

Risk & Regulation

Magazine of the ESRC Centre for Analysis of Risk and Regulation

No 12 Winter 2006

Regulatory relationships

**CIVIL SERVANTS AND POLITICIANS
SCIENTISTS AND TECHNOLOGISTS
NON-EXECUTIVE DIRECTORS
PILOTS AND DOCTORS**

PLUS

Meet the Better Regulation Commission
The rise of the Meso-Regulators

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NO 12 WINTER 2006**

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The Balancing Act

CARR Director **Bridget Hutter** argues that balancing the interests of consumers and business, and balancing the advantages of regulation against its burdens, is a necessary part of a responsible debate.

Risk regulation is a balancing act between different interests and interest groups. It involves balancing risks against protection, determining levels of risk aversion and risk taking in ways which reasonably allow innovation and which do not unreasonably harm others. This edition of *Risk&Regulation* includes articles written from a variety of different perspectives on the checks in place around risk regulation in the UK. Notable here is discussion of the changing nature of the relationship between politicians and their civil servants, and the ways in which this has influenced political risk taking and the emergence of risk management within the civil service.

The politics of managing the tensions and interests involved in risk regulation are well demonstrated in governments and their executives. In the UK the mood is presently one of caution about regulation. The Better Regulation Commission and Better Regulation Executive have explicitly deregulatory agendas. The Executive has responsibility for the Government's commitments to regulate only when necessary; set exacting targets for reducing the cost of administering regulations; and rationalize the inspection and enforcement arrangements for both business and the public sector.

The first of these – to 'regulate only when necessary' – is a potential minefield. The phrase 'when necessary' typically looks different from different perspectives. The politician, the regulator, the consumer, the trade association and the business representative may all have various takes on the phrase 'when necessary' and these may change over time and vary according to circumstances.

Politicians may feel it necessary to legislate in the wake of a major disaster or the development of a moral panic, a classic example being the dangerous dogs legislation which followed in the wake of a series of highly publicized attacks by dogs on children. In other cases politicians may be under pressure to resist regulation or deregulate, notably from the business community. But this is not to say that business is unilaterally against regulation. There is well documented evidence that some businesses favour regulation – sometimes as an anti-competitive tool, while others complain that irresponsible areas of their own industries should be more rigorously regulated to maintain sector, and even national, reputations. Trade associations may also be contradictory, ritually complaining about regulation while themselves 'gold plating' the requirements through their interpretations of legal compliance. Consumers are similarly volatile, simultaneously complaining about too little regulation when something goes wrong and too much 'red tape' when they are directly affected. These are persisting problems for governments and regulators.

Risk regulation is of course not just the preserve of the state: a variety of organisations may become involved in regulation – it's not just about 'red tape', it's about the negotiation of 'appropriate' levels

of risk regulation by the state in conjunction with others. Decisions made by non-state organisations are increasingly important as regulatory regimes co-opt actors beyond the state. Often, new layers of 'meso regulation' emerge to oversee the activities of state and non-state actors in the public interest. This issue of *Risk&Regulation* discusses those tasked with regulating the regulators and it explains how the arrangements being put into place may not best serve those beyond the regulated professions.

Regulation is also increasingly transnational. The case of EU legislation is an interesting example of how state and supranational governance systems interact. The Davidson Review of the Implementation of EU Legislation is a classic example of how local and national politics interplay and different interest groups set agendas. The remit of the review was '...to ensure that EU legislation has not been implemented in the UK in a way that results in unnecessary regulatory burdens'. The emphasis on cases of over-implementation is made clear in the report when evidence of under-implementation is pushed aside as irrelevant. The biases under consideration and the interest groups taking the foreground and setting the agendas are only too clear here. In few of these government- and quango-led discussions is the voice of the consumer much in evidence. Risk regulation is about balancing interests and a balanced view means taking into account not just cases of over-implementation but also under-implementation. It also means listening to more than one narrow section of stakeholder interests. Achieving this balance is a persistent problem, which will never be perfectly resolved. Risk regulation is inherently political and ensuring that all stakeholders are properly represented is the task of good government – and one they may wish to shy away from, especially in the face of some highly organised and vocal interest groups. ■

Bridget Hutter
CARR Director



MEET THE REGULATOR

Meet the Better Regulation Commission

The Better Regulation Commission is the successor to the Better Regulation Task Force. We spoke to its chairman **Rick Haythornthwaite** about good regulation, risk communication, public engagement and evidence-based policy



Rick Haythornthwaite

Can you explain how the work of the Better Regulation Commission differs from that of the Better Regulation Task Force?

Rick Haythornthwaite: Our composition is different. There are eighteen unpaid members from a very broad range of areas: from business, from academia, professions, trade unions.

In principle the role is no different. We're a source of advice and challenge for the government. But the focus of the task force, by virtue of that phase of the whole better regulation agenda, was very much focussed on the process of governance. That of course culminated in the 'Less is More' report.

One consequence of the 'Less is More' report is that the internal machinery of government – in the shape of the Better Regulation Executive – has been far better resourced and focused on the delivery of the immediate goals: the 'Less is More' process goals, getting simplification plans in place and measuring administrative burden. That releases the Commission to spend more time on thinking 'where next?'

So how does your work relate to that of the Better Regulation Executive?

RH: There is something of a symbiotic relationship. We work very closely with them – they're working as our allies within government. They are inside. They are very much focussed on the here and now. They are working closely with departments on the measurement of administrative burden, setting targets, delivery simplification plans and the detailed analysis of the impact of any new regulation that is being considered, making sure that everything from improved regulatory impact assessments to consideration of alternatives, consultation style and so forth is very much part of the thinking every minister and civil servant. I regard them as being, along with our secretariat, a key stakeholder for us in understanding how best to get the culture change that is required.

We sit outside government and we have a scrutiny role of that short-term material. But we have a view that generally they are competent. Then when we think about where to take the agenda next, that's where they readily stand back.

But you're not like the Health and Safety Commission and the HSE?

RH: You're right, and that's a big confusion. We're nothing like that relationship. People will come to realise that after a while, but the nomenclature is what it is.

The BRE, as you say, is very much focussed on what government does. Obviously a lot of what we think of as regulation happens outside government – self-regulation, for instance. Is that going to be a focus for the BRC?

RH: The Better Regulation Executive is concerned with the regulatory agenda and toolkit within government. That means making sure that everything from improved regulatory impact assessment to consideration of alternatives is very much part of the thinking of ever minister and civil servant. We want everyone in government to think about self-regulation as an alternative as much as we do. We have members of the Commission who are from self-regulation bodies, from the professions, so all those areas we see as ripe areas for work. The further away you get from government, the whole dynamic of implementation and enforcement means that that's where a lot of things were getting bogged down and where we've seen regulatory creep in the past. So it would be natural for us to step further and further away from central government.

How do you see risk-based regulation being used as a tool for regulators?

RH: What we're looking at is how society perceives risk and by extension how the government manages and communicates risk, and why those relationships are seemingly resulting in any ever increasing burden of regulation. We're asking ourselves how did we get ourselves into the situation where the 'do something' syndrome has led to a lot of inappropriate regulation.

We're asking questions around our assertion that increasingly regulation is seeking to mitigate a negative perception of risk as opposed to the actual objective risk, and indeed is almost totally ignoring the fact that sometimes mitigation of risk can be beneficial.

If you were to summarize the questions we're asking in our latest report, one is fundamental: what is society's perception of risk and how is that related to the process of regulation. Is regulation actually starting to replace trust and proper engagement in the UK? Do we have the right balance between personal responsibility and societal management of risk? Who is best placed to bear the cost of mitigating risk? Indeed, who is best placed to reap the benefits of mitigating risk? And then the final question we come back to, how should the government respond when under pressure to regulate?

