

PUBLIC ADMINISTRATION SELECT COMMITTEE INQUIRY INTO CHOICE, VOICE AND PUBLIC SERVICES

**Joint Memorandum From Minister For State For Department Of
Health; Minister of State for Local and Regional Government; and
Minister of State for School Standards**

THE CASE FOR USER CHOICE IN PUBLIC SERVICES

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'People should not forget the current system is a two-tier system where those who can afford it go private, or those who can move house get better schools... Choice mechanisms enhance equity by exerting pressure on low-quality or incompetent providers. Competitive pressures and incentives drive up quality, efficiency and responsiveness in the public sector. Choice leads to higher standards...The over-riding principle is clear. We should give poorer patients...the same range of choices the rich have always enjoyed. In a heterogeneous society where there is enormous variation in needs and preferences, public services must be equipped to respond'. Tony Blair, South Camden Community College, 23 January 2003.

'Many on the Centre Left argue that, whilst services should be responsive and user-friendly, the language and values of choice have no place in public provision. I reject that dichotomy. It would be foolish and politically suicidal, in my view, to reject the concept of choice, and the importance of tailoring services to individual needs'. David Blunkett (2003) Towards a Civil Society. IPPR p.9.

‘These choices will be there for everybody...Not just for a few that know their way around the system. Not just for those who know some-one ‘in the loop’ – but for everybody with every referral. That’s why our approach to increasing choice and increasing equity go hand in hand. We can only improve equity by equalising as far as possible the information and the capacity to choose’. John Reid, 16 July 2003, Speech to the New Health Network.

‘Traditionally the left turned its back on choice as the preserve of the right. In a consumer society where the consumer is king, vacating this political terrain is not a feasible strategy for progressive politics. A modern approach calls for choice to be redistributed. Today people who can afford it buy choice over health and education. Those without, do without. This is unfair and must be changed. Expanding choice, then, is about enhancing equity and opportunity not undermining it’. Alan Milburn ‘In public services too, make the consumer king’ Wall Street Journal 17 March 2004.

‘Changing the way in which public services are delivered can dramatically transform the relationship between providers and service users – from passive dependency to active participation in a process where the providers see their role as responding to customers needs and aspirations, and helping them to get the best available outcome’. Nick Raynsford (2004) Enhancing user choice; a fair and just approach, NLGN.

‘...we need to set up a system that is not based on the common denominator. The central characteristic of such a new system will be personalisation – so that the system fits to the individual rather than the individual having to fit to the system...And the corollary of this is that the system must be both freer and more diverse – with more flexibility to help meet individual needs, and more choices between course and types of provider so that there really are different and personalised opportunities available.’ Charles Clarke, Department for Education and Skills: Five Year Strategy for Children and Learners, July 2004.

“I come to this as a parent as well as a politician ...And believing that parents and children must be at the heart of what we do and how we think. Parents helping to shape the education agenda to deliver real opportunity for their children. Parents supporting schools and supporting their children’s education. Parents with rights but with responsibilities too. Rights to a top quality education for their child and to a voice in how that education is delivered...The prize is a real one. A system that is not only universally excellent, but universally responsive to its users too. Where parents and the community know they have a voice and that their voice will be heard.” Ruth Kelly, North of England Conference Speech, 6 January 2005.

‘Where the Government is committed to public services free at the point of use and available to all on the basis of need, it is important to ensure that choice is not promoted at the expense of equity or efficiency, particularly where there are market failures and capacity constraints’. HM Treasury (2003) Public Services: Meeting the Productivity Challenge.

THE CASE FOR USER CHOICE IN PUBLIC SERVICES

1. INTRODUCTION

1.1 The Government is committed to extending choice throughout public services where that is feasible and desirable. The Government welcomes the Committee's enquiry into this important area of public service reform and looks forward to hearing the Committee's views in due course. The Committee has invited the Ministers of State for Local and Regional Government, Health and School Standards to give oral evidence to the Committee. They will be happy to illustrate the way in which the general principles outlined here are being applied to the particular public services, as set out in the 5-year strategy documents and the 10-year vision document for local government published last year. Further examples from each Department are provided in annexes to this memorandum.

1.2 Both theoretical and empirical evidence points to choice serving as an important incentive for promoting quality, efficiency and equity in public services – and in many cases more effectively than relying solely or largely upon alternative mechanisms such as 'voice'. Choice emerges as both a means of introducing the right incentives for improving services for users, and as a desirable outcome in and of itself: that is, it is both intrinsically and instrumentally valuable. In this sense, it is at the same time both a tactical and strategic contribution to the drive to improve services for the people who use as well as vote for them.

