The Blair Legacy? Choice and Competition in Public Services

Transcript of Public Lecture
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The central idea of this lecture is a simple one. The reforms involving choice and competition that the Government of Tony Blair is introducing into public services such as health and education will make those services not only more responsive and more efficient, but also – contrary to popular belief - more equitable or socially just. As such they are not only desirable, but essential if the welfare state is to survive.

Now choice and competition in the context of public services are not easy to sell. They are controversial, and make for great caricatures. I like these ones particularly:

Figure 1: The Spectator – 7th January 2006

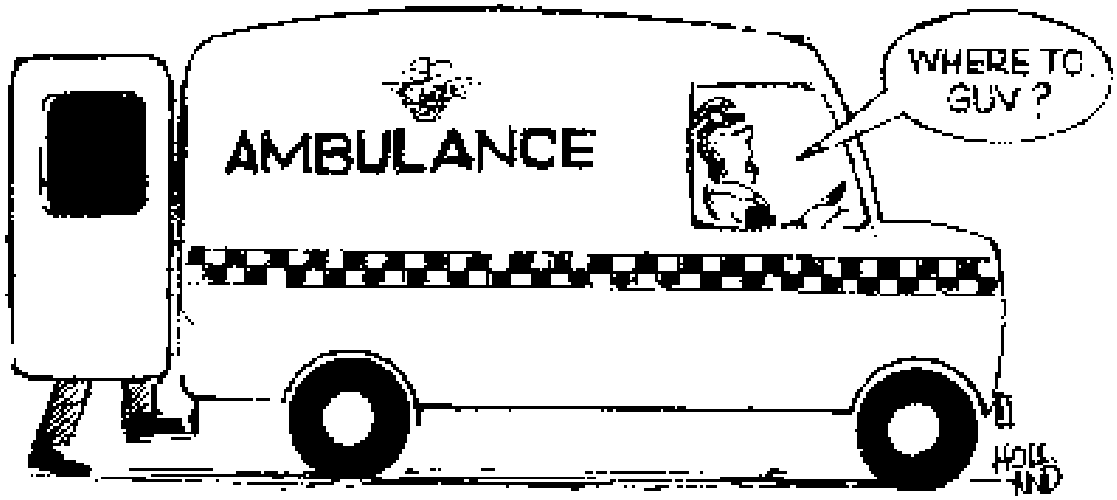


Figure 2: David Austin, The Guardian (2005)

But I'm going to try and sell you some of these controversial ideas tonight. I hope to convince you that the policies concerned are not simply the result of scribblings by mad-eyed policy wonks at No 10, desperate for short-term solutions, but actually reflect a well grounded analysis of the problems with public services, and the ways in which these problems can be resolved. Obviously in 50 minutes or so I can't hope to cover all the arguments involved, and there will be many difficulties that no doubt many of you will be totting up as we go. But we will, I hope, have time for questions afterwards and perhaps I can address some of the omissions then.

To begin with the problems that the reforms are trying to address.

When Tony Blair's Government came into power, it found public services that were creaking at the seams.

Take the National Health Service. This had - and has - many virtues. Not the least of these is its founding principle – that health care should be freely available to all, regardless of income, class, gender, ethnicity, or religion. But the problems in practice were legion.

Waiting times were long – unbelievably so to foreign observers. Patients were supposed to live up to their appellation, and be patient. A year after the Government was elected, 185,000 patients were still waiting more than 9 months for elective surgery in England and 67,000 for more than 12 months.

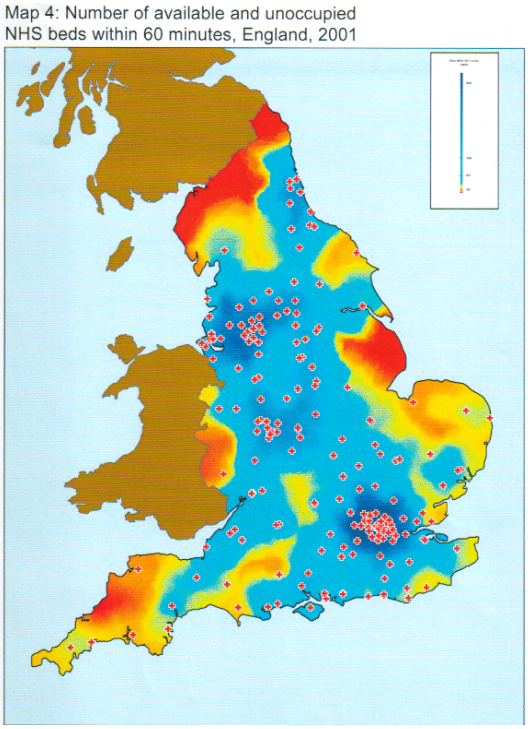
Resources were wasted. A recent study by Carol Propper and others at the University of Bristol found that as late as 2002 98% of the population lived within an hour's travel time of up to 100 available and unoccupied NHS beds, and 76% within a hour's travel time of 500. And this at a time of massive waiting lists.

Figure 3: Map: the number of available and unoccupied NHS beds within 60 minutes. England 2001

Blue:200-3000

Yellow:100-200

Red:<100



The system was generally unresponsive to patients' needs and wants. There was a widespread feeling that it was organised more in the interests of those who worked within it than for those who used it. And if patients were dissatisfied, only the better off – those with private insurance - had the opportunity to go elsewhere.

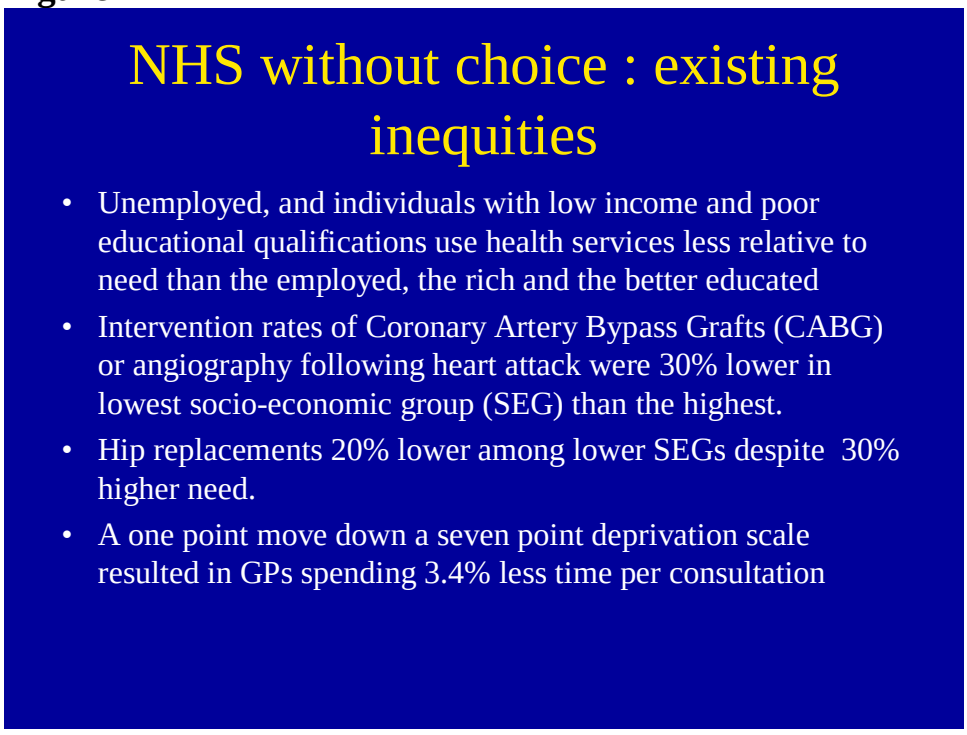
And there were more subtle problems. The NHS was poor on innovation. When I was working at No 10, I lost count of the number of times people came to me with often what seemed to be brilliant and innovative ideas, but incredibly frustrated by their inability to get the NHS even to try them out - let alone adopt them across the service. Simply demonstrating good ideas or good practice or even publicising them were not sufficient: the incentives for adoption were not there.

Even equity – the founding principle - was not achieved. Many services favoured the better off at the expense of the needs and wants of the poor

and disadvantaged. For instance, a recent review by me and colleagues at the LSE and the Department of Health found that:

- Unemployed, and individuals with low income and poor educational qualifications use health services less relative to need than the employed, the rich and the better educated.
- Intervention rates of Coronary Artery Bypass Grafts (CABG) or angiography following heart attack (AMI) were 30% lower in lowest socio-economic groups 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

Figure 4



Education was in not much better shape. According to the Government's recent White Paper, in 1997:

- One third of children left primary schools without having mastered the basics in English and maths.

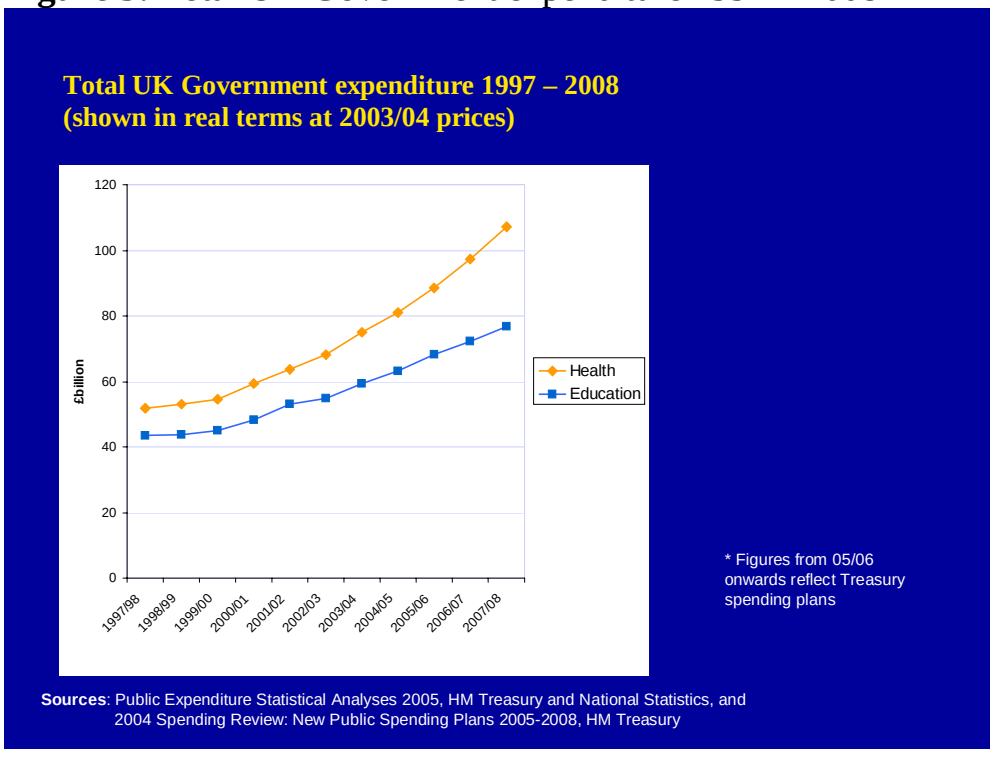
- Only around a third of pupils in Inner London and Birmingham got 5 or more good GCSEs.

