SPEAKING TO POWER

- as customers or citizens?

David Donnison

The post-war settlement

In every generation there are people who remember events that occurred early in their lives which changed their world. I cannot recall where I was when news of John Kennedy's assassination broke, but I shall never forget the moment when I heard of Labour's victory in the 1945 election. I was a midshipman standing on the bridge of a cruiser steaming through the Indian Ocean in a black tropical night when the news reached us from the radio cabin. By next morning the lower decks were buzzing with it. Meanwhile, in parts of the wardroom there was considerable dismay.

Two weeks later we docked in Portsmouth to reload before returning to fight the Japanese in the Pacific. Given a 48-hour pass, I soon found myself standing in the corridor of a train, crammed with service men and stuck at Reading Station. Two men with dark suits, bowler hats and brief cases came hurrying across the platform to get aboard; but seeing there was no hope of squeezing into our packed corridor, they turned away saying "Let's try a first class carriage". The sailor standing next to me leaned out of the open window and shouted "First class? First class? There'll be no more bloody classes when this war's over!" – his voice echoing through the cavernous station. I could sense the support he was getting from soldiers and sailors all along the corridor.

Britain, like many other countries, was in a pre-revolutionary mood. Two hapless civil servants were seen as representatives of the class that had led these men and their families into two murderous world wars, and slumps that had condemned millions of them to poverty-stricken dependence on humiliating poor laws. When the war ended, the ruling classes of Western countries had to reach settlements with their workers that would hold their societies together – bearing in mind that, beyond the Elbe, there lay the vast Red Army; a constant reminder that other regimes were possible.

Along with full employment and the recognition of trade unions and workers' rights, these settlements included various guarantees of incomes, educational opportunities, health care, and eventually housing; provided by services which came to be called "the welfare state".

The public service professions come to power

For as long as anyone could remember, British governance, as working people experienced it, had been run by the local gentry. It was they who had chaired the improvement commissions, the municipal authorities, the school boards, and the poor law, hospital and public health committees. They were also the landlords and employers of the people who depended on these services, their vicars on Sunday, their

commanders in time of war, and the magistrates before whom they appeared when in trouble with the law.

Some of the gentry had been humane and radical reformers – particularly their most distinguished women, who had few other opportunities for leadership. Where would we have been without Florence Nightingale, Josephine Butler, Octavia Hill, Beatrice Webb, Eleanor Rathbone…? But the Peterloo massacre, in which sabre-wielding publicans, mill owners and landlords cut down a crowd meeting for peaceful protest showed what the gentry could do when frightened by threats of reform. Later, the more brutal of the Highland clearances showed what they could do when frightened by threats of bankruptcy.

The coming of the welfare state changed all that, shifting many of the local gentry's powers to central government and to the public service professions which staffed the expanding social services. Another recollection illustrates the change. When I took up my first academic job, in the University of Manchester in 1950, Professor Metcalfe Brown, our formidable professor of public health, told me how, in the 1920s, he got his first job as a medical officer of health for a rural district in Kent. He was asked only one question by the committee interviewing candidates for the post. "Do you hunt?" It happened that he could answer "Yes" to that question and he was immediately appointed. A few months later he felt compelled to close the local all-age school which was plainly unfit for human use. He was promptly summoned to the Hall where the chairman of his committee boomed at him as he walked up the drive, "We only appointed you because you said you would hunt. You've never been with the hounds. And now you want to close my school!" (And it was, in a sense, "his" school because his family had built it long ago.) By the 1950s, when I knew him, Metcalfe Brown was teaching the young doctors he trained to be medical officers that they should never call their committees together without writing the minutes of the meeting beforehand. But take care not to circulate the minutes with the papers for the meeting.

Julian Tudor Hart, in his great book on *The Political Economy of Health Care,* (1) reminds us that before the second world war many doctors were poor. Few were regarded as social equals by the gentry. The senior partner in the poshest medical practice in the South Wales town where he worked for most of his life always had to go into the biggest houses through the servant's entrance. Only when Lord Horder, King George the Fifth's doctor, was summoned from London to confirm the local man's diagnosis was a doctor let in for the first time through the front door. It was the N.H.S., Tudor Hart points out, that ensured British doctors would never be poor again.

