Choice, competition and the political left

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Summary: Choice and competition can no longer be viewed as an exclusive tool of the political right. Beyond creating incentives to drive up quality and increase efficiency in the English NHS, choice and competition stand to promote equity. While many left-leaning critics are quick to point out ways in which choice and competition could induce inequity, few critics objectively compare the equity implications of choice and competition to the no-choice system which preceded it. This article lays out the basic arguments for how choice and competition stand to improve equity. If the political left is serious about reducing inequities in public services, the time is right for them to open their eyes to the potential for choice and competition.

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Since 1955, when Milton Friedman published The Role of Government in Education,1 the political right has had a virtual monopoly on choice and competition in public services. Traditional thinking on the right posited that greater user choice of providers tied to a reimbursement system where money followed users’ choices would promote both allocative and technical efficiency. The political left not only disputed the right’s efficiency claims, but went one step further and argued that any increase in user choice would come at the expense of equity.

This left/right battle over choice and competition continued until quite recently, when left leaning policy-makers began to come around to the notion that choice and competition in public services might not be such a disaster. Not only did the political left begin to argue that choice and competition could incentivise efficiency, they began to draw attention to the fact that injecting choice and competition into public services could improve the care that is delivered to traditionally under served users.

We argue that this emphasis on the potential positive impact of choice and competition on equity is quite justifiable. In what follows, we draw on theory, past experience and empirical evidence to articulate a case for the equity benefits of choice and competition.

A new rhetoric…

From 2002 onwards, Tony Blair’s Labour Party embarked on an ambitious reform agenda to modernise the English National Health Service (NHS). At the core of the former Prime Minister’s health service reforms was a belief that greater user choice and provider competition would create a more personalised NHS with better quality and less inequity than traditionally collectivist public health systems.

Speaking in 2003, Tony Blair said:

“People should not forget the current system is a two-tier system when those who can afford it go private…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 overriding principle is clear. We should give poorer patients… the same range of choice 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.”\(^2\)

Echoing the former Prime Minister’s sentiments, former Health Minister John Reid said:

“These choices will be there for everybody … not just for a few who know their way around the system. Not just for those who know someone ‘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.”\(^3\)

What sets John Reid and Tony Blair’s comments apart from the choice and competition rhetoric of old is their focus on the potential of choice and competition to promote equity. Their rhetoric was clear and consistent: the political right need not fear choice if users are not happy with their care, they can have access to the same quality services. This collectivist ideal sounds ok in theory, but fails (rather dramatically) in practice. In particular, the faulty assumption in the old left’s thinking was taking for granted that there was no choice for users in systems without formalised choice mechanisms. There is. Even in public service systems without formalised choice mechanisms, choice still exists for users who are (1) able to negotiate with their general practitioners and other medical providers for more choices using their louder voices; (2) able to move to areas with better local services; and (3) when all else fails, opt out of public services and enter the private sector.

“Giving a choice of providers to all service users would take away the advantage that the middle and upper classes have long had accessing privileged care”

Using voice, moving to areas with better local services, and paying for care in the private sector all favour the middle and upper classes. The wealthy and the more educated tend to be more articulate, more confident and more comfortable speaking to doctors and as a result, are more persuasive negotiating for more care. Home prices tend to be closely correlated to the quality of local public services, so those users who move to areas with better services tend to be users with greater incomes. Finally, middle and upper class citizens tend to have the ability to pay for private sector care and live in areas where there is greater availability of private sector services.

Greater choice of provider, tied to a reimbursement scheme where money follows user choices, if users were not happy with their care would be to negotiate with providers and voice their preferences or turn to a formal complaint mechanism. The only incentive for providers to listen to patients was appeasing unhappy users (and quieting their complaining) or heeding to their greater sense of professional responsibility. When money follows users’ choices and users have the option of exiting their current service, providers have a financial incentive to be responsive to their patients. In a health service with choice of provider and a reimbursement scheme where money follows patients’ choices, if providers do not listen to their patients, then patients can choose to seek care elsewhere and providers will see their income start to fall.

The old left has two primary criticisms of choice on equity grounds. First, they argue that the well off are better equipped to make choices and will take the best options for themselves, leaving what they do not choose for everyone else. Second, the old left argues that choice is going to lead to cream-skimming; if providers are paid per episode of care they deliver, then they are likely to select patients who are the cheapest to treat. Wealthier patients are usually healthier, so the old left argues that this type of scheme will embed incentives for providers to avoid treating poor patients.