1.3 However, none of this is to say that extending user choice is applicable to all services. Nor is choice unproblematic even in those areas where it can be usefully applied. On the contrary, there are some reasonably stringent conditions that have to be met if choice is to achieve the aims of government policy in the reform of public services. Good policy design will be integral to its success. This paper therefore not only examines some of the more general arguments for extending user choice but tries to highlight the conditions necessary for choice to be effective, the areas where progress is being made in appropriate policy development, and the areas where more progress needs to be made.

2. THE MEANING OF CHOICE

2.1 There are a number of dimensions of choice in public services: choice of provider (where?); choice of professional (who?); choice of service (what?); choice of appointment time (when?); and choice of access channel, such as phone, web or face-to-face (how?). The principle of 'choice' in public services includes decisions on all these dimensions (OPSR 2003).

2.2 These decisions are not necessarily independent. In health care, a patient may choose a particular provider because of its opening hours or shorter waiting times, or in order to see a particular professional. In education, a parent may choose a particular school for a child because of the type of curriculum (e.g. specialist school) or style of pedagogy (e.g. Montessori) it offers. However, it is useful to keep the distinctions in

mind because the arguments for and against extending user choice in public services can vary according to which type of choice is being considered.

2.3 It is also important to distinguish who is doing the choosing. This could be the users themselves (such as patients in elective surgery, the direct payments scheme, choice-based lettings), relatives of the users (such as parents for schools or curricula), or collective agents choosing on behalf of users (such as local authorities awarding contracts to suppliers on behalf of users). This paper concentrates primarily on choice by users and/or their families, using examples from health, education and local government.

3. JUSTIFICATIONS FOR INCREASING USER CHOICE

3.1 Extending user choice in public services may be justified on four grounds:

- It's what users want
- It provides incentives for driving up quality, responsiveness and efficiency
- It promotes equity
- It facilitates personalisation

Paradoxically, with the possible exception of the last, it can also be criticised on all these grounds.

3.2 What Users Want

3.2.1 It is frequently asserted - often by those who have a good deal of choice in their lives already - that users of public services do not in fact want choice. This assertion of the essential irrelevance of choice is often contrasted with what is claimed to be an apparent preference for better quality, often phrased as 'people don't want choice; they want a good local service'. This argument has been bolstered by the recent publication by a US academic, Barry Schwartz, *The Paradox of Choice*, arguing that where consumer goods are concerned, people frequently find excessive choice unsatisfying and de-motivating (Schwartz 2004).

3.2.2 We return to the question of the relationship between choice and 'a good local service' below. In the meantime it is important to note that, whatever may be true for consumer goods such as jam or instant coffee, any assertion that users of public services do not want choice is simply wrong. In fact, there is substantial evidence that users of public services in Britain desire increased choice. There is also evidence that this support for choice is not confined to the middle classes. A recent survey on local government services found that it is the lower socio-economic groups who show the strongest support for increased choice (Audit Commission, 2004).

3.2.3 The direct payments schemes are initiatives in which local authorities make cash payments to individuals to purchase their own community care services. The schemes were introduced in the mid-80s in America, Canada and Scandinavia, and are now widely adopted across Europe. Research commissioned by the NLGN pointed to overwhelming evidence that direct payments are generally very welcome, making a

significant difference to the lifestyle and basic rights of many people in need (Lent and Arend 2004, p.29):

'The scheme gave me flexible, adequate assistance. I became liberated, more fulfilled, and light hearted...I've gone from non-involvement to choice'.

'Before I went on the scheme I felt I was just existing, but now I can choose to live my own life'.

3.2.4 Giving a choice of provider is not always practical or desirable, and examples from local government demonstrate that the alternative dimensions of choice can also provide positive outcomes for users:

- Local authorities have successfully implemented choice of access channels for service users, including call centres, on-line services, one-stop shops and computerised kiosks. Residents are also offered greater choice of appointment time and home visits
- The Supporting People Scheme provides more choice to residents with the greatest need by pooling together several housing related funding streams into one pot for allocation to vulnerable users. This removes the burden of applying for different benefits and enables a more personalised benefit package to be designed.

