Accountability in the Public Sector applied to Municipal Social and Health Care

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ABSTRACT

Accountability in the public sector applied to municipal social and health care.

Demanded and desired accountability in result-oriented and performance-based management plays a large role in the delivery of service to the public sector. The aim of this study was to analyse the concept of accountability in theory and to apply it to the municipal context in Finland. In this study the application model of accountability was formed to municipal social and health care. Also this study showed that the four types of accountability relationships in the field studied are utilized similarly but with different emphasis. It can be concluded that the municipal and social and health care context create tension and complexity between accountability relationships. Demands and pressures to achieve expected performance can divide administrators into two groups: winners and losers. The outcomes of accountability have to be seen in a wider perspective, even a social one. Therefore it is very important to develop and examine the means and the measures of performance that will help to define and place in context suitable goals with proper evaluation of the expected level of accountability.

Keywords: accountability, public sector, social and health care, municipal organizations.

INTRODUCTION

The interest in this paper is accountability in the public sector, especially in the municipal context. Accountability is important in administration because of the efforts, programmes and strategies made to gain efficiency in public services. To improve resource allocation, new actions have also been implemented in Finnish municipalities. The most important of these are co-operation with other municipalities (Hirvonen 1997, Kaivo-oja ja Rajamäki 2001) and the third sector (Aronen 1994, Helander 1999), low administrative structures (Hoikka 1991), contracting (Kettunen 1999), management by results (Meklin 1991, Möttönen 1997), team organizing (Vainio 2000), delegation of decision-making (Mäki-Lohiluoma ja Hartikainen 1993), privatization and incorporation (Aronen 1994, Valkama 1994).

To provide quality health and social services, changes in structures have also been made in the United Kingdom. In Manchester the National Health Service (NHS) stimulated more effective co-operation by creating Primary Care Trusts (PCT), which offer local people greater involvement in health service decision-making and the benefit of local solutions to local health problems. The PCTs have a responsibility to use resources to the best effect and to explain their decisions. (Consultation 2000).

Surveys of accountability and continued discussion about accountability are common in the USA. In 1997 the Missouri legislature passed a law that addresses primarily the Department of Insurance rules and regulations for health maintenance organizations (HMOs). Under the Department of Health (DOH) a managed-care advisory committee determined the appropriate plan for fulfilling the intent of the law; among other things, their task was to select quality indicators. (Managed Care Organizations and Qua-

lity Indicators 1999). Associations, for example, The Society of Thoracic Surgeons and The American Association for Thoracic Surgery, gave their opinion about accountability, recommending that Medicare should act as a catalyst to stimulate new approaches to health care centred on patients and their needs through the power of accountability. (Accountable Health Care 1998).

Kathryn E. Newcomer (1998) surveyed the current role of the inspector general in federal agencies (USA) in the maintenance of accountability of federal programmes. In an environment of declining resources, result-oriented management led to contradictory behaviour among inspectors general, who had to please both executive and legislative masters. Furthermore, M. Katherine Kraft and Irene R. Bush (1998) studied public welfare services and service quality from the consumer's perspective. They proposed a public welfare system that empowers workers to be accountable to consumers; this is known as a consumer-focussed perspective. (Kraft and Bush 1998).

Professor Barbara Romzek, together with several colleagues, has examined the concept of accountability in public administration. First, in 1987 the much publicized Challenger Tragedy, concerning accountability NASA's technical and managerial problems were demonstrated to be a result of efforts to respond to legitimate institutional demands. (Romzek and Dubnick 1987). In addition, in the study of the Ron Brown plane crash, the main conclusion of accountability dynamics was that the institutional and managerial conditions encouraged entrepreneurial behaviour; but when things went wrong, the administrative reality still emphasized a risk-averse, rule-oriented approach to accountability. (Romzek and Ingraham 2000).

In the 1990's new management strategies appeared, i.e. self-managed teams, shared power, empowerment, participation, re-engineering, partnership and privatization (Thompson 1998, Sanders 1998). Well-known examples of these procedures are President Bill Clinton's National Performance Review (NPR) in the USA (Arnold 1995, Kamensky 1998) and Prime minister Margaret Thatcher's re-inventions in the UK. In fact, previous foreign studies have shown that applications of accountability have been adapted more to the military system than to social and health care. The social and health care field and the Finnish municipal context give different empirical dimensions to accountability.