Power was not handed over indiscriminately to the professions. It went to their dominant groups. Thus it was that we got, not the Health Service based on front-line general practices that Nye Bevan had hoped for, but a hospital-dominated service in which the most prestigious specialisms – not geriatrics or psychiatry - got the lion's share of resources. Likewise, the grammar schools and their backers in the more powerful universities hung on to their dominant role long after most other Western countries had recognised that this selective system penalised the families whose children most needed good schools. And when the Robbins Committee called for a great expansion in our universities, they brushed aside the pleas of expert witnesses

who argued that these be placed, like the American City Colleges, in the centres of old industrial towns where they could be reached by families who had never been to a university before. Instead, they were set up in attractive but somewhat decayed cathedral towns with good train services enabling professors to get to London and back within a day for professional and political meetings: the kinds of places where dons like to live. There were no conspiracies. None were needed. These are the ways in which power tends to work.

The post-war settlements achieved in many Western countries – with crucial help from Marshall Aid when their first ambitious hopes faltered – brought great advances for their working people; particularly through high levels of employment, and patterns of economic development that created a steady increase in opportunities for white collar work. For many years British society grew more equal in its distributions of housing, income and wealth.

A changing social structure

In the early 1970s these equalising trends came to an end. Slowly at first – and then rapidly in the second half of the 'eighties – Britain grew increasingly unequal; partly because of changes in the economy, but largely because of changes in taxes and benefits deliberately introduced by the Government. Class conflict was back, but in new forms. No longer did the main conflicts divide the two-thirds of our people who depended on manual work from the one-third who depended on non-manual work – those I glimpsed from a railway train in 1945. There were now fewer manual workers, and the main divisions ran between "middle England" - the central strata of our society (many of them readers of our most popular newspapers, the Daily Mail and News of the World) – and diverse minorities excluded from mainstream opportunities by a variety of factors: illiteracy, racial prejudice, physical and mental frailties, lone parenthood, residence in unpopular peripheral housing estates; and often by combinations of these and other things. Their diversity explains their political weakness: the old working class had a solidarity that was a source of great strength, but there is no rainbow coalition of the excluded. Meanwhile other conflicts were to emerge at the top end of the economy as small minorities secured runaway increases in income and wealth.

Some of these social conflicts were played out across the counters, the classrooms and consulting rooms of the welfare state. The public service professions and the services in which they worked were entangled in these divisive patterns and played their parts in the exclusion of vulnerable minorities.

Some conflicts were brutally explicit. "What would you call a thousand dead housing officers?" ran a familiar joke on Glasgow's big housing estates. "A start" was the reply. The people who coined that one called social security officials on whose benefits so many of them depended "the S.S." And the officials, if asked by strangers what they did for a living, would demurely reply "I'm a civil servant". Other conflicts were implicit but more fundamental. Research on public health long ago taught us to recognise the "inverse care law" which seems to apply all over the world: the poorer and sicker a population is, the less the quantity and the poorer the quality of health care it will receive. Those who need most always tend to get least. It is possible to

break out of that negative correlation, as Tudor Hart showed in his own practice. But that took a great deal of work, in collaboration with his patients, the trade unions representing them, and his local authority.

Health is not the only field in which inverse care laws operate. Britain's top ten per cent of school pupils perform about as well as any in the world; but our bottom thirty per cent generally do worse than their counterparts in other developed countries. If you look at the resources devoted to the education of each group that is not surprising. Even our tax system takes proportionately more from the poor than the rich. While the public service professions are not entirely responsible for these patterns, they are deeply implicated in them.