We've found that it's struck a chord with people – this is an area that many people are interested in. There are a lot of people who actually have quite emotional voices on it. What we're trying to do is bring all this together in a way that's actionable for government. That's our main audience.



How do you engage the public in the BRC's work?

RH: We first of all have a Commission that is comprised of a broad church of individual backgrounds. They then along with the secretariat will consult widely. We do get evidence from a lot of sources. I get a pretty healthy postbag, I publish articles in the media, we publish all our opinions and it sets up a convection current of comment. And because we have people from a broad range of backgrounds we have good access and we know where to go to talk to people about a range of issues. We don't see ourselves as representatives of different groups, we see ourselves as windows into communities.

I meet a lot of people in the role, so I get a sense of what are the issues being faced by people generally in society. And so we have enough connections to get a feel for what are the issues here and now, and more importantly what are the issues that are just appearing on the horizon. One of the strengths of the Commission is that it does pick up issues that are looming when it's time to tackle them.

And how do you try to incorporate evidence into your policy-making?

RH: We don't see ourselves as academic researchers, we're not a think-tank. We see ourselves as an expert advisory body. We only incorporate research findings to the extent that our witnesses seek to give it us, and we would never pretend to be any more expert than that. And in seeking evidence we need to have a balance between having sufficient evidence that we feel underpins any assertions and recommendations we make, but recognising that we are here to deliver at a quick pace actionable reports to government and to move on and make sure they are followed up.

How do you deal with SMEs [Small-Medium Enterprises]? That's often where we hear the most complaints about regulation. SMEs face the greatest challenge from regulation, they're less used to it, they don't have the systems in place to cope with it, but at the same time they're very often the organisations that cause risk, for the same reasons.

RH: I think that there are three particular areas that affect SMEs. The first is a deep awareness that this has to be the focus, testing from the standpoint of what regulation would mean to SMEs. And increasingly talking of trying to tailor regulation so it is proportionate – simple to say but not always easy to do. There is a recognition of that within government and that's a start. The second is that the risk-based approach is appropriate - there is as much variability of leadership quality within SMEs as there is in any business. And then the third is simplicity. One of the toughest things for an SME to work with is just the complex array of touch-points with the regulators and the regulation itself, simply understanding it, let alone enacting it. This is a continuous drive that is actually proving to be difficult, because regulation has been layered on generation

after generation and has become this impenetrable mess, it's going to require a systematic rethink.

As a Commission we don't believe all regulation is bad. We believe that there are an essential number of legal, social and environmental protections that enhance free markets. What we do say though is that they should be delivered in the least burdensome manner possible. And where possible, do nothing.

But if regulation is necessary, there are many different ways of delivering it, and quite often we choose to deliver it in a very complex burdensome manner. Sometimes it's an accident of history, sometimes it's because we don't think enough about what the alternatives are.

Can you give me an example of good regulation?

RH: If you look at the Unfair Commercial Practices Directive, to have something that is horizontal, simple, based on outcomes, that's what an SME can understand and work within. As opposed to the myriad of equivalent unfair commercial practices legislation we have. So I think there are areas one can have a go at. It's a paradox if we are seeing initiatives like this actually coming from Europe!

If you look at the debate that's been held over pensions reform, actually it was quite a good example of sound regulatory process. There was a very considered balanced report coming from Adair Turner, and the initial instincts of closing down the political debate were suppressed for a long time. We're starting to see a high quality of input coming in.

And bad regulation?

RH: Now you compare that to something like the Licensing Act 2003. Here is a classic example. The Task Force had actually made the recommendation that the antiquated licensing acts, many of them, should be rationalized, and so we were very supportive of it. But the way it was implemented was very complex, poorly thought through, and in the end actually undermined perceptions of the need for reform in the first place. We've gone back over the Licensing Act process and pointed out the gaps in project planning, the unnecessary bureaucracy that was heaped on many of the publicans and licensees and some of the disproportionate impacts that were created by extending it too far. It's particularly disappointing when you see something that is fundamentally a good piece, a necessary piece of legislation poorly implemented.

You talked about de-layering legislation, this was specifically designed to address that.

RH: It was to de-layer legislation. Having de-layered the legislation it was completely countermanded by the actual implementation.

And we're not going to talk about Home Information Packs, are we?

STUCK IN THE MIDDLE

the rise of the meso-regulators

Robert Kaye argues that a new tier of regulation is by no means a guarantee of securing the public interest in regulation.

In an age where regulators are exhorted to reduce burdens and told that 'less is more', the creation of new bodies remains an instinctive response of government to regulatory failures. But this 'creep' does not always involve attempts to plug gaps in regulation. Governments can also apply a new layer of regulation where existing regulation appears patchy or has failed to penetrate.

Professional services in the UK are an important arena for studying regulation because self-regulation has long been seen as a defining characteristic of a profession. But developments over the past decade suggest that this 'paradigm' of professional self-regulation, which has admittedly been the subject of reforming pressures in the period since the second world war, is being replaced by a new paradigm of regulated self-regulation.

Last year a review for the Lord Chancellor's Department recommended that a new Legal Services Board be created to oversee the regulatory work of bodies like the Law Society and the Bar Council. This mirrored almost perfectly developments in healthcare and accountancy. The Council for Healthcare Regulatory Excellence now oversees the work of regulators bodies in thirteen healthcare professions – including medicine, nursing and dentistry – while the Financial Reporting Council now oversees the work of the professional accountancy and actuarial bodies, and has created its own investigation and discipline scheme to take 'public interest cases' away from the professional bodies. The Legal Services Review did not explicitly model its proposals on those in place for healthcare and accountancy, but since it was driven by many of the same concerns, it is perhaps unsurprising that it found a similar solution. The extension of this model across key professions, however, suggests that the traditional model of professional regulation - in which regulatory bodies were dominated by members of the regulated profession – has dwindled. The front-line regulators are now accountable to a new tier of sectoral 'meso-regulation'.

'Meso-regulators', such as the CHRE, the FRC and the LSB, sit above the front-line regulators, and are primarily accountable to established political institutions, such as parliament or ministers, rather than to the regulated profession. They are explicitly designed to address concerns over the extent to which the traditional regulators have been more responsive to practitioner than public concerns. But like the independent regulators characteristic of the 'regulatory state', they are designed to provide a 'sustained and focused oversight' over the front-

line regulators that central government departments lack the specificity to provide. Meso-regulators, by implication, exist to guarantee that primacy of the public interest in professional regulation.

The experience of the Commission for Healthcare Regulatory Excellence highlights the ambiguous nature of this new tier. It was initially created as the Council for the Regulation of Healthcare Professionals. But it never regulated healthcare professions – 'council for the regulation of healthcare professions' would be a more fitting description, as would 'council of professional healthcare regulators'. Instead, it regulates profession-specific regulators such as the General Medical Council or the Royal Pharmaceutical Society.



The new title recognises this gap between nomenclature and function, but it also reflects an organisational reorientation towards the development and encouragement of best practice. The existence of a body which, in the last resort, can force a regulator to change its constitution, rules and practices may give an impetus to otherwise passive forms of 'horizontal' policy transfer, in which front-line regulators adapt their own practice in response to that of other regulators. However, if this is all the regulator does – if best practice is identified from within the sector – then there is a huge conservative bias. Not only is best practice from outside filtered out, but the central imposition of regulatory practice can in the longer term prevent diversity and stifle regulatory innovation within the professions.