Concerning accountability a discussion has arisen on an important issue: measurement of performance. For example, Ronald A. Gabel, M.D. suggested that participation in a programme for measurement of performance should be a requirement for physicians in order for them to be allowed to provide patient care. (Gabel 1999). In the USA in a workshop for state and local health officials there was a broad discussion about measurement of performance (Ensuring Quality Health Care 1997). Publicly financed health programmes are being asked to account for their performance, and the methods of performance measurement have emerged as essential tools for operationalizing this quest for accountability (Perrin, Durch, Skillman 1999).

The aim of this study was to describe the theoretical analysis of accountability in the public sector and to form an application for use in municipal social and health care in Finland. The application was based on author's view, understanding and long experience in municipal context and in social and health care. Concerning method the study had subjective perspective. The approach of this study is administrative, while other approaches have been, for example, linguistic, philosophical, economic and social. The focus of administrative accountability in the field mentioned is interesting and important, because accountability with increasing expectations is demanded from administrators and from social and health professionals. Another reason for the importance of this article is that studies and applications of accountability in social and health care in Finland are still scarce.

PUBLIC SECTOR ACCOUNTABILITY

Nowadays, an often used word is accountability, which is connected to result-oriented management, to performance-based management and to responsive organizations. In a fundamental sense, accountability refers to answerability and means that somebody is responsible to someone else for expected performance (Romzek and Dubnick 1987, Romzek 1998, Johnston and Romzek 1999, Romzek and Ingraham 2000). It is important to note that preset expectations of performance are required and monitored, and

controllers are interested in the acts performed to achieve goals.

The four types of accountability relationships are based on two dimensions: autonomy and control/expectations. (Figure 1). The degree of autonomy is either low or high, and the source of control is internal or external. The low degree of autonomy reflects the controller's ability to determine the range and depth of actions which a public agency and its members can take. The high degree of autonomy provides the use of wider discretion by a public agency. Internal control means hierarchical relationships and informal social relationships with an agency. External control appears in formalized arrangements set forth in laws or legal contacts by interests located outside an agency. (Romzek and Dubnick 1987, Romzek 1998).

There are four types of accountability relationships: hierarchical (bureaucratic), legal, professional and political. (Figure 1). Hierarchical accountability relationships are based on tight supervision to meet the standards of performance. The expectations of public administrators are managed by focussing attention on priorities set by top bureaucrats. Obedience is highly respected behaviour and efficiency is an emphasized value. Subordinates are expected to follow orders without questioning, and this is confirmed with regulations, rules, standard procedures and organizational directives. The relationship between controllers and the controlled is based on the ability of supervisors to punish or reward subordinates. As noticed in hierarchical accountability, the degree of autonomy is low. (Romzek and Dubnick 1987, Romzek 1998, Johnston and Romzek 1999, Romzek and Ingraham 2000).

Legal accountability has features similar to hierarchical accountability but dissimilar to control, which is external. The controller outside is in a position to impose legal sanctions or assert formal contractual obligations. External detailed oversights and close scrutiny of performance are checked by contracts, fiscal audits, legislative oversight hearings, inspections and court proceedings. These outsiders make the laws and policy mandates, which the public administrators are obligated to enforce or to implement. Thus, the behavioural expectation is compliance with externally established mandates, and the value of accountability is the rule of law. The relationship may be described in the following way: lawmaker (controller) and law executor (the controlled, administrator). (Romzek and Dubnick 1987, Romzek 1998, Johnston and Romzek 1999, Romzek and Ingraham 2000).

The degree of control over agency actions in professional and political accountability is low; in other words, the degree of autonomy is high. Trust in workers' problem-solving ability and wide discretion are typical features of the professional accountability relationship in an organization. This is obvious because governments deal increasingly with technically difficult and complex problems. Public administrators and officials have to rely on skilled workers to provide appropriate solutions and managerial responses and to do the best job possible. Otherwise, if they do not

Source of Control and/or Expectations **Degree of Autonomy**	*Internal*	*External*
Low	Hierarchical	Legal
High	Professional	Political

Figure 1. Types of accountability relationships. (Romzek ja Ingraham 2000, Johnston ja Romzek 1999, Romzek ja Dubnick 1987).

meet the job-performance expectations based on professional norms, best practices and accepted protocols, they may be fired or reprimanded. Thus expertise and experience are strongly valued, and behavioural expectation is deference to individual judgement and expertise. In the professional accountability organization the key relationship is that the manager is the controller as a layperson and the controlled workers are experts. (Romzek and Dubnick 1987, Romzek 1998, Johnston and Romzek 1999, Romzek and Ingraham 2000, compare Kearns 1994).