3.2.5 Evidence from tenants making choice-based lettings (CBLs) in social housing are equally positive. In CBLs, the decision whether or not to apply for a property is taken by the prospective tenant rather than the housing officer. Interim results of the assessment suggest that user satisfaction has been raised considerably by the schemes, and that properties that have been traditionally hard to let have become occupied much more rapidly. (Lent and Arend 2004, p.31).

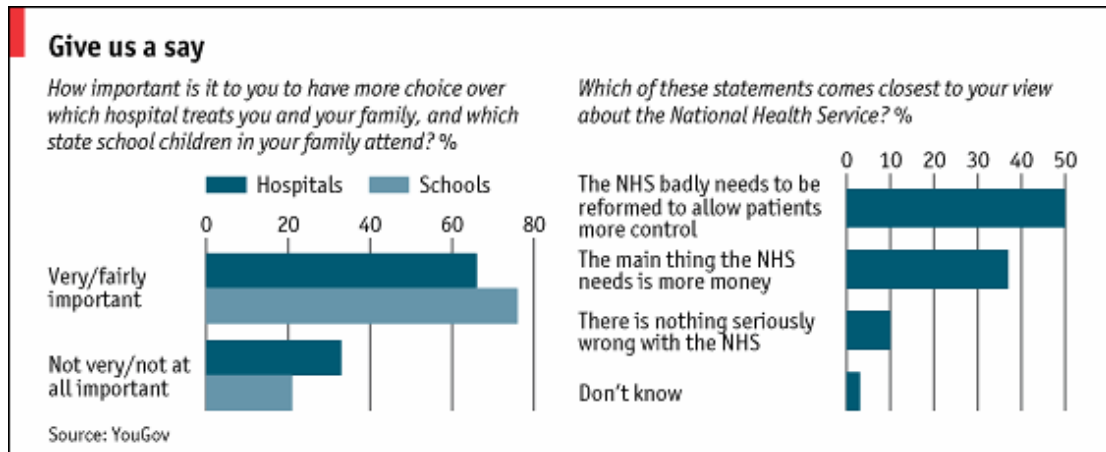
3.2.6 In healthcare, the choice pilots in elective surgery running from October 2002 to March 2004 had a very high take-up of choice: 67% of patients accepted choice in the London Patient Choice Project, 88% in Manchester and 50% of those involved in the Choice Initiative in Coronary Heart Disease. From April to the end of August 2004, choice at six months was rolled out across the NHS and, since April some 30, 000 patients have accepted an offer of choice.

3.2.7 MORI interviewed 1,208 members of the general public in August/September 2003, asking what would best represent their feelings if a GP had decided they needed treatment and offered them a choice of hospital both in the local area and in the rest of the country. 15% said they would like to make the decision themselves, and 62% said they would like to make the decision, but would need advice and guidance to help them decide. Just 23% said the GP should make the choice. Interestingly, of this last group, most were elderly (65 or over), and more were working class and/or from ethnic minorities: a point to which we shall return.

3.2.8 A poll undertaken by YouGov for the *Economist* on choice in both health and education is also illuminating. This sampled 2,250 voters in 2004. The study found that 76% of those with children in state schools consider it very important or fairly

important that they have more choice over which schools their children attend, while 66% considered it important that they have more choice over the hospital that treated them (see Figure 1 below). With respect to health care in particular, 50% thought that giving more control to patients was more important for the NHS than giving it more money.

Figure 1



Source: *The Economist* April 7, 2004

3.2.9 With respect to more specific services, the choice pilots in elective surgery have generated a high degree of patient satisfaction with the processes and the outcomes (Le Maistre *et al* 2003). Representative comments include:

‘The patient choice idea is brilliant when it means that the operation is available much sooner - definitely to be recommended’

‘I think the patient choice initiative scheme is an excellent one. I hope it will continue and that other people will be able to benefit from the scheme as I have done’

3.2.10 It is also clear from the research that there are a variety of reasons why people value choice. For some, it is because of the increased sense of power and control over their lives that choice gives them: 61% of the *Economist* poll felt that increasing choice in health care and education would give them some or a lot more control over their lives. Also, it seems likely that this is a major factor in the popularity of the direct payments scheme.

3.2.11 For others, it is the more mundane concern that thereby they can get a better or quicker service. In this connection, it is fair to note that some of the MORI/NCC respondents argued that choice ought to be unnecessary:

“If your local hospital is as good as it should be, why would you want the choice?”