- Less than half of primary schools had good or excellent teaching in primary schools, as judged by Ofsted, and only just over half of secondary schools.

Now, of course, part of the problem was money. The Wanless Report estimated that, relative to EU average spending on an income-weighted basis, the cumulative underspend on the NHS was £267 billion in 1998 prices: the equivalent of more than five times what we currently spend on the NHS.

And spending is going up. Public spending on both the NHS and education has risen by least 50% in real terms between 1997/8 and 2004/5 and, of course, is projected to rise by even more by 2008/9

Figure 5: Total UK Government expenditure 1997 – 2008



But money wasn't the only problem. Although the resources that are being put in are historically unprecedented in magnitude, previous Governments have put large sums into both the NHS and education before - and have not had the results.

In particular, the old state monopoly NHS did not deliver, even when its mouth was stuffed with gold. As we shall see, even now the Welsh,

Scottish and Northern Irish health services – in some ways similar in structure to that which prevailed throughout the UK in the 1970s and 80s - have struggled, despite the fact that they have had more resources per head than England.

In fact, if we go back to the problems with the NHS that I listed earlier - waiting lists, inefficiency, unresponsiveness, slowness to innovate, inequity - it is interesting how little of them have to do directly with money. Perhaps only the waiting list problem could be directly related to resources – and even that, it could be argued, was at least as much a result of the inefficient use of capacity as of lack of it.

So where did these problems – and the comparable ones in the education system - originate? I contend they derive from the monopoly nature of state provision.

In the unreformed NHS patients had little choice over where, when and how they were treated; in the unreformed education system parents had little choice of school. This was bad in and of itself, because it disempowered both patients and parents. But, even more importantly, it was destructive because the absence of choice also meant an absence of incentives for providers to improve.

Chaining people to their local GP practice, hospital or school meant that providers who offered a poor or a tardy service could continue do so with impunity; for those badly treated had nowhere else to go. Giving providers a monopoly has never been a good way to improve a service of whatever kind; and the 'old' health service and school systems were no exception.

So some kind of reform was essential. The question was: what form should this take? One strategy for dealing with monopoly is top-down performance management: telling monopoly providers that they have to provide a good service, setting targets for that service, and penalizing them if they fail. And indeed this has been a part of the Government's strategy so far.

Moreover – and I have to confess somewhat to my surprise – to some extent it has been successful. Most NHS targets have been met, and some aspects of service delivery (particularly waiting times) sharply improved, at least in England.

Figure 6: % patients spending less than 4 hours in major A+E Departments

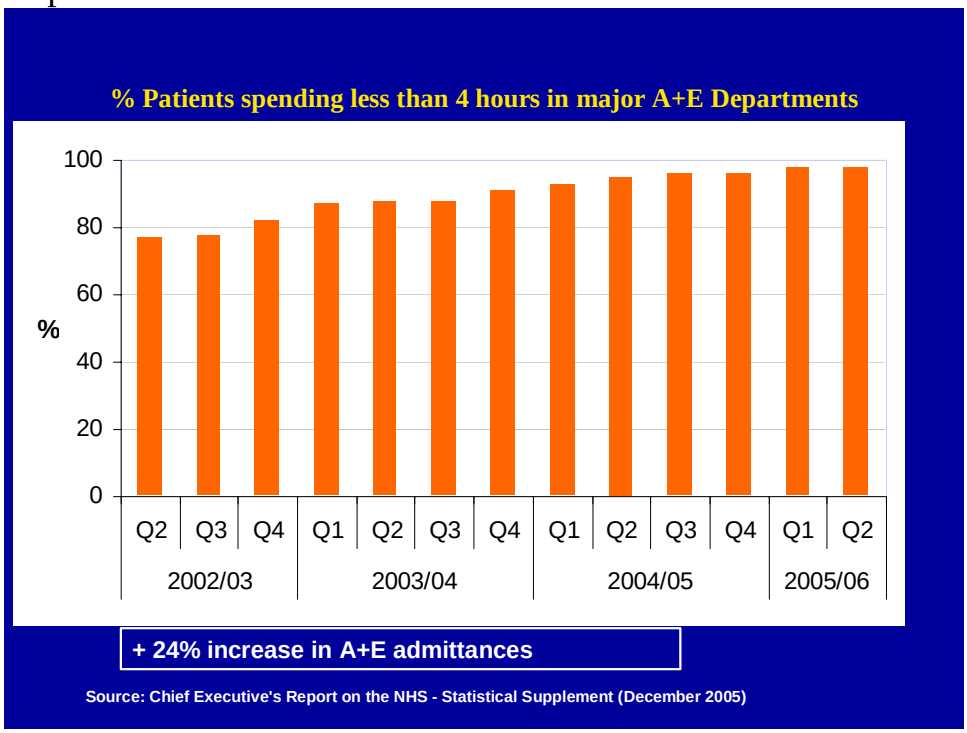
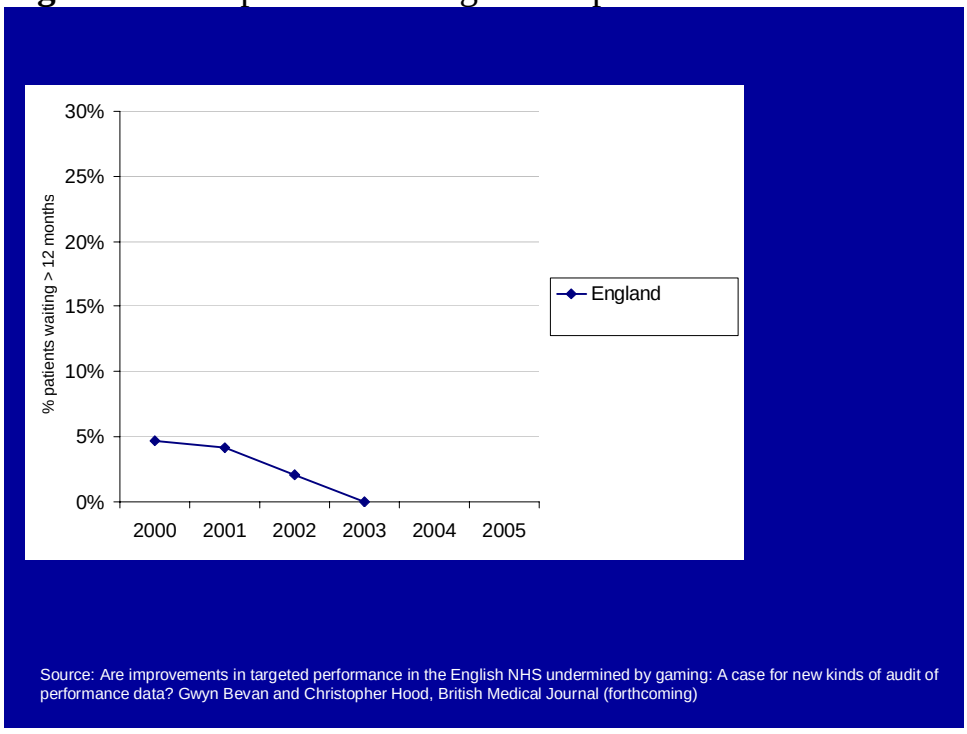


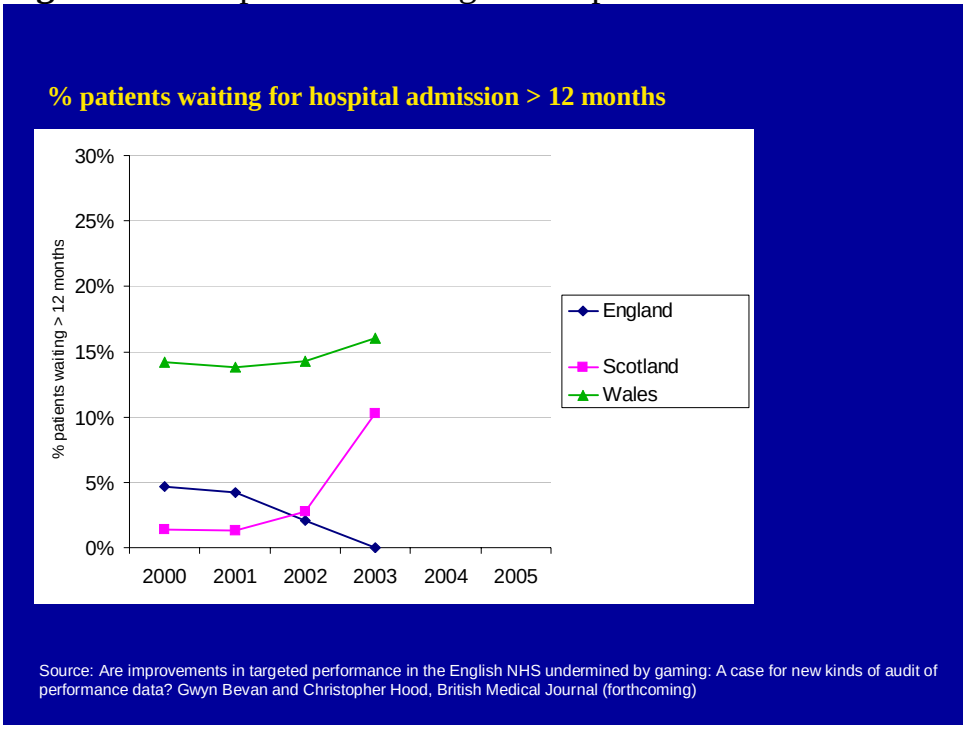
Figure 7: % of patients waiting for hospital admission > 12 months



Actually, it is very interesting to compare the good performance in England with the relatively poor performance in the rest of the UK. Here I must pay tribute to the work of my colleague LSE, Gwyn Bevan, who has done some very interesting work in this area.

Wales and Scotland, for instance. Immediately after devolution, the Welsh Office abandoned waiting time targets and reduced its reliance on directive policy, concentrating instead on promoting co-operative working between health, local government and the voluntary sector. And this is what happened.