The most visible and the most practical of the meso-regulators' powers is the ability to 'call in' the front-line regulators' disciplinary or 'fitness to practise'

decisions. There has long been an imbalance in these proceedings, with only practitioners having a right of appeal to the Courts. Now, however, the CHRE is able to appeal 'unduly lenient' decisions to the High Court. The Courts, however, have interpreted 'unduly lenient' in such a way as to equate 'unduly' with 'unreasonably' or even 'irrationally'. Provided the professional body's decision is not manifestly unreasonable, it will stand. So if the front-line professional organisation and the meso-regulator clash over their view of the public interest, the advantage lies with the professionals. In practice, this circumscribes the CHRE's attempts to ensure that the public-interest trumps professional self-interest or bias.

To compound these limitations, a recent report from government proposes that the lay members of the CHRE should be limited to an oversight role, while the professional representatives would become, in effect, an executive council. To a political scientist, such a move looks like a classic case of a regulator being 'captured' by the interests of those it is supposed to represent. The risk for meso-regulators is that because 'the public' are only represented through proxies professional interests will dominate. The CHRE for one has been slow to develop ways to incorporate 'the public' in its decision making. It may, perversely, sideline the meso-regulator by encouraging central government – as the elected representatives of the public – to engage directly with the front-line regulators. In the regulatory landscape for professional services, dominated by behemoths like the General Medical Council, the Law Society, or the Bar Council, bodies like the CHRE or the Legal Services Board are minnows. The GMC has recently embarked on an ambitious programme of reform which will, among other things, remove the doctors' majority on the GMC's council and allow disciplinary findings to be made against doctors on the balance of probabilities rather than the criminal burden of proof. But this has been the result of a dialogue between the GMC and central government, largely bypassing the middle regulatory tier.

In short, meso-regulators are squeezed. They are squeezed between two powerful institutions. They are squeezed by structural considerations which limit their ability to make the public interest in regulation paramount. And they are squeezed because crisis and regulatory failure usually allows only a short period for the reform to take place in the face of practitioners understandably hostile to greater regulation. ■

Robert Kaye is ESRC Research Officer at CARR.

CARR IMPACT

Carl Macrae's work on air safety regimes was discussed in the annual report of the Chief Medical Officer, Sir Liam Donaldson. Carl discusses the implications of his findings for the NHS on page 8.



Will Jennings discussed his findings on the relationship between public opinion and asylum and immigration policy on Radio 4's 'More or Less' in November. The same programme featured CARR Research Associate **Gwyn Bevan** discussing statistical manipulation by NHS hospital trusts.

Mike Power spoke to the National Audit Office on 'pressures for change in accounting'.

Bridget Hutter and **Julia Black** have had meetings with the Better Regulation Executive and the Office of the Rail Regulator.

CARR VISITORS

Didier Torny of the French National Institute for Agricultural Research visited CARR during October, giving a stimulating seminar on the management of infectious diseases.

CARR also welcomes two Visiting Professors; **Keith Hawkins**, Professor Emeritus of Law and Society, Oxford University is working on decision-making by legal actors. He will be a CARR visitor until 2008.

Sally Lloyd-Bostock, Professor of Law and Psychology at the University of Birmingham also joins us until 2008, furthering her work on the psychological effects of disputes and legal decision-making.

ACADEMICS ABROAD



Bridget Hutter and **Clive Jones** presented a paper 'Businesses Responses to Regulation' at the Law and Society Association Annual Meeting in Baltimore, USA. Bridget Hutter also gave a keynote speech at a workshop on risk-based regulation and the aviation sector, organized by FOCA and the Ecole Polytechnique Fédérale de Lausanne.

In September, **Will Jennings** presented a paper at the American Political Science Association's annual conference in Philadelphia.

In July, **Martin Lodge** gave a paper on 'trajectories of administrative change' at the International Political Science Association congress in Fukuka, Japan. In August he spoke on public management and regulation to the Office of the Chief of Staff in Brasilia, Brazil.

Peter Miller gave a series of lectures at the University of Upsala in September. He also spoke at the Boston Accounting Research Colloquium and gave a keynote address at the Global Management Accounting Research Symposium in Copenhagen.

STAFF NEWS



CARR welcomes **Sarah Dry**, who joins us as ESRC Postdoctoral Research Fellow. Sarah's research area is the history of government science and safety in Victorian Britain. Her work focuses on government offices (such as the Meteorological Department), government science advisers, and the contributions of local actors such as fishermen and jury members to the centralized administration of safety interventions.

We welcome **David Demortain** and **Jakob Jorgensen** who are joining CARR as ESRC Postdoctoral Fellows.



We also welcome **Amy Greenwood**, who joins the CARR team as Communications and Publications Administrator. Amy will be the assistant editor of *Risk&Regulation* 13.

Robert Kaye retires as editor of *Risk&Regulation* with this issue. Will Jennings will inherit my red pen, highlighter and repetitive strain injury for *Risk&Regulation* 13.

We say goodbye to **Clive Jones** who has been working at CARR as Research Assistant and Project Manager.

Finally, we also say goodbye to **Henry Rothstein** who is leaving us to take up a lectureship at Kings College, London, and to **Javier Lezaun**, who has taken up a position as Visiting Assistant Professor at Amherst College, Massachusetts. Henry and Javier will both remain Research Associates of CARR, and we wish them all the best in their new positions.

From airside to beside

Organising safety in healthcare and aviation

Patient safety remains a key priority for the health service. **Carl Macrae** considers some of the lessons offered by experiences in the airline industry.

The rapid emergence of patient safety as an organising concept in the healthcare sector is startling: startling in the scale of the challenges being faced, startling in the extent of the resources being made available, and most startling of all, perhaps, that all of this has happened only recently.

Hardly a week goes by without a tragic healthcare accident hitting the headlines. Estimates suggest that between three and sixteen percent of hospital patients suffer some form of injury due to preventable mishaps and errors. The United States Institute of Medicine suggests that these adverse events result in somewhere between 44,000 and 98,000 deaths per year in US hospitals. The financial costs of patient safety incidents are equally shocking, costing the National Health Service some £2 billion in extra bed days alone in 2005.

In his recent annual report, the UK Chief Medical Officer Sir Liam Donaldson exhorted healthcare leaders to learn from the safety successes of aviation and other safety-critical industries. In contrast to healthcare the safety record of commercial aviation seems astonishing. Carrying some 1.8 billion passengers worldwide in 2004, airline accidents resulted in only 466 fatalities.

So what can healthcare learn from aviation? Caring for patients and operating airliners clearly involve radically different kinds of work. On the surface it is hard to think of two more dissimilar domains. But in many ways the core challenges and objectives of risk regulation in these two domains are aligned, focusing on the organisation and supervision of safe work practices in complex, dynamic and unforgiving settings. As such, the organisation and oversight of safety in aviation offers a range of insights remarkably relevant to healthcare. Here I suggest five areas where my research on safety oversight in the airline industry connects with current dilemmas in healthcare. These observations relate both to the supervision of safety by national regulatory agencies, and to the role of risk management units within individual operators and service providers.