Under political accountability, the answerable party has the discretion and choice to respond to key stakeholders. In the public sector in the terms of accountability, the answerable party is called representative, meaning that administrators and controllers are called constituents such as the general public, elected officials, agency heads, clientele groups and other special interest groups. The main characteristic of the political accountability system is responsiveness; in fact, administrators are expected to anticipate the wishes of key stakeholders and to respond to their policy priorities and programmes. The previous statement reflects an emphasis on customer-oriented service and responsiveness to the client. Customer-orientation encourages more open and representative government, which leads to transparency of administration and governmental programmes. (Romzek and Dubnick 1987, Romzek 1998, Johnston and Romzek 1999, Romzek and Ingraham 2000).

Turo Virtanen (1997) examined the relationship between financial autonomy and the accountability of public managers. It was found that managers were more accountable to tax payers, the ministry, the Government and Parliament, while workers were more accountable to customers. As a conclusion it was noted that an increase in financial autonomy does not lead to stronger political accountability as such. (Virtanen 1997).

THE CONTEXT OF THE STUDY

This study is placed within the context of municipalities and social and health care in Finland. First, the main responsibilities of municipalities are to organize services for citizens and to secure welfare. The arrangement of services also means financing them by municipalities. Second, municipalities have the right and possibility to decide whether they will deliver services themselves or buy services from other organizations such as other municipalities, non-profit organizations, private firms, parishes and even the citizens themselves.

Every year the municipal budget is a complicated issue of discussion in municipal councils. The largest proportion of the budget is for social and health care; average expenditure is 44 % (Kunta ihmisten yhteisö 2000). Also, from 1975 to 1998 in social and health care the average expenses per citizen have increased (Valtonen and Martikainen 2001, 22-23). So it is quite clear that allocation of resources and outcomes of care are expected. Citizens want value for their tax money in the form of good social and health services and better customer-oriented management procedures.

Furthermore, municipal social and health care organizations in Finland are classified as professional organizations. In the application of accountability to Finnish municipal social and health care, it is good to perceive the features of professional organization. According to Henry Mintzberg (1989), the context of professional organization is complex yet stable and bureaucratic yet decentralized. Its structure consists of the skills of its many operating professionals, autonomy and subjective control of profession; and because of its diversity, controlling and monitoring are used as means of coordination. Strategies are made based on professional judgement and collective choice. The advantage of the model is democracy and autonomy; however, the disadvantages are problems of coordination, the misuse of professional discretion and reluctance to innovate. (Mintzberg 1989, 173 - 195).

Finally, from the standpoint of this study, a notable aspect is the politico-administrative feature of municipalities in which a municipal community contains both political and administrative organizations. The political organization represents citizens by representative democracy, while the administrative organization is responsible for implementation of actions and measures in practice. A municipal council elected by citizens is the highest decision-making organ. In this application of Romzek's model, councillors and top managers are seen as stakeholders in different relationships of accountability.

APPLICATION TO FINNISH MUNICIPAL SOCIAL AND HEALTH CARE

The model of public sector accountability made by Professor Romzek and her colleagues was selected as an approach in this study. Theoretically, Romzek's model is based on two factors, source of autonomy and source of control, from which accountability categories are formed. For its open system and cycle characteristics, it gives the freedom to analyse and to apply the model in a complex context. In other words, it is clear, simple and flexible, and concerns the public sector; this is why it is suitable and reasonable for use in application to municipal social and health care.

Hierarchical accountability in social and health care.

Social and health care organizations are characterised as hierarchical and bureaucratic structures, which are steered and controlled by several rules, regulations and directives. These rules deal with administrative procedures, authority, budget, manager-worker relationship and supervision. Administrative procedures are like a pattern where all the participants know the steps and therefore are able to cope with all participants. These procedures (forms and applications, working agreement, managers' decision catalogue etc.) are planned to keep the social and health care organization in order and in control; on the other hand, a formality (formal agreement) guarantees equal and predictable management. In fact, a manager has the privilege and the ability to punish or reward, of course, within the limits of authority. By obeying administrative procedures, the social and health care organization and its workers are hierarchically accountable. (Figure 2).

