the goals of direct democracy: to educate citizens, to teach skills and virtues.

Over the years, the 'domain' of citizen participation has been expanded to include accountability (Damgaard & Lewis 2014; Schillemans et al 2013). The same logic that applies to citizen participation in decision-making holds for citizen participation in 'accountability' as well: it enables citizens as the ultimate 'principals' in democracies to address those empowered with public tasks, money and powers. The claim for direct accountability to citizens is couched in the fragmentation of the public sector in many countries, where public tasks in the new public governance are provided by a plethora of public, semi-public, nonprofit and even for-profit organizations; if not by a network of any or all of the above (Pestoff et al 2013). These complex networks of public service delivery challenge traditional conceptions of democratic accountability in which elected bodies take central stage. Conversely, by focusing on the direct accountability relationship between public service providers and clients and cities, a new and promising direct democratic venue opens up.

4. Accountability

The quest for participatory democracy is driven either by citizens who want to make decisions mutually, or by political actors or organizational managers who want to involve citizens, clients, students, or residents. The quest for accountability bears resemblance to this pattern, but originates from a desire to render account; to explain and justify one's choices for an audience of stakeholders or involved citizens. Accountability to citizens has often been described in highly normative terms (see McCandless, 2001) and is said to have important effects on public organizations (Meijer & Schillemans, 2009).

Accountability is generally understood as a *relational* concept that connects an accountor, bearing responsibility for a specific task, to an accountee, demanding an account (Bovens et al 2014). In direct forms of accountability, citizens and clients are the accountees of public service providers as accountors. Processes of accountability normally involve three phases (Mulgan, 2003; Bovens, 2005). In the first phase, the accountor renders an account of his conduct and performance to the accountee. This is termed the information phase. In the second phase, accountor and accountee engage in a debate on this account. The accountee may ask for additional information and pass judgment on the behaviour of the accountor. The accountor will answer to questions and, if necessary, justify and defend his course of action. This is the debating phase. Finally, the accountee comes to a concluding judgment and decides whether and how to make use of available sanctions. This is the sanctions, or consequences, phase. Sanctions may vary from formal disapproval to tightened regulations, fines, the discharge of management, or even the termination of the organization. Many authors notice that there is a hierarchy of sanctions. As Hood et al (1999: 47) indicate: "It emanates with the 'ability to shame', escalates to lighter weapons such as certificates or formal (dis)approvals and culminates in the 'nuclear weapon' of liquidation." From a legal

and institutional design perspective, it is imperative that the accountee have sufficient investigative and sanctioning powers. The literature on accountability often focuses on the 'heavier weapons' amongst the formal sanctions and the adoption of performance standards. This is enhanced by the fact that many authors favour a principal-agent approach to accountability, in which controlling the agent (i.e., the accountor) is a crucial concern (see Przeworski et al, 1999; Strøm, 2000;; Besley and Ghatak, 2003). In addition to formal sanctions, informal sanctions may also follow from accountability. This was already implicit in the above quote from Hood et al. (1999): their hierarchy of sanctions started with 'the ability to shame.' Negative publicity may also be seen as a form of sanctioning, even though no formal retribution is used (see also Harlow and Rawlings, 2007: 545).

Accountability scholars argue that accountability arrangements can and should be judged from three different perspectives: a democratic perspective, a checks and balances perspective and a cybernetic perspective. From a democratic perspective, it is important that citizens (clients, patients, residents, parents, students) control the accountor (the organizational manager who renders an account). From a perspective of checks and balances, it is important that the manager, politician, or director's power is counterbalanced by a countervailing force that weighs up to it, rendering decisions more legitimate. From both of these vantage points, it seems logical that accountor and accountee (or actor and forum) should preferably discuss and evaluate major decisions, such as the annual budget, the yearly management report, mergers and acquisitions, or other major changes in institutional strategy. The third perspective is the cybernetic approach. It posits that the accountor should preferably learn something from the process of rendering an account. This person should not merely justify his or her actions to the appropriate audience, but should also receive feedback that he or she had not previously thought of, but that might be important for the organization or its clientele. From a cybernetic perspective, it seems very well possible that a forum might point

to small elements of daily life that an accountor operating at an organization's apex had not noticed. The sound of the doorbell may be very annoying, the colour of the doormat may seem ludicrous, the ventilation in the bathroom faulty, and the sheets on the bed uncomfortable. The chances that a forum will propose an entirely new perspective on the budget or the annual report are slim. However, the chances that a forum will identify issues that the accountor had not even begun to consider are much higher.