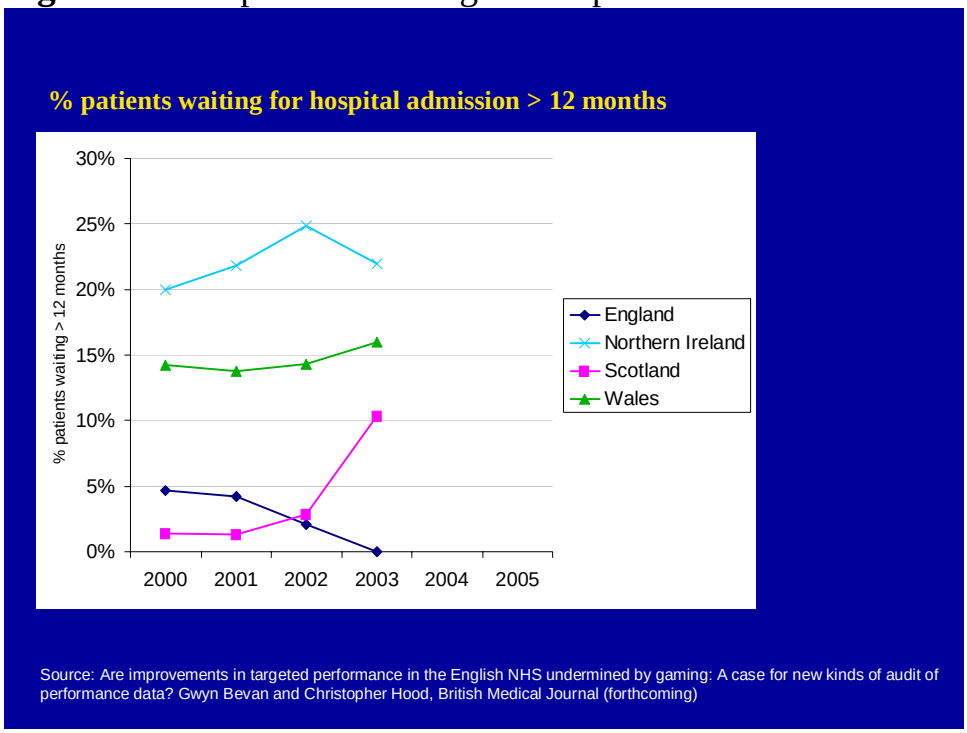
Figure 8: % of patients waiting for hospital admission > 12 months



A massive increase in waiting lists - and this was despite the fact that Wales had more resources per head than England and a similar rate of growth in those resources

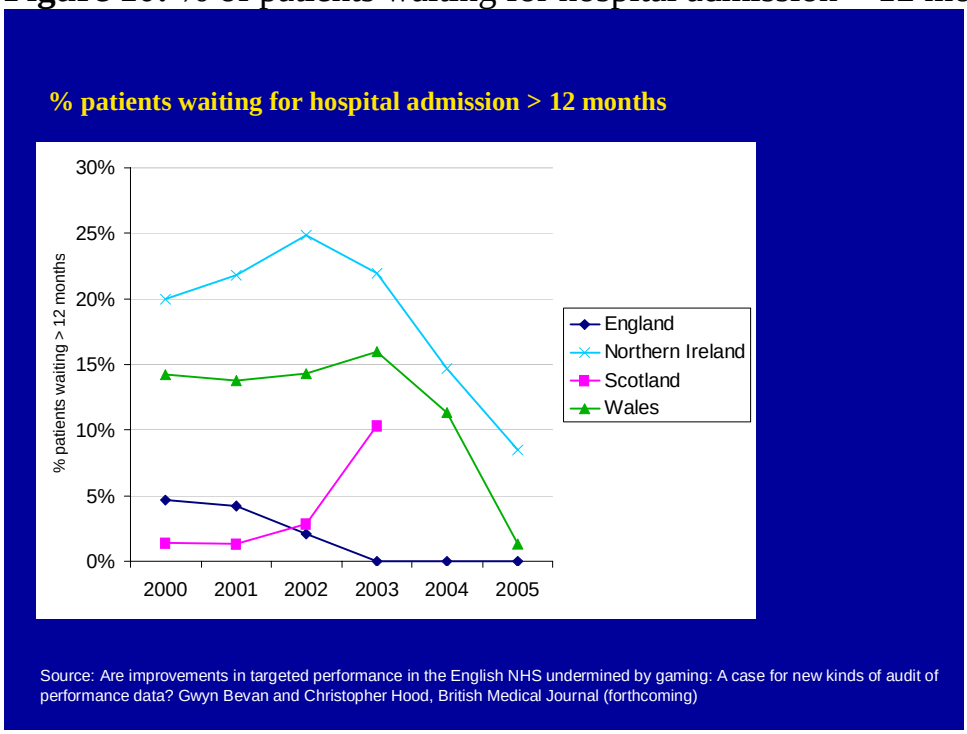
Nor were things much better in Scotland or Northern Ireland – each again with more resources per head than England and the same growth rate, but each again failing to adopt English performance management, choice or competition

Figure 9: % of patients waiting for hospital admission > 12 months



Until that is, 2003 when Wales and Northern Ireland began to introduce performance management, and in the Welsh case, choice - while Scotland adopted a different system of measurement.

Figure 10: % of patients waiting for hospital admission > 12 months



In education, performance management has also worked, with numeracy and literacy sharply improved, not least because of the straightforward top-down imposition of a numeracy and literacy hour.

So performance management can work – at least in the short term. But it has to be recognised that heavy performance management from the top is not trouble free. A ceaseless bombardment of instructions from above demotivates and demoralises providers – especially when those providers include professionals used to a high degree of autonomy and trust.

And targets have their own problems. They discourage continuous innovation and improvement; once the target is achieved there is no incentive to go further. They also distort priorities: what is not targeted is ignored. As is often said, one can hit the target but miss the point.

They can lead to 'gaming': this could range from a straightforward fiddling of the figures, to more subtle changes of behaviour that mean the target is attained but there are long-term consequences that are undesirable. An example might be the unnecessary admitting of patients into a general hospital ward from the accident and emergency department in order to appear to be doing something with them within the four hours. And, since missing targets can happen for reasons beyond managerial control, the penalties can seem arbitrary and unfair: again demotivating and demoralizing.

Overall, performance management, though perhaps necessary in the short term, is not a long-term solution to the problems of public service reform.

What is needed instead is a system with incentives for reform embedded within it. Then providers will automatically provide a high quality service without having to be told to by the top. And these incentives should come from the users of public services: for, at the end of the day, it is the user's needs and wants that have to be satisfied, and he or she is the ultimate authority on what those needs and wants are.

Now one way of empowering users is through strengthening the institutions of what's called in the jargon 'voice'. 'Voice' mechanisms are ways in which users can express their dissatisfaction (or indeed their satisfaction) by some form of direct communication with providers. This could be through informally talking to them face to face – talking to teachers about your child etc - or more formal ways; complaints procedures, talking to parent governors, even become a parent governor,

speaking to patient and public forums, joining a foundation trust board, and so on.

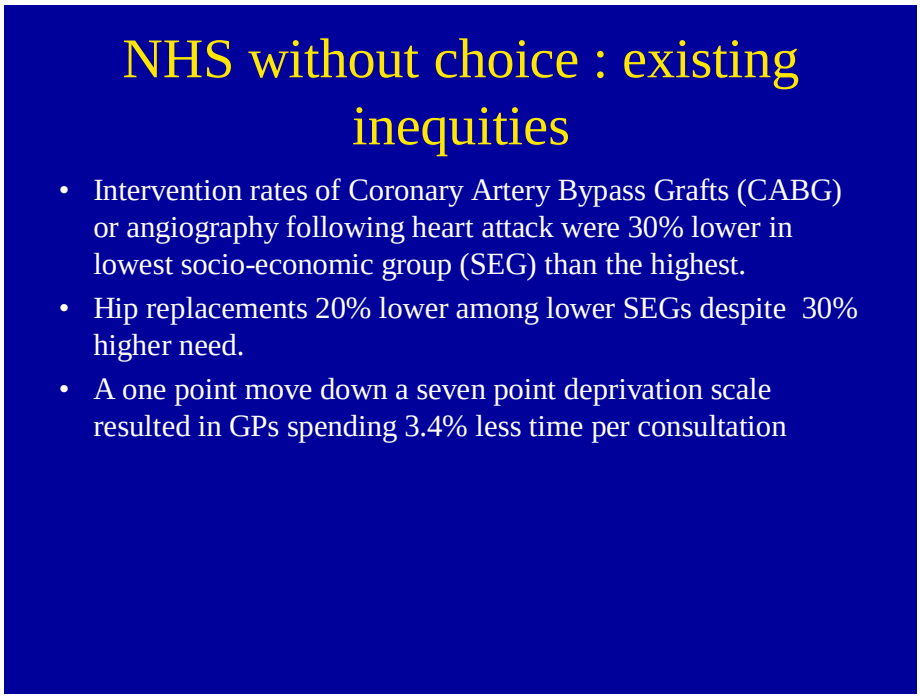
Now I do believe that all these forms of voice have their place, and strengthening them can have its place in a programme of public service reform. But they are not the answer to the fundamental problem that underlie public services. This is partly because of, at least in some cases, their cumbersomeness – as anyone who has tried to mobilise complaints procedures will understand.

But the principal difficulty lies in the absence of choice, or what is called more generally the power of 'exit'. For, on their own, voice mechanisms do not provide much by the way of incentives for improvement. If a provider has a monopoly on the supply of a service, it can ignore the complaints of its users with relative impunity. Only if it knows that ultimately the dissatisfied can exit - can go elsewhere – does it really have an incentive to improve. Choice, in other words, gives power to voice.

Another problem I have with voice is that it favours the better off. For instance, look again at some of the areas of NHS usage that were pro-rich that we saw earlier. It will be recalled that these were:

- Intervention rates of CABG or angiography following heart attack (AMI) were 30% lower in lowest SEG than the highest
- Hip replacements were 20% lower among lower SEGs despite roughly 30% higher need.
- A one point move down a seven point deprivation scale resulted in GPs spending 3.4% less time with time with the individual concerned.

Figure 11



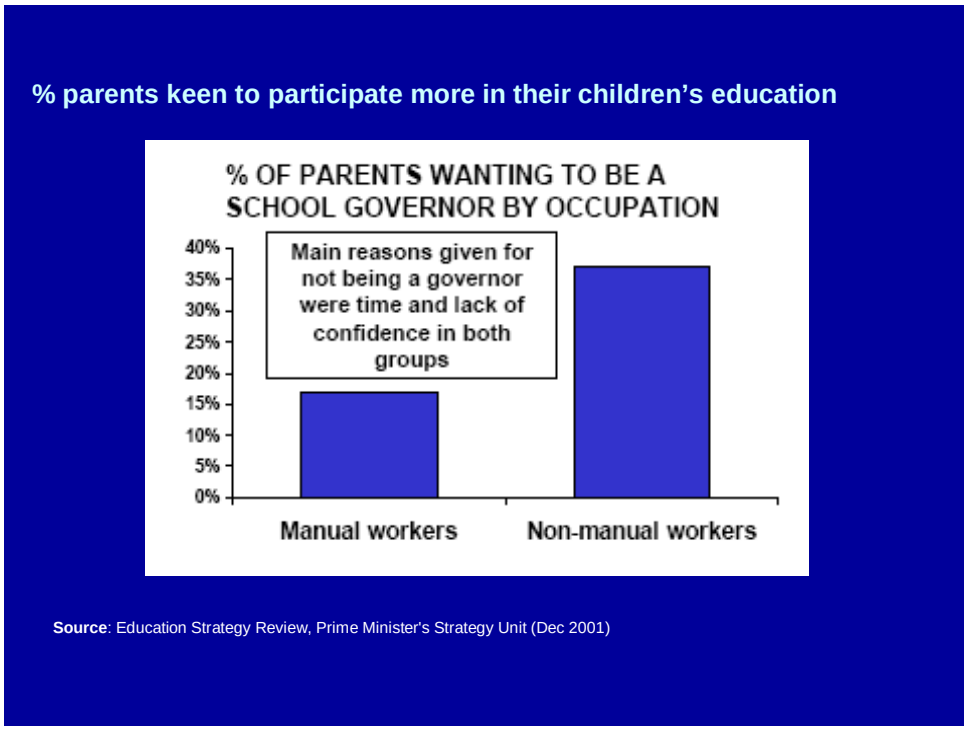
Now all of these can be viewed as illustration of the ways in which the middle class can persuade – through implicit or explicit methods – bureaucratic and professional systems to work to their own advantage. There are two aspects to this. One is that GPs find it easier to deal with middle class people and to respond to their concerns. The other is what has been termed the sharp elbows of the middle classes: by virtue of their education, articulacy, and general self-confidence, the middle class are simply better at persuading GPs that their needs can only be properly addressed by specialist services.