Authority is connected to one's profession and educational level, which is confirmed by administrative rules; in addition, authority is delegated and includes permission to reach solutions and decisions. So doctors, with their higher level of education, have more authority in care decisions than nurses do. In the social field the divisions for social workers are more restrictive in terms of authority in decision-making, which may be due to subjective rights included in social care laws. The chain of authority can be described from bottom to top as follows: patient - assistant - nurse - assistant nurse - ward nurse - head nurse - doctor - head doctor - chief of a department - agency manager - social and health care board - municipal government - municipal council - provincial government. The question is: Even though each of these has a certain authority, who is ultimately responsible?

The municipal budget in social and health care is defined and accepted by the municipal council, and it is expected that the accepted budget will be followed. During the budget year any exceptions have to be presented separately to the council, and the presenters must wait for permission to act. Nowadays municipalities have difficulties with their economies, so obedience in implementing the budget as planned is demanded. It is not rare that social and health care expenditures overstep the accepted budget in fields like special nursing, subjective services for the handicapped, care of the elderly and income support. Experts are wrestling with problems, either to provide services for citizens or to keep the budget under control.

A manager - subordinate relationship stands on a base of obedience. Commonly, in social and health care, the manager tells the staff what to do and the subordinates just carry out tasks. On a ward the doctor defines the patient's care with all its medication and treatment measures, and nurses implement this care. Ordering and commanding is used in management although new management strategies, as stated in the introduction, are available. In social and health care, a hierarchical system of command is used over a long time; changes are hard to make because of the strong and established cultural elements of organizations. In hierarchical organizations the main questions concerning changes often deal with power.

To guarantee coordination managers must supervise and control everything: complete and incomplete tasks, the ways tasks are done, the chain of authority realized step-by-step and so on. A control system as coercion includes a system of reward, an information system and technical observation systems. In social and health care, working hours are supervised, results and the measures of patient work are written in computer systems or in manual documents, a manager checks employees' work, and permission is

required for everything. In one way, a salary system is used as an attraction, and money incentives are expected to raise willingness to follow commands and sanctions. The hope of getting extra money depends on workers' loyalty and on their relationship to the manager, where it is often a question of factors other than competence.

Legal accountability in social and health care.

In Finland the municipal law defines obligations such as arrangements of services and securing of welfare. Municipal law acts on a common level, but special laws with special substances provide measures in social and health care. Most of the laws in the social field are known for providing subjective rights for citizens, which means that the requirements and criteria of the law are met, citizens are privileged and justified in having a service. Such services are day care, certain services for the handicapped and mentally handicapped. The health field is different; there services are based on needs, and in satisfying these needs consideration is still used. Only exception is the right to urgent care. Those who have the authority to use consideration are the key people who affect the expenditures of a municipality. Worth noting is that an accepted municipal budget defines needs. This means that what is included in the budget is a confessed need, and in reality needs may be larger than available resources. (Figure 2).

In difficult economic situations, municipalities are forced or steered to look for new sources of finance, where The European Union, European Social Foundation, The Regional Councils (Maakuntaliitot), Employment and Economic Development Centres (TE-keskukset) and Labour Offices are seen as possible candidates. Usually project finance is not granted to basic and law-defined services of municipalities but to other developmental projects. The economic situation, budget balancing and changed conditions and needs are the reasons why there are several projects going on in municipalities to deal with social problems; in the background there is the idea of synergetic benefit. For such projects, municipalities are accountable to a finance organization to deliver the intended actions, to inform separately about exceptions and to book expenditures and incomes accurately with evidence.

Municipalities have the right to organize their economy, administration and action independently. Social and health care services may be contracted in ways where the organization of social and health care may buy services such as nursing home services, supportive services for the mentally ill, home services, etc. It may also be productive in the economic sense while services, such as services for mentally handicapped, occupational health care, services for drug users, nursing home services, therapeutical services and etc., are sold to other municipalities. In this case the role of a municipal social and health care organization varies from superior to subordinate in terms of expected behaviour. Besides the public organizations, the third sector plays an important role in organizing services. Network with different groups increase pressure to avoid overlapping of services, to maintain fluency in delivery of services and to prepare the necessary documentation.