We can categorize the arguments discussed thus far in the following table:

	Speaks in favor of the Major Decisions Model	Speaks in favor of the Everyday Life Model
Democratic participation		
Gives people a say regarding major decisions	X	
Improves civic skills and fosters civic virtue	X	
Leads to legitimate decisions	X	X
Leads to better decisions	X	X
Accountability		
Principal should control agent	X	
Power should be counterbalanced	X	
Accountor should learn from the process		X

Table 1. The Major Decisions Model and the Everyday Life Model and how they relate to arguments on participation and accountability

We can conclude from the table above that democracy and accountability are intertwined despite their different origins. First, the arguments concerning democratic citizen participation and accountability are strongly related. Both focus on the importance of influencing decision-making, legitimating decision-making, and increasing the quality of public services. Second, formalized participation structures, such as the client councils that are the focus of this chapter, can be seen as an interesting case of social accountability in which case accountability is built *through* citizen participation (Abelson & Gauvin, 2004). Citizens—in this case, patients and clients—may participate in formalized institutional settings where crucial decision makers (i.e. health care managers and health care professionals) are obliged to explain and justify their (proposed) decisions and thus render account to affected parties. In the following sections, we seek to discover how both models fare with respect to the empirical foundations of the Dutch health care system. We will do so by using the three perspectives on which we can evaluate accountability: the democratic perspective, the checks and balances perspective, and the cybernetic perspective.

5. Client participation in Dutch health care as a case of social accountability: a focus on formalized structures

Since the 1980s, the Dutch government has actively encouraged patient participation in the decision-making process. Participation also received increased attention with the introduction of a system of regulated competition in health care in 2006 (Van de Bovenkamp et al., 2013). As a consequence, there are many opportunities for patients to participate in the

management of medical facilities. Interestingly, participation has become highly formalized. Patient organizations are attributed an official 'third party' role in health care (next to health care providers and insurers) and are asked to participate in formal decision-making processes as patient representatives. The Dutch government has enabled patient organizations to play this role by awarding subsidies and by opening up decision-making processes, such as with respect to medical guideline development, medical research agenda-setting, and government policymaking (Caron-Flinterman, 2005; Oudenampsen et al., 2008; Van de Bovenkamp & Trappenburg, 2011). On the level of health care organizations, client councils are attributed an important role in representing patients. Client councils are not just stimulated by government, but have become mandatory under the Co-Determination of Health Care Institutions Act (*WMCZ*). This act gives client councils many rights to advise the Board of Directors of health care institutions on issues such as the goals of the health care organization, mergers, the budget and annual accounts, safety, and quality assurance. In all of these cases, patient representatives are asked to voice their perspective regarding major operational decisions. Alongside these formal institutionalized participation possibilities, other participation methods have also been introduced. Their aim is to gain insight into patient experiences through both quantitative measurements (e.g. surveys) and qualitative instruments (such as focus groups, patient interviews, mirror meetings, etc.). Unlike the more formalized participation forums, these methods draw upon a broad swath of patients' experiences as opposed to those of only their representatives. Furthermore, these methods, especially those drawing on patient stories, are examples of methods that put 'every day quality' center stage, whereas, at first sight, the formal institutionalized participation possibilities can be described as possibilities that draw on the Major Decisions Model.

When evaluating participation possibilities, reference is often given to Arnsteins' participation ladder (1969) or adaptations thereof (e.g. Caron-Flinterman, 2005; Van

Veenendaal et al., 2004; Damgaard & Lewis, 2014). Based on this line of reasoning, formal modes of participation focusing on major decisions are valued more highly because patients are able to participate as equal partners with other actors in the health care sector. As client councils represent a perfect example of a formalized participation structure that draws upon the Major Decisions Model, this chapter will explore their use as a social accountability mechanism in the Netherlands. When analyzed from the three phases of accountability, we see that Dutch client councils are entitled by law to a) receive the relevant *information* from Board of Directors and b) *asses* this information and give advice based on this assessment on many subjects concerning the organization. The health care institution should take this advice into account when determining its policies. Regarding certain subjects (food provision, safety, complaint procedures, quality assurance policies, and the appointment of management positions) the council has strong rights of advice. This means that in terms of c) *sanctioning power*, client councils have certain rights as well, since on these subjects the health care institution cannot officially depart from their advice unless a dispute committee concludes that this is warranted. In addition, in theory client councils also have informal sanctioning possibilities, such as through contacts with patient organizations, the health care Inspectorate, or the media. Compared to other formal participation possibilities, these powers are quite strong. To once more take the example of participation in guideline development, we can see that patient representatives are increasingly asked to participate in working groups with other actors, health care professionals, and scientists. They are now also asked to assess large amounts of information. In the case of a disagreement, however, it is easier for these other actors to put the input of patients aside. Patient organizations can decide not to endorse the guideline as a sanctioning power, but the effects of this move seem limited (Van de Bovenkamp & Zuiderent, 2013).

6. Empirical observations

We will now turn to our analysis of client councils in Dutch healthcare and analyze them in terms of the criteria mentioned above: 1) democracy; 2) legitimacy; and 3) learning.

Accountability to clients & democracy

As discussed, democratic participation can be seen as form of social accountability, in which the benefactors of a public service are given the direct opportunity to demand accountability from the service provider. In order to actually make these specific forms of democracy 'work', a number of conditions must be met. Clients should *want* to participate in these bodies, should be able to *translate* their views, interests, and experiences effectively to decision contexts, and should be able to *speak on behalf* of their constituency. These competencies belong to the "hard core" (Audigier 2000) of democratic citizenship. Democracy depends on active citizens, who are willing to engage and participate (at the very least they should be willing to vote), who are able to represent their interests (see Przeworksi et al 1999). Citizens in democracies should in principle have the "capacities for democratic citizenship: the ability to argue, which is related to debate and the ability to reflect" (Audigier 2000: 22).