In relation to this last point, it has been established that the better off are more likely to have family or friends who work in the health services than the less well off; they will therefore have a better knowledge of the system. In addition, when talking to health care professionals, patients from more deprived backgrounds may have more difficulty describing their symptoms, thus inhibiting a diagnosis and access to appropriate treatment; they may also simply be less confident and less assertive in expressing their wants and needs.

In short a major reason for the inequity within the NHS is that the middle class have a louder ‘voice’ than the less well off – a voice is more likely to be heard, understood and indeed even empathised with, by the professionals concerned.

Let me give you another illustration in relation to parent governors. Who are most likely to become parent governors? Unsurprisingly the answer is the middle class:

Figure 12: % parents keen to participate in their children's education



So if we cannot rely upon performance management or 'voice' to reform public services, what can we do? You will not be surprised to learn that it leaves us with one alternative: choice and competition. Let me explain how it works.

There are three key elements: **user (patients or parents) choice, money following the choice, and new forms of provider (including foundation trusts and independent sector treatment and diagnostic centres, academies, trust schools)**. Although to some eyes, both within and outside the public sector, they appear to be unconnected, in fact they all form a coherent whole.

To begin with the foundation of the policy: user empowerment through **choice**. As noted above, this is desirable in and of itself, because it directly empowers users. But it is also essential from a system reform perspective. For it is a way of breaking down the monopoly power of providers and providing incentives for them to improve.

However, certain conditions have to be fulfilled if choice is to work in the way desired. First, **the money must follow the choice**. If being chosen has no favourable consequences and not being chosen has no

unfavourable ones, then choice will not deliver the required incentives. Hence payment–by-results in the NHS where by hospital and other providers get paid according to the treatments they actually provide; and formula funding for schools where schools are paid according to the number of pupils they attract.

This encourages providers to be attractive to would-be users, and to be efficient in their use of resources. For, if providers can reduce their costs below the amount hey receive without reducing quality, they will attract users and make a surplus: a surplus they can spend on further improvement of services and on improving pay and working conditions for staff.

A second condition for choice to provide the appropriate incentives is that there must be alternative providers from which to choose. The illusion of choice is worse than none at all. Moreover, to provide proper contestability, the providers must be such that they have real independence, and are entrepreneurial and innovative.

Now research evidence from other sectors of the economy suggests that the entrance of new providers is the only effective way of increasing contestability and driving up productivity. Hence the policy towards developing **new forms of provider**, including foundation trusts, the independent sector treatment and diagnostic centres, academies and trust schools.

Now of course there are many other conditions that have to be fulfilled if incentives are to work properly and the injection of choice and competition is to achieve the ends that we want. If patients and parents are to make choice on the basis of quality, they have to have good **information on quality** – not always easy to provide. There have to be ways to deal with **failure**; what to do about hospitals and schools that are not chosen. Then there is the **capacity** argument. And what about **excess demand**: by giving power to users, will they demand more than can be realistically supplied, and, if so, how can this be managed in a fair way and one that does not frustrate legitimate expectations?

I do have ideas about all of these, but there is not the time to go into that now. Instead, I want to concentrate on three major lines of criticism of the policy.

People don't want choice; they want a good local service

The better off will get the good choices: the poor will be left with the poor hospitals, the sink schools

Choice and competition in public services – especially from the private sector – will undermine the values of the public sector. Choice threatens the public realm

Figure 13

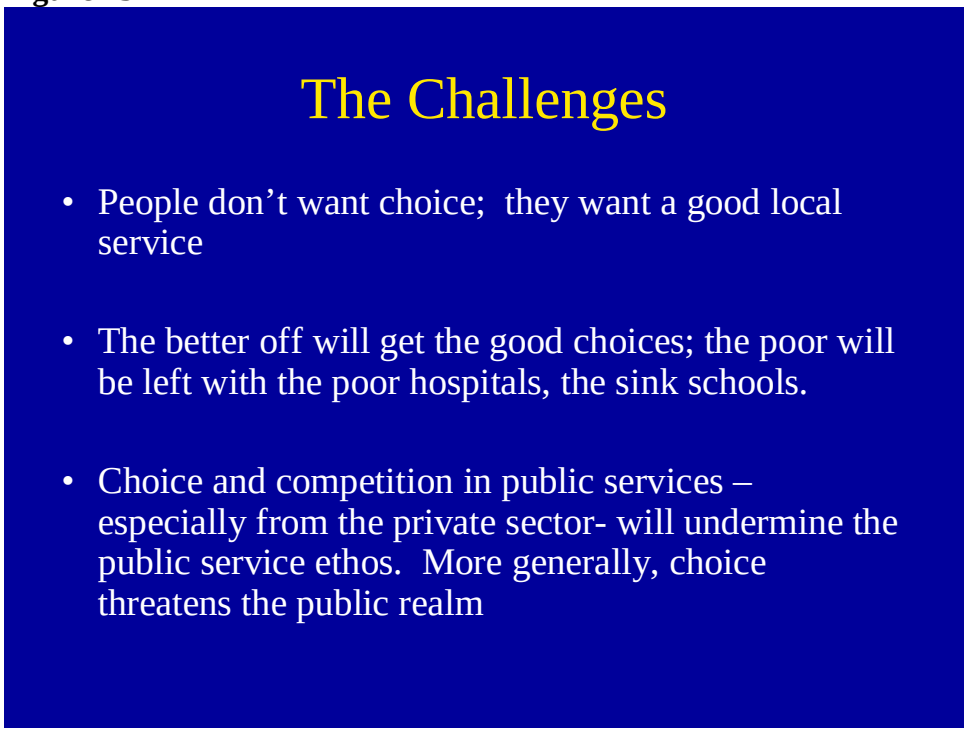
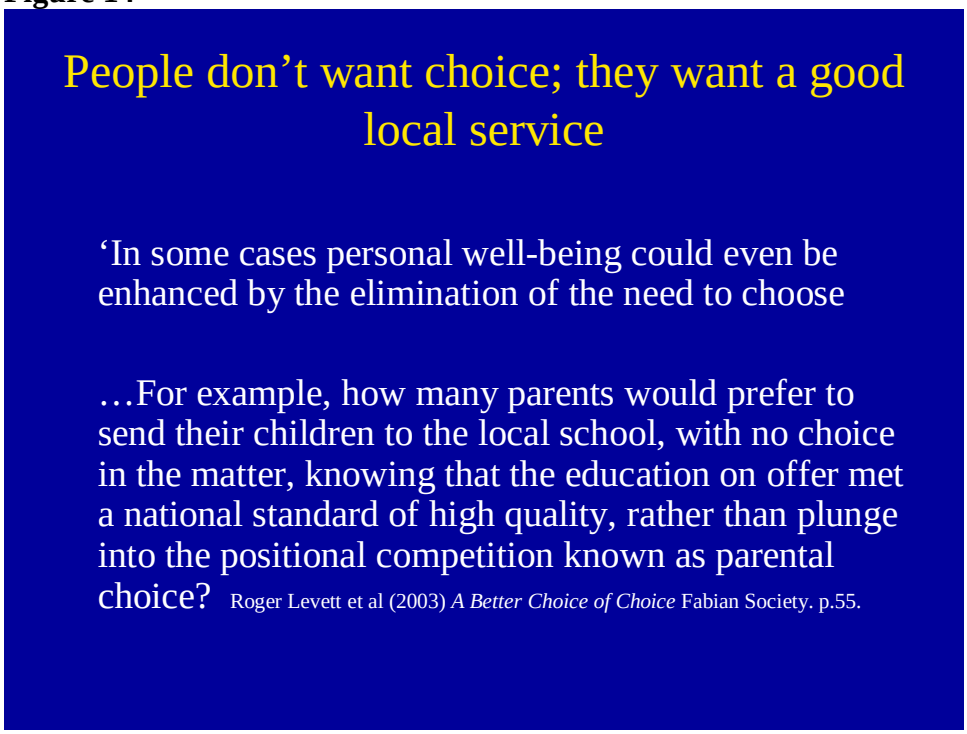


Figure 14

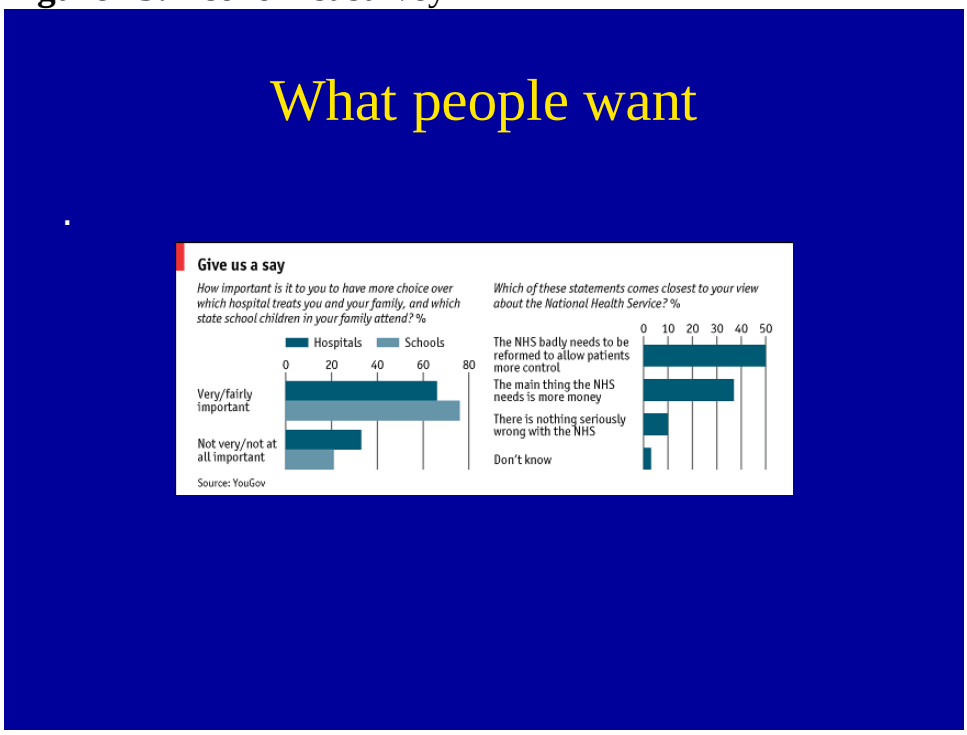


To begin with ‘people don’t want choice: they want a good local service’. Consider the first part of this: people don’t want more choice. In fact, contrary to this and indeed to much anti-choice propaganda, choice is popular.