Even in the 1980's long-term plans were used that were dictated by the state, where precise instructions were given, what to do in social and health care. Despite environmental differences the same method was demanded in every municipality. The ministry concerned and The National Board of Health closely supervised plan implementation. In the end of the 1990's municipalities had independence in municipal administration. Now The National Research and Development Centre for Welfare and Health (STAKES) and The Association of Finnish Local and Regional Authorities (Suomen kuntaliitto) oversee and direct municipalities by providing information and recommendations. The Finnish judicial system with court lawsuits is the citizens' means to solve unclear and contradictory administrative decisions concerning municipal social and health care. The judgements handed down concerning such complaints outline the interpretation of laws.

Professional accountability in social and health care.

Many professionals and experts provide and deliver various services in response to increasing demands. These workers are the key to decision-making about care; and their preferen-

ces, professional frames, experience and expertise dictate the utilization and the width of the care alternatives used. And it is important to note that they decide who is taken care of and to what degree. So it is evident in a complex context that professional organization managers are unable to control everything by themselves. In professional organizations managers are seen as laypersons and workers are seen as experts, so it is clear that workers' loyalty and trust is a widely respected value. Managers have to trust that doctors and social workers make and are able to make the "right" decisions according to accepted organization policy. In fact, social and health care decision-making is connected to the use of money, the implementation of organizational main visions and the key tasks of an organization. (Figure 2).

The touchstones of an organization are its organizational ideologies, legends and professional ethics, which cause cultural confusion and sometimes even resistance and disobedience. The ethics of professions are very powerful in social and health care because they are formed over time beginning with schooling and ending in practical work with a mature professional identity. Expressed briefly, professional ethics includes rules and ways of realizing a certain social and health profession, in other words, what is valued as a desirable behaviour. Nowadays workers to a growing extent face contradictory situations where the need to care for a client is weighed against money. Anxiety is caused by knowing a client's (patient's) possibilities for care and the force of a restrictive finance policy. Care of the elderly is the focus of the discussion: is it really necessarily to operate on an elderly patient in a certain health situation, and is it productive and effective considering both the economic and the total benefit?

Professional ethics and maturing of professional identity are strong elements which are used to improve cohesion in professions. Despite improvements in cohesion, it may put obstacles and boundaries on professional co-operation. In social and health care some are afraid that another profession will take away or even steal something belonging to their profession, for example, professional working methods and professional theories and concepts. This type of competition occurs all the time and it may also appear as competition for clients (patient) and lines for treatment and consulting hours. The question reflected in the background is: What profession is the most important for obtaining clients? Who is the most powerful and who has enough authority?

Political accountability in social and health care.

Responsive organization is the word of the day, containing the ability to respond quickly and flexibly in a changing environment. This tendency is strengthened, as at the same time independence and self-government by laws have grown in municipalities. Municipal services are financed mainly by citizens' taxes, so the payers are the controllers. In Finland the payers are represented on councils and boards by elected councillors. For the politicians and citizens, social and health care experts are accountable for good and available services based on observed and apparent needs, which both administrators and politicians observe. Thinking in terms of customer-oriented municipal service, the administrators are in between politicians and clients, struggling in the cross-fire. (Figure 2).

Every year in municipal budget procedures administrators and politicians are wrestling with the problem of what can be accomplished with a certain amount of money. Reality is that budgets are unbalanced and municipalities have problems even to arrange services which are defined in laws. The Board of Social and Health Care, with the co-operation of administrators, sketches and sets goals and allowances, which become binding and must be obeyed and followed under the boards and council. Policies are expected to be implemented, and a stream of questions is presented if they are not.

Social and health care professionals working in a certain field may disagree about the goals set by managerial administrators and politicians. In Finland municipal workers and politicians have different opinions about citizens' needs for social and health services (Niiranen and Kinnunen 1997, 196 - 200) and the citizens' participation in these services (Niiranen 1999). Professionals frequently see their own field as the most important and they look at goals from their own professional viewpoint, and often some dispute and quarrelling is expected. It is important in this competition among professionals for a particu-

lar group to become heard, that they present strong evidence and arguments for needs, goals and strategies such as calculations of costs and benefits, figures for needs. The dilemma is who to believe: administrators, professionals, clients, politicians or scientists? It has been found that in municipalities there have been problems in mutual contacts between the elected representatives and the employees, but there has been a desire to improve these contacts (Niiranen and Kinnunen 1997, Niiranen 1999).

Furthermore, responsiveness is another factor that causes trouble. In constantly changing circumstances workers, etc. are expected to change quickly; simultaneous development is expected as self-evident and belonging to workers' characteristics and abilities. Here the question may be asked: Is individuality mostly lost? Besides result-oriented management, there are also fringe phenomena in Finland, such as the often repeated expression "Tulos tai ulos" ("Get results or leave"). This illustrates two extremities where no middle way is accepted.