Existing evaluationsand studies of citizen participation suggest that these conditions are not easily met. It can be very challenging to find citizens or clients willing to participate, who are able to represent the citizens or clients in general and who are able to operate effectively. These troubles are not restricted to direct citizen accountability per se. The propensity of

citizens to vote in elections and the ability of political parties to represent constituencies is challengedas well (Flinders 2012). But for direct accountability to citizens it is nevertheless crucial that these conditions are met as least at a base level, which, unfortunately, is not always the case.

The first condition of effective **recruitment** is a difficult nut to crack in many settings. Clients are not particularly keen to participate in formal bodies where they can hold health care organizations and public service providers in general accountable, even if they might subscribe to the general principle. There is a variety of reasons why clients may find it difficult or unappealing to participate in these bodies in the health care context. As a result of recent policy changes encouraging people to remain in their communities elderly or disabled home care residents are those least capable of effective participation on management boards. The remaining population is now much smaller, much older, or more severely handicapped. These are not exactly conditions conducive to effective participation in complex administrative decision-making (Trappenburg, 2008). Hospitals also have trouble finding clients willing to serve on their constituent bodies, because the average duration of hospital treatment has decreased significantly over the past several years. This means that the group of people to draw from has shrunk and that those potentially available, who stay in the hospital for longer time periods, are more seriously ill (Trappenburg, 2008). The category of remaining patients is thus much less capable, let alone motivated, to participate in client board meetings. Many members of such boards are effectively former clients or even non-clients, representing the interests of clients without ever having been a client themselves (Hoogerwerf et al., 2004). Moreover, council members are not so much selected to join the board because of their experiential expertise, but rather because of a professional background in finance, management, law, ICT, or medicine (Kuijsten, 2014; Van der Meide et al., 2014). Such

selections implicitly recognize that high levels of expertise are needed to be able to properly discuss matters with the Boards of Directors.

The recruitment problem is not unique to the health care domain. The client boards of some Dutch government agencies administering benefits have also had a hard time 'finding' proper clients. Available seats have, to some extent, been taken by people who are *not*, nor have ever been clients, but who instead work for trade unions or interest groups. Professional participants have had to step in because it has often been, for whatever reason, too difficult to recruit 'real clients' (Schillemans, 2007). The same has been noted for Dutch universities. Dutch universities sport numerous bodies where students as clients may hold their service provider accountable. A study found that representative bodies on the central level had severe recruitment problems (72% of the cases), while bodies on a departmental level (62%), and on a program level (39%) were troubled by the same patterns (De Boer, Goedegebuure & Huisman, 2005, p. 44).

It is not insignificant to note that the recruitment problem, while relevant to all bodies, is markedly less pronounced at the lowest programmatic levels and is experienced much more strongly at the 'abstract' level of the university. It is, apparently, more attractive for participants to become part of managerial bodies concerned with their everyday (educational) experience than in the complex organizations behind it. The problems mentioned with respect to the health care sector are likely to have a similar impact: it will be easier and more relevant for (residential) clients to participate in issues relating to their daily experience of living with a condition and health care than it is to participate in policy decisions. An indication that this is indeed the case is the fact that other participatory methods, which focus on the use of

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patient stories to improve quality on specific hospital wards, do not seem to suffer from this recruitment problem (Vennik et al., forthcoming).

The issue of recruitment easily spills over into one of **translation**. In other words, are representatives effective in translating the client's perspective into formal decision-making? This question is again most relevant in the Major Decisions Model, because the gap between clients' everyday reality and long-term, abstract policy decisions is widest. Existing studies provide reason to question client councils' abilities to achieve such a task.

The Major Decisions Model assumes that clients operate as counterparts to senior managers and executives in key organizational decision processes. This effectively means that clients are supposed to read and discuss complex documents pertaining to budgets, annual reports, staffing policies, mergers and acquisitions, and long-term strategic plans. The constituting legislation has given various councils rights to information and advice regarding these types of, admittedly, major organizational decisions. The underlying rationale is that clients are supposed to read the budget from the perspective of *clients* and ask themselves how budgetary decisions affect the interests of those they represent. It is a noble, important, but very demanding expectation.

Existing evaluation studies suggest that client councils have a hard time meeting this challenge. Whether explicitly or not, evaluation studies often point to various 'quality'-problems. This finding is often supplemented by the suggestion that clients representing the interests of other clients should attend courses and training that will help them become more effective in their dealings with the managers of health care organizations (see De Savornin Lohman, Rijkschroeff, Oudenampsen, Van Gelder & Overbeek, 2000b; Hoogerwerf et al.,

2004; Van der Kraan & Meurs, 2008). This problem is not only identified in the case of client councils. In other formal decision-making processes where representatives of patient organizations are asked to participate, such as medical guideline development and government policy making, problems concerning 'the quality' of representatives have been identified. In these cases, patient representatives are asked to participate in formal decision-making bodies with policy makers, health care professionals, and scientists in which they are expected to contribute to discussions on policy plans and evaluate scientific literature (Van de Bovenkamp et al., 2010; Van de Bovenkamp & Zuiderent-Jerak, 2013). When they are not able to perform this role, their professionalization is called for. In the Netherlands, there are different bodies and institutions providing on-demand training to the clients in these bodies.