Take, for example, a poll undertaken by YouGov for the *Economist* on choice in both health and education that 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.
- 66% considered it important that they have more choice over the hospital that treated them.
- 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 15: Economist survey



And this was not a freak result. A MORI survey in 2003 for Birmingham and the Black Country Strategic Health Authority found that 77% of people would like to make their own choice of hospital. Another MORI survey 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.

Results for the latest British Social Attitudes Survey (22nd report) are even more revealing. In total, they showed a similar picture to the surveys. Asked whether patients should have choice of treatment, hospital and outpatient appointment time, 65% of those surveyed thought that patients should have a great deal or quite a lot of choice of treatment, 63% of hospital and 53% of appointment time.

Bu this study also broke down the results by gender, social class and income. And these results many will find quite unexpected.

- 69% of women wanted choice of hospital; 56% of men.
- 67% of the routine and semi-routine working class wanted choice, compared with 59% of the managerial and professional class.
- 70% of those earning less than £10,000 p.a. wanted choice, but only 59% of those earning more than £50,000.
- 69% of those with no educational qualification wanted choice, compared with 56% of those with a higher education qualification.

Figure 16: British Social Attitudes Survey

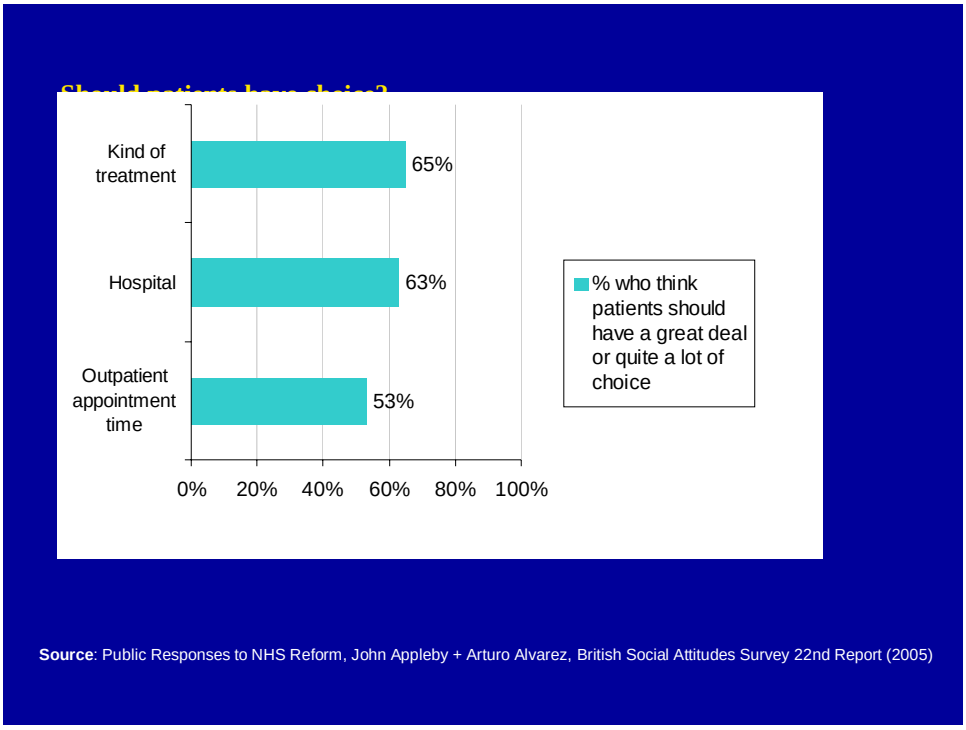
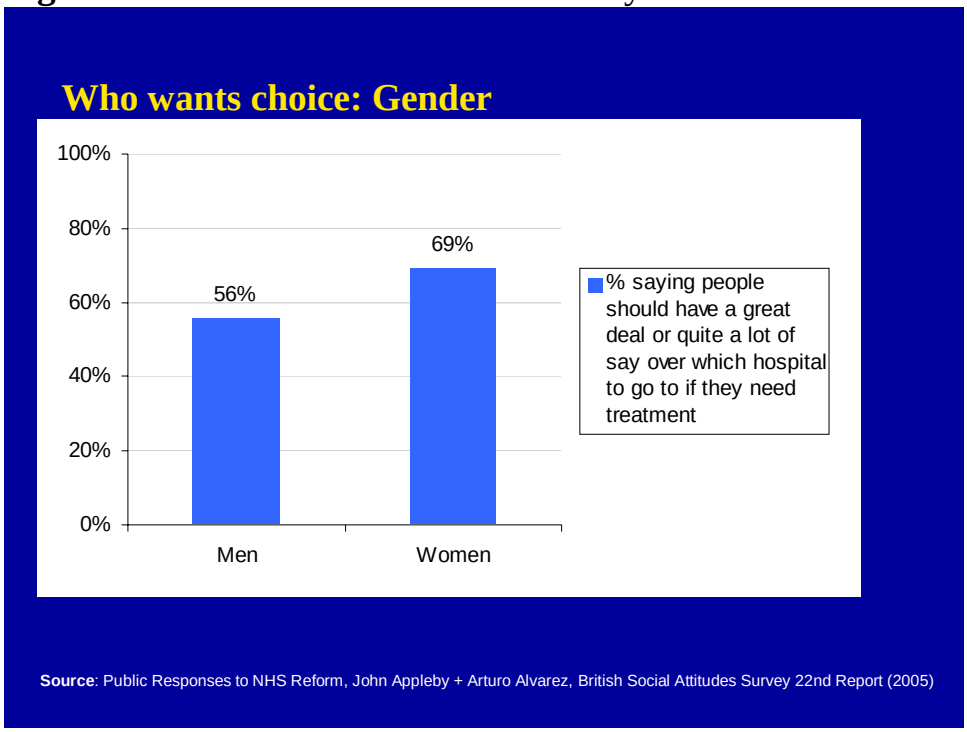


Figure 17 : British Social Attitudes Survey



Source: Public Responses to NHS Reform, John Appleby + Arturo Alvarez, British Social Attitudes Survey 22nd Report (2005)

Figure 18: British Social Attitudes Survey

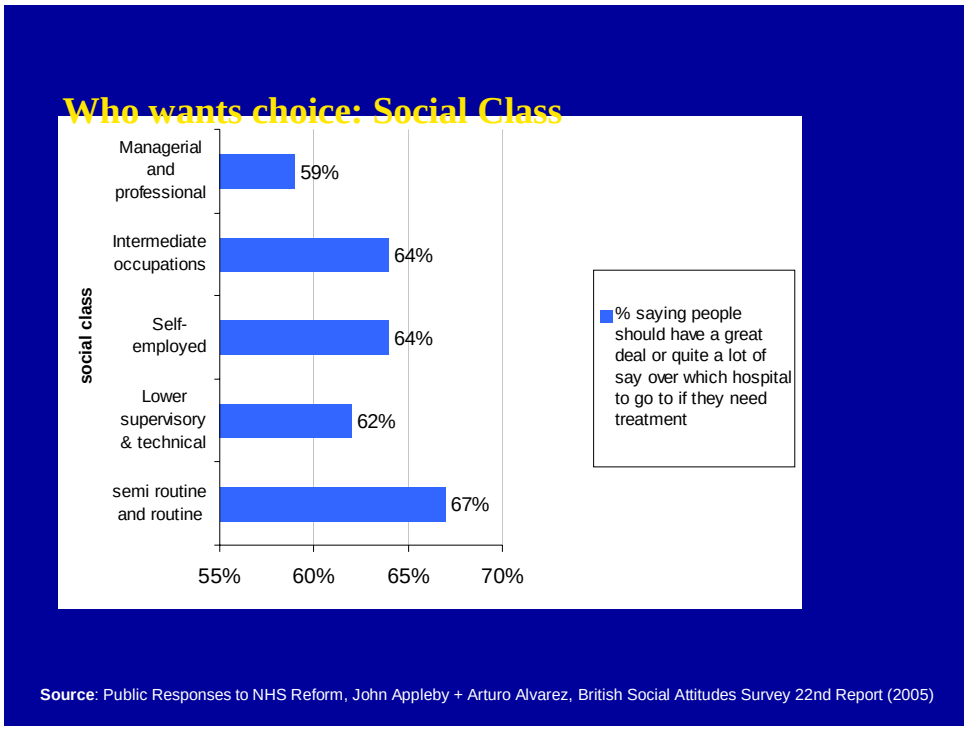


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Figure 19 : British Social Attitudes Survey