The Millan Committee's report (2) on Scotland's mental health services and the Mental Health (Care and Treatment) (Scotland) Act of 2003 which followed from it contained paragraph after paragraph designed to protect patients from unjustified incarceration, unnecessary violence, covert medication, financial exploitation, sexual abuse and other painful and humiliating experiences. That was not because these things had become more common. It was because Bruce Millan's Committee was the first to include users of the mental health services among their members. They met repeatedly with them and the families caring for them, and listened carefully to what they said. Recognising the power relationships operating within mental health services, the Committee said every patient with learning disabilities or mental health problems should be entitled to the help of a free and independent advocate, and the Mental Health Act provided for that.

The professions dethroned

These conflicts had political implications which became clear when Margaret Thatcher's Governments made their assault on the public service professions. Royal Commissions and Committees of Inquiry were drastically reduced in number; trade unions and professional associations were disempowered; so were local government and the universities. These were the power bases of the professions. Nye Bevan had to negotiate for months with the B.M.A., the Royal Colleges and the top hospitals before he could put together the Bill that eventually created the N.H.S. Forty years later, when Kenneth Clark carried out the biggest reforms of the N.H.S. since Bevan's day, these bodies first heard about them with the rest of us from the "Today" programme.

When the public service professions turned out in the early 'eighties under the banners of their unions and professional associations to demonstrate against "the cuts", their patients, students, tenants, claimants and clients did not march at their side. When, in 1980, the T.U.C. mounted what was to be a big demonstration against the Government's assault upon the welfare state, hardly anyone turned up. They did not try again. Thatcher and her colleagues noted that – and pressed on. Determined to bring the providers of social services under closer control, they developed fairly coherent doctrines for this purpose.

The purchasing and providing of services were to be split; the state doing the purchasing and, wherever possible, commercial and voluntary agencies doing the providing. Services were to be contracted out to providers who had regularly to bid

for renewal of their contracts in a competitive market place. New plant, previously created by the state, was to be commissioned through private enterprises which rented schools and hospitals back to the state under profitable, long-term contracts. Other services remaining in the public sector were to be priced, evaluated and compared. More information was to be published about their performance. Their "customers" (as they were encouraged to describe themselves) were in various ways to be offered more choices between the various schools, surgeons or old people's homes available to them. The process has been taken further by Tony Blair's and Gordon Brown's Governments. "Individualisation", "monetisation" and "choice" are central characteristics of a system designed to increase the efficiency and accountability of public services by subjecting them to market disciplines.

There is a lot to be said for some features of this regime. It is helpful to us all if politicians, central and local, can speak whole-heartedly for the users of public services, instead of speaking mainly for their providers as they often have done in the past. It is useful to know what each service costs and what it achieves. But the market regime has provoked a formidable response from distinguished critics who deplore its other effects. Vivien Stern's magisterial analysis of prison services in many countries and the malign effects of commercial enterprise in this field is perhaps the most powerful indictment of "marketisation" within a particular service.(3) Embedded in Julian Tudor Hart's massive review of health care, informed by much research and a lifetime of clinical experience, is a passionate condemnation of the effects of market forces within the N.H.S. Allyson Pollock offers a well researched and more polemical attack on the same trends.(4) And, as I write, the current issue of *Soundings* magazine presents two articles by Peter Beresford and Sally Baker and others on social and community care (5) that criticise the effects of "… the Government's continuing commitment to the market agenda in public services." (6)

These, I think, are the main reasons for the anger of these writers.

1. Priorities for the care of patients, prisoners, social work clients and other "customers", and for the valuation of staff (now "factors of production") depend increasingly on comparisons of the costs they impose and the revenues they attract, not on the needs of service users, the quality of care and treatment provided, or the human potential of those who care for them.

2. The staff dealing with patients and social work clients tend to become more numerous, employed by larger numbers of agencies, and they turn over more rapidly (both on a daily basis and over the longer term). So they have less opportunity to work as a team and to provide continuity of care. Coordination of their work becomes harder, and no-one is really in over-all charge of a patient's care. Small but essential tasks (bringing a bed pan, asking why a patient isn't eating the food brought to her and finding some more acceptable alternative) get neglected because no-one is specifically paid to do these things or to check that they are done.