The 'clash' between a policy agenda and clients' perspective was, for instance, described by Van Bloemendaal (2006). She painted a sad picture of elderly residents trying to address very complex policy reports, while they would much rather talk about smaller issues that really bothered them: ticking heating pipes, nurses without nametags, how to celebrate Christmas, and unstable coffee mugs. Their concerns were not addressed in the formal agenda. A similar finding was reported by Bouma (2000). She interviewed participants who told her that their main concerns related to variation in the quality of breakfast foods, policies about going to the bathroom, overdue maintenance, unpractical thermostatic showers, and service surcharges. She wrote: "Members of these councils care about issues in their everyday living conditions. Data and annual reports are less interesting. The organization should just take care of that" (see Bouma, 2000, p. 41). Others would complain about this approach, stating it was necessary to focus on overarching *policies* rather than to dwell on individual *incidents*. Similar 'clashes' between requests for input based on daily patient experiences and the demand for a focus on the major decisions (and the abstract scientific knowledge needed

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to make them) have been described in in other participation studies as well (Brooks, 2008; Van de Bovenkamp & Zuiderent, 2013). Once more, this problem of translation is hardly restricted to the health care sector alone. Respondents in higher education have, in a similar vein, pointed to council members' lacking managerial skills, low levels of knowledge, and inability to reach a policy consensus (de Boer et al, 2005, p. 36). Furthermore, in various cases where organizations hold formal discussions with client representatives *and* conduct surveys among clients, they discover contradictory opinions. While representatives should represent all clients, they do not necessarily successfully communicate or understand the full range of their concerns (Schillemans, 2007).

As mentioned, education and training may help participants become more effective in their roles. This solution, however, may trigger a new problem. Extensive education and training will surely help clients understand the language of policy decisions in which they are to operate and will arguably make them more effective participants. Nevertheless, it is unclear whether the trained representative still adequately represents the views and concerns of his constituents. Existing evaluation studies sketch a somewhat murky picture in which council participants' substantive representativeness is often questioned. (De Savornin Lohman et al, 2000 a; Hoogerwerf et al, 2004; Van der Kraan & Meurs, 2008). An executive of a large public agency aptly expressed the dilemma: "We want to speak with real clients, but they should be able to speak about it at an appropriate level." The third problem, then, consists of the **institutionalization** of client council members. They may become more effective at influencing the organization at the expense of their ability to represent and express the concerns of all clients. This can lead to 'capture', whereby board participants identify with and understand the concerns of the health care organization while losing contact with their constituency.

All in all, a fairly gloomy picture evolves. On the one hand we can say that the Major Decisions Model holds the biggest promise in terms of democratic accountability to clients. When organizational decision makers need to render an account of their choices, policies, and organizational behaviors to a body representing clients, a true form of direct democracy evolves. However, existing reality falls well short of expectations and many of these bodies have a hard time coming to terms with their responsibilities.

Accountability to clients & legitimacy

A second evaluative perspective from which to judge accountability to clients is the fiduciary perspective, which focuses on the effects of citizen accountability on the legitimacy of, and trust in. organizations. In the academic literature, this 'trust'-issue is possibly the most important driver behind and argument for direct accountability to clients or citizens (Van Montfort, 2004, p 92; Bovens, 2005, p 49). In a context of concerns about the loss of trust in, and legitimacy of, governments and governance, accountability to clients and customers is seen as one of the ways to 'repair' contemporary democratic systems (see McCandless, 2001).

The evidence found in a number of studies suggests that representative bodies of clients may actually have a moderately positive effect on trust and legitimacy, though one that is methodologically difficult to trace. At the very least, chief executives in public service organizations, including many health care organizations, take this position. In a survey study in eight public service sectors, including four sub fields of health care, executives were asked whether and to what extent a number of external stakeholders contributed positively to the organization's public stance and reputation. The large majority of the executives came to

positive conclusions. 43% of the respondents were strongly positive, 49% were 'positive', while only 8% of the responses were negative (Schillemans, 2007).

The responses are thus supportive in both an absolute and a relative sense. As mentioned above, respondents were asked to answer the same question for a list of nine different (more or less external) stakeholders. Figure 1 below summarizes the results for the different stakeholders. This comparison illustrates that client representatives, including client councils and customer forums, ranked secondly in this artificial contest in terms of ascribed positive impact on the organization's standing. Non-governing, supervisory boards were the only stakeholders evaluated more positively on this aspect.