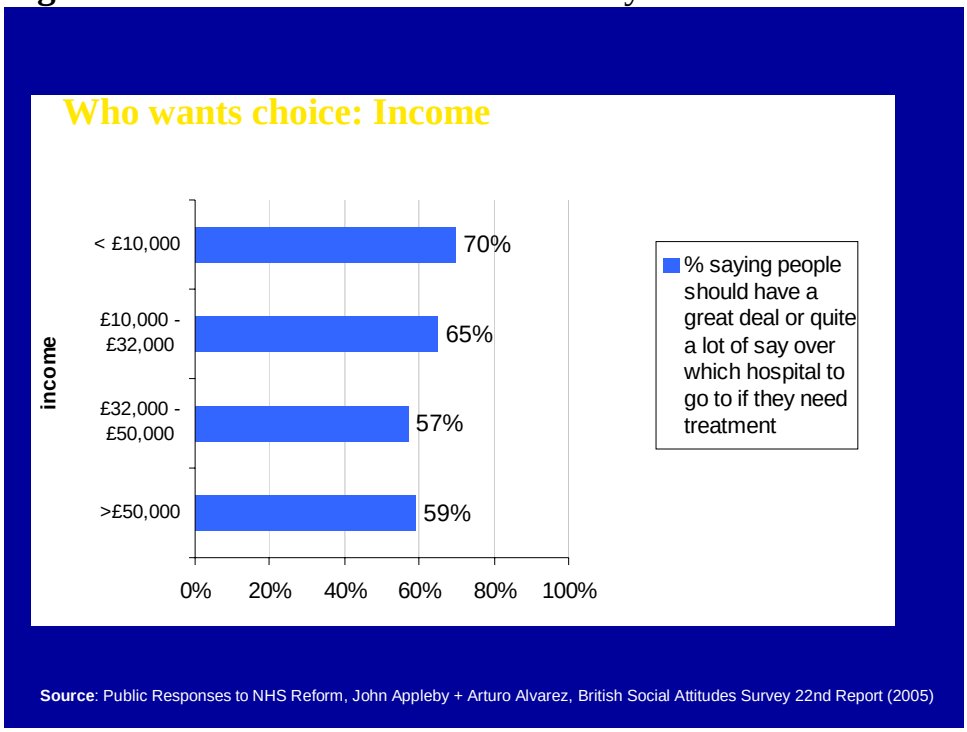

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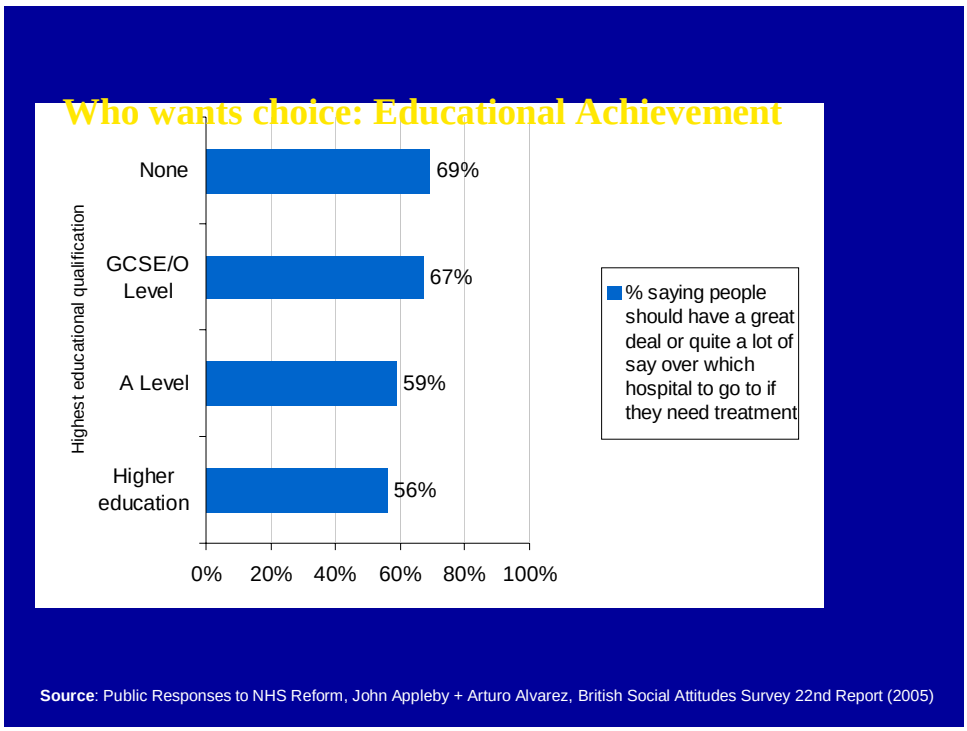
Figure 20: British Social Attitudes Survey

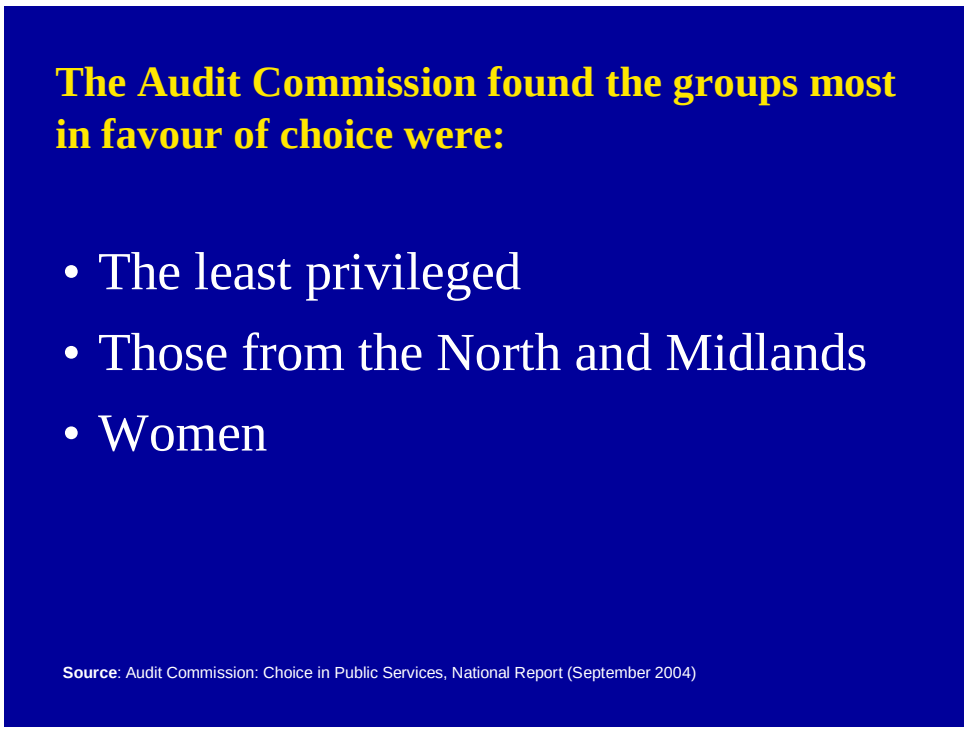


Source: Public Responses to NHS Reform, John Appleby + Arturo Alvarez, British Social Attitudes Survey 22nd Report (2005)

In other words, a majority of all groups wanted choice; but it was precisely those groups whom critics of the choice programme think will be disadvantaged by it are the ones who want it most.

Nor is this a freak result, or one confined to health. The Audit Commission found exactly the same when it surveyed people's reactions to more choice for local government services. More specifically, the Commission found that those in favour of choice were 'the least privileged, women and those who lived in the North and Midlands'.

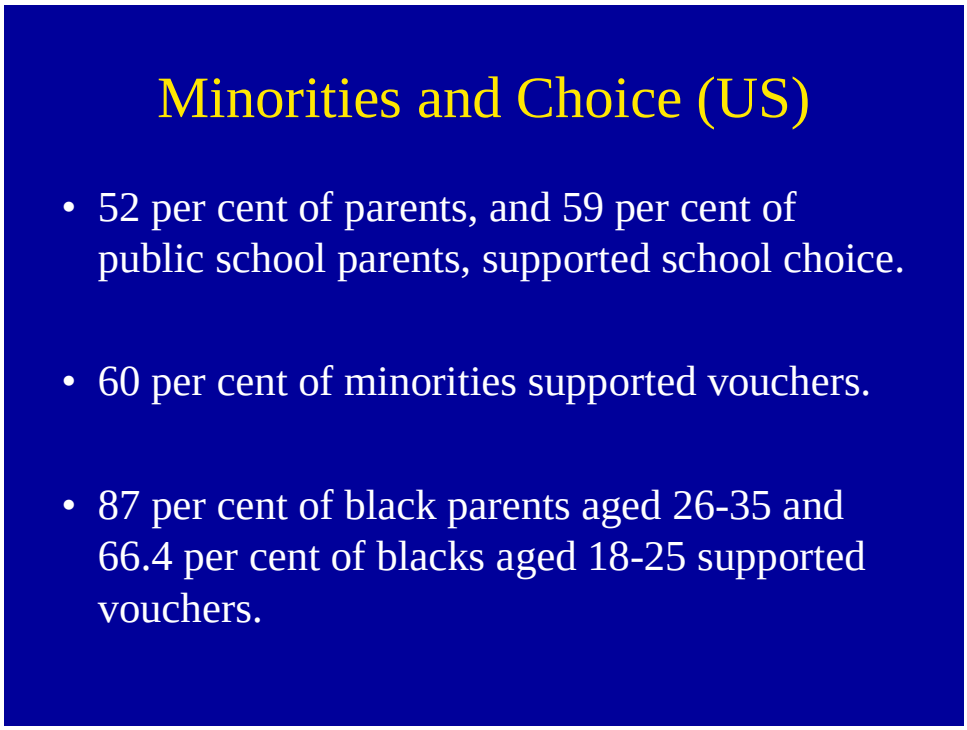
Figure 21: Audit Commission: Choice in Public Services, National Report (September 2004)



These results – sustained majorities for choice, especially among the disadvantaged – are not even confined to this country. The Joint Center for Political and Economic Studies in the United States conducted a National Opinion Poll in 1999 on education support for vouchers and school choice. It found that:

- nationwide, 52 per cent of parents, and 59 per cent of public school parents, supported school choice.
- 60 per cent of minorities supported vouchers.
- 87 per cent of black parents aged 26-35 and 66.4 per cent of blacks aged 18-25 supported vouchers.

Figure 22



All of this is survey evidence about what people want, whether or not they have experienced it. But the popularity of choice is also revealed by what actually happens when people are offered choice. Evidence from the pilot experiments in the NHS on patient choice also show that choice is popular with patients who have tried it. 86% of patients taking part in the Coronary Heart Disease Choice Pilot said they would recommend it to another patient. In the London Patient Choice Pilot 67% of patients chose to attend an alternative hospital to secure faster treatment. A report on the London Choice project published in July 2005 by the King's Fund, RAND Europe and City University found that 97% of the patients who opted to go to an alternative hospital said they would recommend the scheme to others.

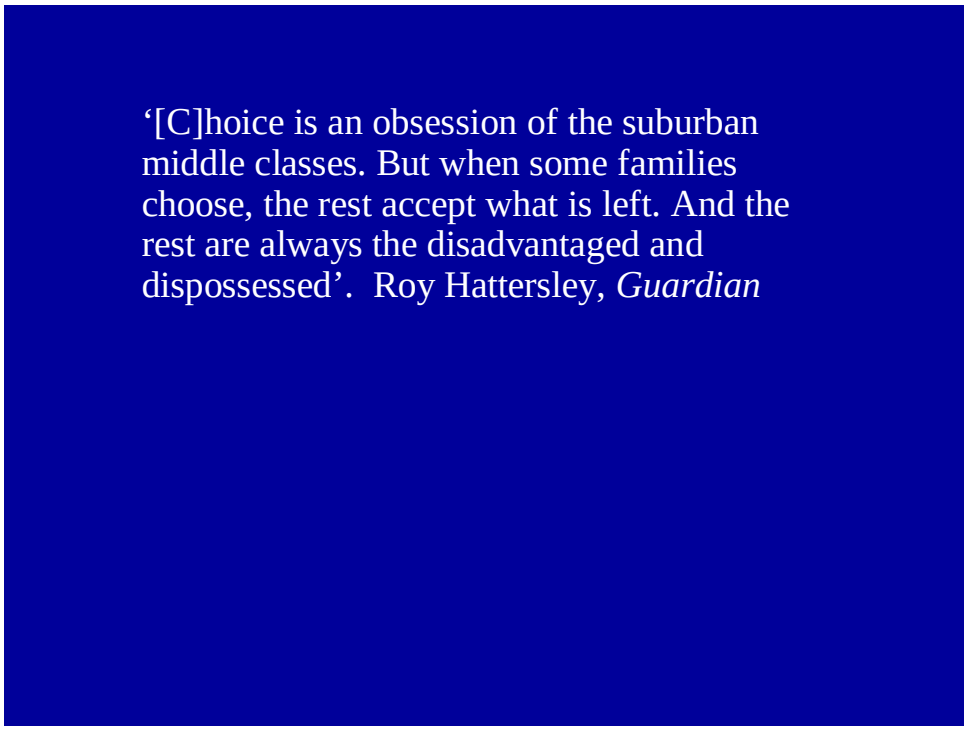
So in general it is the poor, the dispossessed and the disadvantaged who want choice more than the allegedly rabidly pro-choice middle class. Nor, on reflection, should this be surprising. Because it arises from the fact that the middle class already do well out of the unreformed no-choice NHS and education system. With their loud voices, sharp elbows and, crucially, their ability to move house if necessary, the middle class get, as we saw earlier, more hospital care relative to need, more preventive care, and better schools.