3. Information and the power it confers, gain a monetary value, so people become more reluctant to share it with colleagues who have become competitors. (Tudor Hart gives a telling example of Swansea hospitals whose managers acquired deliberately incompatible computer programmes.)

4. Monetisation and marketisation produce unattractive political effects (in the general sense of the exercise of power). For example: (a) Human Rights Law that applies to the public sector does not apply to private employers, so privatised staff lose rights and protections. (b) Employment contracts may forbid public statements about the work of the agency concerned, thus prohibiting normal contributions to public debate, and whistle-blowing. (c) Directors from the private sector sit on committees which make merit awards and offer other benefits – thereby muzzling their best-informed potential critics. (d) The practice of employing expensive press officers to vet all public statements from staff, and to create rapid rebuttal units to rubbish critics is becoming more common. (e) Many of the more aggressive operators in the private sector have got jobs in Ministers' private offices and as policy advisors, where they may have conflicts of interest that lead to further ill-judged expansion of the market ethos. (f) Politicians and senior officials may be reluctant to offend powerful enterprises to which they look for future employment. (g) Private sector "philanthropy" - by pharmaceutical companies for example which fund post-graduate medical education, expensive conferences in luxurious places, and so on - is used to advance the donors' interests.

5. Economic effects can be pretty dire too. Private sector agencies which gain a large enough share of their local market – eg. for nursing and residential homes – secure monopoly power which can make them impregnable. If their contracts were not renewed or their homes closed, no other provider could be found to replace them. They may nevertheless close homes at short notice if they find it more profitable to sell the property for other uses – housing, hotels, a retail park… In South East England rising land prices have often made that an attractive option.

6. The aims of what should be a public service become warped. The companies that provide private prisons, Vivien Stern shows, are always more concerned to get more prisoners, rather than to achieve better rehabilitation that would reduce prison numbers. The essential point being asserted is that the private sector has a set of commercial values – a morality – inappropriate for a public service. The private prison at Doncaster (by no means the worst of its kind, I am assured) provided toilets without seats or lids, and beds without pillows because their 25-year contract only required them to provide "toilets" and "beds and bedding".

7. Some recent research by Paul Gregg and others at Bristol University's Centre for Market and Public Organisation (7) suggests that the public service ethos encourages staff to help each other out and work unpaid overtime when needed. This brings massive extra resources to bear that would not be available if the same people worked in profit-making enterprises. "Our estimate … suggests that an additional 120 million hours are donated in the public sector compared with similar people working in similar jobs in the private sector. This is equivalent to an extra 60,000 people". (Which is interesting. But did they ask whether private enterprise gets harder, more disciplined work from its employees during the hours that *are* paid for? Less tea drinking? Less sick leave? We need to know the *net* effects.)

These are essentially progressive liberal criticisms of "marketisation" within the public services. Less often heard, but equally cogent, are some hard-nosed economists' criticisms. When a product succeeds in the private sector there are investors ready and waiting to meet rising demand by producing more of it – putting

less popular competing products out of business as they do so. But the state is not going to promptly expand popular clinics and schools and close down their competitors. It cannot clone the brilliant doctors and head teachers who made them successful. So more "choice" means that queues will develop, rationing of various clumsy kinds will occur; and we know which "customers" will be most skilled at finding their way through this jungle, and thereby exclude others less skilled at this game. Inverse care patterns will be reinforced, not eliminated.

In the private sector, more is better and "greed is good": more output, sales, customers and profits. In the public sector, "success" calls for fewer offenders and prisoners, fewer smokers and cancer patients, less litter to be picked off our streets and parks. The strategies required and the incentives to support them are quite different.

More generally, increasing reliance on the ethos of competitive markets tends to destroy the collective ethos – the social solidarity – fostered by a sense of shared citizenship and the mutual trust nurtured by such a culture; and mutual trust is a basic requirement of innovative and productive economies.