Figure 1: Relative contribution of nine external stakeholders to public standing and image of the organization[4]
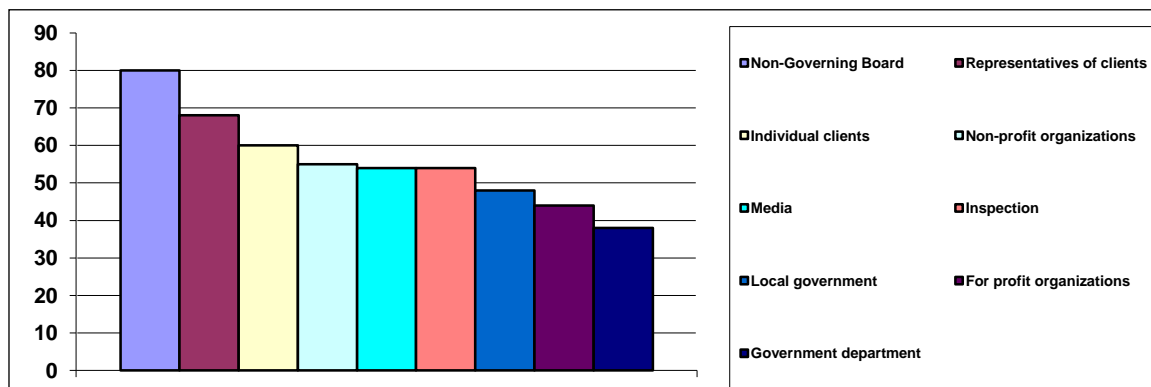
Qualitative research on public organizations confirms this general picture. Executives in public organizations, for example, indicate that the body representing clients is "simply a part of your total system of legitimation" (Schillemans, 2007). Another public organization expresses a similar view. This particular organization was subjected to severe public criticism

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[4] Figures 1 and 2 have been taken from Schillemans et al. (2008) and have been adapted slightly.

for apparently rigid bureaucratic behavior to the detriment of their most vulnerable clients. There was a great deal of political pressure to improve. This led to an improvement program that should make the organization more customer-friendly and more legitimate in the eyes of its target audience. The institutionalization of a voluntary client council was one important cog in the wheel of organizational improvement, which in particular served to 'befriend' alienated citizens.

This example, however, also demonstrates that client bodies may be instrumentalized by cunning executives to support their decisions and to enhance their reputation more generally. Harrison and Mort have coined this 'to play the user card'. Executives may push the right client forward whenever it serves their organizational, strategic interests. Clients may then be instrumentalized in what is essentially a bureau-political struggle between an individual health care organization and its policy environment (Harrison & Mort, 1998). In Dutch health care, the participation of patients in formal decision-making structures has been shown to run this risk of instrumental use (Trappenburg, 2008; Van de Bovenkamp et al., 2010). It is the 'price' of multiple accountabilities; a confluence of accountability types may be vulnerable to exploitation.

Apart from this last critical remark, however, the overall conclusion here is moderately positive: formalized bodies representing clients are seen by many as fairly effective means toward legitimacy and trust.

Accountability to clients & learning

The third 'promise' (see Dubnick & Frederickson, 2011) of accountability to clients is that their feedback may provide a useful contribution to the learning capacity of health care organizations. Customers and clients are the sole owners of a unique and highly important perspective on the quality and practice of health care services: they experience them 'on the ground'. They are, despite a broad array of formal experts, the only experts in knowledge of how it is to be treated, cured, cared for, or taught by public professionals (Caron-Flinterman, 2005). Their experiences and insights are potentially of utmost importance to the managers of health care organizations. Formal representative bodies may be the vehicle distributing the gist of client experiences as feedback to the executive level.

Again, the previously mentioned study of public service provision in the Netherlands lends moderate support to the actual efficacy of client councils to organizational learning and improvement. Respondents – the highest executives in public organizations in eight policy sectors – were also asked to indicate whether and to what extent nine different types of (external) stakeholders contributed to 'promoting the quality of services.' Client councils were rated fairly positively, with 40% of the respondents claiming they had a strongly positive impact on the quality of services, 50% indicating that they had a slightly positive impact, and only 10% of responding they had a negative impact on services. In a comparative perspective, the executives again indicated that client councils are the "best of the rest", following non-executive / supervisory boards.

Figure 2: Relative contribution of nine external stakeholders to 'improving the quality of services'
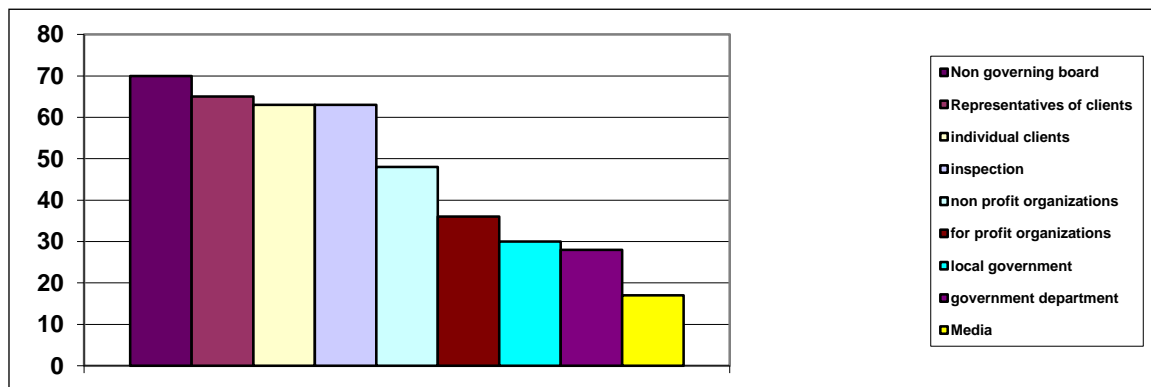

Figure 2 suggests that client councils play a relatively positive and fairly unequivocal role in promoting service quality. Interviews, however, portray a more diverse image, as has already been suggested in earlier excerpts from formal meetings. In particular, client councils in the Major Decisions Model face severe challenges. Many participants struggle openly with the detailed and often technical policy documents that they must engage with. Speaking on par with highly skilled, educated, and paid professional managers is a formidable challenge.