Now what about the second part of the proposition that 'the poor don't want choice; they want a good local service'. Well, I hope I've said enough to convince you that choice and a good local service are not alternatives: through the incentives it creates, choice is in fact the way to get a good local service. I think it is legitimate to ask those who question this proposition whether they really believe that having local monopolies is the best way to achieve good local services. For, in rejecting choice and competition, that is implicitly what they are advocating

Now the second line of attack on choice:

The better off will get the good choices: the poor will be left with the poor hospitals, the sink schools

Figure 23

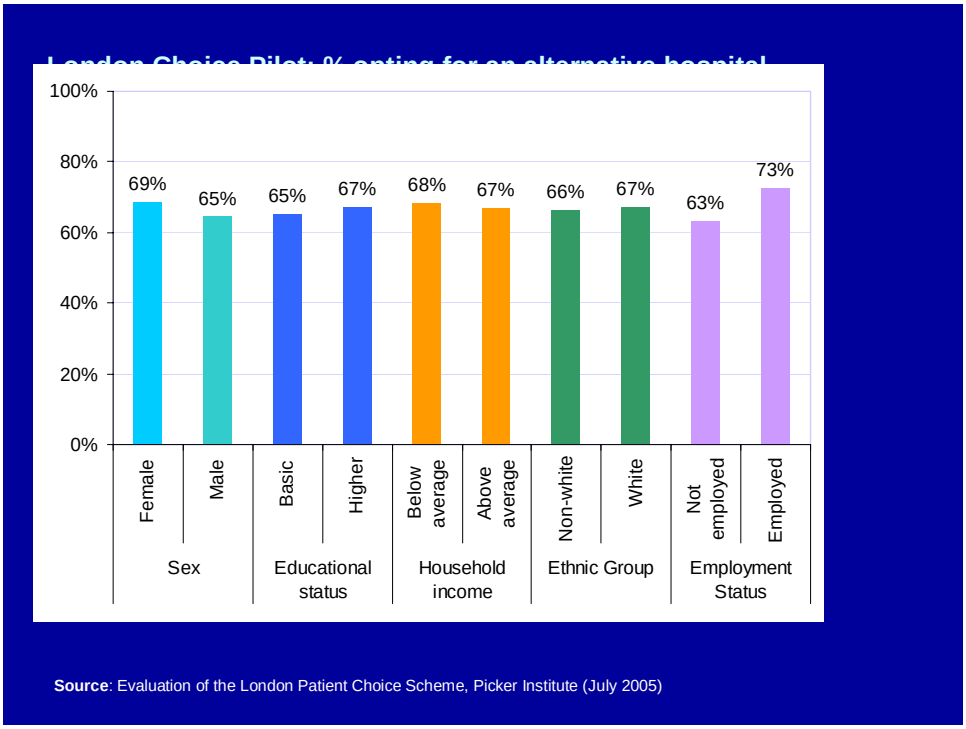


There seem to be three bits to this proposition. One, that the poor will not want to make choices or exploit the opportunities open to them. Two, even if they do make choices, they will not do it as well as the better off, Three, even if they do make choices and make them effectively, the good schools and hospitals will cream-skim or cherry-pick the good pupils, the easy patients; and since these are most likely to come from the middle class, this cream-skimming will discriminate against the poor. Of these the first is

wrong, but the others are more serious points that have to be addressed.

As we have seen, it is not true that the poor do not want choices. There is also evidence that the poor will take up choices if offered at least as much as the better off. The evaluation of the NHS choice pilots undertaken by the Picker Institute found no significant differences in the take-up of choice between the social groups either defined in terms of gender, educational status, household income, or ethnic group: all were 65% or more. The only difference the evaluation did find was between the employed and unemployed, with, unsurprisingly, more of the former (73%) willing to take up choice than the latter (63%).

Figure 24: Evaluation of the London Patient Choice Scheme, Picker Institute (July 2005). Characteristics of those who took up the option of treatment at an alternative hospital



Source: Evaluation of the London Patient Choice Scheme, Picker Institute (July 2005)

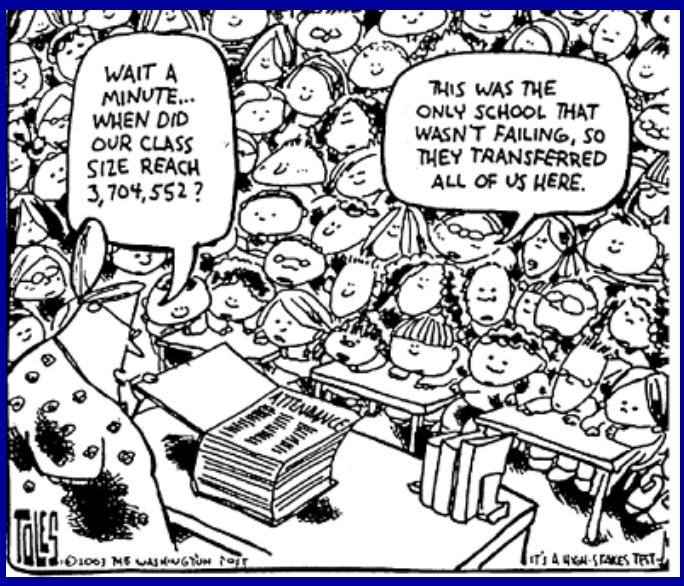
However, and this relates to the second point about the effectiveness of choices made by the less well off, there was considerable assistance given to the choosers in the pilots. They were given help with transport costs; and each was also allocated a Patient Care Adviser (PCA), a trained professional to help with the relevant decisions.

The PCAs were so successful that the idea has been taken over by the Government White Paper on education (if I may say immodestly, at my

suggestion). This proposes dedicated choice advisers to help the least well-off parents to exercise their choices. And – to take on board the transport point – the White Paper also proposes extending the rights to free school transport to children from poorer families to their three nearest secondary schools within a six mile radius (when they are outside walking distance).

What of the danger of cream-skimming? I think this is a real problem that advocates of choice have to address – especially in education.

Figure 25: Washington Post 2003



Source: The Washington Post (2003)

But it is not an insoluble problem. There are several ways of dealing with it.

One possibility is to introduce some kind of stop-loss insurance scheme whereby providers faced with a user whose costs lie well outside the normal range gets 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 hospitals or schools concerned have no incentive to economise on service provision once the threshold has been passed.

A second possibility is to take the admission decisions completely away from hospitals or from schools. In fact, this is already envisaged in the

NHS with the introduction of e-booking and choice at the point of referral. And the compromises that look like being agreed on the Education Bill are moving in this direction.

A third alternative is to risk-adjust the funding system such that higher cost users have higher 'prices' associated with them. A certain amount of this is going to happen under the national tariff system in health. If fully risk adjusted, this could eliminate the incentive to cream-skim completely. However, risk adjustment is a complex and difficult business; perfectly accurate risk adjustment is arguably an impossible one.

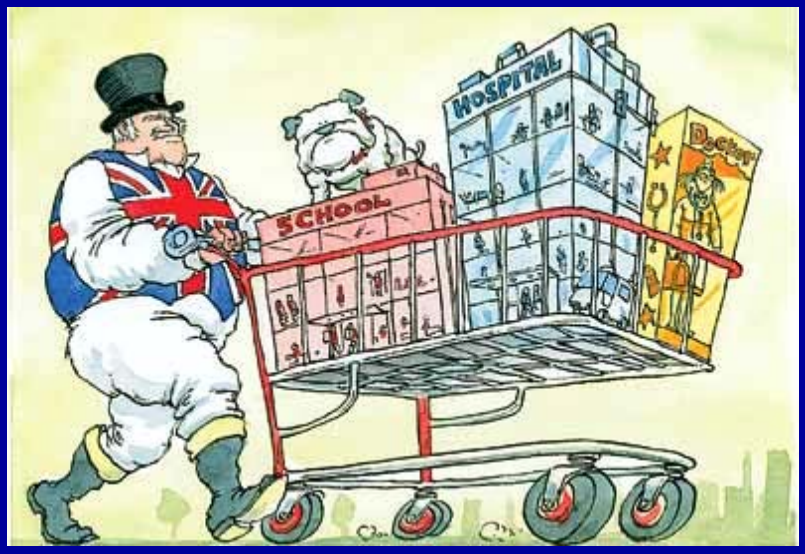
A form of adjustment that would be rather simpler and help assuage any socioeconomic inequities arising from cream-skimming would be to deprivation-adjust the money that follows the choice. In education, for instance, the amount each school receives could be associated inversely with an area deprivation index, such that pupils from poor areas would carry a higher weight (more cash) than those from wealthier ones. This would have the advantage that schools who took on children from poorer areas would not be penalised; indeed, if the weight were large enough, it would provide schools with a strong positive incentive to specialize in the education of these children.

One final point in this connection. One should not forget the incentives that will be on poor performers to improve: and this might well outweigh any consequences from cream-skimming. The Harvard economist Caroline Hoxby has reviewed the evidence on the impact on the performance of public schools in Milwaukee, Michigan, and Arizona of competition from 'choice' schools. 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 found evidence of strongly improved performance by the public schools, from which she concluded that the quality-inducing effects of competition were more than enough to offset any potential effects of cream-skimming.

Now the third line of attack

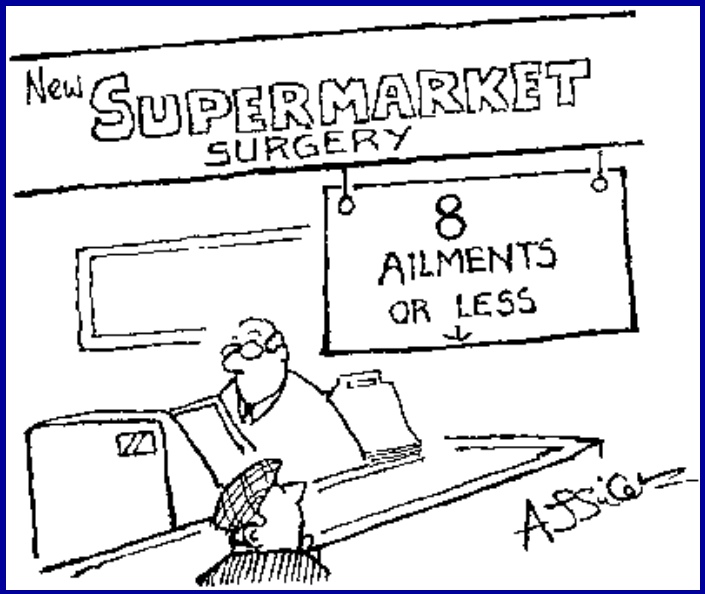
Choice and competition in public services – especially from the private sector – will undermine the values of the public sector. Choice threatens the public realm

Figure 26: The Economist (2005)



Source: Economist (2005)