Producing and circulating knowledge

A core function of safety oversight in the airline industry is facilitating the production and circulation of specialist safety knowledge. Regulatory agencies and risk management units serve to coordinate and foster knowledge production around safety issues, and provide a range of direct and indirect mechanisms for the circulation of this knowledge. The clearest instance of this is the regular publication of investigations into major incidents and accidents, such as by the UK's Air Accident Investigation Branch. These reports provide detailed analyses of the technical, organisational and regulatory factors that contributed to an event, and offer recommendations on how to resolve these. These reports play a crucial role in the development of expert safety knowledge beyond the specific recommendations they offer. Analysts and managers throughout the industry use these reports extensively to develop their understanding of the risks they face, drawing on them to interpret and understand new incidents in their organisation often years or decades after the original event. For similar reasons individual airlines and aviation regulators, such as the UK's Civil Aviation Authority, distribute information on the thousands of minor safety events reported to them every year. Processes like these support the use and development of safety knowledge in local, decentralised and innovative ways. The creation of new systems of safety management in healthcare rightly focus on solving immediate problems and providing definitive answers. But experiences in aviation equally emphasise the importance of developing the less tangible social and participatory foundations of knowledge production that support learning throughout an industry.

Defining and shaping safety

Regulatory agencies and risk management units have an enormous influence over what is defined as safe and which aspects of organisational performance are deemed relevant to safety. What these oversight bodies attend to, monitor and focus on in their day-to-day work plays an important role in shaping local understandings and definitions of safety – and subsequent efforts to achieve it. Despite the technical engineering at the heart of every airline, in air safety oversight activities there is a strong focus on people and practice. Monitoring

safety typically means monitoring the resilience of the skills, tasks, tools, and interactions required to get a job done and asking, do these operational practices support the identification, containment and correction of the problems and mishaps that are inherent to this activity? This has created a widespread acceptance in aviation that serious issues of safety run through the seemingly trivial and mundane. In airlines this can mean signing every spanner in and out of the workshop. In healthcare it can mean the clear labelling of intravenous drugs and cleaning fluids that are stored near each other on wards. A range of initiatives have emerged in healthcare that aim to strengthen the resilience of practice, such as procedures for multiple checks to confirm that operations are being performed on the correct surgery site. Experiences in aviation reaffirm the importance of focusing on the details of daily practice, and emphasises the need for data and analysis tools that support these interventions.

Identifying and monitoring deficiencies

The monitoring of safety and the identification of new risks and safety deficiencies requires a range of analytical approaches, both quantitative and qualitative. Even in the hard-nosed and data-driven engineering world of the airline industry, however, these activities remain heavily dependent on professional judgement and expertise. The identification of new and previously unknown risks is particularly dependent on the expert analysis of personnel with lengthy practical, operational experience and extensive safety-specific knowledge. The analysis of near-miss incident reports in aviation shows this clearly. Large numbers of minor incidents are reported and gross trends across a range of event categories can be monitored statistically. Identifying new and emerging risks, however, typically depends on understanding the underlying implications of a small handful of reports – in many cases only a single minor event. Identifying new risks quickly inevitably means there can be very little data to go on. Experiences in aviation emphasise the important place of experienced personnel who can draw on a deep understanding and knowledge of safe practice to interpret these weak, early signals of potential risks. Equally important is establishing a professional culture in which these tentative judgements can be voiced and are listened to.



ILLUSTRATION: AILSA DRAKE

Organising investigations and leading change

With the ability to collect and record huge amounts of operational information in airlines, risk management units and regulatory agencies can easily become swamped by safety data. Although a truism in aviation holds that this early information can be inaccurate, and is often wrong, effective safety oversight depends on the routine investigation of troubling incidents or issues. Investigations draw on the expertise available within oversight organisations, but also involve co-opting and coordinating operational specialists and managers within airlines, manufacturers and air traffic service providers. As such, the role of overseeing safety is primarily one of leadership. In the airline industry, processes of safety oversight have evolved less as the handing down of ready-made solutions and more as the coordination of participatory processes of investigation and change. This requires capturing and focusing peoples' attention and so depends on the softer side of risk management: producing engaging news, compelling stories and meaningful initiatives. These experiences point to the importance of developing leadership, as well as analytical skills, in oversight bodies. And they point to the importance of institutional structures through which local investigation and action can be lead.

Managing accountability and blame

Pressures to blame people for perceived errors and mistakes are no different in aviation than in other domains. Blaming an individual is simple, absolves the organisation from any wider responsibility and avoids the need for any costly changes. Yet on the whole the UK airline industry manages to negotiate around these pressures through a set of clear policy statements, gentleman's agreements and conducive organisational and professional cultures. Oversight organisations are again crucial in this arena. Both within airlines and at national and international levels, they are responsible for writing policy, establishing norms and defending these from challengers. Typically, judgemental pronouncements regarding who is responsible or what is the 'root cause' of a problem are avoided. Instead, analytical frameworks have been established that seek to establish accountability for resolving risks and taking ownership of problems – rather than determining who caused them in the first place.

How these frameworks are established and culturally maintained remains an open question, and is perhaps currently the most challenging questions that can be applied to healthcare. A culture of liability and blame seems well established and many patient safety events have victims in a way that air safety incidents do not.

Similarities and difference

There are no simple or guaranteed solutions to the many challenges of safety oversight, in healthcare or elsewhere. In particular, strategies from one industry are unlikely to work if simply imported and adopted wholesale into another. In places, the differences between these regulatory domains are dramatic. But such differences are also instructive, both for the theory and practice of risk regulation. Medical work is far less routine and far more uncertain than many areas – of the modern airline industry. And the contrasts in many ways would have been less distinct three or four decades ago, particularly, for instance, around issues of blame. A closer comparison of these two domains of risk regulation, should be encouraged amongst practitioners and academics. The daily worlds of each may be radically different, but they present common challenges of knowledge, oversight, leadership and control. ■

Carl Macrae is an ESRC Postdoctoral Fellow at CARR.

Treading the Boards

The Systemic Risks of Directors' Interdependence

Will Jennings, Yuval Millo and Robert Wearing discuss how competing notions of independence, and the interlocking relationships of non-executive directors, may undermine their role as risk regulators.

In the post-Enron era, increasing regulatory attention has been directed towards non-executive directors (NEDs) and their role in corporate governance. In the United Kingdom, much of this attention is premised upon a belief that non-executive directors perform an important regulatory function in corporate governance. In response to a succession of corporate transgressions, failures and crises, a number of critical regulatory texts – the Cadbury Report of 1992, the Greenbury Report of 1995, the Hampel Report of 1998, and the Combined Code of 2003 – have increasingly emphasised the importance of the appointment of *independent* non-executive directors for transparent and efficient corporate governance.

Non-executive directors are intended to prevent a concentration of power with the chief executive officer and/or senior executive directors of the firm. To act as an effective counterweight to the executive membership of a board, non-executive directors are presumed to be independent from the firm.

Yet despite the crucial importance attributed to non-executive directors' independence, the formal regulatory definition of that independence is deficient, injudicious and is, itself, a source risk to the governance of firms and – through a systemic effect – the economy.

What are the problems inherent to the present regime of regulatory functions of boards of directors?

The evolution of regulatory definitions of the independence of NEDs reveals the emergence and crystallisation of two related concepts: the 'negative bilateral concept', and the 'negative probabilistic

concept'. The negative bilateral concept assigns independent status to a director according to his/her lack of connections with a specific firm whereas the negative probabilistic concept assigns independent status to a director according to the lack of connections with specific categories and/or groups in the general population. These concepts dominate the contemporary regulatory debate about non-executive directors in Britain, but entail problematic characteristics that introduce systemic risk to corporate governance. First, the concepts do not define positively what constitutes 'independence' but instead provide only a by-default, deducible definition. Consequently, regulators cannot assess the interdependence of firms or the extent to which the interlocking connections might impact upon corporate decision-making. Second, the recruitment of non-executive directors becomes a utility-maximisation exercise. This introduces the possibility of gaming – where firms use appointments to subvert or circumvent regulatory standards. How did this state of affairs arise?