Interestingly, various studies suggest that client councils are much more effective as soon as they are asked to provide feedback on specific policies at the ground level and regarding their own experiences. Schillemans (2007) interviewed executives, members of supervisory boards and client council members about their experiences and came to the following conclusion. The majority of respondents stated that supervisory boards have a strong influence on organizations and that executives will never ignore their opinions. When pressed to provide details, however, respondents found it very difficult to provide good examples, sometimes to their own visible frustration. The same question was asked about client councils and solicited the exact opposite response. Respondents would, in general, tone down the influence of client councils, claiming their impact on overall strategies was very limited. But on specific key decisions, services, and policies, they had no trouble identifying

the impacts of client councils. Moreover, these effects were always tangible and seemingly unimportant: the distribution of mail and flyers, building accessibility, and service frequency—all examples, in other words, of everyday quality issues (Schillemans, 2007: 192). The potentially high impact of client councils on questions of everyday quality has also been indicated in a number of other studies. Bouma (2000) for instance interviewed a member of a client councils in a nursing home who provided the following little tale about what is important in health care policy:

> "Personal attention and a 'personal touch' are very important. It is important to treat people nicely, with dignity, they may be patients but they are still ordinary people. It is incredibly important to set the table properly, sit down in a nice way, the entire atmosphere around dinner. It is difficult to teach young people that this is important. We need to tell them all the time, need to explain again and again. And they also need to tell us what they are going to do so that we know what to expect. And, again, we need to tell them over and again. Consider this example: one day, a nurse arrived and told her colleague, 'that one needs to go to the bathroom'. So they walked over to the wheelchair, unlocked the brake, and set off down the hallway. The patient got a real scare, wasn't expecting this … you can't do that. It seems like such a small thing, but … "

In another study (Trappenburg, 2008), the coordinator of the national organization for client councils also suggests that many client councils are only motivated by, and only effective in, addressing issues of everyday quality. He states:

> "Some of these client councils are very critical about their everyday interests. These client councils focus on the issues that impact the people they represent on a daily

basis, such as eating and drinking, payment for laundry, etcetera. These kinds of things are incredibly important to people. They are in the home 24/7, while the staff will only be there for eight hours at a time. When you are always there, these types of issues become very important. I fully respect that councils decide to focus on those everyday issues, so to speak the width of a slice of cheese or coffee; that is just awfully important. I can imagine that those boards chose to let some of the formal stuff pass, such as a merger plan; that they will just disregard it. Yes, I can imagine that people will do that. People may be pressed for time, and not be in a position to read all the documents. But they may be very successful in improving issues of everyday quality."

The fact that this experiential knowledge is recognized to be important is shown by other participation developments that can be seen in healthcare. In the Netherlands but also in other countries, health care institutions apply additional methods of participation in order to get to these examples of everyday quality, based on which they can improve the quality of their care (Bate & Robert, 2007; de Wit et al., 2008; Vennik et al., forthcoming). Studies into these developments subscribe to the importance and added value of issues of everyday quality which can be brought to the fore by patients.

7. Rethinking Participatory Design

The above analysis has consequences for the design of formal participation structures such as client councils. In the institutionalization of such structures, a number of important design decisions need to be taken. Based on our analysis, we argue that the choice between the standard model of major decisions or the contrasting Everyday Quality Model is crucial. The Major Decisions Model is found in many health care and other public service

organizations. This model is more or less copied from the model of non-executive boards and clients more or less constitute a second board, debating all major decisions and issues with managers and executives. The client councils meet at regular intervals, discuss all major policy documents, and have the right to draft opinions or to demand a reconsideration of a decision. The Everyday Quality Model departs from this pattern. Here, the client council is hardly concerned with policy documents and complex, long-term decisions. Its prime focus consists of the little inconveniences and issues experienced by clients on a daily basis.

As emphasized, the Major Decisions Model has been dominant in the Netherlands, in part because it seems to be the most obvious way of ensuring that clients' perspectives will be accounted for when significant policy decisions are taken. However, as we discussed at length in the previous section, what we know about the effects of client councils would rather point at the relevance of the Everyday Life Model. That such a switch can be made in practice and the fact that it can generate positive effects are shown in a study recently conducted by Zuiderent-Jerak et al. (2009). They report on a case where clients living in an institution for the mentally disabled felt that participating in a client council did not deliver results because of the problems mentioned above: they had to read hundreds of pages of documents they did not understand and often could not keep pace during meetings. Therefore, the clients set up a separate trust in which they were in charge of the agenda. Based on their own agenda, the trust made recommendations to the board regarding problems they encountered in their everyday lives in the institution, such as: being moved to a different room without consent, having to share showering facilities with members of the opposite sex, and not being able to cook their own meals. Everyday issues such as these were indeed taken up by the Board of Directors and policies were changed as a result.

