Hard Choices: Trade Offs Between Goals for Consumer Choice in the Public Services

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What is Choice For?

Whether more individual consumer choice is good for public services depends on what you want to use it to achieve, on how the financial infrastructure is designed and how adequately the system is funded. Both Labour and Conservative parties are promising to extend choice on school places and hospital inpatient stays, and this article therefore focuses on these areas.

In general, we might care about whether choice improves or undermines:

- Cost-efficiency.
- Long-term downward pressure on cost inflation in the school or hospital industry.
- Quality—measured, for example, by examination results or clinical outcomes or by some value-added measure.
- Experimentation, innovation or adoption of innovations.
- Responsiveness to different preferences about the content of services and interventions.
- Consumer satisfaction.
- Fairness between the most and least advantaged, or the sickest and the healthiest—in turn, this might be understood as decreasing the relative gap between the best and worst off, as preventing that relative gap worsening, or simply as providing resources according to current need.
- Retention of a critical mass of middle-class clients within the state-financed or directly-provided sector.

The problem is that a choice scheme designed for one of these measures can make it difficult to achieve some of the others.

Polarization?

Let's start with fairness. One risk with choice is polarization. Some people care about exam results or clinical outcomes more than they do about (say) school ethos or discipline, or hospital staff courtesy or the cost of travel to the site. It is possible that many people could opt out of using certain schools or hospitals, leaving them to the less informed, those who cannot afford to travel, those who care more about things other than exam results and clinical outcomes. The risk is that the first-choice schools and hospitals will become rich, congested and able to choose pupils and patients, while the less popular schools and hospitals will lose money, find it hard to keep skilled staff, have vacancies, and only those will go there who are not wanted by the privileged schools and hospitals, perhaps because they are too expensive or difficult to serve. The result might be two market segments, both with limited choice: in the privileged sector, providers choose; and in the underprivileged sector, there is nothing much worth choosing. In the worst case, the 'sink' schools and hospitals could undergo what is commonly called a 'downward spiral'.

How big a risk is this outcome? The answer from recent academic research seems to be that it depends on how you design the scheme and where you start from. School choice researchers disagree about how severe the effect has been under different systems, but many think it may have been greatest in New Zealand during the 1990s, where choice was least fettered and there were few incentives for schools to want to take the least advantaged: some think things have begun to improve there. In the US, focusing school vouchers and charter schools on the poorer communities has, in some states, been mildly pro-poor or at least broadly beneficial to African-Americans including those who are not poor. For some US voucher schemes have been targeted upon these groups and sufficiently generously funded to make pupils attractive to private schools who might not otherwise have been.

England has had school choice since 1988, and the argument about whether this has happened and if so, by how much, divides statistical researchers as much as it does politicians. Most agree, however, that the English state sector always included some very poor schools in poor areas, some very good ones in leafy, wealthy areas, and a mass of middling schools in middling places. The best assessment of the contradictory research findings that I can make is that if polarization has exacerbated, then the size of the effect is probably rather modest, that the problem may be worse in London and the south east generally and the inner city in particular than in the rest of the country, where fewer parents—but still a majority—get the first choice of school. While disappointingly high numbers of schools have been in special measures since the system was introduced in 1993, recent research suggests that it is very difficult to find very many of which it can really be said that this was the direct result of falling rolls due to school choice: probably, a majority those of which this might be a contributory factor would turn out to be in the poorest London boroughs.

Why, then, was the problem not worse in England than it might have been? The answer seems to boil down to the way in which money flowed, to regulation, to a combination of middle-class inertia and working-class learning, and perhaps, at least at the

margin, to a modicum of competition. The sums given to schools for each pupil are adjusted to reflect disadvantage, although there is room for debate about whether the gradient of the adjustment is steep enough to compensate adequately for the other incentives upon those schools that can do so, to recruit those who will likely do well in exams anyway. Local education authorities have hitherto had a range of instruments for limiting choice in their area. Many middle-class parents continue to use their local school, unless it is very bad: presumably, they trade off exam results against other things, such as travel cost and the cost of housing in areas with better schools. In addition, there may have been a modest 'starting gun' effect, by which less-advantaged parents learned over time, albeit more slowly than the ruthless middle-class, how to inform themselves, appeal and work the system. Finally, it is possible that in many urban and some suburban areas, there is enough competition between schools but not too much, so that they do not need to compete in ways that would lead them to skim the cream of the most promising pupils or get stuck with the least promising.

The Government's new proposals for schools are for some deregulation, allowing schools more autonomy to set admissions policies, and curbing the powers of local education authorities. If this is not to exacerbate polarization, then it will be necessary to provide other counter-incentives. Value-added based funding, a steeper voucher gradient for disadvantage and focusing support for new schools in the poor areas will be critical.