Male carer, 35+

3.2.12 And this brings us to the second part of the ‘irrelevance’ argument: that, instead of choice, people want a good local service. But this dichotomy is false. Part of the justification for extending choice is that it is more likely to create a good local service – or at least a better service than a system with no choice. To this we now turn.

3.3 Incentives for Quality, Responsiveness and Efficiency

3.3.1 An important part of the reason for extending user choice, concerns the incentives it gives for changes in provider behaviour. Looking at the case of choice of provider, those providers who are not chosen have a strong incentive to raise their game. They will have to improve the quality of their service (at least in the eyes of users), to increase their responsiveness to users’ expressed needs and wants, and to use their resources more efficiently so as better to attain these ends. In such cases, choice is acting as an instrument for achieving other desirable social ends.

3.3.2 However, for organisational and political reasons, choice of provider is not always a practical option, and it is important to consider other models of choice that can provide incentives for improved service delivery. Health and education provide examples where a choice of service leads to more personalised delivery and better outcomes for patients, pupils or parents. In local government, choice-based lettings show that the provision of choice by a single provider can drive up service quality and improve customer satisfaction, while at the same time allowing staff to play a more constructive and empowering role. Arrangements for allowing council tenants the opportunity to vote on future landlords under the large-scale voluntary transfer ballots have also received a positive response. Similarly, the allocation of direct payments to individuals in receipt of community care has helped them to become independent consumers who organise their own care around their own wants and needs.

3.3.3 Choice can also enable communities to get involved in the services that affect them. Community involvement in managing local amenities, for example through park trusts, gives local people ownership over the use of public space. In some areas, tenants groups have taken over the housing management system from the council with positive results. Tenant Management Organisations (TMOs) are representative and accountable tenant led bodies. They must meet strict requirements on their constitution and governance and be backed by tenants in a rigorous ballot. A 2002 evaluation shows that TMOs not only perform very well in terms of housing management but also provide a model of civil renewal and community empowerment.

3.3.4 To appreciate the force of this argument for choice as an incentive for service improvement, we must consider the alternative, where no user choice is possible. To obtain a good service users are reliant upon a combination of: (a) the goodwill of the providers concerned not to abuse their monopoly position - that is, in the metaphor of Le Grand (2003) that they are altruistic ‘knights’ rather than self-interested ‘knaves’; (b) ‘voice’ mechanisms, such as verbal persuasion, complaints procedures, public participation, user consultation or, ultimately, elections, to express their dissatisfaction and preferences; and c) centrally driven commands and controls over performance, coupled with some form of independent regulation.

3.3.5 While ‘knightliness’ (or, more generally the public service ethos), central performance management, regulation and ‘voice’ all have an important place in ensuring public service delivery, the public could be forgiven for feeling them to be fairly distant from their day-to-day experience or personal influence. The public service ethos undoubtedly forms part of the motivation of professionals and others working in the public service; but it is only a part, with more self-interested or knavish concerns also playing a significant role (Le Grand 2003, Ch.2). Moreover, self-interest and public spiritedness often conflict for public sector providers (as with private practice for hospital consultants), and when they do it is far from clear that public spiritedness always dominates.

3.3.6 Whatever activists’ hopes and aspirations may be, in fact far fewer people are involved in expressing their views through formal mechanisms of ‘voice’, than through using services. And those that do tell us that there is much more work to be done to make such mechanisms satisfying and effective.

3.3.7 More specifically, voice mechanisms can be collective - voting, or through other mechanisms of collective decision-making – or individualistic: an example would be complaints procedures. Collective voice mechanisms have the advantage that they are indeed collective: that they take account of the interests of the community. On the other hand, they are clumsy instruments for dealing with the kind of individual decisions with which we are concerned here. Parents who are dissatisfied with their local school, or patients with their local hospital, can vote for local elected representatives who are promising to provide better ones; but for their votes to be effective, a number of conditions have to be fulfilled. There has to be an election in the offing; their views have to be shared by a majority of other voters; the issues concerning the quality of schools or hospitals have to be the principal factors affecting the election; politicians promising better schools or hospitals have to be among the candidates; and, if these politicians are elected, they have to have some effective method for ensuring school or hospital improvement. It is rare that all of these conditions will be met.

3.3.8 Further, despite their collective nature, these mechanisms are often poor at dealing with under-performance. Voters are rarely faced with the costs of meeting their service requirements. When they are not faced with those costs, they can simply vote to increase or maintain services at other people’s expense. Indeed, this often happens when school or hospital closure proposals are put to a vote; the voters concerned usually do not have to bear the costs of keeping the institutions concerned open and in consequence usually vote the closure proposals down. And a majority can also vote to segregate a minority, excluding them by formal or informal means from the service concerned.