Looking beyond public versus private

I do not wish to contest anything said in the progressive literature. Indeed, I agree with most of it. But the things not said bother me. None of these authors – or many others writing in the same vein - give frank and serious attention to the failings of the public services. None recognise that the politicians who imposed market values on public services – often crude and destructive values –were contending with real problems that their electorates expected them to tackle.

Nothing is said about the massive proportion of any increase in public expenditure on our health and social services that is devoted to making life easier for the staff rather than for the service users; or the recurring failure to complete public projects within agreed deadlines and budgets. Nothing is said about our schools' and colleges' rejection and betrayal of the children of the less skilled working class – which would be regarded as scandalous in many other Western countries. As indeed it is. Was it acceptable that much of Scotland's new Mental Health Act had to be devoted to protecting patients from the mental health services? Anyone of my age has friends and relatives who have falls, strokes and hip replacements that take them into hospitals. Is it acceptable that so many of them, after (usually excellent) attention from the doctors, end up in wards where no-one will give them a wash or bring a bed pan when they need it, no-one will ask questions if they can't eat the food (just whisking it away uneaten), no-one sweeps the floor or cleans the toilets properly … and this in *teaching* hospitals, for God's sake. It's not surprising that hospital-acquired infections are so common. Some of these failures can be attributed to the spread of commercial values in public services. But not all of them. There are other hospitals which do an excellent job.

I could run on. We all could. But I hope I have said enough to make it clear that anyone who does not like the corrupting effects of "marketisation" must come up with other more convincing ways of tackling the failings of the public services, and of gaining for the public service professions the respect and support of the communities

they serve. Otherwise we shall end up with market incentives as the politicians' last resort.

To repeatedly stage discussions of our public services as an argument between those who believe that the state is always better than the private sector and those who believe that it is always worse is to insult the intelligence of both: an Orwellian chant of "Four legs good! Two legs bad!", and vice versa. Governance is a more complex affair than this. Different services respond to different incentives and call for different kinds of management. Meanwhile this formulation of the issues rules the increasingly large voluntary sector out of the discussion altogether. Are we really sure that housing associations are always worse – or better – than Council housing services? Are we sure that Mountain Rescue, or the Lifeboat Service would work better if taken over by the state or by the private sector from the voluntary organisations that run them?

Making the public service professions accountable

There is not space in the closing pages of this paper to explore alternative regimes with the care they deserve. But we can briefly sketch the territory that needs to be explored. We should be looking for ways of making the providers of public services more efficient, more effective, more accountable and more humane – noting that these objectives will often conflict.

We should be asking questions about widely differing scales of action. Some of the issues to be considered are *strategic and nationwide*. (How can we get much of the work now done in hospitals out into primary care and intermediate units that will be closer and more accessible to the people who need these services?) Some will be focused on *institutions*. (How do we prevent covert social selection of pupils entering secondary schools paid for by the state? How do we give residents in care homes adequate security of tenure?) Some will be focused on *individuals*. (Who will speak up for the elderly lady in a hospital or care home who cannot get a bed pan or a wash when she needs that?)

We need to think of accountability that runs *upwards* to Ministries, Ministers and ultimately the electorate (Is the money honestly and efficiently used? will be one of the questions they will ask); *downwards* to service users and their families (Are the school meals nourishing? - eatable? – and eaten? Do patients feel better or worse after a course of treatment?); and *internally* to staff of the service and their governing authorities (Are rates of pay and pensions adequate? Are there fair and effective arrangements for dealing with whistle-blowers?).

We have already devised many procedures for these purposes. Each deserves a book to itself. Indeed, several already have one. To simplify and sharpen this brief discussion of them I will focus on a key question, asking of each procedure whether it is likely to strengthen our role as citizens: citizens with duties as well as rights, who share a collective concern for the needs of our fellow citizens, and for the general improvement of the public services that each of us may some day have to depend on. If we rely only on the individualistic incentives appropriate for customers in a competitive market we shall be led in socially destructive directions – provoking

more social conflict, wasting more human potential, excluding more marginalised people, and reinforcing inverse care patterns.