When the choice between the models is made, or, rather, the point on the continuum between both extremes has been set, a number of additional design choices come to light. The first important choice concerns the *size and composition* of the client council. How many members should this body have? Sizes currently vary greatly in the Dutch healthcare sector. A client council may count anywhere between three and twenty members and the health care organization is free to determine the size of this body (Hoogerwerf, Nievers & Scholten, 2004, p.16). The size issue essentially boils down to a trade-off between efficiency and representativeness. The number of potential stakeholders for some services can be very large. The advantage of a large body is that many different stakeholders may be given a voice. It may also enable the organization to mix various types of stakeholders together in one council, where clients *and* staff may speak their minds. The potential disadvantage of a broad composition is that this is likely to spark off heated discussions between the various clients within the council and not between the council as a whole and the organization. This makes the council less effective as an instrument of accountability for executives.

A second design question in larger organizations is: *at what organizational level* should a client council be set up? Is the central level of the organization the most appropriate locus, or should councils be set up at more operational levels? In general, one could say that the Major Decisions Model is most suitable for central organizational decision-making, while the Everyday Life Model is more likely to prosper at the operational level of specific units. In a maximalist approach to participation, each level of decision-making should be confronted with its own form of direct accountability to clients. In practice, however, this maximalist approach seems utterly inefficient and overly time-consuming. Nevertheless, some Dutch health care organizations are transforming into complex organizational structures under a central umbrella. Some of these health care organizations are looking for ways to institute

different types of client councils on different organizational levels (De Savornin Lohman, Rijkschroeff, Oudenampsen, Van Gelder & Overbeek, 2000a, pp 38, 42.)

The third design question is, then: how should a client council be *informed* by the organization. What types of documents should be made available? Should information be provided orally or in writing? Should client councils discuss existing documents or should they be adapted to suit their purposes? Or do client councils perhaps need specific information? And, relatedly, what types of support are needed by participants that will allow them to handle the stream of information competently? Participants will often have trouble in understanding the technical jargon of existing documents (see the example on the nursing home from the introduction). It may be necessary to translate documents and opt for more ordinary language, including additional oral explanations and visuals. Generally, it stands to reason that information in the Major Decisions Model should primarily consist of pre-existing policy documents and should be based around the organization's planning and control cycle. In the Everyday Life Model, however, it would be more logical for clients to control the size, type, and frequency of information exchange. It would also be logical in this model to demand specific types of documents and reports. The Everyday Life Model implicitly assumes that the clients will, in effect, set the agenda. Their dialogue with executives will rather concentrate on overall satisfaction, complaints, and experiences than on mergers, annual plans, and new organizational models.

A final issue concerns the *powers* granted to client councils. What, if any, sanctions are made available to clients with which they, as accountability forums, can sanction poor performance and sordid behavior by health care organizations as agents? Some client councils at independent public agencies and local governments hardly have any 'teeth' (Schillemans,

2007, p. 197; Edelenbos, Klaassen & Schaap, 2005, p. 17). Client councils in the Dutch healthcare sector, however, have fairly extensive powers. There is a legal regulation (WMCZ) that stipulates that client councils must have a say on many major issues, such as the goals and enactment of the health care organization, mergers with other institutions, the full or partial closure of a home or institution, relocations or major renovations, significant changes in the organization, the budget and the annual accounts, nutritional policies, safety, complaints, quality assurance, and the appointment of executives at the top or within sub-units. The health care organization is obliged to call for an opinion on these subjects in due time. Health care organizations need to provide a detailed explanation whenever they decide not to follow the council's advice. Clients cannot formally sanction or punish the executives, but they may publish their opinions and thereby try to heap pressure on the executives. The way client councils are embedded in legislation hence also helps explain why the Major Decisions Model is dominant. Our analysis may therefore also provide lessons for policy makers who are currently in the process of changing this legislation.

What model is used?	• *Major Decisions Model* – non-governing board as guiding example • *Everyday Life Model* - focus on everyday experiences of quality and everyday concerns of clients
Which administrative level?	• Group / aggregate level or operational units? • A layered system or a unicentric system?
Size and composition?	• How many members? • Clients or representatives of clients? • Internal or external chairperson?

	• Are all categories of clients represented or only certain groups? • Mixed participation or separate strands?
Who sets the agenda?	• The organization and organizational processes? • Clients and individual experiences?
Information?	• What information is used? • Use of existing documents or special purpose information? • How is information provided: orally, in writing, visuals? • What secretarial support is needed?
Sanctioning power?	• Information rights? • Formal advisory powers? • Weighted advisory power? • Transparency and publicity for recommendations? • Formal sanctiong powers?