3.3.9 Individual voice mechanism such as complaints procedures also have their problems. They require energy and commitment to activate; they take a good deal of time to operate; and they create defensiveness and distress among those complained against. They favour the educated and articulate. Users who complain are not necessarily those who have the most to complain about; and adversarial relations between professionals and users, especially tied to a threat of lawsuits as they often are, can lead to expensive and inefficient defensive reactions on behalf of providers.

3.3.10 The Committee's recent work on targets argued for greater bottom up and local demand to balance the limitations of top-down targets and centrally drive performance improvement. Choice provides such a local, bottom-up option. And though voice, regulation and inspection can play a role, we are also well aware of their limitations as far as generating timely service improvements that matter for customers.

3.4 Conditions for Effectiveness

3.4.1 That all said, as many commentators have pointed out, it is clear that choice will only work as an effective incentive for providers if certain, reasonably stringent, conditions are met. The following discussion focuses largely on the choice of provider model, but some of these conditions are also relevant to models of choice which involve a single provider. For all models of choice, it is necessary for users to be well informed about the services available and for providers and policy-makers to be user-focused from the design of policy through to delivery.

3.4.2 *Information.* For choice to act as an effective driver of quality, it is necessary to rely upon the user's judgement about the quality and responsiveness of the service. This seems appropriate at a fundamental level, for it is that judgment which ultimately counts. Professionals and policy-makers of course make important judgements about service outcomes and performance, but quality is ultimately determined by how the service is experienced by individuals with their infinitely diverse preferences and requirements.

3.4.3 But this does require that the user be well informed. Research asking people what drives both their satisfaction and their dissatisfaction with services, consistently identifies effective information as a critical factor (*OPSR, 2003a and d*). Better-informed customers are more satisfied, and poorly informed ones are dissatisfied. This is where choice becomes an important incentive for users, for it is only when customers have a choice that they have reason to become informed. Without choice, why would they bother? They will get what someone else has decided they will be given, or determined that they will 'need'. Without any choice, they are far more like the passive recipient than the active citizen so often idealised by opponents of choice. Whilst some have suggested that becoming better informed about the range and quality of services available is a 'research cost', it is one that most people could consider a legitimate investment for effective citizenship.

3.4.4 Choice also provides an incentive for service providers and policy-makers to become more user-focussed, and translate their organisational and professional preoccupations and language into information for users. Useful information sets out the nature of the service, the options available, and who might find which option most valuable in what circumstances. Designing options requires providers to think about what the service needs to be like to meet different requirements, and what they need to do to reach the right people with an appropriate response.

3.4.5 Information is important factor in satisfying customers, whether the choice is about the provider, the professional, the type of service, the appointment time, or access channel. Well-informed people making active choices about what they need and how best to obtain it will not only be more satisfied and confident about service

quality. They are also powerful drivers in making services more efficient (because services are used by people who want them) as well as more effective (because services are better targeted).

3.4.6 *Consequences of choice.* The incentive argument in favour of choice is contingent on there being consequences for the providers of being chosen or not. More specifically, there need to be benefits to those that are chosen and costs to providers who are not. Most providers of public services do intend, and will certainly claim, to provide a good service, and choice provides a powerful reality check on how far they are succeeding in doing so as far as customers are concerned. And in many cases that feedback will be sufficient incentive for the service to generate an improvement in performance.

3.4.7 A more radical way of ensuring this is for the money to follow the choice; for the providers not chosen to lose resources, while those who are chosen gain resources. Although this is a powerful kind of incentive, it has its problems if used as the sole lever for improvement and if it jeopardises the viability of a service without providing an alternative to its remaining users. However, choice can provide an effective bottom-up pressure for revealing poor quality and under-performance. Its impact on a service over time can trigger intervention to turn round the service, or to manage its closure before reaching the point where users might be put at risk.

3.4.8 In all these cases, the exercise of choice is acting as a clear signal of success or failure; a signal that is not available in non-choice or monopoly systems, which in consequence often find it difficult effectively to distinguish between good and bad performers.

3.4.9 *Alternatives.* Of course, for choice of provider to exist there must be alternative providers from whom to choose. Here it is often argued that offering choice in most public services is illusory, especially in health care and education. London is usually cited as an exception; but most of the population outside of London cannot realistically be offered a choice of schools or hospitals simply because there are not enough of them – or so the argument goes.