1. Public service managers have, through politicians, some general accountability to the users of their services and the electorate at large, and politicians have incentives to seek the improvement of services for all voting citizens; which is important. But managers have much closer encounters every day with spokesmen of the public service unions and professional associations. If their members withdraw their labour the service collapses: there is no alternative source of supply. So political accountability tends to be sporadic– too often prompted by scandals, such as the death of a child, which are apt to produce panicky and clumsy responses.

2. What countervailing power do the users of these services have? The complex and slow-moving legal procedures available (litigation and compensation, appeals to ombudsmen of various kinds, and to professional authorities such as the General Medical Council or the Law Society) are most likely to be used by the more confident and well-heeled service users – which helps a bit, but may reinforce inverse care patterns. Staff can guess who is likely to use these strategies, and who can be neglected with impunity.

3. Consultation with representative groups of service users has been a favourite prescription for many services. But the influence it exerts has not been impressive. Consultative groups often begin well, but they tend either to peter out, or to get coopted by the professionals. (8) More radical strategies of community *ownership* may take us further. But what works for a small housing association, owned by its residents, cannot be easily transferred to a hospital or a university.

4. Feedback surveys asking service users about their experience of the services they depend on are becoming more common. But we need to ask, Who framed the questions? Who analysed the results? And how fully and freely published were the findings? Unless users of the service were involved in all phases of this work such surveys tend to become yet another way of protecting and defending the management.

5. Social care services of various kinds are now increasingly encouraged to offer their clients individual budgets or direct payments. These are slightly different procedures, but similar in giving public services the duty to assess people's needs and resources and allocate a budget to each of them; then leaving them to select their own providers and make their own arrangements with them. This is a pure market model which makes the service users the hirers and employers of those who help them - but with the crucial difference that the state decides who needs most help. These systems can work pretty well for people with physical disabilities who are supported by loyal and well organised families. More isolated people, and those with considerable mental health or learning difficulties need good support if they are to understand the choices available and make good use of them. Without that, the system may be used to meet the needs of the public authorities, not those of their "customers". This idea originated on the far side of Canada where the families who invented it (for their children with learning disabilities) insisted on getting independent, expert advice from someone – "brokers" they called them – who could help them get the best deals to meet their particular needs. We seem to have imported the system without recognising how

important the “brokers” are. There is a danger that it will create two-tier standards, giving the best treatment to those best able to choose and manage their own caring services while others have to make do with whatever they are given.

6. Stuart Weir and his colleagues (9) argue that human rights laws should now be extended beyond civil and political rights to cover economic and social rights. Where test cases are picked that can confer benefits on much larger numbers of people this strategy can strengthen social solidarity. It worked as a way of compelling the Prison Service to bring slopping out to an end in jails throughout Britain. It is a strategy that attempts to address the collective and competing needs of all citizens. But it operates slowly and will be more effective in tackling large-scale issues (the right to work, adequacy of social benefits, protection from homelessness…) than the plight of a crippled old lady lying in a hospital bed who cannot get anyone to bring her a bed pan. Who would take up such cases? Some trade unions have a good record of helping their members get their rights from public services. But it’s their *members* they work for, not the unemployed; or the old lady. And their members may be precisely the people who are failing to bring the bed pan.

7. We must not forget that the professions themselves can take the initiative in helping people gain their rights from public services. Planning Aid, the charity set up by town planners, provides support and advice for people coping with the system they administer during their working day. It does an excellent job with the help of well-trained volunteers subject to the usual professional disciplines. Housing managers did something similar in creating TPAS – the Tenant Participation Advisory Service – to support people living in social rented housing who wanted to play a part in the management of their housing. Lawyers do pro bono work without charge from time to time which may help clients dealing with public authorities. Should doctors, nurses, social security officials, teachers … be doing something similar?