The negative bilateral concept

The Cadbury Report, published in 1992, was the first attempt to focus on non-executive directors as an important mechanism for improving governance in UK quoted companies. The preface to the report of the Cadbury Committee referred to 'the continuing concern about standards of financial reporting and accountability, heightened by BCCI, Maxwell and the controversy over directors' pay'. Cadbury recommended that quoted company boards should each have at least three non-executive directors, a

majority of them independent. Independence was defined as follows:

'[A]part from their directors' fees and shareholdings, they should be independent of management and free from any business or other relationship which could materially interfere with the exercise of their independent judgement.'

Cadbury signifies the beginning of the bilateral negative definition for non-executive directors' independence: the less connections there are between the director and the firm, the more independent the director is deemed to be.

Three years after the Cadbury report, the Greenbury Committee was formed following widespread public concern over what were seen as excessive amounts of remuneration paid to directors of quoted companies and newly privatized companies. Greenbury recommended that the remuneration committee should consist exclusively of non-executive directors. These non-executive directors should have no personal financial interest, other than as shareholders, in the committee's decisions. Also, there should be 'no cross-directorships with the Executive Directors which could be thought to offer scope for mutual agreements to bid up each others' remuneration'.

Also in 1995, the Hampel Committee published a report in which it reviewed the implementation of the findings of the Cadbury and Greenbury Committees. Hampel recommended that 'boards should disclose in the annual report which of the directors are considered to be independent and be prepared to justify their view if challenged'. These recommendations were then included in The Combined Code, which was published by the London Stock Exchange in 1998. The recommendation to disclose the independence status of the directors and the backing of that recommendation by the London Stock Exchange signified a further strengthening of the bilateral concept: the corporate discourse that interprets the board's independence was no longer hidden, but was placed in the public domain.

The negative probabilistic concept

In 2003, following a string of financial scandals including those of Enron and WorldCom, Derek Higgs was commissioned by the UK government to review the role and effectiveness of non-executive directors. Higgs proposed that nomination committees should 'consider candidates from a wide range of backgrounds and look beyond the "usual suspects"'. He also led the Department of Trade and Industry to commission a report on the recruitment and development of non-executive directors (the 'Tyson Report') which explicitly recommended increased diversity in board membership, particularly with regard to female participation.

In addition, Higgs recommended that the nomination committee should consist of a majority of independent non-executive directors and should be chaired by an independent non-executive director. The nomination

committee should lead the process for board appointments and make recommendations to the board. To stress the relationship between directors' independence and proper corporate governance the *Combined Code* also states that at least half of the board of each FTSE-350 company (excluding the chairman) should 'comprise non-executive directors determined by the board to be independent'. Higgs and the *Combined Code* entrenched independence according to the negative probabilistic approach more deeply by focusing on nomination of directors. Decisions made by a nomination committee would be independent of the board as long as and to the extent that its members are themselves independent. By recommending that nomination committees will be composed of non-executive directors, the committee introduced a structural-recursive element that, in effect, distanced the board from a position of responsibility and accountability.

By calling for a more diverse background from which directors are appointed, the *Combined Code* tried to offer a potential remedy to the 'negative' definition approach and its problems. The implicit assumption here is that if non-execs come from outside the social networks of the existing directors, it is more likely that they would be independent. The organisational tools that are expected to ensure a wide diversity of appointees are set procedures that firms must follow prior to appointments. The presentation of the probabilistic approach may seem like a solution but in fact it simply moves the 'negativity' problem to a different location. By demanding firms to appoint non-executive directors from 'diverse backgrounds' the *Combined Code* actually asks the firms to appoint non-executive directors from backgrounds that are *different* from those from which non-execs usually came. The combined code still does not provide a positive definition about directors' independence.

Assuming that there is a correlation between expertise and vicinity to the firm, simply asking firms to diversify their appointments is not likely to diminish the causes for the optimisation process that firms currently perform. If there is a correlation between the non-execs' expertise and their relative closeness to the firm, requiring that firms diversify appointments is unlikely to remove this underlying trade-off.

Discussion

This brief history of development of corporate governance in Britain over the past 15 years reveals that although the independence of non-executive directors is considered to be an important precept of regulation and good corporate governance, the negative definition – bilateral and probabilistic – of independence leaves a number of important problems unresolved.

First, it constructs a public facade of regulation – where British firms are able to appoint directors without providing positive certification of independent status. Second, these definitions create a risk-laden trade-off between independence and expertise. Since independence is understood in restrictive

terms as where the individual director is not connected to the firm, this enables firms to engage in a game of optimisation – in choice between the independence of a director and his/her relevant knowledge or expertise. It becomes probable, then, that companies prefer to appoint non-executive directors that are as expert as possible, but satisfy the minimal independence criteria.

In order to resolve this systemic vulnerability in the existing regime, it is necessary to formulate an improved model of corporate self-regulation. Instead of a binary classification of directors and boards of directors (where these are independent or non-independent in relation to a single organisation or person) it is possible to develop a definition that calculates the degree of connectedness of a non-executive director to the entire network of connections of boards. This conceptual view of corporate governance requires a methodological solution to assist assessments of independence. The fundamental distinction between a director's 'independence' and 'connectedness' is the focus of this exploration. In order to determine the degree of independence of a director in relation to a board, it is necessary to assess the strength and efficacy of the connections between an individual director and a specific board. In contrast, to measure the degree of connectedness of a director, it is necessary to map a wider network of connections between an individual director and other directors and establish how pivotal that individual is in maintaining the structure of connections among other directors and – through them – other companies.

What advances does this approach promise for corporate regulation in the future? The 'interconnected' view of corporate directors and boards enables us to develop a sophisticated and holistic analysis of independence and systemic risks. While an individual director might not be active in the executive operations of a firm, this is only part of the story. The interlocking position of that director in relation to other directors – and other boards – makes them crucial in relaying information between organisations. Therefore, analysis of the inter-board network of directors as an informational arena of transactions and exchange facilitates a more comprehensive and robust analysis of the degrees of independence and its consequence for regulation of corporate risk. ■

Will Jennings is British Academy Postdoctoral Fellow at CARR. Yuval Millo is a lecturer at the Department of Accounting, Finance and Management of the University of Essex, and is a CARR Research Associate. Robert Wearing is Reader at the Department of Accounting, Finance and Management of the University of Essex.

CARR CONFERENCES

CARR hosts regular risk and regulation conferences

Student conference 21-22 September 2006

This year's conference took place in the LSE's Clement House building. As usual the event combined a wealth of papers by scholars with elements intended to provoke, support and assist the researchers. Ed Humpherson of the National Audit Office gave a spirited defence of regulation in a keynote speech, while students were offered two masterclasses where CARR staff discussed methodology and advised on how to get published.

The main focus of the event, however, remains the students' presentations. A wide variety of disciplines were once again apparent, including law, sociology, political science, economics and science and technology studies. Perhaps even more striking was the range of subjects covered, including terrorism and nuclear safety, flood management and internet television, telecommunications and pesticides, corporate governance and money laundering. It was particularly notable how much the topics of risk and risk management had become the specific focus of research, with papers on the concept of legal risk, aleatory and epistemic uncertainty,

It was particularly notable how much the topics of risk and risk management had become the specific focus of research



heuristics for dealing with uncertainty, and procedural models of risk management.

All this is suggestive of the crystallisation of a distinctive field of 'risk regulation'. CARR's work has been an important driver of this phenomenon and this annual event is particularly important. Today's students will establish the intellectual world of tomorrow, and on the basis of this conference there is a strong future for risk regulation studies.