Table 2 Institutional Design Choices relating to direct accountability to clients

7. Conclusion & Discussion

In this chapter we have analyzed formalized participation structures, most importantly client councils in the Netherlands, as a case of social accountability in which direct account is given to citizens. We discussed this case with the help of two models for democracy: the 'Major Decisions Model' and the 'Everyday Life Model'. The two models figure both in the literature on democratic participation and in the literature on accountability. In both bodies of literature, the Major Decisions Model is preferred. When we look at health care we see a similar pre-occupation with the Major Decisions Model amongst policy makers. In many Western countries, the participation of patients and clients is on the policy agenda and

attention is paid to involving them in decision-making, often in a formalized way. Client councils in the Netherlands are an excellent example of this. Because of their task description in the WMCZ, the Major Decisions Model is often dominant in the activities of these councils, which gives client councils the role of a second supervisory board. In this paper we assessed how this should be evaluated in terms of democracy, legitimacy and learning.

In terms of democracy, the conclusion is a gloomy one. Recruitment of representatives is a problem, as is their ability to translate the client's perspective to formal decision-making. Moreover, the Major Decisions Model quickly results in the institutionalization of client councils because they are trained and educated to take on a formal role— a role, in fact, that other actors are already playing. It is important to note that these mechanisms are also reported on in the broader participation literature. In general, citizens do not jump for joy when confronted with participation possibilities and are often happy if others do the decision-making for them (Hibbing & Theis- Morse 2002). Moreover, it has been established that the people who do become active are often the same highly educated middle and upper classes that also use other voice opportunities, a situation that has been described as a 'diploma democracy' (Bovens & Wille, 2011).

In terms of legitimacy our conclusion is more positive, formalized bodies such as client councils are seen by many as fairly effective means to achieve legitimacy and trust, even though participation can also be used instrumentally by decision makers (Van de Bovenkamp et al., 2010). In terms of learning we identified that the added value of client councils can especially be shown in situations where clients give input based on their own experience (see also Linhorst et al., 2001, Cox Curry et al., 2007, Zuiderent-Jerak et al., 2009). This provides decision makers with an additional perspective and brings to the fore the

consequences of certain choices for clients on the receiving end of service provision. Shedding more light on such experiences can help guarantee that different accountability forums, in this case client councils and supervisory boards, complement each other. Moreover, using patient experiences was also one of the goals of participation in the first place, but this perspective runs the risk of disappearing into the background when the Major Decisions Model becomes dominant and representatives are asked to professionalize.

Our analys of direct accountability to citizens should have three implications for our thinking and research on the issue. The fairy gloomy conclusions regarding the Major Decisions Model should not, we believe and hope, lead to discrediting the idea of citizen participation in accountability altogether. There are solid, democratic but also performative and normative, reasons to stress the importance of direct accountability to citizens. Our thinking is, however, biased towards just one of the possible models of citizens participation and it is almost automatically assumed that the highest rungs of Arnstein's ladder of participation are superior. The relative strengths of the Everyday Life Model of participation on some dimensions, however, suggests that it makes more sense to *calibrate* direct accountability to specific tasks, organizations and populations of citizens and clients. Instead of an automatic focus on the Major Decisions Model, policy-makers and citizens should make a reasoned choice between the two models, or even combinations of both.

A second implication of our anlayses relates to the focus of both researchers and policy-makers. As of yet, a large part of the literature takes the normative desirability of citizen participation for granted and is focused on the institutionalization of formal rights of participation and the creation of specific bodies and venues for citizen participation. Our analysis, however, suggests that realities of participation differ widely and that it is important to go beyond mere forms and rules. While some bodies and venues for citizen participation

are both active and effective, others are lethargic and irrelevant in practice. This suggests that it is important to move our analysis from formal instutions and bodies to the actual practices of these institutions and bodies. This leads to *comparative* research questions – how do various forms of citizen participation *perform*? – and to *explanatory* questions – why do some fare better or worse than others? Qualitative methods that focus on storytelling, for instance, could have an important added value in this regard (Bate & Robert, 2007; Vennik et al., forthcoming). These types of empirical insights would greatly deepen the currently primarily descriptive and normative literature.

Finally, although the Major Decisions Model has a strong ideological appeal because it gives clients the chance to become important players in decision-making processes that directly affect their lives (Damgaard & Lewis, 2014), practical experiences with this model provide us with ample reason to rethink its desirability. Based on our analysis, we come to the conclusion that a shift towards the other end of the continuum, to an Everyday Life Model in which clients are seen as 'everyday makers' (Bang & Sorensen 1999), is appropriate. This can be done by giving clients' day-to-day experiences a leading role in the council's agenda. Even within the Major Decisions Model, room can be created for these experiences, such as by not casting such input aside as purely subjective or marginal (Brooks, 2008), or by employing new participation methods that are specifically designed to explore everyday experiences and effectively integrate them into client council meetings.

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[1] See, for example Van de Bovenkamp & Trappenburg (2008).

[2] Figure 10.1 is taken from Schillemans et al (2008) and light edited.

[3] Edited and taken from Schillemans et al. (2008).

[4] A similar picture also emerges from international research (Cox Curry, 2007; Linhorst,

Eckert, Hamilton & Young, 2005).