Skimming the Cream?

Will patient choice bring polarization between sink hospitals and a protected privileged sector? Government is now introducing or extending patient choice for elective surgery and other services, backed up by a payment system based on a national tariff for each clinical activity, adjusted for the case-mix and for regional differences in costs, based on a set of national reference costs. Hospitals have always shown a normal distribution by clinical outcomes and costs, much like schools: there have always been many more than two tiers. During the internal market experiment of the 1990s with GP fundholding providing a weak proxy for choice, it turned out that there was much less cream-skimming than had been expected. The combination of the stop-loss insurance scheme, the hospital payment system with its end-of-year negotiations between health authorities and hospital trusts allowing some protection, and the inertia of patient choices all seem to have limited the effect. Under the new 'payment by results' scheme, much will depend on whether the case-mix adjustment is set at a gradient steep enough to deter cream-skimming, whether the reference costs are adequate and can affordably be updated, and just how determined hospital managers and clinicians are to game the system and for what ends: they may maximize money or they may focus on an easy life or just specialize in a particular case-mix. What is lacking from the scheme is a heavy incentive for price competition: for it relies upon a very tight national price regulation set a level that will hurt some hospitals and cushion others. By defining the payments around inpatient stays for each category of activity by severity of illness ('healthcare related groups', in the jargon) subject to other regulatory incentives to reduce periods of stay, rather than finished clinical episodes, the Government hopes to reduce the incentives for hospitals to provide unnecessary care, undertake lots of diagnostic tests and find secondary and additional problems with patients in order to make more money from the system. Whether this works will depend on the details of the scheme, and whether there some scope for negotiation with primary care trusts as purchasers at the end of the year.

Still, there are big differences between school and hospital choice. In hospitals, choice was first introduced as a way to reduce waiting lists—that is, to improve responsiveness and efficiency—rather than to retain the middle class. In schools, however, retaining the middle class in the state sector was always key. In some ways, polarization matters more with schools because there is a zero-sum game in peer composition effects. Disadvantaged pupils do better from being schooled alongside better-off, more ambitious, more motivated pupils, whereas those better-off children do better from being with others like them, and their parents are very well aware of it. Moreover, school outcomes affect mobility chances, and middle-class parents work the system with the overriding motive of reducing the risk of downward mobility to their less bright offspring. In health care, peer effects are very small (except for hospital acquired disease), and because most hospital inpatients are older, their social mobility trajectories are often already complete.

Efficiency?

Will choice lead to greater efficiency? That is, will it mean that hospitals and schools generally improve their exam results and clinical outcomes to attract parents and patients? This will happen only if most consumers care more about these things than, for example, ease of access or ethos, and if well placed providers are not able to choose the consumers most likely to enable them to achieve these things without too much work and cost.

Moreover, choice works best for goals such as responsiveness and quality when bad providers can quickly exit the market without disadvantaging the last pupils and patients left using them, when new providers can enter the market to create additional capacity where it is

needed, and when the overall level of cash flowing into the system sustains this inflow and outflow. The Government has promised enough cash for schools and hospitals to enable this. However, the experience of school choice in the turn of the 1980s and early 1990s and of the internal market in its early days, when resources were much tighter, suggests that when times are hard, financing choice can be a challenge. Choice also has important transaction costs. Information is expensive: returns have to be made; league tables have to be assembled and published; 'patient choice advisors' have to be hired and deployed; schools and hospitals have to spend money marketing their services to the niche they can and want to attract; and appeals systems have to be supported.

All Good Things Do Not Go Together

The ways in which we might design money and regulation to limit the risks of cream-skimming and polarization also work to limit the effect of choice in promoting competition for efficiency, because they blunt the price signals. That there is an equity–efficiency trade off, at least in the short run, is hardly news, but remains important.

Choice in public services has many merits, of which popularity and the possibility of competing up standards are by no means the least. But neither of these outcomes are guaranteed, and there are other pressures on standards from grade inflation and gaming of clinical outcome reporting, through to regulatory pressure standards. There are risks of inequity and there are transaction costs in choice schemes: responsiveness may be improved but at the price of lower levels of achievement of other goals. Retaining the middle class may require some unfairness: controlling cream-skimming may mean accepting lower productivity; and so on. To be sure, there have always been inequities, and lack of choice has its transaction costs too, such as complaints and dealing with low satisfaction. Everything depends on the design of the scheme for the money and the regulation, the starting point, the motivations of the providers, and the degree of political commitment to sustain expenditure to support choice. ■