DNA Lab

In a paper for the CARR Student Conference, **Myles Leslie** looks at the effects of Quality Assurance regulation on the work of DNA testing laboratories.

The scientists responsible for the DNA profiles that identify suspects in criminal legal cases have learned from the mistakes of their predecessors. In the past, forensic biology laboratories have seen their credibility eroded. Both the O.J. Simpson trial and numerous commissions investigating miscarriages of justice have raised the possibility that racism or incompetence rather than expertise have, at times, informed the scientists' work. In the 15 years since Simpson, however, forensic biology laboratories have redesigned their organizational routines and professional standards, regained their credibility, and come to provide near bullet-proof testimony in most criminal cases. The risk management solution to aggressive barristers intent on casting doubt on their methods and evidence has been a remarkably simple one. Quality Assurance (QA) audit protocols have become a major feature of laboratory life as it is lived out by forensic biologists.

On a number of levels, audit-based QA is ideally suited to bolstering courtroom credibility. It provides objective proof that sample processing robots are calibrated properly, that fridges filled with reagent kits are kept at the proper temperature, and that tagged samples match up to the correct case file. Introducing numbers and strict organization where a lawyer for the defence might once have been able to impute prejudice or sloppy work has significantly reduced the amount of testifying forensic biologists do. As the labs expand their ability to process samples, most of the growing supply of DNA evidence is now stipulated to by both parties to a criminal proceeding. From a position of disgrace, credibility derived from QA has brought DNA to pre-eminence in the field of criminal identification.

While the legal community continues to wrestle with using audit measures to validate scientific evidence, my research follows the biologists out of the courtroom – where they spend less and less of their time – and back into the labs where the mountains of DNA evidence are produced. It investigates the effects of this trend towards audit as a way of managing legal risk, asking how the adoption of QA measures has changed the daily organizational routines of forensic labs and the science that they produce?

Generally, there is a division of labour within labs that separates technical work from the generation of either written or oral testimony. What most outsiders

oratory Testing

would consider to be the lab's 'scientific work' is in fact performed by workers called technologists. Technologists wear the white smocks and splatter goggles. They work in isolated, positive-air-pressure rooms, free from contaminants. Their daily companions are garments and sheets stained with blood, semen and saliva, along with the pipettes, robots, and gel kits required to transform these stains into viable DNA profiles.

Where technologists produce numbers and profiles, scientists produce legally valid interpretations of these pieces of paper for oral or written presentation in court. Scientists, who wear business suits and work mostly on the phone or in seminar rooms, are first and foremost case managers. They work with, among others, police officers, prosecutors, coroners, and toxicologists to ensure that samples are processed in an efficient, effective, and timely manner. When a police or identification officer first collects, or contemplates collecting, a sample, it is their job to prevent nuisance material that will waste limited resources on unwinnable cases from entering the lab. As a case develops, the scientist is in constant contact with the other players, fielding calls from not just prosecutors and defence counsel, but sometimes defendants. Unlike the technologists, scientists spend their days working with other human beings, not in isolated rooms with blood-stained garments and robotic batch processors.

Although the daily lives of technologists and scientists are quite different, laboratory QA audits, at least on paper, apply equally to both groups. Closer inspection, however, reveals that technologists are the most affected by the new audit regime. They must constantly retrain themselves, recalibrate their machines, check the temperatures of their sample fridges, and confirm that their colleagues have not mislabelled their vials. Scientists do not engage in easily auditable activities. They negotiate with police officers. They testify before juries and are badgered by barristers. While there are several mechanisms in place to assess the 'quality' of this type of work, they are largely ineffective if not completely ignored by both the scientists and their clients. Although the evidence the scientists deliver in their testimony derives its authority from the quality assuring audit activities of the technologists, audit routines have very little impact on the scientists' working lives. Operating in an essentially un-auditable world of human relationships rather than inert samples and pieces of equipment, the scientists do not feel the heavy hand of QA checking their every action.

Nonetheless, QA systems demand the scientists cross-check one another's case notes and interpretations for consistency. Yearly QA reviews place senior scientists in open court to evaluate their more junior colleagues' ability to testify. Both

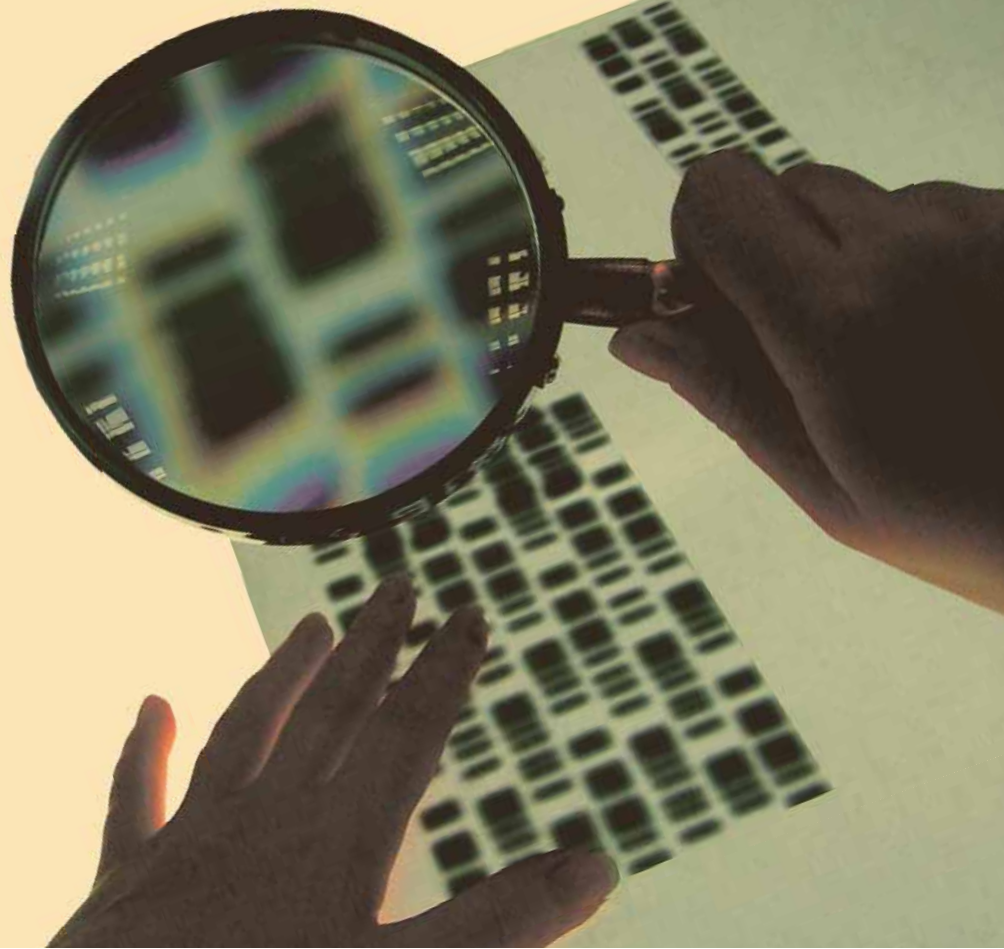
of these QA mechanisms work to entrench local organizational practices and social hierarchies. Mentors and students sit down to discuss 'how it is we testify' in a given situation. Colleagues confirm that the appropriate people have been called in the appropriate order, and that a declared match is being presented in a manner consistent with office practices. For technologists QA is trained upon them as an external auditing surveillance system. Scientists, on the other hand, are referred back inside their own social and expert networks by Quality Assurance measures.