Figure 27: The Spectator – 4th February 2006



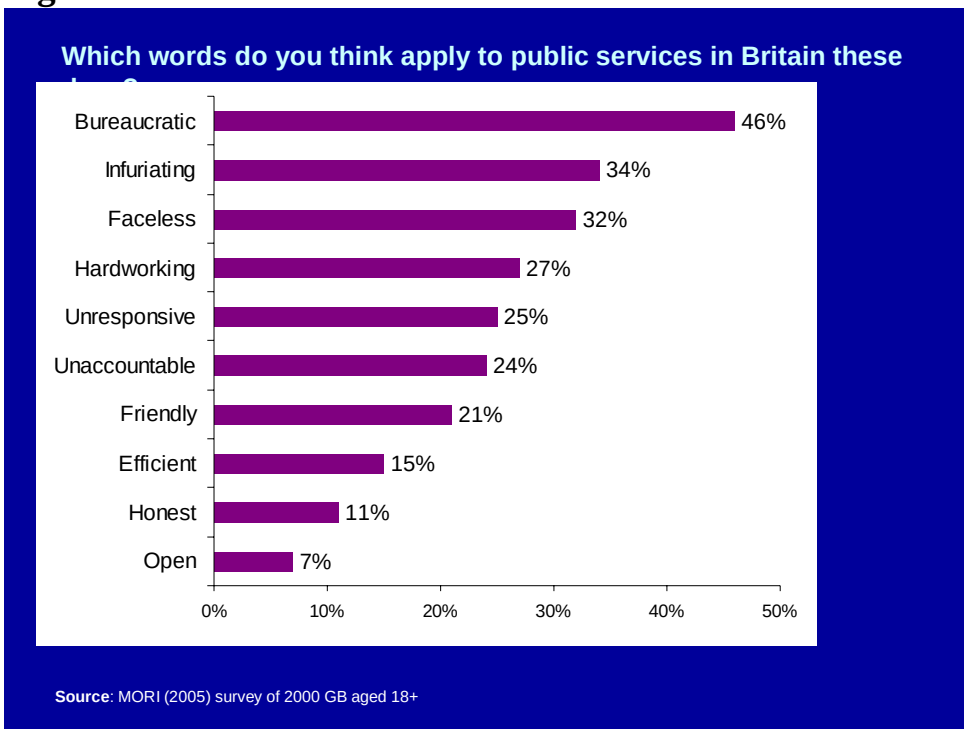
Source: The Spectator – 4th February 2006

The presumption underlying this argument seems to be something like this. Public service providers are not like supermarkets, especially when you consider those who work in them and their responsibility to users

(who are not consumers). In fact, those working in the public sector incorporate values of altruism and social justice - in contrast to those in the private sector, who are driven by a ruthless seeking for profit. In other words, to use a metaphor that some people might think I have already over-used, the public sector is run by knights, the private sector by knaves. The introduction of private sector competition will thus inevitably lead to the driving out of altruism or the public service ethos. The knaves will replace the knights. Hospitals and schools will become Tescos and Sainsburys.

I've written a whole book on this, and you will be relieved to hear that I don't propose to go on about it here. However, it is worth noting that this is the view that the public services are staffed by helpful, welcoming knights is not one necessarily held by the public. When asked by MORI what words they think applied to public services in Britain today, the highest ranked adjectives were (in descending order) bureaucratic, infuriating, faceless, hardworking(a positive note there), unresponsive and unaccountable. The lowest ranked were friendly, efficient, honest and open.

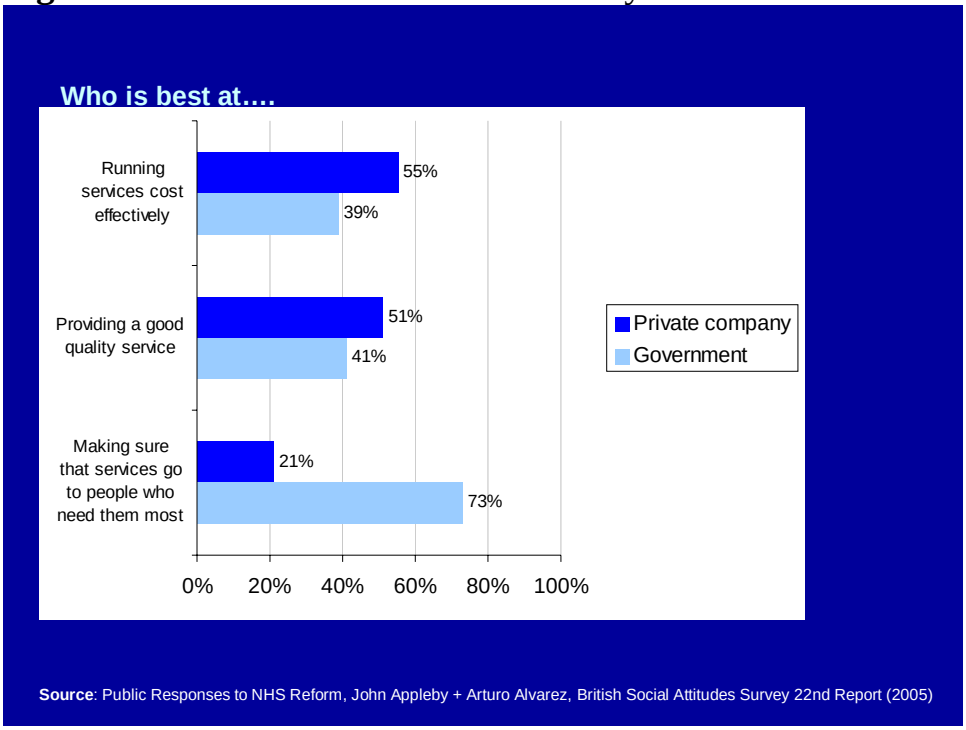
Figure 28: MORI 2005



Nor is the public afraid of the knaves in the private sector. When MORI told people in the Black Country that the NHS will now pay for patients to have their operations in private hospitals and asked them whether they

were happy about this, 71% said they were, compared with just 11% who said they were unhappy. When the British Social Attitudes Survey asked people whether government or business were best at providing a good quality service, 51% said a private company compared with 41% for government. And when asked whether private companies or government were best at running services cost effectively, 55% preferred private companies, compared with 39% government.

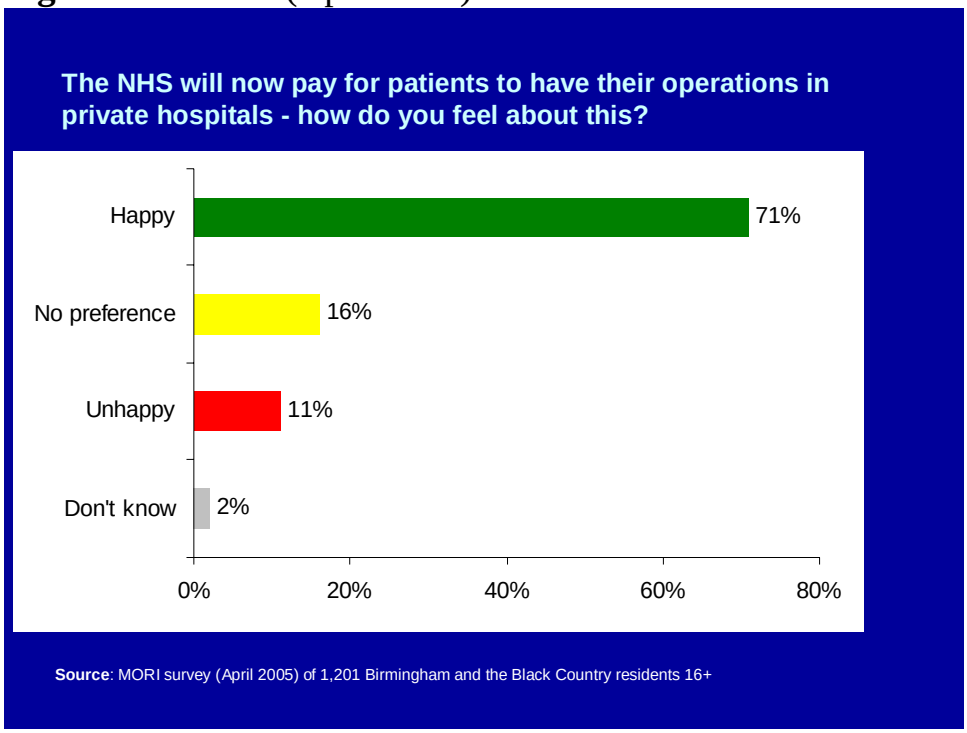
Figure 29: British Social Attitudes Survey



Source: Public Responses to NHS Reform, John Appleby + Arturo Alvarez, British Social Attitudes Survey 22nd Report (2005)

Understandably, the area where people did prefer government over private companies was on the ability to direct services where they were needed most. This is presumably because they saw private companies following normal private markets in favouring the better off. But as we have seen, the funding policies under the choice and competition reforms can be designed to encourage providers to meet the needs of the less well off, and even to specialise in doing so

Figure 30: MORI (April 2005)



That the private sector can be more cost-effective is being borne out by evidence. Provisionally, it appears that the new independent sector treatment centres are carrying out operations three or four times faster than the average for the NHS. One estimate suggests that cataract units are operating at a rate almost eight times faster.

The comparison is not direct, since the average for the NHS includes some more complex procedures than the ISTCs normally perform. But the difference is way too large for this to be a plausible explanation of the phenomenon.

And the success of the private sector is also apparent from patient experience. The new independent sector treatment centres have 97% satisfaction ratings from patients. Furthermore, a Kings Fund, Rand Europe and City University report found that those treated in specially designed treatment centres or private hospitals were more positive about their experience than those who had surgery in a normal NHS hospital. And quality is being maintained. An audit of independent diagnostic centres by the Royal College of Radiologists found no difference in quality from the NHS.

The overall point here is not that the NHS is intrinsically inefficient or that it could not match private sector productivity and other

areas of performance if it were appropriately organised. It is simply that it does not organise itself in that way; and, that at least until recently, it had no incentive to do so. Now, with the competition and choice reforms, the incentives are there – and I would fully anticipate we will see some dramatic improvements in NHS efficiency and productivity.

The truth is that the public sector has no monopoly on virtue, the private sector has no monopoly on vice. Public institutions are not only run by knights; private firms are not run only by knaves. The key is to understand the complexity of individual motivations and to design incentive systems accordingly. And, as I've argued in my book, the best way to do that is through competition and choice.

In conclusion…..

The Government is pumping a massive amount of resources into public services. It is essential that this investment pays off - and is seen to pay off. But, if public services were left unreformed, the investment would not succeed. And in that case taxpayers would legitimately ask why they were pouring resources into services that were not delivering. And the result could be irresistible pressure to cut taxes and ultimately to dismantle the welfare state.

So some kind of reform is essential. This could include stronger performance management, or a parallel strengthening of the institutions of voice. But, although I do believe that reforms of this kind have their place, I have given reasons why they also have severe limitations as the principal instruments of reform - especially if the key goals of quality, responsiveness and equity are to be attained. So there seems to me to be ultimately no alternative to the introduction of the Blair reforms of choice and competition. And, so long as they are properly designed, then the outcome will be a high quality, responsive, and equitable welfare state: a legacy that any Prime Minister could and should be proud of.