3.4.10 However, again the facts do not bear out this claim. Take secondary schools. Departmental data show that 32% of maintained mainstream secondary schools in England have two or more schools within one mile of them, 70% within two miles, and 80% within three miles. Since the National Travel Survey shows that the average length of the journey to school for 11-16 year-olds in England is three miles, this implies that four fifths of English schools have at least two other potential choices, attendance at which would entail little if any extra travelling. If having one other school or more in proximity is regarded as sufficient for choice, then the figures are even more impressive, with 61% of secondary schools having one school or more within one mile, 82% within two miles and 88% within three miles. In short, barely one in ten schools in England has no potential alternative within three miles.

3.4.11 Hospitals offer a similar picture – indeed in some ways an even more striking one. A recent study found that 92% of population had two or more acute NHS trusts within 60 minutes travel time by car. Further, 98% of the population have access of up to 100 available and unoccupied NHS beds and 76% to 500 (Damiani *et al* 2004).

The only areas that came close to monopolistic provision were the relatively lightly populated parts of Cornwall, North Devon, Lincolnshire and Cumbria. However, the fact that many trusts offer services on more than one hospital site means that, even in these areas, patients will have a local choice over where they are treated. In addition, they will of course be free to travel further to alternative providers if they wish. In passing, it might be noted that these figures also suggest that there may be considerable under-utilised capacity in the NHS; capacity that could be utilised with a well-designed policy of user choice.

3.4.12 What the argument that choice is illusory ignores, but that is evidenced by these figures, is just how urbanized is the British population. Almost 90% of the population lives in urban areas, with over half the population resident in just 66 areas with populations of 100,000 or more (Denham and White 1998). Of course there remains the problem of rural areas where users will often need to be prepared to travel further to take up choice; and here other policies for ensuring quality will have to be developed.

3.4.13 *Entrance and Exit.* The questions of ‘exit’ – how to deal with failing providers – and ‘entrance’ – how to encourage new, innovative providers to emerge – present perennial difficulties for all systems of delivering public services, including those based on voice or hierarchy, as well as those based on choice.

3.4.14 One effective entrance strategy is that involving the provision of explicit, time-limited, subsidies to potential new entrants. Another part of such a strategy would be to remove the barriers to entry arising from existing rules and procedures (as arguably was the case from the surplus places rule in education – now indeed abolished). The most satisfactory exit strategy for public services may not involve ‘exit’ at all, but rather special measures types of intervention to turn the institution round.

3.4.15 Generally, further policy development is necessary here, drawing upon British and overseas experience in these areas as appropriate.

3.4.16 *Capacity and Economies of Scale.* Some argue that there are negative implications for efficiency arising from the claim that choice requires there to be excess capacity in the system. This may be true under some circumstances but the margin of extra capacity needed to permit contestability is likely to be small. Moreover, it is worth noting that the choice-based lettings schemes in social housing are operating with success in conditions of scarcity (Lent and Arend, 2004, p.32). For there to be choice, there will need to be diversity and that may prevent the exploitation of economies of scale (but is everyone getting the same service really an economy?). Overall, however, if there are efficiency losses that arise from these causes, they may have to be accepted in order to reap the gains in efficiency and other areas that arise from the positive incentive effects of choice on user and provider behaviour.

3.4.17 *Evidence.* Finally, it is worth noting that hard evidence is accumulating from both the UK and elsewhere concerning the net positive impact of choice on aspects of quality, efficiency and responsiveness in health care and education. For instance, the choice pilots in elective surgery have dramatically brought down waiting times in the

areas in which they operate. Following the introduction of patient choice in London, average waiting times fell by a substantial 19.4% compared to 7.6% in the rest of England. (Dawson et al, 2003)

3.4.18 There is evidence from micro-studies of school performance that choice and competition in the UK has a positive effect on both quality – as measured by exam and test results - and efficiency (Bradley *et al* 2001).

3.4.19 Internationally, there is evidence from Sweden that standards in the education system have improved faster in government-run schools that face a lot of competition from state-funded but independent schools than in those that do not. Further, there was no evidence that inequality in educational outcomes has increased, although some evidence of increasing segregation, as those who choose independent schools are likely to be more educated than those who do not. In addition, there was evidence that satisfaction with the education system has increased in areas that offer more choice (Bergstrom and Sandstrom 2002).