This flexible, work-specific approach to risk management through QA has consequences within the laboratory. Operating as audit for technologists and expert self-regulation for scientists, QA is creating new and competing notions of objectivity within forensic science labs. On the one hand the technologists assume the positive air pressure of their clean work rooms, and their well calibrated machines protect them from the taint of subjective interpretation. On the other, the scientists assume that interacting with humans, not objects, is the most effective way to attain and maintain consensus on just what the correct protocol is. The divide between these two objectivities – one mechanical and the other social – has developed to a point where some scientists do not trust that the technologists in their

lab are being completely objective as they go about their duties. The scientists feel the technologists, in their isolation, may harbour suspicions about a given defendant based on the mere fact that semen was found on the incoming sample. They question the technician's ability to separate presence or absence of an identifying fluid from questions of guilt and innocence. Ironically, this misgiving can result in scientists advocating for even further auditing of technologist routines.

Forensic biology's move to audit has, for the moment, been a success in the courtroom. DNA evidence is generally uncontested in the majority of criminal cases. However, the novel, and apparently incompatible, approaches to objectivity born of QA are altering organizational practices and the relationships within the lab. The implications of these changes remain unclear, but where risk, science, and the law meet the consequences are necessarily important. Policy recommendations for the regulation of forensic biology, and the re-integration of technologist and scientist work streams as well as QA regimes may well be required. ■

Myles Leslie is a doctoral researcher at the University of Toronto's Centre of Criminology.



CARR CONFERENCES

Risk, Crisis and Blame Management in Europe

13 October 2006

This joint workshop, bringing together members of CARR with members of the Leiden Crisis Research Centre and the Swedish Institute of International Affairs, Stockholm, sought to identify critical intersections and synergies of the fields of risk regulation and crisis management. It was organized around a series of panels on the themes of 'Risks, Ruptures, Blame' and 'The Routinisation of Crises and Crisis Management', with presentations from participants on the themes of medical regulation and statistics, aviation safety, the Asian Tsunami, Millennium Dome, crisis management in European governance and institutions, and capital management. The notable points of discussion were the problems of wisdom in hindsight in the formation of regulatory regimes, imaginations of crises as modes of regulation, and the European dimension of risk and crisis management.

ESRC Centre for Analysis of Risk and Regulation

International Conference, LSE, London

22-23 March 2007

Organising risk regulation: current dilemmas, future directions

Risk is increasingly influential in the organization of public services and the management of business. Risk regulation encompasses the governance, accountability and processing of risks. It is increasingly undertaken within organisations as part of their risk management and compliance functions, as well as by regulatory and other agencies that constitute 'risk regulation regimes'.

The evolving nature of risk regulation is of critical importance to policy, practice and theory. CARR's international conference will bring together leading academic experts, policymakers and practitioners to consider the organisation of risk regulation, the social and institutional character of risk management, and the increasingly de-centred and participatory nature of regulatory activities.

This conference will provide opportunities to engage with leading members of the risk and regulation field. It offers delegates the chance to keep abreast of current developments, forge professional networks, and participate in robust and topical debate.

Participants include:

- Dan Carpenter, Harvard University
- Richard Ericson, University of Toronto
- Lord Haskins, former Chairman, Better Regulation Task Force
- Christopher Hood, University of Oxford
- Barry Neville Head of Government Affairs, Centrica
- Charles Miller, Regulatory Policy Institute
- Nick Pidgeon, Cardiff University
- Eric Stern, Sweden National Defence College
- Diane Vaughan, Columbia University
- CARR Research Staff

Special panels will focus on issues including: political and regulatory risks; regulation in the public sphere; reputation, security and trust; accountability and new regulatory spaces; regulation, risk and resilience.

Early registration rates (ends 12 January 2007)

Student – £50
Other – £125

Standard registration rate

Student – £60
Other – £150

For a booking form, please visit www.lse.ac.uk/collections/carr and follow the link, or email Regulation@lse.ac.uk



More information on CARR events can be found on CARR's website: www.lse.ac.uk/collections/carr

Full abstracts and details of seminars can be found on the CARR website: www.lse.ac.uk/collections/carr

The Normalisation of Sanitary Alarms – a sociological analysis of the revision of WHO International Health Regulations

Didier Torny, French National Institute for Agricultural Research, Paris

Tuesday 10 October 2006, 1-2.30pm

At the beginning of the 1980s, in the context of diminishing infectious diseases and the confirmed eradication of small pox, IHR seemed to be a remainder of the past, with international sanitary action focusing on different threats: malnutrition, access to drugs, hygiene programs, nicotine, alcoholism or chronic diseases. From a process of norms based on local policing powers, regulatory interventions kept moving towards the establishment of international standards into the biomedical or medico-social field. However, the revised 2005 version of IHR shows a much more normative character than its predecessor of 1969 (amended 1984). Didier Torny analysed the necessary conditions of this revision and the underlying role of (re-)emerging diseases as a key concept. He described the ten-year process of revision (1995-2005) in its key moments (especially the SARS epidemic), questioned the absence of public interest in IHR (contrary to other similar regulations, such as WTO texts) and suggested that this soon to be implemented set of rules and devices embodies an impending international community based on the management of sanitary alarms.

Drug Risks: A brave new world?

Lucien Abenheim, Professor of Public Health, University of Paris, Professor of Epidemiology and Biostatistics, McGill University

Tuesday 24 October 2006, 1-2.30pm

Drugs are among the most frequent risk factors to which persons are exposed in the developed world as their side-effects affect millions of persons every year. They thus represent an interesting model to study the relations between scientific knowledge, risk assessment, decision-making under uncertainty, the conflicts of various interests, risk perception and policy-making. The seminar addressed these issues in comparing two examples experienced by the lecturer: the story of the marketing and withdrawal of 'appetite suppressants' in Europe and the US in the 90s and the story of Vioxx in the years 2000. The new so-called 'Risk Management' policies set up both at the US FDA and European Medicine Evaluation Agency since 2005 were discussed in these perspectives.

Black Boxes, Red Herrings and White Powder – perspectives on the audit committee

Laura Spira, Professor of Corporate Governance, Oxford Brookes University Business School

Tuesday 7 November 2006, 1-2.30pm

Audit committees have become a central feature of the architecture of corporate governance in the UK since the publication of the Cadbury Committee's recommendations in 1992. This seminar outlined the history of the audit committee idea and used a metaphorical approach to provide different perspectives on its role, identifying its limitations as a mechanism for improving corporate governance and considering the consequences of these limitations in the context of UK corporate governance policy.

Risk Management and Regulation: two years into the Barroso Commission

Ragnor Lofstedt, Professor of Risk Management, King's College London

Tuesday 21 November 2006, 1-2.30pm

Ragnor Lofstedt's seminar examined the European Commission's (EC) Better Regulation Agenda, from the time that President Barroso came to power – in November 2004 – to the 2006 summer recess. It particularly focused on whether the Commission's regulatory thinking has moved away from the precautionary principle and towards Regulatory Impact Analysis (RIA), something he predicted in 2004 (Lofstedt 2004). The article summarises the papers and communications in the Better Regulation area put forward by the Commission since November 2004, and makes a number of observations about how the Better Regulation Agenda may develop in the future. In conclusion he argued that the Commission's Better Regulation Agenda has plateaued. Commissioner Verheugen will not be successful in pushing the Agenda further forward because of issues such as REACH and opposition from member states, notably France. It is based on a combination of desk research and interviews with policy-makers, regulators, academics and stakeholders who have been involved either in shaping or fighting the Better Regulation Agenda.