The first equity criticism of choice is summarised by Roy Hattersley, who wrote:

“[C]hoice is an obsession of the suburban middle classes. But when some families choose, the rest accept what is left. And the rest are always the disadvantaged and dispossessed.”\(^4\)

To be sure, the wealthy and educated may be better equipped to interpret information, but that is not to say that those who are less well equipped to make choices cannot be assisted in getting the most from a public service scheme with choice. In an effort to help patients choose, provider quality information needs to be made as accessible as possible and there must be staff assigned to help users choose and determine which providers and options are best for them.

This is precisely what was done in the London Patient Choice Pilot, where patients were assisted in choosing by Patient Care Advisers (usually specially trained nurses). The Patient Care Advisers were very well liked and nearly every piece of evidence from the London Patient Choice Pilot suggests that there was no difference in outcomes or likeliness to choose between social classes or age groups.\(^5\)
In addition, implicit within this old-left critique of choice are assumptions that (1) referral patterns will dramatically change after choice is introduced and (2) that patients need to choose in order to get the benefits of choice. However, rather than creating a mass exodus away from current providers, user choice will not dramatically impact current referral patterns; it is most likely to induce change at the margins with a small percentage of patients opting to receive care elsewhere.

Traditional micro-economic theory posits that an “exit” of five to ten per cent of users will send sharp signals to providers to raise their performance. In effect, users who choose to remain with their local services benefit from the minority who choose to leave. Looking at school choice in the US, Caroline Hoxby examined the outcomes of students who did not exercise choice and who remained in their original school.8 Hoxby found that students in schools with greater competition (where more students chose to exit) did better than students in schools where fewer students exercised their ability to exit. Essentially, Hoxby’s results suggest that greater choice and competition in public services creates a tide that lifts all boats: users who do not exercise choice are positively impacted by users who do and everyone’s public services improve together.

The fear that increased choice of provider and provider competition will lead to providers cream-skimming and selecting healthier, wealthier users is perhaps the strongest strike against choice and competition. However, cream-skimming is not inevitable. For starters, there is nothing to say that providers should be afforded the opportunity to select their patients in advance. Policy-makers could organise public services in such a way that providers had no choice of who they see.

Beyond that, a more appealing option to thwart cream-skimming might be by making provider reimbursements inversely proportional to service users’ socio-economic status. Providers could be reimbursed more for seeing less wealthy patients and reimbursed less for seeing wealthier patients. Not only would this mute any incentives for providers to cream-skin, it would create incentives for providers to become more responsive to less advantaged service users. The more policy-makers weight reimbursements in favour of the less-well off, the more likely providers are to compete with one another to see patients who are often marginalised in the health system. This would prompt a dramatic shift from the doctor-patient dynamic we would ordinarily expect in a traditional collectivist health system.

“Choice creates strong incentives for providers to become responsive to all users, not just those with the loudest voices”

Some closing thoughts…

The question before us is not whether a particular reform is equitable or inequitable in toto; rather, the question we need to address is whether a particular reform stands to be more or less equitable than the structures that precede it. Critics of choice and competition have been ravenous in their desire to point out every conceivable way in which choice of provider and provider competition could induce inequity. While this is certainly a valid academic exercise, it is not policy relevant. Instead of pointing out every detectable flaw (of which there are many in any reform, whether collectivist or market-based), health policy commentators would be better off examining the equity implications of choice-based reforms in comparison to the collectivist structure it replaced.

When viewed in the context of traditional collectivist public services, it is clear that there is a strong argument to be made that increased choice and competition have the potential to promote equity. Greater user choice, tied to a reimbursement scheme where money follows user choice ameliorates many of the ways middle and upper class citizens have historically been able to garner more privileged care. Moreover, they create strong incentives for providers to become responsive to all users, not just those with the loudest voices.

If the traditional left is serious about addressing equity, it is time that they shake off their intuitive dislike of market-based reforms and take a hard look at whether choice and competition has the potential to improve the care delivered to traditionally underserved users. We think it does.

References

New Health Systems in Transition (HiT) profile

The latest addition to the Health Systems in Transition series has just been published and is available online.

It focuses on Denmark, a small country with 5.4 million inhabitants. Danish health care is dominated by the public sector, financed by local and state taxes and administered by the regions. In recent years the focus of health care reform has been on patient choice, waiting times, quality assurance and coordination of care.

The publication of the HiT is very timely because a major structural reform in 2007 changed the political and administrative landscape dramatically. Reforms in the way health care is financed also took place.

Available at http://www.euro.who.int/Document/E91190.pdf