DEDUCTIONS OF PUBLIC ACCOUNTABILITY IN SOCIAL AND HEALTH CARE

As described briefly and applied above, accountability in social and health care differs

Source of Control and/or Expectations **Degree of Autonomy**	*Internal*	*External*
Low	**Hierarchical** Administrative procedures Authority Budget Manager-subordinate relationship Supervision	**Legal** Municipal law Social and health care laws Contracts with public organizations, private and third sector Projects with EU, ESF etc. Public recommendable oversight
High	**Professional** Experts and professionals Approved practices Professional identity Professional ethics Professional culture	**Political** Responsive organization Priority-selection Customer-orientation Municipal council and board policies

Figure 2. Accountability relationships applied to municipal social and health care.

from military accountability in the types utilized and the emphasis on these types. Researchers studying the plane crash demonstrated that in the military system one or two accountability relationships (hierarchical, professional) are utilized on a daily basis (Romzek and Ingraham 2000, 242). It was also stated that in times of reform there is often a shift in emphasis and priority among different types of accountability (Johnston and Romzek 1999, 387, Romzek and Ingraham 2000, 242). It is important to notice, however, that the context of their study differs from the issue in this paper; the military organization is known for its rigid hierarchy and orders. This leads to the conclusion that in this situation there are not many options for flexibility in accountability. Considering military organizations as a stable and simple context working with bureaucratic procedures, the results of the accountability relationship are quite predictable.

This study revealed that the application of public sector accountability to social and health care shows the complexity of accountability demands and growing pressures at work. Professionals are in the tense position of having to stand up to pressure with a possibility to fall into one of two categories: winners and losers. Also in the case of the military accident, a gap between rhetoric emphasizing entrepreneurial behaviour and the reality of risk-averse accountability culture in administration caused a situation where a single error could be fateful to a career (Romzek and Ingraham 2000, 249-251).

It can be concluded that in municipal social and health care all four types of accountability relationships occur simultaneously, but with a different emphasis each day. In the health care field, professional accountability is stressed most with interaction of hierarchical and legal accountability while political accountability remains in the background. In social care the emphasis can be a quite similar utilization of legal, hierarchical and professional accountability where political accountability is seen as broadly directive. In the minds of workers and administrators, political accountability directs actions concerning clients as tax payers and politicians as stakeholders.

Here more evidence and arguments are shown with examples. A client arrives at a doctor's consulting hours with a health problem. While making a decision about the client's care, the doctor considers the following things more or less deeply. First, the viewpoint of professional accountability is considered: Does the client's health problem require care; if so, at what level will care be delivered, and does the doctor's care decision follow medically approved practices and procedures? Are the criteria of a care decision based on the doctor's own preferences or on organizational ones? Does the doctor follow the ethics of his profession?

Second, the doctor may think about what kind of procedures the care decision leads to. Is a prescription, a medical remittance or a medical certificate needed? Does the doctor have to contact some other profession to organize care? An organization may also have its own common approaches where the doctor's decision must be confirmed by a superior expert, for example, a head doctor. Here hierarchical accountability is utilized. Third, special laws in health care direct the decisions made; these facts are observed constantly. Does the client's need fill the criterion of laws? The consideration of laws means the weight of legal accountability. Lastly, while making the decision about the client's care, political goals are hardly in the doctor's mind rather than serving the client properly. Customer-oriented service and accepted goals are directive measures of action which influence the doctor's decisions continuously and are considered as a totality.

In social care the discipline of following laws is greater than in health care, partly because of their character as subjective rights. An example is given here. A social worker meets a client with a need for income support. As a first action, the expert evaluates whether the client's needs fill a criterion specified in the law and in what parts; then he/she thinks about whether there are any applications that have to be made or convincing evidence that is important to prove need, what organizational procedures come into question, and after this he/she makes a written decision about the case. By taking these actions, the social worker faces legal and hierarchical accountability relationships. At the same time the expert's professional accountability meets the ethics of the profession and accepted practices. The political accountability, however, is similar to the doctor's case.

CONCLUSIONS

Many re-inventions are made in the public sector in the form of re-engineering: result-oriented management, performance-based management, lower organizational structures, empowerment, participation, team work etc. With these reforms accountability becomes demand due to increased authority; it may be said that accountability is monitored as a value for authority. The aim of this paper was to analyse theoretically the concept of public sector accountability developed by Professor Romzek with her several colleagues and to apply it to the municipal social and health care in Finland.