8. I have already mentioned the free and independent advocacy service for people with mental disorders introduced by the Mental Health (Care and Treatment) (Scotland) Act of 2003. Hector Mackenzie, an official of the Scottish Health Department who played a key part in getting advocacy into the Act, challenged his colleagues in other Departments to contribute to a budget that would fund an advocacy service to help citizens dealing with *any* public service in Scotland. They refused. But his challenge has not gone away, and the new service is in fact expanding in various directions to serve other kinds of clients. If we go further down that road, other questions arise. Will every service need its own escorting advocacy agency? Or should one be developed to provide for all needs? Which? – The CABx…? Would such a development reinforce the customer ethos (get yourself an advocate to get your mother into the *best* old people’s home, your daughter into the *best* secondary school)? Or could it help to rebuild a citizen ethos? Individual advocacy helps people to cope a bit better with the existing system. It is when people who share similar experiences of a public service get together that they start thinking of new and better ways of doing things and pressing for changes. They have the authority of hard-won experience. And they all have votes. There are groups of people with mental health or learning difficulties who have an impressive list of battle honours in helping to improve the services they depend on.

9. We have too readily assumed that “community care”, now replacing institutional care for so many people, means sending professional staff out to help them in their own homes instead of in hospitals, children’s homes or old people’s homes. But *real* community care begins when neighbours and relatives provide more of the support that frail and vulnerable people need. They are more likely to do this when advised and supported by good professionals. The public service professions will still be needed – but doing a rather different job. Sixty per cent of N.H.S. expenditure is devoted to long term conditions: diabetes, HIV, schizophrenia, dementias…. That means there are thousands of people out there who often know better than the doctors how to manage their condition and certainly have more time to devote to patients newly diagnosed as having it. Many of them have already formed groups set up to help fellow patients. Those groups can have an advocacy role. By working with them we may do more, and at less cost, than by expanding clinical services. It was Graham Watt, Glasgow University’s Professor of General Practice, who said “We have to teach the professionals to ask, not “What do I do?” but “What am I part of?”

In conclusion

Within the limits imposed on them by their duties to the state, how can public service professions become more accountable to the people they serve – treating them, not as self-seeking customers or subservient subjects, but as responsible citizens and collaborators: co-producers of health, education and welfare? How can they avoid becoming agents of oppression, social division and exclusion? Some services will have to learn a whole new culture, from top to bottom, if they are to take down the barriers - literal and psychological –which they have built to protect themselves from the people they are supposed to serve.

Can we create a widely respected public service ethos among the professions that helps them to become more strongly rooted in the communities they serve? If so, when their services are again drastically cut back (which could be any day now) the patients, the pupils, the tenants, the claimants and social work clients may be out there marching alongside them.

David Donnison develops these ideas in his book about advocacy, *Speaking to Power,* to be published by Policy Press in June 2009. A revised version of this paper is to appear next year as a chapter in *Active Citizenship,* edited by Andrew Lockyer for Edinburgh University Press.

Notes

(1) Julian Tudor Hart**,** *The Political Economy of Health Care. A clinical perspective,* Bristol, Policy Press, 2006.

(2) The Millan Report: *New Directions. Report on the Review of the Mental Health (Scotland) Act, 1984*. Scottish Executive, 2001.

(3) Vivien Stern, *Creating Criminals. Prisons and people in a market society,* Zed Books, 2006.

(4) Allyson Pollock, *N.H.S. P.L.C. The Privatisation of our Health Care,* Colin Leys, 2004.

(5) Peter Beresford, "Whose Personalisation?", and Sally Baker et al., "The Rise of the Service User", *Soundings,* Issue 40, Winter 2008.

(6) *Soundings* editorial. Issue 40.

(7) Paul Gregg et al., "How Important is Pro-social Behaviour in the Delivery of Public Services?" *CMPO Working Paper* 08/197, Bristol University.

(8) David Brandon's *Innovation Without Change. Consumer power in psychiatric services,* Macmillan, 1991, discusses these patterns in the mental health services.

(9) Stuart Weir, *Unequal Britain. Human rights as a route to social justice*, London, Politico's Publishing, 2006. For a later and more global analysis of the philosophy and practice of human rights law, see Peter Bailey, *The Human Rights Enterprise in Australia and Internationally,* London and New South Wales, LexisNexis, 2009.