FORTHCOMING LUNCHTIME SEMINARS

Analytic-Deliberative Processes in Risk Assessment

Professor Jacquie Burgess

Professor of Environmental Science, University of East Anglia

Tuesday 30 January 2007, 1-2.30pm

Fear and Terror in a Post-Political Age

Professor Bill Durodie

Senior Lecturer in Risk and Security, Cranfield University

Tuesday 20 February 2007, 1-2.30pm

Safe in their Hands? Licensing and Revalidation of Safety-Critical

Professor Rhona Flin

Professions in Industry and Healthcare, Professor of Psychology, University of Aberdeen

Tuesday 6 March 2007, 1-2:30pm



ESRC Festival of Social Science Week

Tuesday 13 March 2007

See CARR website for further details:

www.lse.ac.uk/Depts/carr

Political Risk and Public Service

A New Deal for Politicians and Top Public

Martin Lodge and **Christopher Hood** examine the changing relationship between politicians and civil servants.



Today's quasi-technocratic language of risk assessment and risk management has pervaded the organizational and regulatory world for barely more than a decade. But long before that, the ability to spot political risks was considered to be a – perhaps the – key skill of higher civil servants in Britain. An essential quality of the top mandarins, it was said, was a talent, born from inherent acumen and experience, for spotting developments that could cause political trouble to ministers and governments. This risk-spotting capacity was essential for government's capacity to execute political swerves, U-turns or whatever other manoeuvres were needed to avoid the various political elephant traps in its path.

That capacity for what could now be termed political risk management was part of an overall bargain between politicians and senior civil servants. The bargain was conventionally understood to mean that politicians gave up the right to blame and fire civil servants at will (meaning that politicians carried the ultimate political risk), while civil servants gave up the right to an open political life. In return, politicians were said to get better-informed and more acute advice about political risks than anyone else could

provide, while civil servants were largely shielded from political risk and gained a trusted role at the heart of government and job security with generous (and early) pensions and honours to compensate for relatively modest salaries.

Today, that bargain looks rather different. In recent years the role of senior departmental civil servants has increasingly been cast as that of 'deliverers' or project managers rather than gurus advising ministers on political risk. The previous role has increasingly passed to the 80-odd special advisers, a category of political civil servant first formally created in the 1970s, who form ministers' political bodyguards. Moreover, the risks that those senior departmental civil servants have to assess are now about potential damage to their own careers rather than (or as well as) those of the politicians they serve. That is because a central thrust of the new 'managerial' structures that have been developed over the past two decades is to put the blame onto senior bureaucrats for operational failures in government, rather than on ministers. Indeed, a report last summer by the IPPR, New Labour's favourite think-tank, proposed to put exactly that approach onto a firmer and more formal basis.

Could we therefore be seeing the birth of a new public service bargain over the handling of political risk in government, in which the top civil servants are project managers rather than advisers to ministers on political risk, are risk-takers rather than backroom risk assessors and are paid high-level corporate salaries in exchange for being in the front line of fire for political blame when things go wrong?

That is a beguiling prospect. It does not require a PhD in political science to see why politicians should be attracted to it, and why it could complete a shift in the way political risks are handled in Whitehall. But our analysis in *The Politics of Public Service Bargains* suggests that things may be more complicated than that. Americans have been seeking for over a hundred years, without success, for a way of slicing cleanly between 'politics' and 'administration' and no country has so far managed to achieve a stable bargain that reflects such a distinction, however 'commonsense' it might seem. A key part of the problem is that to manage their own personal career risks, both sides have an incentive to cheat on any such bargain. Bureaucrats can cheat by ducking behind 'political' conditions when the going gets tough, and politicians can cheat by secretly intervening in 'administration' behind the scenes. Both parties can try to twist the risk bargain so that they get the credit when things go well but shift the blame to the other side when things go badly. Some of the political fallout from the messy sackings of civil servants in the midst of media firestorms – such as Michael Howard's sacking of prison chief Derek Lewis after a prison escapes debacle in 1995 and Estelle Morris's sacking of exams regulator Sir William Stubbs after a fiasco over A level grades in 2002 – indicate how much scope there can be for mutual blaming in those conditions, and similar cases occurred in New Zealand after its attempt to shift the political-risk part of its public service bargain in the 1980s.

Risk bargains that seek to specify and 'targetise' particular outcomes are also likely to come unstuck in two ways; one, by organisations solely focusing on the specified targets and therefore ignoring the larger picture and, second, in the light of unintended or unexpected policy developments that have not been foreseen in the formal 'bargain', raising the question as to who is to carry the responsibility for

Bargains: Servants?

those residual risks that have not been specified. Who is to take the blame when the event neither fits with the 'risk' of the bureaucrat or the politician because it falls outside the contract?

Accordingly, it seems more likely that the deals over who carries what political risk at the top of British government will be further complicated (as they have been during the 1970s, 1980s and 1990s with the advent in each of those decades of new classes of senior civil servant with their own special deal over political risk), rather than shifted once and for all into a new stable arrangement that reverses the traditional bargain on political risk. A more plausible future for the political risk bargain in Whitehall would seem to be one that resembled the world of British eighteenth-century naval administration (as famously caricatured by Voltaire), in which an admiral is hanged from time to time to encourage the others – but not all the time. ■

Martin Lodge is CARR Research Theme Director: Regulation of Government and Governance and Lecturer in Political Science and Public Policy. Christopher Hood is Gladstone Professor of Government at the University of Oxford and a CARR Research Associate. *The Politics of Public Service Bargains* is published by Oxford University Press 2006 (ISBN 0-19-926967-X).



CARR BOOKS



Global Governance and the Role of Non-State Actors

Gunnar Folke Schuppert (Ed)
Nomos, 2006.



Regulatory Innovation: A comparative perspective

Julia Black, Martin Lodge and Mark Thatcher (Eds)
Edward Elgar 2005
Now out in paperback



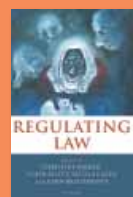
Organizational Encounters with Risk

Bridget Hutter and Michael Power (Eds)
Cambridge University Press 2005



Controlling Modern Government: Variety, Commonality and Change

Christopher Hood, Oliver James, B Guy Peters and
Colin Scott
Edward Elgar 2004



Regulating Law

Christine Parker, John Braithwaite, Nicola Lacey and
Colin Scott
Oxford University Press 2004



On Different Tracks: designing railway regulation in Britain and Germany

Martin Lodge
Greenwood Press 2002



The Government of Risk: understanding risk regulation regimes

Christopher Hood, Henry Rothstein and
Robert Baldwin
Oxford University Press 2001

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Withering in the Heat? The regulatory state and reform in Jamaica and Trinidad and Tobago

Martin Lodge and Lindsay Stirton, *Governance* 19 (3), July 2006

The Risks of Risk-Based Regulation: insights from the environmental policy domain

Henry Rothstein, Phil Irving, Terry Walden and Roger Yearsley, *Environment International* 32(8)

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Robert P. Kaye, *Public Policy and Administration* (2006) 21(3)

Risk, Regulation, and Management

Bridget M. Hutter, in Peter Taylor-Gooby and Jens O. Zinn (eds.) *Risk in Social Science*, Oxford University Press

The Institutional Origins of Risk: a new agenda for risk research

Henry Rothstein, *Health, Risk and Society* 8(3)

Managing Regulatory Risks and Defining the Parameters of Blame

Julia Black, *Law & Policy* 28(1)

Have Targets Improved Performance in the English NHS?

Gwyn Bevan and Christopher Hood, *British Medical Journal* 332

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Tobias Scheytt, Kim Soin, Kerstin Sahlin-Andersson and Mike Power, *Journal of Management Studies* 43(6)

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