As described and demonstrated above, in the municipal social and health care accountability appears more complex than in military organization. All four types of accountability relationships are utilized but with different emphases. The pressures to cope with demands has grown to the extent that experts and administrators may be divided into two classes: winners and losers. In health care the emphasis is mainly on professional accountability with interaction of hierarchical and legal accountability, while in social care legal, hierarchical and professional accountability are utilized similarly. In both fields, political accountability exists in the background and is broadly directive.

We can consider the consequences of the increased pressures and demands caused by accountability. Does this mean that the experts have to be the same, and does it force professionals into the same mould? The reality is that workers have different working skills and differing capacity to deal with work assignments and to cope with environmental changes. Important aspects such as work satisfaction, work management, quality of services, number of results, performance achievement, approval of innovations, demands for professional education and competition among fellow workers and managers are then highlighted. What is valued most, and for what price, depends on an individual's own preferences.

Another important dimension is flexible accountability with delegated authority. Do workers in social and health care really have professional freedom to make decisions or is bureaucratic approval by a superior still necessary? According to researchers, in the military system, administrative reality further emphasized a risk-averse and rules-oriented approach in conflicts while it encouraged entrepreneurial behaviour (Romzek and Ingraham 2000, 249-251). But application of new management styles in the municipal context is not unambiguous. For example, in the application of management by results, a contradiction was found between the goals of management by results and the policies of the politico-administrative system (Möttönen 1997).

Since the 1990's the economic situation of municipalities has been critical, and it is known that savings and huge cuts are being made in the hope of obtaining a balanced municipal budget. Often in the municipal budgets, goals and performance expectations are not compatible with resources. The lack of money, personnel, work space or equipment and the increase in complicated needs are reality; and it is obvious that this contradiction between resources and needs puts further pressure on workers. Kathryn Newcomer (1998) also paid attention in Federal Agencies to budget cuts and downsizing the number of personnel with more demanding responsibilities. Besides this, municipalities often change programmes and strategies very rapidly without waiting to determine their effectiveness or even measuring or evaluating them. Managerial problems arise because of a time lag between the administrative action and the desired outcomes, which may take years (Romzek 1998, 213-214).

Because new management strategies like result-oriented management and performance-oriented management, results in stress in one way or other, the unavoidable question is how to measure (qualitatively and quantitatively) accountability in the social and health care, where services are seen as outcomes. Is it better to investigate performance measurement as a whole performance chain: inputs-processes-results-outcomes? If so, precise and stable indicators must be selected. What is the measure or indicator which defines the level of achieved goals in the specific social or health field? Are mortality, morbidity and other epidemiological rates in the health field only measures for good outcomes or is there more to be done? Professor Romzek let understand that they are (Romzek 1998, 212). Disagreement is evident and further surveying is really needed to validate reliable and evidence-based performance measures. When, for example, publicly financed programme results

are evaluated, it is important that the measurement produces reliable results (Sofaer, Woolley, Kenney, Kreling, Mauery 1998). Even in the situation of Federal Agencies where resources were downsized, the offices of inspector general were trying harder to measure results in their audits and inspections (Newcomer 1998).

It is reasonable to think about whether morbidity and mortality rates, for example, in the social and health care are outcomes or whether these rates are results. Medicine has developed both in technology and in knowledge and its means to repair human body dysfunctions have increased, leading, of course, to a decrease in mortality. It can be concluded that this is evidence for the claim that mortality is a result. Then what are the outcomes of decreasing rates of mortality due to the development of medicine? The outcomes may be the growing problems in arranging care for the elderly on the level needed, the increase in the aging population, growing pressure for young people to deliver tax-money for services and the need to change service structures. The concept of outcome has to be seen in a wider, even a social, perspective.

How can hierarchical, legal, professional and political accountability be measured in municipalities? How do measures of performance take into account municipal differences, changing and different social and health needs and results in relation to resources? A system of performance measurement should promote the development of identifiable sets of measures from which states and communities can select subsets appropriate for their programme priorities and strategies (Perrin, Durch, Skillman 1999). Today this is a necessary but also very interesting and demanding study issue. There should be firm commitment to ongoing research that will increase the appropriateness of accountability, while defining well-achieved and suitable goals and performance expectations with proper measures.

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