3.4.20 In Milwaukee, Michigan and Arizona, the effects on public schools of competition from ‘choice’ schools has been examined. All three of those areas have experimented with allowing parents to choose schools other than their local public schools either through the mechanism of vouchers (Milwaukee) or charter schools (Michigan, Arizona). It had been widely predicted that, because of cream-skimming, public schools in the areas concerned would suffer an overall drop in performance as the better students were sucked into the choice schools. However, Hoxby (2000) found evidence of strongly improved performance by the public schools, from which she concluded that the efficiency-inducing effects of competition were more than enough to offset any potential effects of cream-skimming. She also examined the effects of competition with private schools on public schools and of competition between public schools through parents choosing place of residence. Again she found that competition had a positive impact on performance.

3.5 Choice and Equity

3.5.1 Extending user choice creates two kinds of concerns about equity. First, there is an argument that the poor and other disadvantaged groups lack the capacity to make effective choices. Several commentators (see, e.g., Appleby *et al* 2003, Hattersley 2003) have voiced concerns that, however effective extending user choice may be in terms of increasing the efficiency and responsiveness of public services, it will also worsen equity: that it will privilege service utilisation by the articulate, confident middle class and disadvantage the allegedly less capable poor.

3.5.2 The second anxiety concerns cream-skimming or selection. It is argued that providers, especially if they are over-subscribed, will have the power to select the users to whom they provide services; the easiest, the cheapest, those who are most likely to boost their ratings in any league tables. User choice thus turns into provider choice – with again particularly adverse consequences for the poor and disadvantaged.

3.5.3 *Incapacity and the poor.* It is far from clear that choice will disadvantage the poor and unconfident any more than non-choice or ‘voice’ systems. The voice of the poor is generally much quieter than that of the middle class. Their ability to deal with

professionals, to articulate their dissatisfactions and to utilise complaints procedures if necessary, is significantly less than that of the better-off.

3.5.4 This was substantiated in a recent review of equity in the NHS, in areas where there is currently little choice (Dixon *et al* 2003). This found substantial inequalities:

- 'Affluent achievers' had 40% higher Coronary Artery Bypass Grafting and angioplasty rates than the 'have-nots', despite far higher mortality from Coronary Heart Disease in the deprived group.
- Intervention rates of CABG or angiography following heart attack (Acute Myocardial Infarction) were 30% lower in lowest SEG than the highest.
- Hip replacements were 20% lower among lower Socio Economic Groups despite roughly 30% higher need.
- Social classes IV and V had 10% fewer preventive consultations than social classes I and II after standardising for other determinants.
- A one point move down a seven point deprivation scale resulted in GPs spending 3.4% less time with time with the individual concerned.

3.5.5 It is worth noting, too, that the principal supporters and beneficiaries of opportunities to exercise education choice in the United States are minority and ethnic groups, who find that such arrangements give them much more control over the education of their children than previous non-choice systems. Their children appear to achieve higher standards of education in schools chosen by their families, than they did in schools they were previously obliged to attend. And as Nick Raynsford argues in his essay for NLGN on choice and fairness, the experience of direct payments for social care provides no evidence that the extension of choice to poorer service users results in 'bad' choices which undermine the quality of service provision (Raynsford, 2004).

3.5.6 That said, it is likely that extending user choice of provider may create some problems for the exercise of choice by the less well off, including a need for help with transport costs and with information and advice. The Government is thus considering assistance policies targeted on poorer families that can be grouped under the heading of *Supported Choice*. This could involve assistance with transport and travel costs for users and families of users, and identifying a key worker who would act as an adviser to those users and families.

3.5.7 In health care, patient support services may include direct support for choice from the GP or referring primary care professional, support from practice staff, the Patient Advice and Liaison Service (PALS) or from voluntary sector organisations. For those few patients with the greatest needs, this might build on the highly successful Patient Care Adviser experience in the choice pilots or from voluntary sector organisations and the experience of other similar patient advocacy and support roles in the NHS. Responsibilities of this role could include monitoring care plans, offering choices of provider, discussing treatment options, identifying special needs regarding travel, disability (mobility) and language (communication), providing

information and updates about the care pathway (including assessment, treatment and aftercare), booking appointments with providers, arranging transport, helping patients navigate the system, and supporting /coaching patients on self-care, self-management and behavioural change.

3.5.8 *Cream-skimming*. The second equity problem for choice, cream-skimming or selection is likely to be a significant problem for choice, especially in education.

3.5.9 The problem of ‘cream-skimming’ is closely related to restrictions in entrance to the choice system and in the expansion of existing providers. In education the ability of a school to engage in such behaviour only arises where restrictions in capacity of some schools lead to a need for rationing of available places among applicants. For example, comprehensive schools must accept all who apply if spare capacity exists – only if there is excess demand for places can admissions criteria be applied. Another important point is that even if a school is not deliberately ‘cream-skimming’, the criteria applied often lead to inequitable outcomes – admissions criteria are primarily based on geographical factors (see e.g. West and Hind 2003) and many studies have shown how over-subscribed school places increases house prices in catchment areas as a result of this (see e.g. Cheshire and Williams 2000, Leech and Campos 2001), excluding the less well-off from the best schools. If school capacity was more responsive to demand for school places, there would be a resultant improvement in equity in the choices available to parents. Policy options to address this include the Expansion of Successful and Popular schools program introduced by the DfES and other mechanisms for improving supply responsiveness. Inequity in the choices available to parents is to a large extent caused by restrictions in supply.

3.5.10 There are variety of policy options for addressing cream-skimming. These include:

- stop-loss insurance
- restrictions on the admission freedoms of providers
- weighting funding formulae, so as to favour the less well off.
- Improving the responsiveness of capacity in popular providers to demand from service users

3.5.11 Stop-loss insurance is a scheme whereby providers faced with a user whose service costs lie well outside the normal range are allocated extra resources once the cost has passed a certain threshold. This has the advantage of removing the incentive to discriminate against high cost users, but carries with it the problem that the providers concerned have no incentive to economise on service once the threshold has been passed.

3.5.12 A second possibility is to restrict the amount of freedom providers have over admissions to reduce the potential for cream-skimming. In this case, a careful balance would need to be struck between local autonomy and central policy to achieve more equitable outcomes.

3.5.13 A third alternative is to risk-adjust the pricing system such that higher cost users have higher costs associated with them. Using the example of the national tariff system for health care (based on Health Related Groups or HRGs), it would, in

principle, be possible to increase the sensitivity of the tariff by ensuring that the complexity or morbidity of the patients is included within the price mechanism. This could take the form of an adjustment to the price for the number or nature of the comorbidities that a patient presents. This would still present the potential for HRG "creep" (upcoding patients to more lucrative high cost categories) but would increase the ability of the price mechanism to reflect the cost of care. A further option would be to adjust the price for deprivation. In the work being done to develop HRGs, consideration is being given to the use and ease with which it would be possible to derive groupings of conditions that take account of socio-economic and other factors.

3.5.14 A form of risk adjustment that would be rather simpler and help assuage any socioeconomic inequities arising from cream-skimming would be to deprivation-adjust the tariff or price. The tariff could be associated inversely with an area deprivation index such that treatments for users from deprived areas would carry a higher price than treatments for those from wealthier ones. This could in fact be a form of risk adjustment since it is widely believed that poor users have greater need than better-off ones.

3.5.15 The policy challenge is to identify which of these options is likely to be most effective and most consistent with other government policies.

3.6 Choice and Personalisation

3.6.1 As with choice, personalisation has many meanings. At one end of the spectrum, it can mean simply the tailoring of services to meet individual needs and wants. In that case, it comes close to what we have described above as responsiveness. At the other end, it can imply joint involvement of both user and provider in the development and implementation of the service as it is to be rolled out: what has been termed 'co-production' (Leadbetter 2004).

3.6.2 In either case (and for those in between) it is difficult to see how personalisation can be implemented without choice – in this case, choice of service, and/or choice of access of service. The concept of personalising a service for an individual implies that there are alternative ways of providing the service and that one is better than the other for the individual concerned. The question as to who makes the choice may vary (the professional, the user, an interaction between the two); however, in every case some form of choice is integral to the concept.

4 CONCLUSION: CHOICE AND POLICY DESIGN

4.1 Both theoretical arguments and empirical evidence point to being choice being an effective instrument for promoting quality, responsiveness, efficiency and equity in public services – and in many cases more effective than alternative methods of doing so, such as relying upon voice mechanisms. However, none of this is to say that extending user choice is applicable to all services, or that it is the principal determinant of reform. Nor is choice unproblematic. On the contrary, there are some reasonably stringent conditions that have to be met if choice is to achieve the aims of government policy in the reform of public services. Good policy design is the key to

extending user choice; undertaking such design is a key task of the current Government.

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